CONSUMER AGGREGATION AND SOPHISTICATED PURCHASING:

ELECTRIC RESTRUCTURING LESSONS FROM THE HEALTH CARE INDUSTRY

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ABSTRACT

In the business of consumer aggregation for the purchase of health care --or electric service-- "bigness" isn't everything. The purpose of health care aggregation is not only to attain and exercise market power through size, but to become big enough to socialize the cost of sophisticated searches for information on price, quality, and service offerings. Size contributes, also, to lowering per customer costs by spreading fixed administrative and marketing expenses, as well as by spreading the risks of service amongst a bigger group of customers. If size isn't everything, however, public policy is needed to promote the acquisition and exercise of "sophisticated purchasing." Even "big" groups have been ineffective in controlling health care costs when they lacked the resources and expertise to engage in meaningful negotiations with prospective service providers. In the health care field, purchasing cooperatives performing negotiations for small users did not arise as a market phenomenon. Specific public policy was needed to promote and support them. In recent years, state government initiatives supporting small user health insurance aggregation by providing legal, technical and administrative structures for public purchasing cooperatives have become popular. Similar initiatives should be pursued in a restructured electric industry.

INTRODUCTION

Millions of people go without service each year. As the industry heads into a new era of competition, consumers fear that millions more will see increased prices, decreased quality, and reduced availability. Large consumers negotiate substantial discounts, with the shortfall in revenue picked up by remaining consumers. Low-income consumers are shunned by service providers, not only because of their inability-to-pay, but because of the various special and expensive services that they frequently require. Small users are considered both risky and unprofitable. Increasing competition has resulted in a wave of mergers and acquisitions. Neighborhood and community offices are being consolidated and closed in the name of cost-cutting and efficiency.

Predictions about electric industry restructuring?

No. Welcome to the health care industry of the 1990s.

The consumer responses to these health care issues, however, *do* offer many lessons for consumers soon to face identical (or closely related) issues in the electric industry. At their core, universal service issues arising in the competitive electric and health care industries are very similar. The question posed below is whether the responses can (or should) be similar as well.

A growing movement exists today to move the electric utility industry toward competition.

Through July 1998, 13 states have enacted legislation;[1] nine additional states have seen comprehensive orders from their regulatory commissions[2] that either require or enable direct competition for retail customers. Through such competition, electric service providers other than those which have traditionally provided electricity will be allowed to solicit business from, and sell electricity to, all end users.

Therein lies the rub, however. Being "allowed" to compete for customers and choosing *actually* to engage in such competition are two very different things. Concerns exist that many customers will be left out of the competitive market, not because of consumer disinterest in exercising choice, but because of industry disinterest in providing service.[3] Small users, in particular, are subject to this disinterest.[4] Additional concerns exist that low-income, payment-troubled, rural, and other high cost consumers will be shunned by competitors. These consumers will not simply go unsolicited, but will be subject to active avoidance. As the New Jersey Board of Public Utilities observed:

> . . .there may well be a tendency for certain suppliers to focus their marketing efforts on the most lucrative customers, which may well include industrial and large commercial customers, and perhaps a subset of larger, more affluent residential customers. As a result, while all market segments are simultaneously and proportionately provided the opportunity to shop, there is a concern that in actuality certain customer groups will have few options available. Such an outcome is inconsistent with our intent that all customers benefit simultaneously.[5]

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[1] California (9/96), Connecticut (4/98), Illinois (11/97), Maine (5/97), Massachusetts (11/97), Montana (5/97), New Hampshire (5/96), Oklahoma (4/97), Pennsylvania (12/96), Rhode Island (8/96), Virginia (4/98), and West Virginia (4/98). Pam Silberstein (June 1998). ***NRECA Retail Wheeling Report***, National Rural Electric Cooperative Association: Washington D.C.

[2] Arizona, Delaware, Georgia, Louisiana, Maryland, Michigan, New Jersey, New York, Vermont. *Id.*

[3] Kathryn Kranhold, "ENRON Scales Back California Power Sales," ***Wall Street Journal***, A2 (April 22, 1998) ("three weeks after California officially opened its electricity market to competition, Enron Corp., the biggest and most aggressive outsider looking to sell power in the state, has given up trying to win residential customers. . .Enron also has decided, for the time being, against pursuing residential customers in Massachusetts and Rhode Island, the two other states where competition is also being phased in, and has pulled out of some pilot programs elsewhere. . .").

[4] Roger Colton (1996). ***Assessing Impacts on Small-Business, Residential and Low-Income Customers: The Electric Industry Restructuring Series***, National Council on Competition and the Electric Industry, National Association of Regulatory Utility Commissioners: Washington D.C.

[5] New Jersey Board of Public Utilities, ***Restructuring the Electric Power Industry in New Jersey***, at 71 (1997).

One alternative repeatedly offered as a mechanism to help prevent these impacts involves helping low-income (and other at-risk) customers participate in a competitive market through aggregated groups. Facilitating the aggregation of these consumers, the reasoning goes, will help make the market more competitive for these customer classes.

Aggregation, of course, is not a concept invented by or for the purchase of electricity. And the creation of electric aggregation mechanisms need not (and should not) proceed without a review of what has been done elsewhere, why, and with what results. The purpose of the discussion below is to examine existing efforts to aggregate consumers in the health care market, in particular, to determine what, if any, lessons might be gleaned for electric aggregation. The discussion will not simply consider the purposes and mechanisms of aggregation, but rather will seek to determine whether problems that have arisen in the health care field can be expected to occur, as well, in the electric industry. If so, possible remedies will be discussed.

HEALTH CARE AND THE HARD-TO-SERVE CONSUMER

The similarities between consumers of health care and consumers of electric service are striking. The problems facing consumers are not surprising. As with utility consumers, health care consumers "typically confront providers as individuals--a situation that usually pits unorganized diverse interests (consumers) against concentrated interests (*i.e.*, third party payers, MCOs [managed care organizations], and medical providers)."[6] The disparity in power between the consumer and the industry is considerable. In the health care market, "consumers are unorganized and lack the means to assert collectively their voice or purchasing power."[7] Out of these problems grew proposals for consumer aggregation.

> The lack of funded, institutionalized advocacy groups for consumers within MCOs places consumers at a competitive disadvantage compared with organized providers. One way to address this problem is to create institutions that help consumers organize or pool resources, expertise, purchasing power, information, or professional assistance.[8]

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[6] Marc Rodwin, "Consumer Protection and Managed Care: Issues, Reform Proposals, and Trade-Offs," 32 ***Houston L.Rev.*** 1319, 1352 (1996) (*hereafter,* ***Consumer Protection and Managed Care***).

[7] *Id.*, at 1353, *citing*, Jessie Coles (1978). ***The Consumer-Buyer and the Market***, 33 - 34 (stating that the lack of organization of consumers makes it difficult for them to exert power on producers).

[8] *Id.*, at 1353.

Small consumers in the health care market currently face the same type of exclusion that residential customers fear *will* happen in a competitive electric industry. An estimated 38 million Americans--over three-quarters of whom work or are dependents of workers--lack health insurance today.[\9\] It is the small user that faces exclusion. A distinct fall-off in the offer of employer-sponsored health insurance occurs for small business. While 98 percent of firms with 100 or more employees offer health insurance benefits, 87 percent of firms with 25 - 99 employees do, and 75 percent of firms with 10 - 24 employees do. Only 27 percent of firms with fewer than 10 employees offer health insurance.[\10\] As with ENRON's decision to not solicit small user electric business in California, Rhode Island and Massachusetts,[\11\] health insurers simply do not choose to serve the small user markets.[\12\] The health insurance market presents to small employers virtually the identical problems presented to small users in the electric industry.[\13\]

Health insurance cooperatives are increasingly seen as an appropriate state response to this lack of insurance coverage.[\14\] These cooperatives "build[] on the concept of pooled buying power."[\15\]

> Small groups and individuals are particularly vulnerable in today's market. Some cannot obtain insurance at any price because of their actual or perceived health status. And even those able to secure coverage may face very high premiums because their health costs are unpredictable and the costs attributable to one sick individual must be borne entirely by each small group. The creation

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\9\ General Accounting Office, ***Access to Health Insurance: Public and Private Employers' Experience with Purchasing Cooperatives***, at 1 (May 1994) (*hereinafter*, ***Public and Private Experience***).

\10\ Mark Hall, "The Role of Insurance Purchasing Cooperatives in Health Care Reform," 3-WTR ***Kansas J. L. & Pub. Pol'y*** 95, 97 (1994) (*hereafter*, ***Role of Insurance Purchasing Cooperatives***).

\11\ *See*, notes **Error! Bookmark not defined.** - **Error! Bookmark not defined.**, *supra*, and accompanying text.

\12\ U.S. General Accounting Office, ***Access to Health Insurance: State Efforts to Assist Small Business*** (May 1992) (*hereafter*, ***State Efforts to Assist Small Business***).

\13\ *Compare*, ***Small User Impacts***, *supra* note **Error! Bookmark not defined.**, *with* Catherine McLaughlin, *The Dilemma of Affordability--Health Insurance for Small Businesses* in ***American Health Policy: Critical Issues for Reform*** 152, 162 -164 (Robert Helms ed. 1993); *see also*, W. David Helms, et al., "Mending the Flaws in the Small Group Market," 11 ***Health Aff.*** 2:7, 12 - 22 (Summer 1992).

\14\ Mark Hall, ***Reforming Private Health Insurance***, 47 - 53, 88 - 93 (1994) (health purchasing cooperatives at core of health care reform efforts).

\15\ ***Public and Private Experience***, *supra* note **Error! Bookmark not defined.**, at 3.

> of larger risk pools gives small employers greater bargaining clout with health insurers, plans, and providers, approximating that traditionally enjoyed by large businesses. Furthermore, pooling reduces the administrative costs of buying, selling, and managing insurance policies--costs that are particularly high with respect to small firms and individuals. \16\

Aggregation, in other words, is seen as the answer.

THE RISE OF THE HEALTH CARE CO-OP MODEL\17\

In response to the problems faced by small users of health care services, health care consumers have increasingly turned to health insurance purchasing cooperatives (HIPCs) (also sometimes called health alliances: HAs) as a mechanism through which to assert their collective interest.\18\ The Institute of Medicine defines a "purchasing cooperative" as:

> A term broadly used in discussion of health care reform to describe an entity that would buy health coverage on behalf of some group (*e.g.*, small employers or all residents of a geographic area) and that would generally operate to pool risk, reduce marketing and other administrative costs, provide coverage that was portable from one job to another, and otherwise attempt to overcome problems that particularly affect individual or small-group purchasers of insurance.\19\

Looked at another way, a health care purchasing cooperative is simply one type of "sponsor."\20\

> Sponsors are those who purchase health benefits on behalf of a group and assume the role of actively managing competition among the health plans for

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\16\ *Id.*, at 4.

\17\ Health care aggregation mechanisms are called many different things: health purchasing cooperatives, health purchasing alliances, health alliances, and the like. They will be referred to collectively as health purchasing cooperatives in this article.

\18\ "The ABCs of HIPCs," 3 ***J.of Am. Health Policy*** 2:29 (Mar/Apr. 1993).

\19\ Institute of Medicine, ***Employment and Health Benefits: A Connection at Risk***, 342 (Marilyn Field and Hard Shapiro, eds. 1993).

\20\ Catherine Dunlay and Peter Pavarini, "Managed Competition Theory as a Basis for Health Care Reform," 27 ***Akron L.Rev.*** 145 (Fall 1993).

> that group. Examples of sponsors in the current market include employers and government agencies. The purchasing cooperative is the mechanism by which those purchasers without sufficient size or market power to act effectively as sponsors are represented by an entity with the necessary size and power.[21]

The design of a purchasing cooperative can take many forms, ranging from a purely private non-profit group to a governmental or quasi-governmental entity.[22] In addition, cooperative purchasing often piggybacks small groups and individual organizations on the state employee system.[23] This piggybacking serves the dual purposes of gaining size and sophistication both.

Historical Antecedents

Health care purchasing cooperatives find their antecedent in institutions known as multiple employer trusts (METs) and multiple employer welfare associations (MEWAs). METs and MEWAs represent associations of employers, usually in the same industry, that band together to arrange for benefits to be provided to workers of two or more firms. METs and MEWAs have been marketed in recent years as mechanisms to allow small employers to gain access to health insurance.[24]

These plans have a special appeal to employers with ten or fewer employees who have had difficulty in obtaining health insurance at reasonable costs. They became popular because they are more affordable than traditional insurance or self-funding, offering coverage at rates which are often 25 to 40 percent below those charged for traditional group coverage by creating a larger risk pool.[25]

In effect, through METS and MEWAs, small and high-risk employers were allowed to set up cooperative arrangements through which their employee benefit plans would be administered.

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[21] *Id.*, at 145.

[22] Debra Lipson and Jeanne De Sa, "Impact of Purchasing Strategies on Local Health Care Systems," 15 ***Health Affairs*** 2:62, 72 - 75 (1996).

[23] ***Role of Insurance Purchasing Cooperatives***, *supra* note **Error! Bookmark not defined.**, 3-WTR ***Kansas J. of Law and Pub. Pol'y*** at 98 - 99.

[24] Edward Scallet, "The Regulation of Multiple Employer Trusts: Past, Present and Future," 61 ***Wash. Univ. L.Qrt.*** 359, 360 (1983).

[25] Alson Martin and Gregory Kuhn, "MEWAs: An Exception to ERISA Preemption: Why, What and When," C724 ***ALI-ABA*** 363, 365 (1992).

All of the assets of the individual employers' benefit plans were to be deposited into a common fund and administered by trustees.[26]

In recent years, however, public policy has recognized that these private institutions are insufficient. In their place, state governments have taken an increasingly active role in promoting the development of public health care purchasing cooperatives.

> Public cooperatives were originally established by state governments to purchase insurance for state employees and were subsequently expanded to allow voluntary participation by county and municipal workers or other public entities. As with small firms, obtaining reasonably priced coverage for small school districts or fire departments has frequently been difficult. . .Recently, several states have again expanded public programs by creating voluntary cooperatives targeted at small businesses.[27]

Indeed, in just the three years 1992 through 1994, 20 state governments enacted statutes authorizing the establishment of health care purchasing cooperatives. More were expected to follow. According to one industry observer, "As long as participation in the cooperatives is voluntary,[28] state policymakers appear to believe that purchasing cooperatives can help to make health insurance more available and affordable to small business owners, self-employed persons and others."[29]

PURPOSE OF THE PURCHASING COOPERATIVE

While the purpose of "aggregation" in the electric industry is generally spoken of in terms of acquiring market power by grouping enough "small" users together to become a "big" user, aggregation in the health care industry is seen to serve multiple purposes. These purposes need not underlie all efforts to aggregate. Indeed, they need not necessarily even be

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[26] Comment, "Regulation of Uninsured Multiple-Employer Trusts Under ERISA: An Open Question Again?", 1979 ***BYU L.Rev.*** 913 (1979); Brummond, "The Legal Status of Uninsured Noncollectively-Bargained Multiple Employer Welfare Trusts Under ERISA and State Insurance Laws," 28 ***Syracuse L.Rev.*** 701 (1977).

[27] ***Public and Private Experience***, *supra*, at 4, *citing* Kevin Haugh, Elliott Wicks and Richard Curtis (1993). ***Health Policy Reform and Health Purchasing Alliances: A Guide for State Policymakers*** : Institute for Health Policy Solutions: Washington D.C.

[28] *But see*, notes **Error! Bookmark not defined.** - **Error! Bookmark not defined.**, *infra*, and accompanying text.

[29] Debra Lipson and Jeanne De Sa (1995). ***The Health Insurance Plan of California: First Year Results of a Purchasing Cooperative***, 1, Alpha Center: Washington D.C.

consistent with each other as a result. It is critical to articulate the purpose[s] of an aggregation effort. The purpose[s] not only may drive different policy responses to the aggregation effort, but they will certainly require different layers and levels of expertise on the part of the aggregator, as well as different types and amounts of resources.

In the health care industry, separately recognized purposes of aggregation include (but are not limited) to: (1) acquiring and exercising market power; (2) socializing the cost of acquiring expertise; (3) spreading risks as well as spreading the costs of fixed administrative expenses; and (4) providing equal access to disparate groups of customers. Each of these purposes will be examined in more detail below.

Socializing the Costs of Expertise

The primary purpose of aggregation in the health care markets is not to acquire and exercise market power, but rather to socialize the cost of acquiring and exercising shopping expertise.[30] Health service products are "notoriously difficult to evaluate, price and police for quality."[31] The purpose of a health care cooperative, therefore, is not simply to become bigger. Instead, health care co-ops seek to increase the sophistication of employee bargaining by pooling information and analyzing joint outcomes data and subscriber satisfaction measures.[32] This approach to health care aggregation is sometimes referred to as the "good broker" model.

Unquestionably, size is important under the "good broker" model. The good broker approach, for example, requires that the cooperative reach a certain size to justify the investment in gaining expertise.[33] The effectiveness of bargaining under this approach imposes upon the co-op a duty to learn about the prices, terms and quality of the various alternative health plans from which to choose. The theory of the "good broker" model is that consumer choice which is informed under such a comprehensive information-gathering approach would serve to

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[30] "A firm's small size impairs its ability to obtain low premium costs due to economies of scale. That is, premiums reflect high insurance marketing and administrative costs, and small employers lack the time and skilled personnel to negotiate suitable, affordable coverage." U.S. General Accounting Office, ***Access to Health Insurance: States Attempt to Correct Problems in Small Business Health Insurance Market*** (May 1992).

[31] Frances Miller, "Health Insurance Purchasing Alliances: Monopsony Threat or Procompetitive RX for Health Sector Ills?," 79 ***Cornell L.Rev.*** 1546, 1552 - 1553 (1994) (*hereafter*, ***Health Insurance Purchasing Alliances***).

[32] *Id.*, at 1552 - 1553.

[33] Henry Greely, "Policy Issues in Health Alliances: Of Efficiency, Monopsony, and Equity," 5 ***Health Matrix: Journal of Law-Medicine*** 37, 72 - 73 (1995) (*hereafter*, ***Policy Issues in Health Alliances***).

control health care prices.

Processing price information

The primary function of a health care purchasing cooperative under the good broker model is to obtain and process price information. Without aggregation, proponents of the model assert, consumers would lack the resources (or the financial incentive) needed to gather the information to make good choices and thus make the market work. The amount of resources devoted to the task of searching is limited by the amount of resources available. As with telecommunications and electric service, as well as other goods and services, small employers simply do not have the size or money to justify hiring benefits managers to perform the task of investigating health insurance alternatives for them.\34\ In addition, small employers are faced with competing demands on their limited time. "Studies and demonstrations reveal that insurers have to exert much greater effort to attract small employers' attention since they are often too busy running the business to attend to the complexities of selecting health insurance."\35\

Aggregation is seen as a way to generate the advantages of increased sophistication in purchasing. Health care purchasing cooperatives are a mechanism to provide small employers or other small groups --it is discussed elsewhere, for example, how small local governments and school districts have trouble purchasing affordable health insurance-- the same expertise and create the same economies of scale available to larger employers.\36\ Health purchasing cooperatives could, therefore, help consumers be well-informed about price, access, and quality.\37\

The ability and willingness to obtain information and to use this information as a basis to negotiate is seen not only as important, but as critical to the success of a cooperative in serving its customers.\38\ Starting in 1983, for example, Wisconsin's health purchasing

\34\ In addition, on pure cost-benefit grounds, the sophistication of the search is governed by the principle that a consumer will continue to incur search costs until the amount of potential gain equals or exceeds the incremental cost of the search. *See generally*, Roger Colton, "Consumer Information and Workable Competition in the Telecommunications Industry." XXVII ***Journal of Economic Issues*** 775 (1993). By aggregating the potential gain of many consumers, the resources that can be justifiably devoted to the process of seeking and processing information can thus be expanded as well.

\35\ ***Policy Issues in Health Alliances***, *supra* note **Error! Bookmark not defined.**, 5 ***Health Matrix*** at 99.

\36\ *Id.*, at 99.

\37\ *Id.*

\38\ ". . .existing cooperatives believe that their authority to negotiate with health plans is their most effective cost control tool." ***Public and Private Experience***, *supra* note **Error! Bookmark not defined.**, at 36.

cooperative, began to accept sealed bids from health plans without any discussion of premium increases. Even though this process generated small premium increases in the early years, the co-op later began to experience repeated years of substantial price increases. In response, in 1993, the Wisconsin co-op stopped simply accepting sealed bids and instead began to negotiate with providers. The co-op required health carriers to submit cost data to it, and, with the help of its own actuarial consultants to evaluate that data, the co-op developed its own "target premiums" for each plan. Those plans that submitted bids the co-op found to be out-of-line with the cost data were asked to justify the difference. "Wisconsin officials [said] that best-and-final offers from nine of the ten plans contacted for discussion had substantially lower premiums."[\39\]

CalPERS does virtually the same thing. During its negotiations with health plans, CalPERS develops its own analysis of the justification for proposed rate requests based on health plan service, cost and utilization data submitted to it by the carriers. In addition, CalPERS develops its own recommendations for potential cost savings for the carriers.[\40\] Using standardized benefit structures, begun in 1992, to reduce the differences that health plans can cite during negotiations as justifications for rate increases, CalPERS relies on its own staff and consultant analysis to determine the reasonableness of prices submitted by carriers.[\41\]

Minnesota's health care purchasing cooperative, too, hires actuaries to develop target premiums for each health plan based on cost and utilization data submitted by competing plans. "If a plan bid is significantly higher than the target premium developed for that plan, cooperative officials discuss the discrepancy with plan representatives. Plans are then asked to submit a best and final offer."[\42\]

This process of independently analyzing cost, quality and utilization data is not the exception. In fact, the U.S. General Accounting Office (GAO) has found that *most* cooperatives utilize plan operating data during negotiations.

Quality control information

In addition to analyzing cost data, an increasing number of cooperatives are insisting on measures of quality of service. Starting in 1994, CalPERS required plans to submit data on a

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\39\ *Id.*, at 8.

\40\ ***Public and Private Experience***, *supra* note **Error! Bookmark not defined.**, at 19.

\41\ *Id.*, at 47.

\42\ *Id.*

list of indicators[43] during the rate renewal process. After the information is analyzed, health plans are ranked according to their ability to meet target guidelines for delivering these services. The comparative information is then published and distributed to CalPERS members prior to the open enrollment period.[44] Similarly, Florida's health care purchasing cooperatives issue "report cards" on health care quality. Health plans are required to submit quality data to the state Agency for Health Care Administrative (AHCA), which analyzes and packages comparative information for publication and distribution by each cooperative.[45]

Quality control can be both before-the-fact and after-the-fact. Several cooperatives constantly monitor the services being delivered to the ultimate consumer and seek redress when that service is less than that bargained for. Health care purchasing cooperatives:

> monitor enrollments and disenrollments to ensure that plans are not targeting only healthy people. For example, [California's] HIPC reviews all extraordinary transfer requests to make sure than a plan has not been deliberately providing poor service to sicker enrollees. Even COSE, which allows Blue Cross to screen for and deny coverage to groups with individuals at risk for certain health conditions, receives weekly reports on denials. A COSE official told [GAO] that a sharp jump in the denial rate was traced to a unilateral Blue Cross decision to include pregnancy as a basis for rejecting new applicants. COSE informed Blue Cross that pregnancy was not a valid condition for rejection under the terms of their contract.[46]

Socializing Risks and Spreading Costs

One primary purpose of health care cooperatives is not so much to exercise market power as to gain the efficiencies generated by larger groups. Many health purchasing cooperatives are designed to address the cost issues of high fixed costs and high risk premiums without intending to gain and wield "market power." The purpose of the cooperative in this regard is to achieve economies of scale. "For those interested solely in efficiency, health alliances are essentially purchasing cooperatives that allow small buyers to benefit from the economies of

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[43] Childhood immunizations, mammography screening, cervical cancer screening, prenatal-care--first trimester, cholesterol screening, low birth weight, asthma inpatient admission rate, diabetic retinal exam, and ambulatory follow-up after hospitalization for major affective disorder (mental health). ***Public and Private Experience***, *supra* note **Error! Bookmark not defined.**, at 10, n. 11.

[44] *Id.*, at 10.

[45] *Id.*

[46] *Id.*, at 42.

scale in bargaining and in implementation that are available to large purchasers of health coverage."[47]

Spreading fixed costs

Controlling costs is one fundamental purpose of health care purchasing cooperatives. The primary problem with cost, however, is not an excessive rate of return on the part of the service provider. Health insurance costs to individuals and small group purchasers reflect much higher overhead costs as compared to larger employers. Overhead costs are that portion of the premium that is not paid out in direct claims.[48] These costs as a percentage of incurred claims can range from 25 to 40 percent for firms with fewer than 50 employees. Those costs decrease to 5.5 percent for businesses with 10,000 or more employees.[49]

In addition to high administrative costs, higher costs to small groups of consumers can be attributed to increased marketing costs as well. Because one-time marketing costs are spread over fewer persons, the per enrollee cost of marketing is quite high for smaller consumers.[50] Indeed, for many, the core idea of purchasing cooperatives for small groups of individuals is to streamline marketing.[51]

Particular public policy decisions, can interfere the efficacy of a cooperative in this regard. Public health care purchasing cooperatives can be either "voluntary" or "mandatory" in nature. This attribute, alone, can have a significant impact on the costs of operating a co-op. On a broad level, larger co-ops have smaller operating budgets as a percentage of total revenue. The U.S. General Accounting Office has found that because larger cooperatives were able to spread their fixed costs over more members, those larger co-ops spend a much smaller share of premiums on operating costs.[52] To the extent that mandatory participation increases co-op size, per-enrollee costs decrease.

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[47] ***Policy Issues in Health Alliances***, *supra* note **Error! Bookmark not defined.**, 5 ***Health Matrix*** at 37.

[48] ***Role of Insurance Purchasing Cooperatives***, *supra* note **Error! Bookmark not defined.**, 3-WTR ***Kansas J. of Law and Pub. Pol'y*** at 99.

[49] ***Public and Private Experience***, *supra* note **Error! Bookmark not defined.**, at 4, n.2, *citing*, Congressional Research Service (1988). ***Costs and Effects of Extending Health Insurance Coverage***, 46, Washington D.C.; *see also*, U.S. General Accounting Office, ***Health Care Reform: Proposals Have Potential to Reduce Administrative Costs*** (May 1994).

[50] ***Role of Insurance Purchasing Cooperatives***, *supra* note **Error! Bookmark not defined.**, 3-WTR ***Kansas J. of Law and Pub. Pol'y*** at 98.

[51] *Id.*, at 98.

[52] ***Public and Private Experience***, *supra* note **Error! Bookmark not defined.**, at 11.

One additional way in which the "voluntary" vs. "mandatory" nature of a cooperative manifests itself is in deciding whether a person must "opt in" to the cooperative, or "opt out."

> Because they must advertise to increase enrollment, voluntary cooperatives incur marketing costs that mandatory purchasing pools are able to avoid. Florida estimates that marketing will be a significant portion of each cooperative's operating budget as well as the primary task assigned to the staff. HIPC officials told us that one-third of their operating costs of 3 percent of premiums are marketing related. [The Minnesota health care cooperative's] experience with marketing costs is similar.[53]

It makes little sense to promote the aggregation of consumers to gain efficiencies of scale on the one hand and then to deny the aggregator the ability to generate those efficiencies on the other hand by establishing an opt-in rather than an opt-out enrollment procedure.

Socializing risks

One purpose of most health care cooperatives is to spread the risks from high cost or hard-to-serve groups of customers over a broader customer base. Spreading the costs of any particular loss results in higher premiums to small users for two reasons. First, the cost must simply be spread over fewer persons, thus driving the per person cost up. Second, as the size of a group decreases, the ability to accurately predict the amount of total loss becomes less. As a result, small risk pools require a larger risk premium per equivalent expected loss than do larger groups.[54]

Health care cooperatives have addressed each of these problems in several fashions. First, a purchasing cooperative can try to dilute the high costs of some consumers by including them in much larger pools. This can occur through public or private mechanisms. Some states use their existing public employee insurance system as a small group purchasing cooperative. "Adding small groups to a large stable pool of healthy government employees will help dampen the effects of adverse selection."[55] The same thing can be done privately. The private Tulsa Health Option (Oklahoma), with over 4,000 enrolled small firms, obtains premium reductions of 20 to 30 percent by aggregating large and small firms into one pool to

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[53] *Id.*

[54] ***Role of Insurance Purchasing Cooperatives***, *supra* note **Error! Bookmark not defined.**, 3-WTR ***Kansas J. of Law and Pub. Pol'y*** at 99.

[55] *Id.*, at 100.

help the small firms spread their risks.\56\

A second approach is to simply mandate, by contract, that all consumers be treated equally. One explicit requirement by health care purchasing cooperatives operating in California, Minnesota, Wisconsin, Washington state is that health plans are not allowed to screen applicants.\57\ In some instances, however, separate pools are created for state employees, local employees and private employees.

A third way in which health care cooperatives have socialized the risk of certain populations is by incorporating them into larger groups and then requiring the use of "community rating." Indeed, health purchasing cooperatives have *generally* required "community ratings." "Community rating would mean not only that older and younger, male and female, and healthy and sickly people would pay the same for health coverage, but also that the residents of all parts of [a health cooperative] would pay the same amounts. . ."\58\

A fourth approach to socializing risk is to mandate inclusion as well as to prohibit exclusion. Health care cooperatives using this approach have specifically required carriers to serve less profitable market segments within a state as a precondition to serving other more attractive markets.

> [California's] HIPC requires health plans who contract with the cooperative to offer coverage in rural areas such as Monterey Peninsula as a precondition for access to the more profitable San Francisco and Los Angeles markets. Finally, Minnesota also requires participating carriers to offer coverage anywhere in the state in which they have a provider network. This policy is intended to (1) insure coverage to rural areas, and (2) discourage plans from only targeting more lucrative markets.\59\

Finally, a fifth way to socialize risk is by operations oversight. Some health care purchasing cooperatives routinely review marketing materials to ensure that consumers are not left out.

> For example, the Wisconsin cooperative approves all direct mailings by plans and actually controls the mailing lists for its members. A purchasing

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\56\ ***State Efforts to Assist Small Business***, *supra* note **Error! Bookmark not defined.**, at 54 - 55.

\57\ ***Public and Private Experience***, *supra* note **Error! Bookmark not defined.**, at 21, 22, 24.

\58\ ***Policy Issues in Health Alliances***, *supra* note **Error! Bookmark not defined.**, 5 ***Health Matrix*** at 60.

\59\ ***Public and Private Experience***, *supra* note **Error! Bookmark not defined.**, at 41.

> cooperative official told [GAO] that, by reviewing all marketing materials, it has been able to prevent health plans from trying to exclude certain groups who could be more expensive to insure. For example, plans might advertise coverage for all pharmaceuticals except insulin, in an attempt to dissuade diabetics from enrolling.\60\

"Another example of such a strategy would be a southern California health plan advertising only in English, to avoid enrolling poorer, foreign-speaking minorities. HIPC in California also approves the marketing used in all participating plan brochures, which has resulted in revisions or clarifications to plan advertising."\61\

A caution about socializing risks

Caution must be taken when the explicit purpose of aggregation is to minimize costs by spreading risks over a larger group of consumers. The exclusion of high risk groups need not be the sole province of the service provider. A cooperative seeking to minimize the costs of service in such a fashion may find itself drifting toward an exclusion of the very customers it was first designed to serve. Consider the situation, for example, of the Council of Smaller Enterprises (COSE) in Ohio. Cleveland's COSE (pronounced Co-zee) reports that its success in keeping premiums low has resulted from its growing emphasis on managed care and its aggressive oversight of Blue Cross and Kaiser administrative costs. In addition, however:

> COSE also relies on medical underwriting. Although COSE originally required its carriers to accept all applicants, it decided to allow underwriting in 1983 because it had attracted many older and sicker individuals who could not obtain coverage elsewhere. By screening for and denying coverage to people who are sick or at risk, Blue Cross can lower its costs and thus offer lower rates to COSE members. COSE, however, requires Blue Cross to accept or reject the entire firm.\62\

In addition, "older people pay more for their health insurance than younger people, regardless of the plan chosen. By requiring the elderly to pay a higher premium for coverage, COSE is able to cover the higher costs that are likely to be incurred. The rate structure also encourages elderly members to choose HMOs, while younger members face lower rates for [fee for

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\60\ *Id.*, at 42.

\61\ *Id.*

\62\ *Id.*, at 29.

service] plans."[63]

A cooperative, if geographically based, can serve to exclude high cost consumers, and thus deny those customers the benefits of risk socialization, through its choice of boundaries. Community rating, in particular, is considerably less meaningful if high cost communities can be excluded from the formation of cooperatives from its inception. Because of the differences in the costs of serving certain areas, for example, "[s]ome commentators foresaw massive fights in state legislatures, with suburban representatives trying desperately to avoid having their constituents in health alliances with the inner cities."[64]

Specific policy responses are available to prevent this geographic segmentation from happening. The potential for geographic conflict, for example, was foreseen at the federal level. In the proposed federal legislation on health purchasing alliances, three limits were placed on drawing a cooperative's geographic boundaries:

1. Each health alliance had to cover a population large enough to give the alliance an adequate market share to negotiate effectively;

2. In setting the boundaries of the alliance, a state could not discriminate on the basis of or otherwise take into account race, ethnicity, language, religion, national origin, socio-economic status, disability, or perceived health status; and

3. States could not divide any part of a metropolitan statistical area contained in the state.[65]

Similar limits on geographic aggregation in the electric industry are merited.

The Acquisition and Exercise of Market Power

It is undeniable that in the health care field the lesser bargaining power of some small groups "raises the possibility that insurers are able to exact a higher profit margin from smaller purchasers."[66] A third purpose for health care cooperatives, therefore, has been to acquire

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[63] *Id.*

[64] ***Policy Issues in Health Alliances***, *supra* note **Error! Bookmark not defined.**, 5 ***Health Matrix*** at 60 - 61.

[65] *Id.*, at 104.

[66] ***Role of Insurance Purchasing Cooperatives***, *supra* note **Error! Bookmark not defined.**, 3-WTR ***Kansas***

and exercise market power through sheer size of numbers to demand lower prices from service providers.[67] This purpose has been referred to as the "countervailing power" model of consumer aggregation.

> . . .the "countervailing power" solution posits a different and deeper market failure. Under this view, insurers and providers reap inappropriate returns as a result of market power. . .Merely making the health coverage market more competitive would not work, just as increased competition over the preceding decade has not noticeably slowed the growth of health expenditures as a percentage of gross domestic product. Under this theory, costs could only be controlled by coercion, forcing insurers and providers to disgorge profits and cut costs.
>
> This coercion could be exercised by direct price controls, but need not be. Instead, one could build up market power on the other side, through pulling consumers together into one large buying organization. If that organization had a large enough share of the market, insurers and providers would be forced to deal with it - after all, neither hospitals nor doctors can quickly and easily change states. Its large share of the market would make it a monopsonist, a monopoly on the purchasing side. And its monopsony power could be used to force down prices without resorting to price controls.[68]

According to this commentator, "the countervailing power approach. . .requires both a substantial market share to give the [cooperative] the effective power to dictate terms to health plans, and the right to use [that power]."[69]

The exercise of market power is precisely what was sought by Cleveland's COSE. COSE is open to firms with fewer than 151 employees. Limited to firms who are members of the Cleveland Chamber of Commerce, COSE serves roughly 200,000 enrollees.[70] COSE reports

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J. of Law and Pub. Pol'y at 95.

[67] Some economists argue that monopoly and monopsony are simply two sides of the same antic-competitive coin. Jeffrey Harrison, "Cooperative Buying, Monopsony Power, and Antitrust Policy," 86 ***NW Univ. L.Rev.*** 331 (1992). Others, however, disagree. Jonathan Jacobson and Gary Dorman, "Joint Purchasing,Monopsony, and Antitrust," 36 ***Antitrust Bulletin*** 1, 4 (1991).

[68] ***Policy Issues in Health Alliances***, *supra* note **Error! Bookmark not defined.**, 5 ***Health Matrix*** at 72 - 73.

[69] *Id.*, at 73.

[70] ***Public and Private Experience***, *supra* note **Error! Bookmark not defined.**, at 28.

that its rates with Blue Cross "are 35 to 50 percent cheaper than those available to most small businesses in the Cleveland metropolitan area."[71]

> COSE, in Cleveland, attributes its low and stable annual premium increases to the long-term relationship it has maintained with two carriers--Blue Cross and Kaiser Permanente. COSE reduced the number of carriers it does business with [in 1982] with the goal of being a `really big' customer to only a few insurers. In fact, COSE is Blue Cross's single largest customer, constituting about 15 percent of Blue Cross business in the Cleveland metropolitan area. COSE officials point out that this significant market share gives them substantial leverage during negotiations with Blue Cross. According to COSE officials, Blue Cross knows that they could `shop around' when their current contract expires.[72]

The price reductions obtained by wielding market power can be substantial. Since Florida's legislation establishing health care purchasing alliance was created:[73] "numerous provider affiliations have banded together to offer comprehensive health plans through the purchasing alliances at prices below the current market rate; seventy-five percent of all plans offered through the alliances are lower in price than rates offered outside those alliances."[74]

Similar price results have been generated in California. "PERS has had the time and staff to analyze health plan bids and bargain effectively, and, in recent years, it has been willing to be aggressive. In 1992, when its largest HMO, the Kaiser Health Plan, failed to keep its 1993 premium to what PERS considered an acceptable level,[75] PERS froze Kaiser membership for eight months. PERS members who were Kaiser members could remain in that system, but no PERS member, new or existing, could join Kaiser. Kaiser's premium increase the following year was acceptable."[76]

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[71] *Id.*, at 29.

[72] *Id.*, at 47.

[73] Fla. Stat. Ann., §408.0014 (West Supp. 1994) (the Florida Health Access Corp. Act) (establishing the Community Health Purchasing Alliances).

[74] Karen Jordan, "Managed Competition and Limited Choice of Providers: Countering Negative Perceptions through a Responsibility to Select Quality Network Physicians," 27 ***Arizona St. L.J.*** 875, 895 (1995).

[75] CalPERS had sought a zero increase in HMO premiums in 1992 with no change in benefits. Kaiser insisted on premium increases of more than 10 percent. ***Public and Private Experience***, *supra* note **Error! Bookmark not defined.**, at 9.

[76] ***Policy Issues in Health Alliances***, *supra* note **Error! Bookmark not defined.**, 5 ***Health Matrix*** at 48.

> In the fall of 1993, PERS announced that it wanted a 5% reduction in premiums from all the HMOs it contracted with, without any allowance for inflation. It ultimately gained an overall reduction of 1%, in a year when health coverage premiums throughout California and the nation continued to rise. This reduction brought the total premium increase for 1992 through 1994 for PERS to 6%, well under the 30% increase experienced by the average California employer.[77]

Despite these success stories, others are more skeptical of this bargaining power. "One public cooperative director noted that cooperatives may be hesitant to exclude plans because enrollees would be required to change health care providers, potentially leading to significant enrollee dissatisfaction. For example, Kaiser covers almost 40 percent of CalPERS' members. Similarly, about 90 percent of COSE enrollees are in Blue Cross plans. In Minnesota and Wisconsin, unions representing state employees have a strong voice in the operation of the cooperative and elimination of a plan would require close consultation."[78]

The disadvantages to the exercise of market power

A cooperative's use of market power can yield lower prices, but this power has its *dis*advantages as well. Given low-income concerns over price, it might be difficult to believe that the control of any aspect of price might pose a problem. After all, on one end of the spectrum, there is a concern that even negotiated prices will be unaffordable.[79] Indeed, the most fundamental concern is whether co-ops are capable of serving one of their primary functions.

> The most elemental drawback of purchasing cooperatives in a voluntary market is that no matter how successful, they will not lead to universal coverage because a recalcitrant core of employers and individuals will continue to find even reasonably priced insurance too expensive to afford. . .[I]t is certain that prices will not drop on their own sufficiently to induce most small employers to

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[77] *Id.*, at 48.

[78] ***Public and Private Experience***, *supra* note **Error! Bookmark not defined.**, at 48.

[79] *See e.g.*, Nebraska Department of Health (1995). ***The Feasibility of Developing Insurance Pooling Groups in Nebraska: A Report to the Governor and Legislature***, 3, Nebraska Department of Health: Lincoln (NE) ("insurance pooling groups are not designed to achieve insurance coverage for everyone, because it is doubtful insurance premium costs could be reduced enough to be feasible for the poor or the near-poor.")

purchase voluntarily.[80]

Even if a cooperative can achieve lower prices, however, there is no guarantee that the new lower prices will be "right" from the perspective of the consumer. Several problems need to be foreseen and addressed. First, as has been demonstrated by the success of health cooperatives in Ohio and California, in particular, insurers or providers faced with a monopsonist often have to accept the terms propounded by the purchaser or find a different business. The resulting prices might well be "too low," thus not providing for the long term marginal costs of delivering care and, in effect, forcing some health plans or providers either to operate at a loss or to "ration" care inappropriately, thereby compromising quality. Experience in the health care field is that the price and service range is often "far too narrow, both at the low-quality and the high-quality end."[81] One commentator predicts that health purchasing alliances will:

> *inevitably* coerce health care insurers and providers into restricting necessary services because they would have sufficient power to push prices below competitive levels. Many providers would consequently be forced to exit the market, while those that remained would be compelled to reduce costs at the expense of quality.[82]

In this regard, "quality" may take on a somewhat non-traditional meaning. In the health care industry, one aspect of "service" about which concern is repeatedly expressed in the diversity of care. One analyst talks, for example, about how "large public hospitals are often the only source in a region for trauma care, burn units, neonatal intensive care units and other specialized services that are necessary but tend to be money-losers."[83] Another talks of how public hospitals "handle proportionately more patients with conditions that have considerable financial and social, as well as medical, impact including drug addiction, alcohol abuse, trauma, tuberculosis, and AIDS."[84] Poison control units, emergency psychiatric care, and

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[80] ***Role of Insurance Purchasing Cooperatives***, *supra* note **Error! Bookmark not defined.**, 3-WTR ***Kansas J. of Law and Pub. Pol'y*** at 101.

[81] *Id.*, at 102.

[82] ***Health Insurance Purchasing Alliances***, *supra* note **Error! Bookmark not defined.**, 79 ***Cornell L.Rev.*** at 1549 (emphasis added).

[83] Julie Rovner, "The Safety Net: What's Happening to Health Care of Last Resort?," ***Robert Wood Johnson Foundation Advances***, 1:1 (1996).

[84] Jerome Kassirer, "Our Ailing Public Hospitals--Cure Them or Lose Them?,"333 ***New England Journal of Medicine*** 1348 (November 16, 1995), *citing*, Chris Burch, *et al.*, eds. (1994). ***Preserving Access in the Era of Reform: America's Urban Health Safety Net***, National Association of Public Hospitals: Washington D.C.; *see also*, Larry Gage (1995). ***America's Essential Providers: The Foundation of our***

disaster response teams are also illustrations of services that may be put at risk.\85\ One commentator noted that services to the disabled and chronically ill may be placed at risk, including occupational and physical therapists.\86\

In addition to supporting the diversity of care, some public health facilities, in particular, are noted for providing additional non-health-care services that would be threatened by reduced costs and or lower plan reimbursements.\87\ Public hospitals, for example, "have tried hard to provide culturally sensitive care to socially and economically underprivileged persons through multifaceted programs that include (among other things) social services, translators, security, transportation, and child protection."\88\ Community health centers "provide transportation, translation, case management, and other services to help people gain access to health care."\89\ Community health facilities also provide supplemental services involving home visits and patient education programs.\90\

In sum, the "service" of a health plan may be affected in a variety of ways by cost reductions "bargained for" by a cooperative interested in minimizing costs. Such cost minimizing strategies may well come at the expense of low-income populations, a particularly vulnerable component of the co-op's membership.

This concern is not hypothetical. Consider that Arizona's managed Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS--pronounced "access"), was designed to promote competitive bidding for HMO-style insurance plans. In fact, however, "as competitive bids were received. . .they were consistently higher than the AHCCCS budget would allow. Therefore, the bidding process has evolved to where AHCCCS announces in

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Nation's Health System, National Association of Public Hospitals: Washington D.C.; J.P. LeBlanc and R.E. Jurley, "Adoption of HIV-Related Services Among Urban U.S. Hospitals, 1988 and 1991," 33 ***Medical Care*** 9:881 (1995).

\85\ "Safety Net Providers: Who are They?," ***Robert Wood Johnson Foundation Advances***, 1:1 (1996).

\86\ Howard Larkin, "Medicaid Managed Care: Promises and Pitfalls," ***Robert Wood Johnson Foundation Advances***, 1:1 (Summer 1995).

\87\ Lisa Ikemoto, "When a Hospital Becomes Catholic," 47 ***Mercer L.Rev.*** 1087 (1996).

\88\ ***Our Ailing Public Hospitals***, *supra* note **Error! Bookmark not defined.**, 333 ***N.Engl. J.Med.*** at 1348.

\89\ Cara Lesser, Kathryn Duke and Harold Luft (1997). ***Care for the Uninsured and Underserved in the Age of Managed Care***, Institute for Health Policy Studies, University of California: San Francisco.

\90\ Julie Rovner, "The Safety Net: What's Happening to Health Care of Last Resort?," ***Robert Wood Johnson Foundation Advances***, 1:1 (1996).

advance the per capita price it is willing to pay, and individual plans elect whether to participate."[91] AHCCCS evaluators disagree with any assertion that they are "too" cost conscious. According to an independent review, cost considerations make up only 30 percent of the weight in the selection criteria.[92]

The dispute arises because per capita pricing is based on the "average" price of serving a "typical" customer. As described above, however, many low-income services tend to be services with high costs that tend also to generate low compensation rates. They are precisely the types of services that cannot be supported by per capita pricing.[93]

The exercise of market power in a continuing search for lower prices may result in "turning the screws on health insurer pricing flexibility."[94] The flexibility that is lost will redound to the detriment of one set of the very consumers that the group purchasing through consumer cooperatives was supposed to benefit in the first instance.

EXAMPLES OF HEALTH CARE COOPERATIVES

Consumer health cooperatives can be successful in exerting pressure on service providers to take proactive actions to protect consumer interests. Several examples are briefly considered below. The Pacific Business Group on Health (PBGH) has pushed managed care organizations (MCOs) to provide preventative care.[95]

The group has required plans to target specific preventative services and

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[91] ***Role of Insurance Purchasing Cooperatives***, *supra* note **Error! Bookmark not defined.**, 3-WTR ***Kansas J. of Law and Pub. Pol'y*** at 101; "The Evolution of Arizona's Indigent Care System," 6 ***Health Affairs*** 4:46, 55 - 58 (Winter 1987).

[92] Nelda McCall (1996). ***The Arizona Health Care Cost Containment System: Thirteen Years of Managed Care in Medicaid***, Henry J. Kaiser Family Foundation: Menlo Park (CA).

[93] Stephen Colton and Roger Colton (1998). ***The Interaction of Price and Service Changes in a Mergers and Acquisitions Environment***, Fisher, Sheehan and Colton, Public Finance and General Economics: Belmont, MA. "Obviously, not all consumers are "average." The use of an average is justified only when the averaging process does not mask important differences that diverge from the "norm." In this case, use of the "average consumer" may well mask such differences." *Id.*, at 5.

[94] ***Health Insurance Purchasing Alliances***, *supra* note **Error! Bookmark not defined.**, 79 ***Cornell L.Rev.*** at 1153 - 1154.

[95] Helen Schaeffer and Tracy Rodriguez, "Exercising Purchasing Power for Prevention: Recent Experiences of the Pacific Business Group on Health," 15 ***Health Affairs*** 1:73 (Spring 1996) (*hereafter*, ***Exercising Purchasing Power***).

> provide data on how many members have received those services. Under their contract, the managed care plans can lose up to two percent of their premiums from all group members if their performance falls short of yearly goals; the poorer the performance, the more money is forfeited.[96]

For example, PBGH has pushed for data reporting on smoking cessation rates. "Once a plan shows it can collect reliable data, the group negotiates with the plan to set performance targets and the managed care plan is offered incentives to meet the targets."[97] PBGH believes there are long-term financial advantages, as well as health advantages, that will accrue from these efforts. It believes that its ability to negotiate ongoing premium reductions from health plans in the future depends on employer and health plan efforts to promote a healthier workforce.[98]

PBGH is in no way unique. Other examples of health care purchasing cooperatives include the Group Health Cooperative of Puget Sound;[99] the Washington D.C.-based Group Health Association;[100] and the Memphis Business Group on Health (Tennessee).[101]

Other successful *public* cooperatives exist as well. In addition to the Wisconsin cooperative discussed above, Minnesota has operated a state employee health insurance program since the 1940s.[102] In 1990, the state employee program was opened to voluntary membership by local governments; in 1993, it was opened up to voluntary membership by private employers.[103] Health plans are not allowed to screen applicants for medical conditions and each of the three

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[96] ***Consumer Protection and Managed Care***, *supra* note **Error! Bookmark not defined.**, 32 ***Houston L.Rev.*** at 1356 - 1357.

[97] ***Exercising Purchasing Power***, *supra* note **Error! Bookmark not defined.**, at 80 - 81.

[98] ***California's Uninsured: Employment Based Programs, Funding, and Policy Options*** (1998), http:www.work-and-health.org.

[99] *See generally*, Kevin Grumbach and Thomas Bodenheimer, "Mechanisms for Controlling Costs," 273 ***J.Am.Med.Ass'n*** 1223, 1229 (1995).

[100] Edward Berkowiz and Wendy Wolff (1988). ***Group Health Association: A Portrait of a Health Maintenance Organization***.

[101] Edward O'Neil and Jennifer Ruzek (1997). ***Health Care***, American Association of University Affiliated Programs with Developmental Disabilities: Silver Spring (MD).

[102] *See generally*, Minnesota Department of Health (1994). ***Minnesota State Agency Interaction with the Health Care System, An Inventory of Activities, Recommendations to Improve the State's Health Care Purchasing***, Minnesota Department of Health: St. Paul (MN).

[103] ***Public and Private Experience***, *supra* note **Error! Bookmark not defined.**, at 21.

pools (state, local, private) offers employees an annual open enrollment period. Participating health plans are required to offer benefits that are "roughly comparable but not identical."[\104\] Minnesota reports considerable success in controlling costs.

> In addition to utilizing a lowest cost plan approach,[\105\] the cooperative controls costs by subjecting each health plan's rate proposal to a review by independent actuarial consultants. The purpose of the review is to determine whether the health plan's rate proposal is based on sound methodology and is reasonable. If any inconsistencies are found, department officials meet with the health plan to seek additional information and to negotiate rate changes. Cooperative officials [said] that the rate of premium increases for the state pool fell from 42 percent in 1989 to 14 percent in 1990. The decrease is attributable in part to the introduction of managed competition reforms but also reflects resolution of financial problems related to the cooperative's Blue Cross managed [fee for service] plan. Premium increases in 1992 and 1993 averaged about 6 percent.[\106\]

Other efforts, both public and private,[\107\] have helped spur health care purchasing co-ops. In 1994, for example, the Massachusetts Attorney General proposed health insurance cooperatives for businesses with fewer than 100 employees.[\108\] Other efforts have arisen in Florida[\109\] and Texas.[\110\] Yet additional efforts are taking place in North Carolina and Ohio.[\111\]

\104\ *Id.*, at 22.

\105\ The employer contribution is based on the lowest cost family premium and the employee pays the difference if a more expensive plan is chosen.

\106\ ***Public and Private Experience***, *supra* note **Error! Bookmark not defined.**, at 23.

\107\ ***Health Insurance Purchasing Alliances***, *supra* note **Error! Bookmark not defined.**, 79 ***Cornell L.Rev.*** at 1548.

\108\ "Health Purchasing Coop System Proposed by State Attorney General," 3 ***Health Law Rep. (BNA)*** 184 (February 10, 1994).

\109\ Bruce Platt, "A Summary of the Health Care and Insurance Reform Act of 1993: Florida Blazes the Trail," 21 ***Fla. St.U.L.Rev.*** 483 (1993).

\110\ "Justice Gives Positive Review to Houston Purchasing Associations," 3 ***Health L.Rep. (BNA)*** 37 (March 31, 1994).

\111\ ***Role of Insurance Purchasing Cooperatives***, *supra* note **Error! Bookmark not defined.**, 3-WTR ***Kansas J. of Law and Pub. Pol'y*** at 98.

The California Model

The Health Insurance Plan of California (HIPC), was one of the first state-sponsored and statewide health purchasing cooperatives in the country. Through HIPC, the state of California allows employers with from two to fifty fulltime employees to band together with employees covered by the California Employee Retirement System (CalPERS) to purchase health insurance. HIPC negotiates on behalf of over 133,000 lives and 7,000 employers by late 1997.[\112\]

HIPC was authorized by legislation which, among other things:

- Created one statewide pool;
- Required all participating plans to offer the same set of benefits;
- Delegated responsibility for management of the pool to an independent state agency; and
- Exempted the pool from many of the state's agency procurement procedures.

The experience with HIPC has been positive. The premiums available to HIPC members were roughly six percent below average premiums otherwise available. Just as importantly, in its second year of operation, HIPC premiums *fell* by six percent, while average premiums for other plans *in*creased by the same amount. Overall, HIPC estimates that its lowest rates undercut the market by approximately 15 percent.[\113\] As of 1998, HIPC negotiated rate decreases in three of the past four years. In addition, "HIPC has also had a broader impact on the whole California insurance industry, forcing non-alliance insurers to lower their prices as well."[\114\]

From 20 to 25 percent of *firms* enrolled in HIPC were small businesses that had not previously had insurance.[\115\] Similarly, one report is that only 20% to 25% of HIPC *members*

[\112\] California Health Foundation (1998). ***California's Uninsured: Employment Based Programs, Funding, and Policy Options***.

[\113\] ***Public and Private Experience***, *supra* note **Error! Bookmark not defined.**, at 21.

[\114\] ***Health Insurance Purchasing Alliances***, *supra* note **Error! Bookmark not defined.**, 79 ***Cornell L.Rev.*** at 1555.

[\115\] *Id.*, at 1554 - 1555.

were previously uninsured.[\116\]

Among the lessons California policymakers say they've learned are:

1. Benefits arise from defining the market area of the cooperative as large as possible. This provides a larger base from which to gain co-op participants and increases bargaining power;

2. Cooperatives should not be formed with the expectation of serving 100 percent of the at-risk market (*i.e.*, small firms not previously providing employee health insurance in California); and

3. A purchasing cooperative benefits through hiring experienced negotiators who have previous experience in bargaining with health plans.

HEALTH CARE LESSONS LEARNED FOR CONSUMER AGGREGATION IN A RESTRUCTURED ELECTRIC INDUSTRY

The notion of aggregating small users was not invented exclusively for the purchase of competitive electric service. Indeed, the experience of the *health care* industry to date offers important lessons for small user aggregation in a restructured electric industry. These lessons offer counsel on what aggregation can be done, who might do it, how it might be done, and for whom it might be done. The experience with health care aggregation also provides insights into what pitfalls might exist for future electric aggregators as well as into how those pitfalls might be avoided. In no order of priority, the following conclusions are drawn from the health care experience discussed above:

1. Aggregating consumers through purchasing cooperatives is a viable mechanism to address the lack of market attractiveness for certain classes of customers. While in the health care field it may be small users (such as small business and even local governments), in the electric industry it will likely be residential consumers who face exclusion.

2. Pooled cooperative purchasing is *not* a market-driven phenomenon. The formation of purchasing cooperatives requires specific public policy support, specific publicly-funded technical expertise, and specific publicly-funded administrative support structures. The successful health care purchasing cooperatives in places such as California, Wisconsin, Florida, and Minnesota were all public initiatives.

\116\ ***Policy Issues in Health Alliances***, *supra* note **Error! Bookmark not defined.**, 5 ***Health Matrix*** at 54.

3. The exclusive purpose of consumer aggregation is not simply to "become big" so as to wield market power. The purposes of a purchasing cooperative might include, either additionally or alternatively: (a) the socialization of the costs of expertise; and/or (b) the spreading of risks and/or administrative costs. A cooperative might serve a good broker function, a countervailing power function, or a risk/cost mitigator function.

4. Determining the purpose of a consumer aggregation initiative is important in that such decisions will drive; (a) what tasks the purchasing cooperative will perform; (b) what powers the purchasing cooperative will be vested with; (c) what expertise the purchasing cooperative will need to acquire; and (d) what resources the purchasing cooperative will need. In all cases, however, "being big" is not, by itself, enough to protect consumer interests. Just because an aggregator is big (*e.g.*, a municipality or a pool of public employees), does not mean that the aggregator will have experience and/or expertise in evaluating cost proposals from competitive service providers, in determining the service needs of the aggregated consumers and matching those needs to service offerings, or in assessing service quality data (either before or after-the-fact).

5. Whatever its stated function, aggregation requires an array of specialized expertise. In the health care field, specialists skilled in assessing the price of service offerings have been necessary. Difference specialists in evaluating service offering are employed. After all, it is not the lowest price which is sought, but rather the best buy. Administrative staff, as well as marketing staff, are necessary. The legal, technical and administrative staff necessary for effective aggregation is not provided by volunteers for *ad hoc* consumer groups. There is a need for an institutional structure.

6. Aggregation does not occur at the micro level. Effective aggregation is not built on dozens, or hundreds, or even thousands of persons. Effective aggregation has required tens and hundreds of thousands of customers.

7. Aggregation without negotiation is not an effective means of generating consumer benefits. The lack of negotiation might, for example, occur through the solicitation of sealed bids. Negotiation requires the evaluation of price and service offerings, the preparation of counter-offers, and the solicitation of "best and final offers." The negotiation occurring through aggregation requires not only the solicitation of price quotes, but the ability to review the proferred justification for those price quotes.

8. Negotiated aggregation is an effective mechanism through which to control prices. The procurement of services through negotiated aggregation has resulted in health care costs of from 15 to 30 percent or more below market rates. In addition to forcing down aggregated prices, negotiated aggregation forces down overall market prices as

well, albeit to a lesser extent, whether or not offered to an aggregated group of consumers. Aggregation without negotiation, however, has failed to control costs or gain below-market offerings.

9. Despite price reductions obtained through negotiated aggregation, service offerings remain unaffordable to a substantial proportion of the population. Even effective aggregation is not "the" answer to unaffordability and the lack of universal service. In California's small business health insurance market, only 20 percent of HIPC customers had been previously uninsured. Nationwide, 75 percent of businesses with fewer than ten employees do not offer health insurance, while less than two percent of businesses with more than 100 employees fail to do so. Even after aggregation, service will remain unaffordable to substantial numbers of customers. This unaffordability requires separate policy responses.

10. Aggregation that focuses exclusively, or even too narrowly, on price may, in fact, *harm* consumers. Focusing on price to the exclusion of service considerations may limit the range of service offerings, as well as reduce the quality of service to inappropriate levels in both the short and long-term. While health care cutbacks may involve reductions in preventative services as well as high cost/low compensation services such as care for TB, AIDS or alcohol abuse, electric utility service cutbacks may involve reductions in energy efficiency programs, neighborhood offices, or the offer of various payment plan options.

11. Aggregation, standing alone, does not address the problem of adverse selection (*i.e.*, that process of choosing to serve only the least cost, least risky, consumers). Excluding high cost or high risk customers may occur in the design of an aggregation pool (*e.g.*, if done geographically, excluding low-income communities), in the pricing of services, and in the design and implementation of marketing plans. Public policies restricting adverse selection are necessary but not sufficient. In addition, purchasing cooperatives must engage in ongoing effective oversight by administrators of the aggregation initiative.

SUMMARY AND CONCLUSIONS

What the health care industry teaches us is that purchasing cooperatives are one essential component of controlling costs and promoting universal service in a competitive industry. Purchasing cooperatives are not a market phenomenon, however; they will not arise by themselves. They will not "just happen" and not "just anyone" can be one.

Moreover, being "big" is not enough to be an effective aggregator. In addition to having the necessary size, a purchasing cooperative must have the necessary expertise and resources to

be effective. Those resources and that expertise will need public support. Precisely what expertise and how many resources are required, however, will depend upon the purpose of the purchasing cooperative. The purchase can, and will likely, involve much more than the simple exercise of market power through bigness. Each of these health care lessons is applicable to a restructured competitive electric industry. The industry, consumers, regulators and other policymakers would do well to heed these lessons.