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BRIEFLY NOTED

Would Suspending DACA Withstand a Benefit–Cost Analysis?

✦ BY IKE BRANNON AND KEVIN MCGEE

In September 2017, President Trump announced that his administration would suspend Deferred Action for Childhood Arrivals (DACA). The program, launched in 2012 by executive order of President Barack Obama, grants temporary legal status to young adults without a valid visa who had been brought to the United States by their parents before the age of 16. To qualify, applicants must have lived in the United States since 2007, be younger than 31 on June 15, 2012, have received a high school diploma, and have no criminal record. Under DACA, participants can attend college (although without access to federal or state financial aid) and obtain legal employment.

When Trump announced DACA's repeal, he claimed the program's creation through executive order was constitutionally improper and gave Congress six months to pass legislation to extend and perhaps amend the program. Legislators proved unable to do that, but various lawsuits have prompted the courts to suspend DACA's phase-out until the legality of its repeal can be adjudicated.

We are agnostic as to the legality of DACA's repeal and on the constitutionality of its creation. However, we believe that any major regulatory action taken by an administration should be subject to a stringent benefit–cost analysis. Executive Order 12866, first issued by President Ronald Reagan and honored (more or less) by each of his successors, requires such analysis.

Weighing benefits and costs / In 2017 the Congressional Budget Office estimated that allowing DACA recipients to become

permanent legal residents would cost the federal government \$26 billion over 10 years. To reach that number, analysts assumed the recipients would become eligible for Medicaid, Pell grants, and other federal benefits that they currently cannot receive under DACA. Those benefits were the primary drivers of the estimated cost. This estimate has been used to defend Trump's repeal decision.

However, the CBO analysis does not reflect policymakers' current decision over DACA. The CBO compared only the alternatives of continuing temporary legal status for DACA participants and permanent legal status for those participants. We believe the status quo is politically unsustainable. Because of that, policymakers should be deciding between a different pair of alternatives:

- Congress passes legislation that allows DACA recipients to become permanent legal residents, and thus be eligible for most of the benefits conferred to citizens.
- The president eliminates DACA, making participants ineligible to work legally in this country.

We performed our own benefit–cost analysis of these two alternatives, essentially asking what the opportunity cost would be to the government, as well as the broader economy, if the nation were to end DACA.

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Blanca Lopez of Union City, CA had been protected under DACA, but she did not receive renewal materials under Trump administration policy. As a result, she is now unemployed.

Under the permanent status alternative, we assumed current DACA participants would pursue employment opportunities consistent with their educational achievements. A significant proportion of these participants have earned or are in the process of earning college degrees. Under the DACA repeal alternative we assumed that most of this cohort would remain in the country—the only country most of them know—and join the informal job market, working illegally for cash in low-paying jobs and not paying income or Social Security and Medicare (FICA) taxes.

To estimate the consequences of legal residency, we obtained data from TheDream.us, a college scholarship fund for DACA recipients, on 2,563 DACA recipients currently enrolled in college. The data identify the college, declared major, and expected graduation date for each of these people.

We used the data to forecast each student's income upon graduation, using data from the FinTech company Payscale.com, which has access to information from over 2 million new college graduates. We assumed their earnings would follow a quadratic-shaped age-earnings profile, initially increasing by 4% per annum but slowing to a 2% growth rate after 20 years. Quadratic age-earnings profiles are com-

monly used for college-educated workers in labor economics.

We simulated the full DACA population using 2014 estimates for their educational attainment from the Migration Policy Institute. DACA participants enroll in college at roughly the same rate as U.S. citizens, although their attrition rate once in college is markedly lower. By 2033, we estimate that 36% of the DACA population will have bachelor's degrees, with another 17% having some lesser level of post-secondary education.

We forecasted income over the next decade for three separate DACA populations: those with college degrees, those with some college, and those with only high school diplomas. Forecasted earnings for the latter two groups were based on median 2017 weekly earnings for Hispanics at these two educational levels obtained from the Bureau of Labor Statistics (BLS) and estimated age-earnings profiles for these educational levels. Our resulting income forecasts allowed us to estimate the taxes that the DACA population would pay over the next decade, provided they receive permanent legal residency.

We then generated income and tax forecasts for the second outcome, where DACA status is terminated and the DACA popu-

lation nonetheless remains in the country. We assumed average annual earnings of \$20,000 for these workers. For both the legal-residency and the DACA-terminated scenarios, we assumed that only 75% of the population would be employed, consistent with the BLS's estimated employment-population ratio for Hispanics ages 25–34.

Results / Our calculations indicate that with permanent legal status, current DACA participants would earn around \$380 billion from 2020 to 2029. They would pay around \$43 billion in federal income taxes and \$59 billion in FICA taxes (both the employer and employee shares) over that period, for a total of \$102 billion in federal revenue.

Without that status, they would earn only about \$158 billion over that same decade. It is unclear to us how much, if anything, they would pay in taxes because their employment would be illegal. But if all these DACA workers paid both income and FICA taxes, they would pay around \$6 billion in federal income taxes and \$24 billion in FICA taxes over the next decade.

Comparing the two alternatives, we estimate that eliminating DACA will cost the federal government more than \$70 billion in foregone tax revenue over the decade. The upper bound of this loss could approach \$102 billion. The lost revenue dwarfs any entitlement increases that may accrue to DACA recipients should they be granted full legalization.

We note that providing permanent legal residency to the DACA population would move about a million workers out of low-skill, low-pay job markets, into higher-skill job markets. Roughly half of those workers would move into job markets requiring a college degree. Because we tend to have supply surpluses in the low-skill markets and shortages in the high-skill markets, permanent legal status would have an overall salutary effect on the allocation of U.S. labor. That, in turn, should boost income and resultant tax revenue.

Since DACA participants, for the most part, have spent most of their lives in the United States, the program's continued

BRIEFLY NOTED

existence is unlikely to have much if any effect on the current size of the U.S. labor force. As we've noted, DACA participants are likely to stay here in the country, legal status or not, and any attempt to deport the entire contingent would prove to be both costly and largely unsuccessful.

Permanent legal residency would allow DACA recipients to be far more productive and contribute considerably more to the U.S. economy. All DACA recipients necessarily have high school diplomas, and many have post-secondary education and college degrees. Permanent legal residency would allow them to put to use the human capital they have acquired, benefitting both themselves and American society as a whole. It would also allow them to pay considerably more in federal taxes, and in state and local taxes as well.

Our data—as well as other data on the employment patterns of immigrants—suggest that this cohort promises to be much more mobile than the rest of the U.S. labor market. That means they are less likely to remain in communities where unemployment is high and jobs are low, and they can be expected to relocate to where labor shortages have developed.

This predilection suggests that granting permanent legal status to DACA participants will in fact benefit U.S.-born workers in rural areas by ameliorating incipient skilled-labor shortages. What's more, their legalization means they will not be forced to work in low-paid, unskilled occupations where it is easier to pay people under the table. That, in turn, will mean less competition for U.S.-born workers with relatively few labor market opportunities. R

one anesthesiologist, one operating room, and one six-to-eight-hour surgery window.

Multivisceral transplant candidates get priority on the kidney transplant list. Someone who recently became afflicted with liver disease and who may not even be on a kidney list will routinely get a kidney along with his new liver, as long as a nephrologist—a kidney specialist—approves the procedure. In these cases, it is the liver transplant list that dictates kidney priority.

Here's the rub: in many cases, the transplant kidney ends up being completely redundant. Liver function greatly affects kidney function, and the successful transplantation of a healthy liver restores many recipients' ailing kidneys to working order. In other words, for these patients, the Quality-Adjusted Life-Years (QALYs) that the kidney transplant adds is low. Nonetheless, the surgeons proceed with the multivisceral transplant, leaving the original kidneys in place. As a result, many of these transplant recipients end up with three functioning kidneys.

These transplants reduce the already tight supply of donor kidneys, harming people who have been on the transplant list for a long time and for whom a transplant kidney may extend their life for decades. Many of these patients will never receive a kidney and, as a result, live only a short time longer. The allocation of kidneys to multivisceral transplants has a very low benefit and extremely high cost in terms of potential lives lost.

There is a simple fix to these unnecessarily transplanted kidneys: end the preference given to liver transplant patients for a new kidney.

Perverse incentives / Why do doctors who perform liver transplants frequently insist upon transplanting a kidney with the liver? One explanation that is certainly understandable is that the transplanted kidney makes doctors more confident the liver transplant will succeed. However, other factors likely are also at work in these decisions, and those factors are troubling.

For starters, liver transplants bring in

Wasting Kidneys: The Multivisceral Transplant Conundrum

BY IKE BRANNON

Some 18,000 kidney transplants are performed in the United States each year. People who need a kidney often receive a donor organ from a relative, but people who don't have that option must turn to an organ transplant waiting list. Prioritization on these lists is based on how long a patient has been on dialysis, his current health, and how long he has been on the wait-list. The longer the wait and sicker the patient (but not too sick!), the higher he is on the list.

However, patients who need a transplanted liver are treated differently. It is fairly common for a liver recipient to also receive one of the deceased donor's kidneys in a procedure known as a multivisceral transplant. These constitute about 10% of all kidney transplants done each year. It is worth noting that the kidneys that

typically accompany these transplants tend to be especially good organs, coming from young, otherwise healthy individuals, who make for the best liver donors.

There are two ostensible reasons for transplanting both organs together. First, people with liver failure typically develop kidney failure concomitantly, a condition known as hepatorenal syndrome. Second, even if the recipient does not have an immediate, urgent need for a kidney, it can be economical to do both surgeries at the same time if doctors believe the patient may one day need a kidney; the dual-transplant surgery would require just



much more money for a hospital than kidney transplants. Hospitals typically charge \$500,000–\$700,000 for a liver transplant, as compared to \$200,000 for a kidney transplant (and much less for some patients, as we will see below). Though I don't want to assert that doctors callously make these decisions in a crass chase for dollars, the added revenue provides perverse incentives.

Exacerbating this disparity is the fact that most kidney transplant recipients are on Medicare while most people receiving liver transplants are on private insurance, where reimbursement rates are much higher. For instance, Medicare only pays a hospital around \$70,000 for a kidney transplant. The organ procurement organizations also benefit from multivisceral transplant, as it results in organs being distributed to fewer centers, reducing overhead.

Another reason liver transplant doctors prefer to do multivisceral transplants has to do with their evaluations. These days nearly all doctors in all specialties are subject to some sort of report card on their performance. In the early days of these evaluations, transplant doctors could game the system by deferring surgeries on sicker patients with a lower probability of surviving, and instead doing more procedures on healthier patients. However, improved data allow evaluations to adjust fairly well for the health of the patient, so there is less room for gaming these days.

The improved reliability of these evaluations has resulted in the profession putting more weight on them, and transplant surgeons with a sub-par grade on their report card for a couple of years run the risk of

losing their ability to perform such surgeries. However, one way for a liver transplant surgeon to avoid the strictures of the liver report card is to do a multivisceral transplant. Because they constitute only 15–30% of all liver transplants—or 1,500–3,000 a year—there are too few of them to aggregate for a reliable report card. Thus, a lower survival rate brings less opprobrium.

Recently, transplant organizations have taken steps to limit such gaming of the

Multivisceral transplants further distort an already worrisome racial and class imbalance for transplant organs, shifting organs to wealthier patients.

kidney transplant list. For instance, transplant lists place patients who have already received a liver and now need a kidney at the top of the waiting list, a policy that helps to deter multivisceral transplants. If a hepatologist—a liver specialist—knows her patient can get a kidney later if it becomes necessary, the doctor has less reason to do a multivisceral transplant.

It is worth noting that multivisceral transplants further distort an already worrisome racial and class imbalance for access to transplant organs. A majority of the people on the kidney waiting lists are African Americans, Hispanics, or Native Americans, yet almost two-thirds of all liver transplant recipients are white. Redundant multivisceral transplants effectively take transplant kidneys from poorer,

non-white patients who have been waiting for an organ for years and gives them to patients who, on average, are wealthier, whiter, and have been sick for much less time, and whose gain from the new kidney, as measured in QALYs, is much less.

Conclusion / The United States already has a dearth of usable kidneys. There are 500,000 people on dialysis and over 100,000 on a waiting list for a kidney while no more than 18,000 usable kidneys become available in a year. Almost 10,000 people die each year waiting in vain for a match.

This shortage is exacerbated by taking another 2,000 kidneys out of the system and giving them to liver transplant recipients, many of whom benefit little from the kidney. The fact that this is encouraged by financial incentives, and that it has regressive effects, is a tragedy.

The optimal solution to our kidney shortage would be for the federal government to compensate living kidney donors for their donations. Research suggests that paying potential donors \$50,000 would ensure that all who need a kidney could receive one, which would not only

save thousands of lives a year but also save the government over \$100 billion over a decade through reduced dialysis costs. (See “Could PAYGO End the Prohibition on Paying Organ Donors?” Spring 2016.) Given the data indicating that a person's health changes little whether she has one functioning kidney or two, compensated living donation would present a very large benefit both for those suffering from kidney disease as well as the government and the overall economy, and with very little attendant increase in costs.

Failing that, however, we should reduce unnecessary multivisceral kidney transplants and instead direct those kidneys to the sickest and most deserving patients. Doing this may reduce the income of hepatologists but it would save lives and money. **R**