



# Executive Alert



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ALL THAT'S NEW IN THE WORLD OF IDEAS

NOVEMBER/DECEMBER 1999

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NCPA President John Goodman “In Conversation” with U.S. Supreme Court Justice Clarence Thomas. See related story on page E3.

## Living Wage

More than 40 cities and counties around the country have passed “living wage” laws since Baltimore passed the first one in 1994, and others are considering proposals. A living wage law usually applies to businesses that have contracts with a city or county and their subcontractors. It also usually applies to businesses that receive special treatment from the city or county, such as economic development assistance or subsidies, tax breaks or low-interest loans.

The idea behind the living wage movement is that contractors who receive tax money as payment for their services should in turn be required to pay each employee enough to support a family. Typically, advocates push for a wage between 50 percent and 150

percent higher than the federal minimum wage. At the end of 1998, the city of San Jose, Calif., passed a \$10.75 per hour living wage law, the highest in the country.

Living wage advocates say their ultimate hope is to extend the concept beyond municipal boundaries and cover all employers, not just those with municipal contracts. Economists have calculated the economic impact if a statewide \$10.75 living wage law were passed in California.

- An estimated 612,783 California workers — 43 percent of them in families with incomes of less than \$20,000 a year and 48.9 percent of them Hispanic — would lose their jobs.

- Almost a third of those losing jobs would be workers in service industries, and another 29 percent would be retail

trade workers.

- The wage mandate would raise labor costs in the state by \$22.8 billion per year, even after adjusting for reduced employment.

Lost in the living wage debate is the fact that many workers — especially low-skill workers — develop their skills at entry-level jobs, often at the minimum wage. As their skill base increases, so do their wages. Enacting ultra-high living wages means denying many of these workers the skill-building opportunities they need to make a living for themselves and their families.

*Source: George Tolley, Peter Bernstein and Michael D. Lesage, “Economic Analysis of a Living Wage Ordinance,” July 1999, Economic Policies Institute, 1775 Pennsylvania Avenue, N.W., Suite 1200, Washington, D.C. 20006, (202) 463-7650.*

## More Canadians Wait — and Wait Longer

More Canadians were waiting to receive medical treatment in 1998 than in 1997 — and they were waiting longer. Queues for visits to specialists and for diagnostic and surgical procedures reflect health care rationing under Canada's national health system.

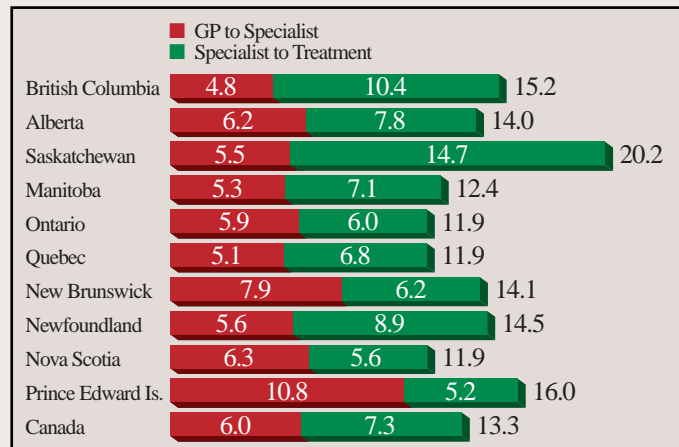
- An estimated 212,990 Canadians were on hospital waiting lists for surgical procedures in 1998, a 13 percent increase from 1997.
- Patients waited an average (median) of 6.0 weeks after referral by a general practitioner for a consultation with a specialist and another 7.3 weeks after the consultation to receive treatment.
- The average total waiting time of 13.3 weeks was up from 11.9 weeks in 1997 and up a dramatic 43 percent since 1993, when the average total waiting time was 9.3 weeks.

The total average wait varied widely, from 11.9 weeks in the provinces of Ontario, Quebec and Nova Scotia to 20.2 weeks in Saskatchewan. The total average wait in 1998 was less than in 1997 in only two provinces, Quebec (5 percent) and Nova Scotia (3 percent). The wait rose by 21 percent in British Columbia, 18 percent in Saskatchewan and New Brunswick and 17 percent in Ontario.

The waiting time rose for all specialties and diagnostic technologies. The gap between the amount of time specialists considered clinically reasonable and the actual waiting time after consultation was greatest for elective cardiovascular surgery, for which the actual waiting time was 8.1 weeks longer. The only specialty for which actual waiting time did not exceed what specialists considered reasonable was medical oncology.

*Source: Michael Walker and Martin Zelder, "Waiting Your Turn: Hospital Waiting Lists in Canada (9th edition)," Critical Issues Bulletin, 1999, Fraser Institute, 4th Floor, 1770 Burrard Street, Vancouver, B.C. V6J 3G7, Canada, (604) 688-0221.*

## WEEKS WAITED FROM GP REFERRAL TO TREATMENT (1998)



*Source: Fraser Institute, annual waiting list survey, 1999.*

## Technology in Canada

In recent years there has been growing evidence of a decline in the quality and quantity of health care available to Canadians under the nation's single-payer system. Excessive waiting lists for specialist treatment have been documented for nearly a decade and they are getting longer. One contributing factor is lack of access to high-technology equipment and procedures.

Although Canada's spending on health care as a percentage of gross domestic product is the fifth highest among nations of the Organization for Economic Cooperation and Development (OECD), it generally ranks in the bottom third in availability of technology. For example:

- Canada ranks 21st out of 28 countries in the availability of computed tomography (CT) scanners, 19th out of 22 in availability of lithotriptors and 19th out of 27 in availability of magnetic resonance imagers (MRIs).
- The average accessibility among OECD nations is 12.9 CT scanners per million persons, compared to 8.1 scanners per million for Canada and 26.9 in the United States.
- Canada has 1.7 MRIs per million persons, compared to the OECD average of 4.2 and the U.S. average of 16.
- Canada ranks favorably only in the availability of radiation equipment, in which it ranks sixth out of 17 countries.

Further, the decline is steeper than ever in some categories. For example, Canada's ranking in the availability of MRIs fell between 1986 and 1995.

Expanding access to technology in Canada is difficult under the existing system. Administrators of acute care hospitals receive their budgets from provincial health ministries. They have very little leeway in spending, since as much as 85 percent of their budgets is consumed by union wages that are largely out of their control. Much of the remainder is consumed by overhead and maintenance, leaving little for capital spending.

Even when a hospital has raised funds to purchase equipment, it is not permitted to charge patients to recover operating costs, and often the government refuses to pay these costs. The result is that decisions on the purchase and operation of high-technology equipment are made not by medical authorities or hospital administrators but by remote government bureaucrats and politicians.

Conversely, the private sector is largely excluded from purchasing and operating such equipment because the government payment schemes prevent most private entrepreneurs from billing for services provided.

*Source: David Harriman, William McArthur and Martin Zelder, "The Availability of Medical Technology in Canada: An International Comparative Study," Public Policy Sources No. 28, August 8, 1999, Fraser Institute, 4th Floor, 1770 Burrard Street, Vancouver, B.C. V6J 3G7, Canada, (604) 688-0221.*

## Prescription Drug Myths

Critics complain that prescription drugs have contributed to a massive increase in health care spending in the United States. Some critics contend that drug prices are too high and propose lowering them through price controls. For example, the Prescription Drug Fairness for Seniors Act, currently before Congress, imposes a form of price controls on drugs sold to the elderly. Many complaints about price, and the laws those complaints spawn, are based on misunderstandings of how the prescription drug market works. Following are some of the most widespread myths.

**Myth: Americans Spend Too Much on Prescription Drugs.** Per dollar spent, drugs offer a better return on health care spending than virtually any other health care option. Using prescription drugs often reduces or eliminates the need for costlier health care services. One recent study found that every dollar spent on drugs is associated with a \$4 decline in spending on hospitals. The decline in total spending due to greater use of prescription drugs is particularly notable in the treatment of cancer, heart disease, Alzheimer's, AIDS and mental illness.

**Myth: Drug Costs Are Rising Because of Price Increases.** Drug cost increases are due primarily to nonprice factors, including increased volumes of prescriptions, record sales of new products and a changing mix of available products. Price increases to date have been relatively modest. According to a survey by IMS Health:

- Of a 14.2 percent increase in total drug costs in 1997, only 2.5 percent stemmed from price increases.
- Of a 15.7 percent increase in total drug costs in 1998, only 3.2 percent was caused by price increases.

**Myth: Drug Prices Are Higher in the United States than in Other Developed Countries.** Drug prices in the United States are not very different from prices in other developed countries.

- Using accurate pricing information, health economist Patricia Danzon has found that drug prices in Canada, Germany, Switzerland and Sweden are higher on average than prices in the United

States.

■ When "purchasing power parity," a means by which economists attempt to compare the price of goods in different countries, is considered, the Organization for Economic Cooperation and Development has found that Americans spend less per capita per year on drugs than do people in Germany or France and only slightly more than those in Canada and Italy — yet all of the other countries have controls.

**Myth: Americans Could Reduce Their Drug Costs If They Paid the Same Prices as People in Less-Developed Countries.** Critics of drug companies complain that consumers can go to Mexico and buy drugs for less than half their cost in the United States. Prices for the same drugs do differ in different countries, but Americans cannot get the newest drugs at Mexican prices. Here is why: The research and development required to ready a drug for production can cost millions of dollars and take many years, yet the cost of actually manufacturing a drug is usually small. Because manufacturers have discretion about pricing, the price may be close to production costs in poorer countries, which could not otherwise afford the drug, and higher in wealthier countries — more accurately reflecting the drug's value to patients. If patients in every country paid the lower price, there would be no money for research and development and no new drugs.

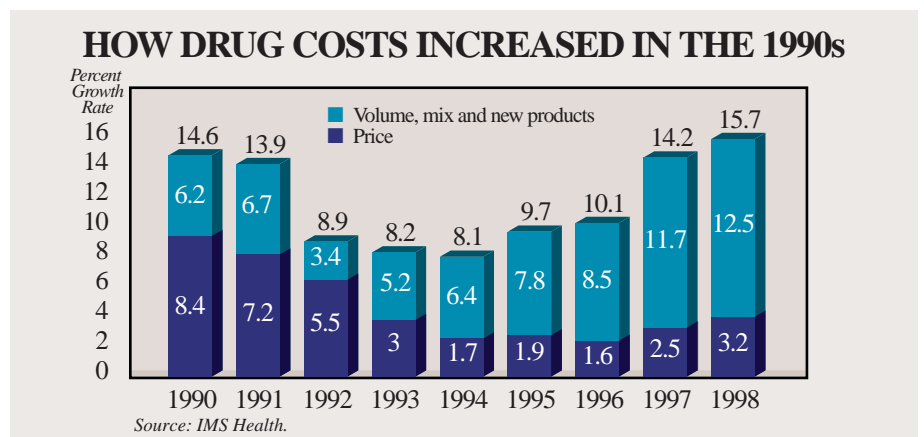
**Myth: Price Controls Can Reduce Drug Spending.** Attempts to drive down drug costs through price controls have two unintended results: (1) they encourage increased consumption of drugs and (2) they lead to the consumption of inferior drugs. Many European health systems with price

controls spend more on drugs per capita than the United States spends, but Americans use newer and more appropriate medications. That is one reason Americans spend less time in hospitals when they are sick and have a higher quality of life than do Europeans.

**Myth: Price Controls Would Reduce Drug Costs for Seniors.** If the Drug Fairness for Seniors Act became law, seniors would likely pay more, not less, for their prescriptions. The legislation would require drug manufacturers to offer all seniors the discounts in the Federal Supply Schedule (FSS), now offered only to a very few government agencies, primarily the Veterans Administration. At the earliest opportunity, drug manufacturers would steeply increase FSS prices. Further, to get the discount, pharmacies would have to do an estimated \$15 worth of paperwork to prove to the manufacturer that each Medicare beneficiary was eligible — a cost pharmacies would pass on if possible. Thus seniors would end up with higher prescription drug bills.

Price controls represent not a mere extension of market pressure but a fundamental shift in values. Controls substitute a political process for the marketplace. For controls to work, individuals must adhere to governmental and bureaucratic decisions. And with controls, a few "experts" would decide what pharmaceuticals millions of physicians, pharmacists, medical researchers and patients "deserve" — and at what prices.

Source: Robert Goldberg, "Ten Myths about the Market for Prescription Drugs," NCPA Policy Report No. 230, October 1999, National Center for Policy Analysis, 12655 N. Central Expressway, Suite 720, Dallas, Texas 75243, (972) 386-6272.



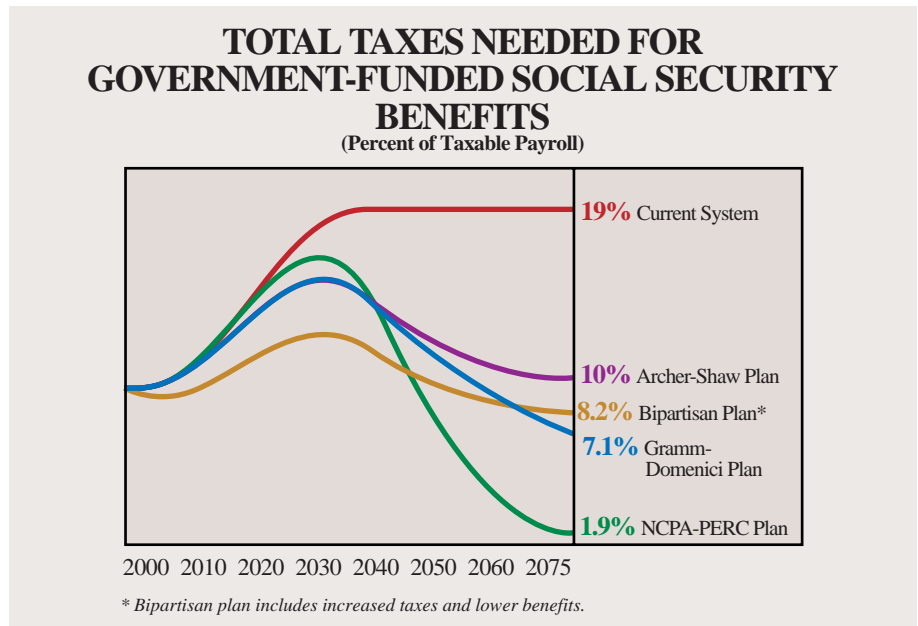
## Comparing Reform Proposals

Our Social Security system is based on pay-as-you-go financing — money collected in payroll taxes today is used to pay benefits to today's retirees. When today's young workers retire, the government will have to call on the workers still active for the money to pay the benefits. However, since the ratio of active workers to retirees drawing benefits is shrinking, Social Security taxes will not be enough. Under the current system, if we don't raise taxes, there will be an unfunded liability estimated at \$4.5 trillion over the next 75 years.

However, it is possible to secure currently promised Social Security benefits indefinitely into the future without increasing tax rates or increasing government debt — and at the same time eliminate the existing unfunded liability. To do this requires at least partially replacing our pay-as-you-go system with a funded system that makes investments in income-earning assets.

The key is diverting part of the Social Security payroll tax to individual personal retirement accounts (PRAs), which would be conservatively invested in broadly diversified portfolios of stocks and bonds. The cost of paying benefits to current retirees while providing funds to the PRAs will be high. Almost all of the projected budget surpluses will be needed in addition to the remainder of the payroll tax. Still, changing the system now will more than pay for itself in future years. If the deposit to PRAs is as much as 4.2 percent, the generation currently entering the labor market — and each succeeding generation — could fully fund its retirement benefits from its PRAs. Beyond that point, it will be possible to completely eliminate the regressive payroll tax that currently funds Social Security.

The federal government can guarantee that every retiree will receive a pension at least as great as that promised by the current system and can do so at a fraction of the current system's cost. The new, fully funded system can still guarantee that low-income retirees with insufficient savings receive a minimum benefit. Policy makers will eventually be able to use the



income tax rather than the payroll tax to pay this minimum benefit. The new system can also enable those with shorter life expectancies to will their PRA accumulations to their heirs prior to retirement.

Several plans for reforming Social Security have been proposed. The Private Enterprise Research Center (PERC) at Texas A&M University and the National Center for Policy Analysis (NCPA) have developed a computer simulation model to analyze reform proposals. The model has analyzed plans proposed by Sens. Phil Gramm and Pete Domenici; Reps. Bill Archer and Clay Shaw; a bipartisan proposal made by Sens. John Breaux, Judd Gregg and Bob Kerrey in the Senate and Reps. Jim Kolbe and Charlie Stenholm in the House; and a reform proposal offered by the NCPA and PERC. All of these plans would institute PRAs. The model confirms that all would assure benefits to future retirees.

Three of the plans do not increase taxes or reduce benefits. The bipartisan proposal increases the maximum income subject to the payroll tax and raises the retirement age. The plans differ in the extent to which PRAs replace Social Security benefits.

- Under the Archer-Shaw plan, young people just entering the workforce today would rely on their PRAs for about half of their benefits when they retire.
- Under the Gramm-Domenici plan, they

would rely on PRAs for two-thirds of their benefits.

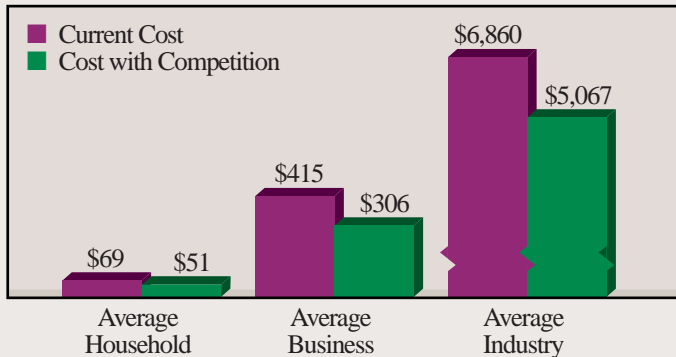
- Under the bipartisan plan, by mid-century new retirees would rely on PRAs for about 70 percent of their benefits — but the benefits would be smaller because of increases in the retirement age and adjustments in the benefit formulas.
- Under the NCPA-PERC plan, by mid-century new retirees would rely on PRAs for all of their benefits.

The model calculates that a payroll tax of 19 percent will be needed to pay Social Security benefits by 2070 under the current system. At that time, the Archer-Shaw plan would require a 10 percent payroll tax, the bipartisan plan an 8.2 percent tax, the Gramm-Domenici plan a 7.1 percent tax and the NCPA-PERC plan a 1.9 percent tax.

Among the benefits of reform are providing a more secure retirement for all workers, allowing workers to own their retirement savings, giving workers the right to bequeath the accumulated savings to their heirs, increasing national savings and ultimately increasing national income. The cost of not making necessary reforms now is the growing certainty that taxes will be raised and benefits will be cut in the future.

*Source: Liqun Liu and Andrew J. Rettenmaier, "Comparing Proposals for Social Security Reform," NCPA Policy Report No. 227, September 1999, National Center for Policy Analysis, 12655 N. Central Expressway, Suite 720, Dallas, Texas 75243, (972) 386-6272.*

## THE EFFECT OF COMPETITION ON MONTHLY ELECTRIC BILLS



Source: Michael T. Maloney, Robert E. McCormick and Raymond D. Sauer, *Customer Choice, Consumer Value: An Analysis of Retail Competition in America's Electricity Industry* (Washington, D.C.: Citizens for a Sound Economy Foundation, 1996).

## Deregulating Electricity

State legislatures and Congress are debating deregulation of the nation's largest, most highly regulated monopolistic industry: electric power. Currently, regulatory inefficiencies cost commercial and residential customers \$20 billion to \$50 billion per year. Regulation also causes electricity prices to vary widely from state to state.

The Department of Energy's Energy Information Administration has estimated that just allowing competition in retail sales to consumers — without eliminating costly federal regulations — could lower electricity prices on average by as much as 6 percent to 13 percent within two years. A Clemson University study estimates that broader deregulation measures and competition would lower electricity prices by at least 13 percent and perhaps as much as 26 percent.

Most states are moving toward retail competition, which will allow consumers to purchase electricity from competing generators. However, retail competition will not be effective if all consumers are required to pay arbitrary fees to reimburse utilities for their so-called stranded costs — utility investments that, while apparently justified under regulation, are uneconomical under competition. Nor is there much consumer choice if there are price controls on power transmission or if local distributors are able to exercise monopoly power.

A solution to these difficulties is divestiture. Today's electric utilities should

divest themselves of power generation facilities and restructure the industry. Divestiture would create two discrete kinds of businesses.

- "Supply" companies would generate power.
- "Wires" companies would transmit and distribute power.

Divestiture would encourage the transition from regulated monopolies to competitive markets by driving down costs and attracting new entrants. States could require utilities to separate into wires and supply companies in order to get compensation for stranded assets.

However, there is the danger that reform would produce *reregulation* instead of *deregulation*. In California, the first state to allow all residential customers to buy competitive retail electric power, many consumers saw their electricity bills increase after reform, due to fees for utilities' stranded costs, subsidies for "green power" and more regulators to manage competition.

If Congress and the states took the divestiture route, most — or even all — of the stranded costs utilities claim would disappear. No expansion of state or federal regulatory powers is necessary to manage competition — it will occur naturally — and consumers can realize the full benefits of market competition: better service at lower cost.

Source: Vernon L. Smith and Stephen Rassenti, "Turning on the Lights: Deregulating the Market for Electricity," *NCPA Policy Report No. 228*, October 1999, National Center for Policy Analysis, 12655 N. Central Expressway, Suite 720, Dallas, Texas 75243, (972) 386-6272.

## Cost-Ineffective Regulations

Government agencies are required to prepare an analysis for any proposed "economically significant" regulation — one with an estimated annual impact on the economy of \$100 million or more. The analysis must show that the benefits of the regulation justify its costs. An examination of federal regulatory activities shows that the benefits of government regulation considered as a whole are greater than the costs. However, fewer than half of all regulations are cost-justified. Further, regulatory agencies do a poor job of analyzing the impact of regulations, and the efficiency of various regulations varies with the agency and the type of risk the regulation is designed to reduce.

- The net benefits for final regulations promulgated from 1981 to mid-1996 are about \$1.6 trillion.
- However, net benefits could increase by approximately \$280 billion if agencies rejected regulations that fail to pass an economic benefit-cost test.

Some agencies do better than others.

- More than half of all the net benefits come from Department of Transportation regulations, although they account for less than 10 percent of all regulations.
- Two-thirds of all regulations are from the Environmental Protection Agency (EPA), but they account for only about a third of total net benefits.
- Half of the EPA rules cost more than \$120 million per life saved, which is eight times more than Labor Department rules and more than 80 times higher than the median for other agencies.
- On the average, regulations that reduce cancer risk are less efficient than other social regulations, and EPA cancer regulations appear to be less efficient than other cancer regulations.

There is evidence that cost-effectiveness rarely drives agency agendas. For example, the EPA only recently began seriously examining the relative rankings of risks.

Source: Robert W. Hahn, "Regulatory Reform: Assessing the Government's Numbers," *Working Paper 99-6*, July 1999, AEI-Brookings Joint Center for Regulatory Studies, 1150 17th Street, N.W., Suite 1100, Washington, D.C. 20036, (202) 862-5847.

## Crime Continues Decline

Serious crime in the United States continued to fall in 1998, whether measured as a rate (number of crimes per capita) or in absolute terms. Based on crimes reported to the police:

- The overall rate of serious crime fell to a 25-year low.
- The murder rate dropped by 8 percent from 1997 and finally slumped to the rates of the late 1960s, even falling below the average for this entire century.
- The rates for rape and aggravated assault fell by 5 percent each, for robbery by 11 percent and for burglary by 7 percent.
- The actual number of murders reported in 1998 was the lowest in more than two decades.

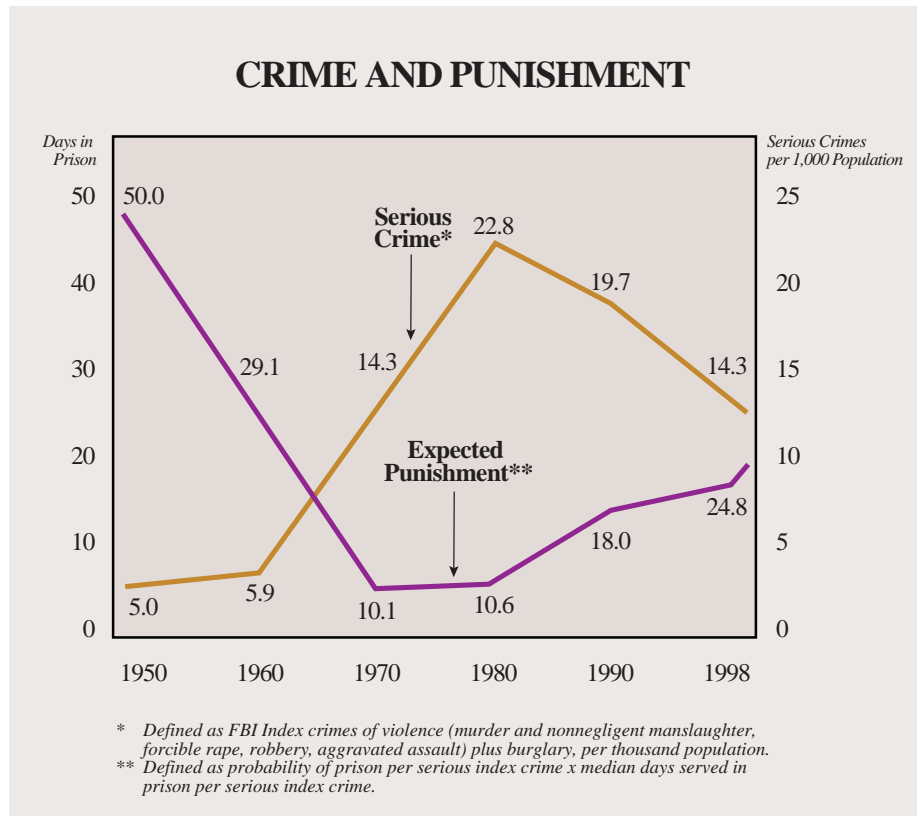
The National Crime Victimization Survey, conducted annually by the Justice Department since 1973, also found the lowest crime rates since the survey began. This survey — which measures crimes by asking randomly selected people whether they have been victims — usually finds a higher rate because fewer than four of every 10 crimes are reported to the police.

Not by coincidence, the likelihood that a criminal will be punished for a serious crime and the amount of time a criminal is likely to spend in prison are higher today than they have been since the 1970s.

What happened in 1998 continued a trend first evidenced in the 1980s, a trend that accelerated in the '90s. Following a fourfold jump in crimes of violence and burglary during the 1960s and 1970s, serious crime reported to the police stabilized and then fell.

Other factors have played some part, but a major reason for the reduction is that crime has become more costly to the perpetrators. The likelihood of going to prison for committing any type of major crime has increased substantially. Moreover, once in prison criminals are staying longer.

The best overall measure of the po-



tential cost to a criminal of committing crimes is “expected punishment.” Roughly speaking, expected punishment is the number of days in prison a criminal can expect to serve per crime, as determined by the probabilities of being apprehended, prosecuted, convicted and going to prison, and the median months served for each crime. In 1997, the latest year for which prison data are available, expected punishment continued to increase compared to 1996.

- Expected punishment for people who commit murder has increased by almost five months.
- Expected punishment for rape or aggravated assault has increased by three days.
- Expected punishment for robbery has increased by seven days.
- Expected punishment for burglary is unchanged.

Since 1980, expected punishment:

- for murder has nearly tripled, from 14 months to 41 months.
- for rape has tripled, to 128 days.
- for robbery has increased by 70 per-

cent, to 59 days.

- for serious assault has more than doubled, to 18 days.
- for burglary has more than doubled, from four days to nine days.

Despite these increases, it is still amazing how low expected punishment is.

Evidence shows that potential criminals respond to incentives. Between 1950 and 1980, expected punishment declined more or less continuously from an average of seven weeks for every serious crime committed to only 10 days — an 80 percent drop. In response, the serious crime rate more than quadrupled. In the 1980s, expected punishment began to increase, accompanied by a leveling off and then a decline in the serious crime rate. Between 1980 and 1997, expected punishment for serious crimes increased from 10 to 25 prison days, a 150 percent increase, and serious crime declined.

Source: Morgan O. Reynolds, “Crime and Punishment in America: 1999,” NCPA Policy Report No. 229, October 1999, National Center for Policy Analysis, 12655 N. Central Expressway, Suite 720, Dallas, Texas 75243, (972) 386-6272.

## Overstating Inequality

The Census Bureau's figures on the distribution of income are misleading, overstating the degree of inequality and obscuring important factors that determine it.

To measure income distribution, the Census Bureau ranks households from highest to lowest incomes, divides them into five quintiles and determines the share of total income received by each quintile. Since the quintiles are based on households, they do not contain equal fifths of the U.S. population, and are in fact unequal in size. For instance:

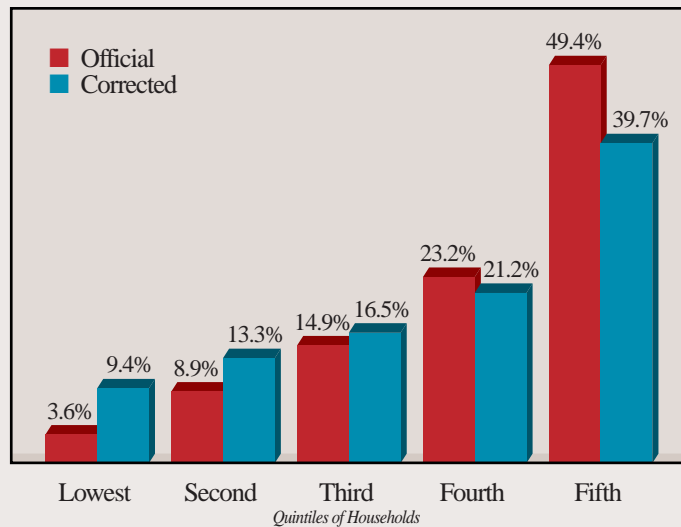
- The top Census quintile contains not 20 percent of the population but 24.3 percent, while the bottom quintile contains only 14.8 percent of the population.
- This is due to differences in household size — for instance, 54.9 percent of the households in the bottom quintile consist of just one person, compared with only 7 percent of households in the top quintile.
- In addition to size, the households differ in other important respects — for instance, more than twice as many people in the Census' top quintile as in the lowest quintile are of working age.

When the figures are adjusted to include a broader measure of income, and the income distribution is divided so that each quintile contains equal numbers of people, the share of income received by the bottom quintile is nearly three times higher than Census reports.

Further, the Census Bureau shows the bottom quintile receiving roughly \$1 of income for every \$4 received by the top quintile, but after the adjustments the difference shrinks to \$1 for every \$2.

*Source: Robert Rector and Rea Hederman, "Income Inequality: How Census Data Misrepresent Income Distribution," CDA Report No. 99-07, September 29, 1999, Center for Data Analysis, Heritage Foundation, 214 Massachusetts Avenue, N.E., Washington, D.C. 20002, (202) 546-4400.*

## DISTRIBUTION OF INCOME, 1997



## Taxes Rise, Deductions Increase

The 1993 tax increase raised only about one-third of the revenue that had been forecast by static models, which did not allow for behavioral responses by taxpayers. But evidence from state income tax returns shows that taxpayers — especially high-income taxpayers — respond to tax rate changes by increasing or reducing their incomes.

Because of the reduction in the number of federal income tax brackets in the 1980s, virtually all married taxpayers with incomes above about \$80,000 faced the same federal marginal tax rate in 1991. But state marginal tax rates varied considerably — from 0 to 12 percent. An examination of 1991 federal tax returns for those reporting incomes between \$100,000 and \$200,000 shows the impact of tax rate increases on income. (For confidentiality, returns reporting incomes over \$200,000 are not identified by state.)

- A 10 percent increase in the total marginal tax rate (federal and state combined) reduces taxable income reported by about 4 percent for taxpayers in high brackets and by about 2 percent in lower brackets.

- More than 80 percent of the shrinkage is produced because taxpayers shift their spending toward tax-deductible categories like mortgage interest payments and IRA contributions.

- The interest deduction on home mortgage payments increases demand for owner-occupied houses, especially in high-tax states, resulting in higher housing prices there.

However, taxpayers did not respond as much in the 1990s as earlier because the 1986 income tax reform lowered incentives and opportunities to avoid taxes.

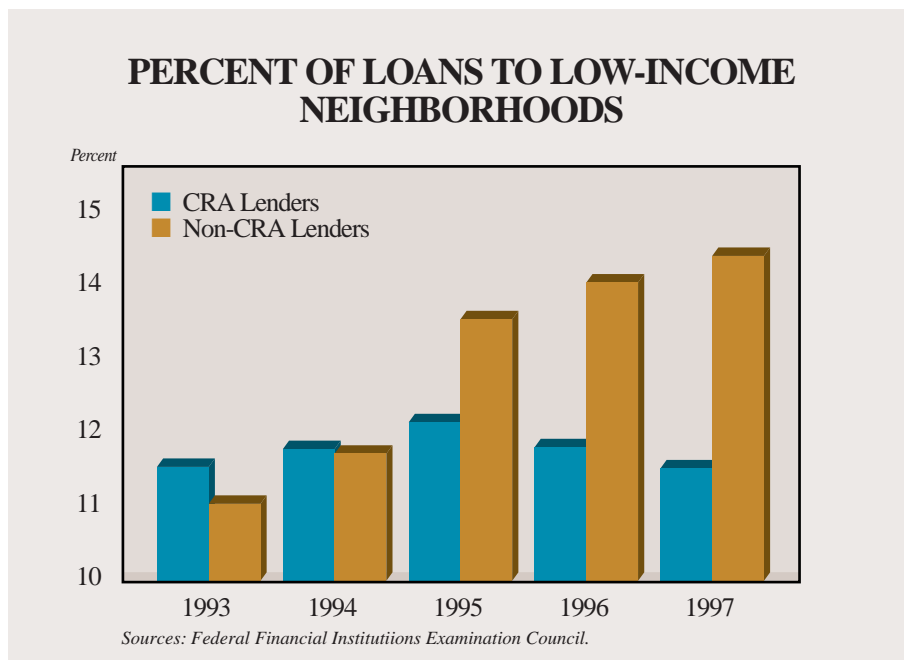
*Source: James E. Long, "The Impact of Marginal Tax Rates on Taxable Income: Evidence from State Income Tax Differentials," Southern Economic Journal, April 1999.*

## Marketplace Broadens Lending

Two decades ago, concerned about discriminatory housing and lending policies, the federal government created a vast regulatory and compliance infrastructure to increase the availability of credit. The centerpiece was the 1977 Community Reinvestment Act (CRA), which requires federal banking regulators to encourage large commercial banks and thrifts to lend to minority communities and low-income borrowers.

From the 1930s through the 1970s, federal laws and regulations restricted competition among financial institutions, limiting the products and services provided, the geographic areas served and the interest rates offered to depositors or charged to borrowers. But since 1980, deregulation has led to increased competition from a variety of lending institutions, many of which are not covered by the CRA.

- As a group, non-CRA institutions have devoted a growing proportion of their home-purchase lending to low-income communities — rising from 11 percent in 1993 to 14.3 percent in 1997 and accounting for just under 40 percent of all



home-purchase loans to low-income neighborhoods in 1997.

- In contrast, CRA-covered lenders devoted about the same proportion of their home-purchase loans to low-income neighborhoods in 1997 as in 1993 — about 11.5 percent.

- For low-income borrowers regardless of their neighborhoods, the proportion of home-purchase lending by non-CRA in-

stitutions rose from 25 percent in 1993 to 32 percent in 1997.

- During this period, the proportion of home-purchase loans by CRA-covered lenders shrank from 27 percent to 26 percent.

Source: Jeffery W. Gunther, Kelly Klemme and Kenneth J. Robinson, "Redlining or Red Herring?" *Southwest Economy*, May-June 1999, Federal Reserve Bank of Dallas.

## SSI Fraud, Abuse

Supplemental Security Income (SSI), administered by the Social Security Administration but completely separate from Social Security, is the nation's largest cash assistance program. SSI cost taxpayers \$29 billion in 1998. An analysis of the SSI program indicates that it is inherently vulnerable to fraud and abuse by people who feign impairments.

- Over 60 percent of SSI disability cases from a statistical sample involved impairments that are difficult to objectively verify — psychoses, neuroses, mental retardation, schizophrenia and various physical ailments that can be feigned.

- Thousands of SSI recipients in the six states studied used suspicious medical providers to gain access to the program.

- Middlemen, especially interpreters,

also play a significant role in SSI fraud and abuse, according to SSA officials and front-line staff.

The cost to taxpayers of providing these benefits is an estimated \$122,000 per person in SSI and Medicaid benefits over 10 years. The Social Security Administration has undertaken several initiatives, including pilot investigative teams in some states, to attack fraud and abuse. However, staff recalcitrance limits the effectiveness of the initiatives. Apparently, staff perceive that the changes conflict with other agency goals, doubt their effectiveness or fear exposure to legal liability.

Source: "Supplemental Security Income: Additional Actions Needed to Reduce Program Vulnerability to Fraud and Abuse," GAO/HEHS-99-151, September 1999, U.S. General Accounting Office, Washington, D.C. 20548.

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