ELECTRIC UTILITY RESTRUCTURING AND THE LOW-INCOME CONSUMER

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Lessons from Other Industries

When low-income advocates talk about electric restructuring, their concern is not that competition will fail, but rather that it will work, thus imposing higher costs and lesser service on those customers least able to protect themselves.

It is a reality that competition does not bring lower prices and better service to poor households. This result is true across-the-board. Competitive unregulated grocery stores in low-income urban neighborhoods tend to charge prices up to 20% higher than in suburban areas because of claimed higher costs. Appliance and furniture prices in inner-city neighborhoods run 50% higher. Institutions financing mortgages for mobile homes charge far more in interest than for loans on more conventional housing, based on claimed higher default rates. A variety of other industries are further considered below.

Banks and Poor People

Competitive banks provide fewer services to poor people. One study in Los Angeles, for example, found nineteen branch banks in South Central Los Angeles, a predominantly poor black community having a population of 587,000 people. In contrast, the study found 21 branch banks in nearby Gardena, a middle class white community of only 49,800 persons. A separate study in Washington D.C. found that residents in predominantly white neighborhoods have three times as many branches available, per person, as do residents of predominantly African American neighborhoods.

Auto Insurance and Poor People

Competitive pricing, too, is not kind to the poor. The auto insurance industry has long been criticized for its process of "territorial rating." Territorial rating bases the prices paid for insurance policies on the residence of the policyholder. The impact is dramatic. One analysis of territorial rating in California reports:

> Territorial rating imposes a substantial economic burden on drivers who choose to, or must, live in low income, predominantly minority, communities. The system has led to an inherently unfair economic result: those residents of urban areas of California with the lowest median income levels are charged the highest rates in the state for automobile insurance.

The disparities in insurance pricing place hundreds of dollars of increased automobile insurance burdens on low-income and minority insurance customers. In 1986, for example, the California Department of Insurance published a comprehensive study of the financial consequences of territorial rating. That study revealed that in almost every instance, residents of areas of the Los Angeles Basin and San Francisco Bay Area that are identifiably African-American, Latino, Asian, and/or poor pay the highest rates for automobile insurance in California.

Telecommunications and Poor People

The most commonly used measure of the success in reaching universal telephone service in the United States is "telephone penetration" --the percentage of all U.S. households that have a telephone on-premises. Using this standard, most people would believe that universal telephone service is the standard in the United States. Yet large portions of the low income population cannot afford telephone service in their homes.

In 1991, while fewer than one out of 100 upper income families did not have a telephone, roughly 25 out of 100 low income families did not.

Amongst low-income households, telephone penetration rates are dramatically low:

- Of households on public assistance, 35 percent lack telephones;

- Of households receiving food stamps, 31 percent lack telephones;

- Of households receiving energy assistance, 21 percent lack telephones.

Indeed, of those households completely dependent on public assistance, the penetration rate of telephone service is only 43.5 percent (leaving more than 56 percent with*out* service).

Health Insurance and Poor People

Health insurance falls short of achieving universal service. At any given time during the last year, approximately 37 to 40 million people were without health insurance. This lack of health insurance is significantly related to low-income and minority racial/ethnic status. The uninsured population is disproportionately poor or near-poor, African-American or Hispanic, young, and unemployed.

In 1991, some 36% of the uninsured population were African-American (17%) or Hispanic (greater than 18%), representing approximately 30% of the African-American population, and over 40% of the Hispanic population. In addition, 38% of the uninsured population were unemployed, and 55% had family incomes below $10,000.

Health Care and Poor People

The failure to achieve universal service in health care has been documented through measuring the use of health services, the quality of those services, and health outcomes. The disparities in access to care are particularly sharp and enduring for persons with low socioeconomic status (the poor or near poor, the uninsured, and those in public programs such as Medicaid) and persons in minority racial and ethnic groups.

Health disparities between poor people and those with higher incomes are almost universal for all dimensions of health. For virtually all of the chronic diseases that are the leading causes of mortality, low income is a special risk factor. Thus, the incidence of heart disease and most all forms of cancer (lung, esophageal, oral, stomach, cervical, prostate) are significantly higher for persons in poverty than for the rest of the population. The poor also suffer disproportionately from infectious diseases such as HIV and respiratory diseases such as tuberculosis. Similar vulnerability is found among the poor for traumatic injuries and death. Finally, the rate of developmental and other disabilities, especially among children, is associated with poverty. The association between economic disadvantage and ill-health is manifested most strongly in strikingly poor pregnancy outcomes (*e.g.*, prematurity, low birth weight, birth defects) and higher infant mortality; the limitations in life activities due to ill health; and elevated mortality rates. Low-income people have death rates that are twice the rates for people with incomes above the poverty level.

Not all poor health outcomes can be attributed to inadequate access to health care. Instead, much can be attributed to environment, housing, behavior, and nutrition. Nonetheless, the Institute of Medicine estimates that one-third to one-half of the gaps in mortality rates between poor and non-poor persons are attributable to difficulties in obtaining access to health care.

Hospital "Dumping"

The same process of "dumping" that happens in the insurance industry has increasingly happened in the health care industry as well as hospitals have become more "businesslike." In addition, nonprofit hospitals have engaged in dumping, transferring record numbers of indigent patients to public hospitals.

In the health care industry, "dumping" involves

the process of transferring poor or uninsured patients to public hospitals, admitting only those persons who are well insured or are affluent enough to pay the high cost of hospital care. In a recent study of 407 consecutive adult transfers to Cook County Hospital in Chicago, Illinois, researchers concluded that 87 percent were transferred because of the lack of insurance.

Property Insurance and Poor People

Competition has served to hinder, rather than to facilitate, reaching universal service goals in the various insurance industries. The property insurance industry is one such example. In the mid-1960s, the property insurance industry reacted to the extensive urban rioting by denying insurance to inner city property owners. The reason for the denial was simple: the insurance companies feared the payouts that would be necessary from the violence and property destruction that arose as a result. Congress reacted to this abandonment of the inner city market by enacting the FAIR laws in 1968.

The new federal statute, however, did not accomplish what it was intended to accomplish. Rather than encouraging the insurance industry to become involved with the urban communities, instead, the competitive insurance companies sought to insure the "best" risks while dumping the remaining risks into the public market. Because the FAIR plans offered less insurance coverage at higher rates and with less supportive service, the markets were subject to *de facto* abandonment notwithstanding FAIR.

It was widely believed the FAIR plans would make insurance available to all "insurable risks." Regrettably, this did not come to pass. The single most devastating factor upon the effectiveness of FAIR was the higher rate it offered as compared to the voluntary market. Denied coverage in the voluntary market for whatever reasons, rejected applicants found themselves paying appreciably higher premiums for less coverage. Some of the plan's rates were over three times those of the voluntary market with the result that risks often were "written-out" by the voluntary market and then "rated-out" by FAIR plans. This combination of inadequate service and even higher prices was devastating for communities.

Summary

Persons who seek universal electric service cannot rely upon a competitive market to deliver such results. By its nature, a competitive market will not only exclude those most in need, but will increase prices to those least able to pay. The essential characteristic of the marketplace is that it allocates goods and services on the basis of the ability to pay rather than on the basis of the need for the service. The market, therefore, excludes those who are unable to afford the service being sold.

This is the consistent lesson to the electric industry from the experience from other sectors of the economy.

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