Income Splitting, Interprovincial Physician Migration in Canada, and Health Care Accessibility

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Abstract: In 2005 the Ontario provincial government introduced a new tax policy that enabled physicians to split income earned from privately owned physician corporations with their family members. This effectively increased the after-tax income of physician households in Ontario that were able to take advantage of the new tax policy. This paper estimates the effect of the 2005 policy change on the interprovincial migration of physicians in Canada. There are two major findings from this study: the interprovincial migration of physicians to Ontario increased after the policy change; and the interprovincial migration of physicians to Nova Scotia decreased simultaneously. These results were most significant for the migration of family doctors. The departure of so many physicians from Nova Scotia between 2005 – 2018 directly threatened the accessibility of health care services provided therein.

1. Introduction

In 2005, the Government of Ontario (ON) expanded the share structure of physician professional corporations to permit family members to own non-voting shares (Wolfson and Legree, 2015). This allowed for income splitting (until abolished by the federal government in 2018) to occur between physicians and their family. The purpose of income splitting is to shift income from one family member to another who is earning less, or nothing, and will then pay a lower marginal tax rate on the additional income. For example, in the year 2005 the federal income tax rate for the highest income bracket was 29%, however, depending on the amount of income transferred and how much the person receiving the transfer already earns, the marginal tax rate on the transferred income could be 0%, 15%, 22% or 25% (Table 3 in the Appendix). The policy change that took place in ON in 2005 therefore gave the possibility to physicians in that province to increase their after-tax income substantially. To benefit from the new policy, doctors had to be located in ON and set up private practices.

After the 2005 policy change the number of private practices in ON increased dramatically, from 1,500 in 2004 to 20,000 in 2017. It should be noted that in 2011 income splitting was extended to all households in Canada. Though income splitting became universal between 2011 – 2018, the case of ON was still unique. The federal law capitated transferable income at $50 000, meanwhile in ON income was transferred indirectly through ownership of non-voting shares in private practices, not capitated at $50 000. This means that there was still a strong incentive for physicians from provinces other than ON to move there and set up a private practice because they could split more of their income using the non-voting share scheme compared to directly transferring income to family members - as they would be able to in their home province. Thus,

for the purpose of this paper, 2005 - 2018 will be considered the years when the income splitting policy was active, not 2005 - 2011.

The question being investigated in this paper is: how did interprovincial migration of physicians in Canada respond to this policy change? The net (number of arrivals minus departures) interprovincial migration of physicians to ON is being compared to the net migration of physicians to British Columbia (BC) before and after the income splitting policy was introduced; and the migration pattern of physicians out of Saskatchewan (SK), Manitoba (MB) and the Atlantic provinces pre- and post-policy change is also being explored.

To estimate the impact of the policy change on interprovincial migration of physicians to Ontario a difference-in-differences (DID) framework is applied, using a panel data model. The results suggest that the 2005, policy change in Ontario increased the net interprovincial migration of physicians. There was a statistically significant increase in the flow of family doctors into Ontario after the 2005 income splitting policy was enacted.

For the influence of the policy change on the out-migration pattern of physicians from SK, MB and the Atlantic's, an Ordinary Least Squares (OLS) model is estimated. Interestingly, the results from the analysis of Nova Scotia (NS) are complementary to the results from the ON & BC model. NS experienced a statistically significant increase in the outflow of family doctors after the policy change in ON (the net interprovincial migration of physicians to NS decreased).

The results from the statistical models directly pertains to one of the five principles of the Canada Health Act (CHA) that being Section 12, Accessibility. The 2014 - 2015 CHA Annual Report states on page 10 that "The intent of the accessibility criterion is to ensure that insured persons in a province or territory have reasonable access to insured hospital, medical and surgical-

dental services on uniform terms and conditions, unprecluded or unimpeded, either directly or indirectly, by charges (user charges or extra-billing) or other means (e.g., discrimination on the basis of age, health status or financial circumstances)" (CHA, 2015). The policy change increased the flow of family doctors arriving in ON while it also increased the flow of family doctors leaving NS. The latter has traditionally been a source province for ON and BC - training physicians locally just to have them move out of province (See Figure 1 below). This problem was exacerbated by the 2005 policy change in ON.

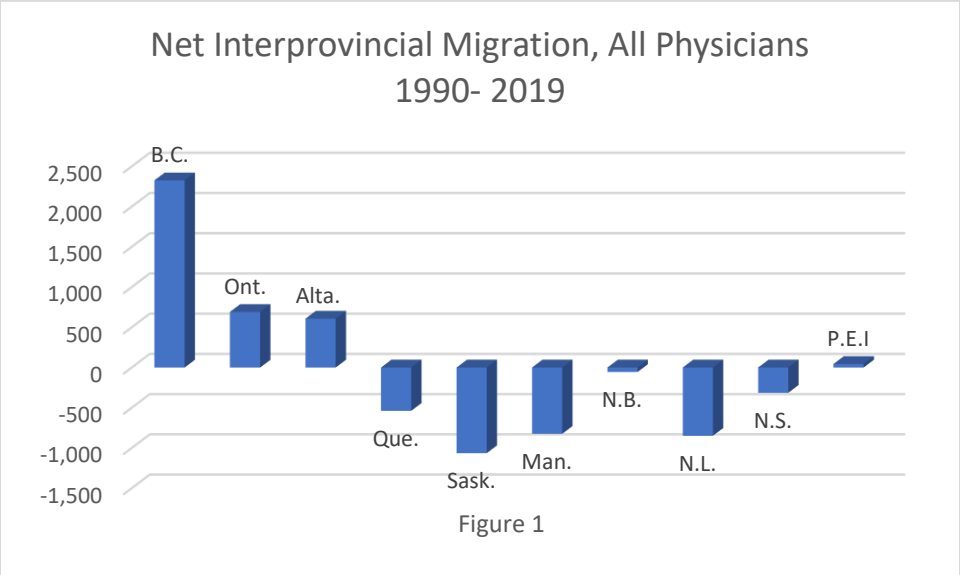

Figure 1

The supply of physicians within a province can impact the accessibility of services provided thereby. If the supply of physicians in province is too low, then wait times could increase; and there may not be the same variety of care available compared to other provinces.

2. Policy Background

The concept of income splitting, at the federal level, was first suggested by Kenneth Carter in the 1966 Royal Commission on Taxation (www.canadianencyclopedia.ca). He argued that the present system was unfair to the poor, who paid a disproportionate share than the rich. In general,

it is argued that taxing the income of individuals, and not households, is unfair because a single earning household would pay more taxes than a dual earning household even though their annual incomes are equal.

Furthermore, Krzepkowski and Mintz (2013) point out that for single earning households with children, the stay-at-home parent is still producing valuable output to society but is not being compensated therefor. Under an income splitting tax system, the stay-at-home parent can be directly compensated through receiving a transfer from their partner and then pay a fair tax rate on that income. Evidence both empirical, and theoretical suggests that income splitting does not achieve several of the objectives outlined above and comes at a cost to society.

A 2011 C.D. Howe Report by Alexandre Laurin and Andrew Kesslemen showed that the benefits of the program are not equally distributed across society. High income single earning households will benefit the most, the middle - and lower-income households would receive little to no benefit, saving at most $500 per year (Laurin and Kesslemen, 2011). According to their estimates 85% of households, would gain nothing at all. While roughly 40% of all the benefits from the income splitting policy are accrued by households that earn $125 000 or more.

3. Relevant Literature

a. Economic Theory on Migration

Laber and Chase (1971) frame the migration decision as Human Capital investment. From their point of view the decision to migrate depends on the difference between the expected benefits and costs of moving, the benefits being defined as the difference in expected wages between two locations, and the costs being related to the distance between the two provinces.

Vanderkamp (1971) focused on the average income differentials and the distance between source and destination regions. However, he categorized migrants differently than Laber and Chase (1971). He grouped migrants into three categories: New Migrants (NM), Return Migrants (RN), and Autonomous Migrants (AM). The determinants of migration decisions varied by category.

For NM, the strongest determinants were income and distance, RN, also accounted for income and distance, however, he suggested that many of those migrants were planning on returning anyway or would be more responsive to income changes in their home region than NM's were. The AM were planning to move from source to destination regions irrespective of the distance or expected income from doing so. The present study focuses on NM in Vanderkamp's terminology and hypothesizes that an expected income differential can attract doctors from another province – the income differential being increased by the 2005 policy change.

b. Migration of Physicians in Canada

Grant and Oertel (1997) detailed the migration patterns of physicians interprovincially and to the US, between the years 1970 – 1995. They found that ON and BC were generally destination provinces for mobile physicians, while MB, SK and the Atlantic provinces were losing physicians. Quebec (QC) did experience outflow, but in smaller magnitude than MB, SK and the Atlantic provinces, probably due to strong preferences over residing in French speaking communities. Alberta (AB) was initially a destination province, however, in the 90's, the Klein government introduced large cuts to healthcare expenditure that led to a massive out flow of physicians.

Bennarroch and Grant (2007) assessed the role of income in determining physician interprovincial migration. Several insights can be drawn from their work. Firstly, annual net

migration flows should be considered in conjunction with the number of MD's produced each year within that province. For example, QC had an average outflow of 4 doctors per year but produced 558 per annum. AB had a mean inflow of 7 doctors per year and produced 181 doctors. Though technically the latter is a destination province, and the former a source province, the impact of interprovincial migration on their supply of doctors is negligible. The outflow experienced by MB/SK and the Atlantic provinces after controlling for the number of MD's produced is substantial. On average, just over 40% of medical students trained in SK migrated out of province, with a similar proportion leaving MB. Again, BC and ON were found to be net inflow provinces.

Worswick and MacDonald (2012) researched the movement of immigrant doctors between provinces and, found that rural physicians are most likely to migrate, moving to urban areas and mostly to ON. Ryan and Steward (2007) focused on where family doctors chose to live after their residency. Approximately 50% of doctors moved to a different province to start their practice, including ON trained doctors. However, on net, there was a positive inflow of doctors to ON, while other regions, the Prairies and the Atlantic faced an outflow of doctors. Rajbhandray and Basu (2006b) produced similar results: most physicians preferred to stay in their own province, those who did move were most likely to chose BC or ON.

Finally, Rajbhandray and Basu (2006a) estimated the characteristics of physicians who did move. Those aged under 45-50, were significantly more likely to move compared to the reference group (45 – 50), while those in the age category of 55-60 and older were less likely to move. Immigrant status mattered as well, that group was significantly more likely to move than non-immigrant physicians; and specialists were more mobile that generalists.

4. Data

a. Health Care and Physician Data

The Canadian Institute for Health Information (CIHI) publishes the Scott's Medical Database (SMDB) which contains information at the national, provincial, and regional levels on the total supply of physicians and interprovincial migration for the years 1968 to 2019. In that dataset, the total supply of physicians is equal to the number of family doctors (grouped together with general practitioners) and the number of specialists – all of which are available in per capita values.

Unfortunately, the SMDB dataset is missing values for interprovincial migration from the years 2007 & 2008 for BC; 2007, 2008 and 2009 for AB and 2008 & 2009 for the rest of Canada. Those observations were omitted from the regression estimates.

The CIHI also publishes data on healthcare expenditure in each province, and inflation measures for the costs of health care services. Data for the years 1990 – 2019 were obtained. Using this information and the population statistics from Statistics Canada, health care expenditure in each province was transformed into expenditure per one hundred thousand persons. This information is used to construct a control variable for the models outlined in Section 5.

b. Statistics Canada

Statistics Canada estimates the ***effective*** marginal income tax rates in each province at the mean for different percentiles. Data from 1992 – 2018 is available. To construct the average marginal tax rate of physicians the average of the estimated ***effective*** marginal tax rates at the 86^{th}-90^{th} and 91^{st}-95^{th} were used. For clarification: the ***effective*** tax rate is the actual tax rate paid on all income, the marginal tax rate is what is paid on the last dollar earned.

At the federal level, Wikipedia, has published a table of the true, not ***effective,*** federal marginal income tax rates in Canada at the different income levels between the years 2000 – 2019.

Tables constructed by Statistics Canada were used to obtain annual estimates, at the provincial level, of the population and the average unemployment rates.

5. Empirical Model

The question being addressed by the empirical model is whether the introduction of income splitting policies in ON affected: the net interprovincial migration of doctors to ON; and the outflow of physicians from the traditional source provinces: MB, SK and the Atlantic region.

A panel data model is used to estimate the effects of the policy on interprovincial migration to ON, using a DID framework. Defining ON as the treated group and BC the control group assumes that before the policy change ON and BC were both attractive destinations for physicians seeking to migrate interprovincially. The policy change did not have any direct effect on BC, while it is likely to have made ON a more attractive destination than it was before. Therefore, after the policy change, we use BC as a comparison for ON to see if the policy increased interprovincial migration to ON. BC was selected as the control group because it has the largest net interprovincial migration of any province in Canada, ON and AB having the next highest net migration levels. This is before controlling for population, taking population into account acts to increase the gap between BC and ON. Another advantage to using BC and ON is that their geographic locations balance out nicely. BC is geographically closer to AB and SK; because of MB's proximity, the case could be made that BC or ON are geographically preferable. ON is closer to QC and the Atlantic provinces.

Equation 1 below outlines the model used to estimate the net interprovincial migration of physicians to ON and BC before and after the policy change.

$$y_{p,t} = \gamma_p + \psi_t + \delta \mathrm{Treat}_{p,t} + \beta X_{p,t} + \epsilon_{p,t} \quad (1)$$

The dependent variable $y_{p,t}$ is adjusted for population size (per one hundred thousand persons) and represents either net interprovincial migration of physicians to province p at time t; the net interprovincial migration of family doctors to province p at time t; or the interprovincial migration of specialists to province p at time t. γ_p and ψ_t are province and time controls, γ_p is equal to 1 if the province is ON, and 0 otherwise. ψ_t is a time trend, increasing by one each year. $\mathrm{Treat}_{p,t}$ is the treatment indicator variable equal to 1 when the policy was active and 0 when it was not, as stated earlier the treatment years were 2005 - 2018.

$X_{p,t}$ are controls that are related to the attractiveness of the province as a destination for migration. The control variables were constructed to reflect the difference between the province p, and the rest of Canada excluding BC and ON. For example, in year t, the average unemployment rates in BC and ON are compared to the average unemployment rates in the rest of Canada. The other control variables considered were the differences between the average marginal effective provincial tax rate for high earners and the difference between health care expenditure per one hundred thousand persons. The difference in health care expenditure is a proxy for the overall quality of the health care system. Finally, $\epsilon_{p,t}$ is the unobservable error term that influences migration interprovincially.

Equation (2) below is the model used to estimate the impact of the policy change on the net interprovincial migration of physicians from MB, SK and the Atlantic provinces. It is structured much like equation (1) however, separate regressions for each province, MB, NB, NL,

NS, PEI, and SK were estimated, holding the model constant while substituting in different data. The intuition is the same: the policy change in ON is hypothesized to increase the appeal of that province as a destination for interprovincial migration which in turn should decrease net interprovincial migration to the traditional source provinces (increase the outflow of physicians from those provinces).

$$y_t = \psi_t + \delta \text{Policy}_t + \beta X_t + \epsilon_t \quad (2)$$

y_t is either: net interprovincial migration of physicians at time t; the net interprovincial migration of family doctors at time t; or the interprovincial migration of specialists at time t (measured in per one hundred thousand persons). Policy_t is the same for all the provinces and is a binary variable, assigned a value of 1 for the years 2005-2018 when the policy change was active in ON and 0 otherwise. X_t contains the same set of control variables as described in equation (1), however, here the rest of Canada is defined as AB, BC, ON and QC. That is, we exclude MB, NB, NL, NS, PEI, and SK. Then for each of those provinces health care expenditure per one hundred thousand persons, marginal effective tax rate for high earners and unemployment rates are compared to the rest of Canada (AB, BC, ON and QC). ψ_t represents a time trend, increasing by one every year and ϵ_t is the unobservable error term.

6. Results

The results from the DID model, equation (1) and the provincial model of NS are discussed below. Each of which were estimated for the interprovincial migration of all physicians, all specialists and then family doctors. The results from the MB, NB, NS, NL, PEI, and SK models were not significant and will not be presented or discussed.

Table 1

	nPrONBC				nPrspec				nPrfam			
Predictors	*Estimates*	*std. Error*	*CI*	*p*	*Estimates*	*std. Error*	*CI*	*p*	*Estimates*	*std. Error*	*CI*	*p*
(Intercept)	1.57	0.55	0.47 – 2.68	**0.006**	0.76	0.26	0.25 – 1.28	**0.004**	0.81	0.34	0.12 – 1.50	**0.022**
Treat	1.29	0.54	0.21 – 2.38	**0.020**	0.43	0.25	-0.07 – 0.94	0.091	0.86	0.34	0.18 – 1.54	**0.014**
Time	-0.04	0.02	-0.08 – -0.00	**0.042**	-0.02	0.01	-0.04 – -0.00	**0.014**	-0.02	0.01	-0.04 – 0.01	0.152
prov	-2.37	0.37	-3.11 – -1.64	**<0.001**	-1.15	0.17	-1.49 – -0.81	**<0.001**	-1.23	0.23	-1.69 – -0.76	**<0.001**
diffUR	0.54	0.19	0.16 – 0.91	**0.006**	0.26	0.09	0.09 – 0.43	**0.004**	0.28	0.12	0.04 – 0.51	**0.022**
Observations	56				56				56			
R^2 / R^2 adjusted	0.521 / 0.483				0.586 / 0.554				0.393 / 0.345			

Table 1 presents the results from the DID model. Column 1 is the results for the model using interprovincial migration of all physicians, column 2 is for all specialists and column 3 is for family doctors – each of which are adjusted for population size. The control variables for differences between population adjusted health care expenditure and provincial marginal ***effective*** tax rates were both highly insignificant and dropped from all three DID models. Starting with column 1, the intercept is equal to 1.57 and significant at 1%. The estimate represents the difference between interprovincial migration to BC and ON after controlling for the rest of the variables in the model. A positive value implies that BC has a larger inflow of physicians than ON. The time trend is -0.04 and significant at 5%, this suggests that between 1990 - 2019 for both BC and ON interprovincial migration is declining slightly each year. The binary variable prov is negative and significant at less than .1%, meaning that ON has lower net interprovincial migration than BC in each year. The difference between each provinces unemployment rate and the rest of Canada has a coefficient equal to 0.54 that is significant at 1%, meaning that as unemployment increases in the rest of Canada compared to BC and ON the interprovincial migration to those provinces increases. Most importantly the coefficient for Treat is equal to 1.29 and significant at 2%. This is very strong evidence that during the period 2005 – 2018 when income splitting was

available to physicians in ON there was increase in interprovincial migration of all physicians to that province by 1.29 physicians per one hundred thousand persons each year.

Moving to column 2, here the estimates are for the interprovincial migration of all specialists. The signs of the intercept, time trend, difference in unemployment and the provincial dummy remained the same as in column 1 and so did their level of significance. The coefficient for Treat shrunk in magnitude and because less significant, it is now equal to 0.43 and only significant at the 10% level. Compared to all physicians there is slightly weaker but still marginally significant evidence that the interprovincial migration of specialists to ON increased between 2005-2018.

Column 3 presents the results for family doctors. As with column 2 the signs and significance of the control variables did not change dramatically. The coefficient for Treat is now more significant than it was for all physicians and all specialists, the p-value is .014, compared to 0.2 for all physicians. The coefficient is 0.86, suggesting that for each year between 2005-2018 interprovincial migration of family doctors to ON increased by 0.86 per one hundred thousand persons.

To complement the results above the estimates from running the model outlined in equation (2) on data from the province of NS is presented in Table 2. As was the case for Table 1, the results

Table 2

	nprNS				**nprNSsp**				**nprNSfam**			
Predictors	*Estimates*	*std. Error*	*CI*	*p*	*Estimates*	*std. Error*	*CI*	*p*	*Estimates*	*std. Error*	*CI*	*p*
(Intercept)	7.09	4.55	-2.44 – 16.62	0.136	30.52	29.53	-31.27 – 92.32	0.314	35.94	25.27	-16.94 – 88.83	0.171
Time	0.06	0.17	-0.31 – 0.42	0.745	0.46	1.13	-1.89 – 2.82	0.686	0.06	0.96	-1.96 – 2.07	0.952
Policy	-2.13	1.38	-5.02 – 0.76	0.139	-2.20	8.95	-20.93 – 16.52	0.808	-17.72	7.66	-33.75 – -1.70	**0.032**
diffExpNS	-0.03	0.02	-0.07 – 0.01	0.151	-0.12	0.12	-0.37 – 0.14	0.347	-0.15	0.10	-0.36 – 0.07	0.179
difftxNS	1.87	0.86	0.08 – 3.66	**0.041**	11.59	5.54	-0.02 – 23.19	0.050	5.88	4.74	-4.05 – 15.82	0.230
diffURNS	-0.72	0.32	-1.39 – -0.05	**0.037**	-3.42	2.07	-7.76 – 0.91	0.115	-3.29	1.77	-7.00 – 0.42	0.079
Observations	25				25				25			
R^2 / R^2 adjusted	0.412 / 0.258				0.267 / 0.074				0.426 / 0.275			

from the model for all physicians, all specialists and family doctors can be found in columns 1, 2 and 3, respectively.

Here the difference in provincial tax rates and health care expenditure were included as control variables. They were also the only two control variables that had any statistical significance – though for all physicians, not specialists nor family doctors. Focusing on the coefficient of Policy, we can see in column 1 that it is negative and almost significant at the 10% level for all physicians. Interprovincial migration of all physicians to NS during the years 2005 – 2018 appears to decline, even after accounting for all the control variables. In column 2 the sign of Policy is still negative; however, the p-value is massive 0.808. As a result, there is insufficient evidence that interprovincial migration to NS declined during the policy period. On the other hand, for family doctors the sign of Policy is negative, while the size of the coefficient has increased substantially and so has the level of significance. Between 2005-2018 interprovincial migration of family doctors to NS decreased by 17.72 per one hundred thousand persons, after controlling for other determinants of interprovincial migration. This result has a p-vale of 0.032. Due to the disparities in the size and significance of the coefficient of Policy when we move from column 1 to 3 it is clear that the migration of family doctors out of NS is driving the results. This outflow occurs simultaneously with the inflow of family doctors to ON, as can be seen in column 3 of Table 1. Therefore, it is highly probable that the policy change in ON enticed family doctors into moving from NS to ON.

7. Conclusion

In 2005 the provincial government of ON enacted a tax policy that gave physicians an opportunity to significantly increase their after-tax income by setting up private practices and transferring non-voting shares of the private corporation to family members. A panel data model,

using the DID framework, was employed to address the responsiveness of physician interprovincial migration to ON after the policy change. To estimate the impact of the policy change on physician interprovincial migration from MB, NB, NL, NS, PEI and SK an OLS model was applied to data from each province.

For both the DID and regular OLS model three versions were estimated, one for the net interprovincial migration of physicians to ON. The second and third model were concerned with the migration of specialists and family doctors. There is evidence that the policy change in ON led to an increase in the net interprovincial migration of physicians to that province; and even stronger evidence that inflow of family doctors increased between 2005 – 2018. During the same period there was a significant decrease in the net interprovincial migration of physicians to NS. The result was most pronounced for family doctors, more were arriving in ON and leaving NS between 2005 – 2018. The accessibility of the health care system in NS was threatened by the exodus of so many physicians, while the accessibility of the system in ON was either unaffected or improved after the influx of physicians.

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https://www.cihi.ca/en/scotts-medical-database-metadata

Appendix

Table 3. Marginal Federal Tax Rates 2002 -2019						
Year	Income (Top)			Marginal Tax Rate (Bottom)		
2019	$12,069	$0 – $47,630	$47,630 - $95,259	$95,259 - $147,667	$147,667 - $210,371	over $210,371
	0%	15%	20.50%	26%	29%	33%
2018	$11,809	$0 – $46,605	$46,605 - $93,208	$93,208 - $144,489	$144,489 - $205,842	over $205,842
	0%	15%	20.50%	26%	29%	33%
2017	$11,635	$0 – $45,916	$45,916 - $91,831	$91,831 - $142,353	$142,353 - $202,800	over $202,800
	0%	15%	20.50%	26%	29%	33%
2016	$11,474	$0 – $45,282	$45,282 - $90,563	$90,563 - $140,388	$140,388 - $200,000	over $200,000
	0%	15%	20.50%	26%	29%	33%

2015	$11,327	$0 – $44,701	$44,701 - $89,401	$89,401 - $138,586	over $138,586	
	0%	15%	22%	26%	29%	
2014	$11,138	$0 – $43,953	$43,954 - $87,907	$87,908 - $136,270	over $136,270	
	0%	15%	22%	26%	29%	
2013	$11,038	$0 – $43,561	$43,562 - $87,123	$87,124 - $135,054	over $135,055	
	0%	15%	22%	26%	29%	
2012	$10,822	$0 – $42,706	$42,707 - $85,413	$85,414 - $132,405	over $132,406	
	0%	15%	22%	26%	29%	
2011	$10,527	$0 – $41,544	$41,544 - $83,088	$83,088 - $128,800	over $128,800	
	0%	15%	22%	26%	29%	
2010	$10,382	$0 – $40,970	$40,971 - $81,941	$81,942 - $127,021	over $127,021	

	0%	15%	22%	26%	29%	
2009	$10,320	$0 – $40,726	$40,727 - $81,452	$81,453 - $126,264	over $126,264	
	0%	15%	22%	26%	29%	
2008	$9,600	$0 – $37,885	$37,886 - $75,769	$75,770 - $123,184	over $123,184	
	0%	15%	22%	26%	29%	
2007	$9,600	$0 – $37,178	$37,178 - $74,357	$74,357 - $120,887	over $120,887	
	0%	15%	22%	26%	29%	
2006	$8,839	$0 – $36,378	$36,378 - $72,756	$72,756 - $118,285	over $118,285	
	0%	15.25%	22%	26%	29%	
2005	$8,648	$0 – $35,595	$35,595 - $71,190	$71,190 - $115,739	over $115,739	
	0%	15%	22%	26%	29%	

2004	$8,012	$0 – $35,000	$35,000 - $70,000	$70,000 - $113,804	over $113,804	
	0%	16%	22%	26%	29%	
2003	$7,756	$0 – $32,183	$32,183 - $64,368	$64,368 - $104,648	over $104,648	
	0%	16%	22%	26%	29%	
2002	$7,634	$0 – $31,677	$31,677 - $63,354	$63,354 - $103,000	over $103,000	
	0%	16%	22%	26%	29%	
2001	$7,412	$0 – $30,754	$30,754 - $61,509	$61,509 - $100,000	over $100,000	
	0%	16%	22%	26%	29%	
2000	$7,231	$0 – $30,004	$30,004 - $60,009	over $60,009		
	0%	17%	25%	29%		