

# **A Proposal to Finance Long-Term Care Services through Medicare with an Income Tax Surcharge**

Leonard E. Burman and Richard W. Johnson\*

June 2007

\* Leonard E. Burman, Ph.D., is a senior fellow at the Urban Institute in Washington, D.C., director of the Tax Policy Center in Washington, D.C., and a visiting professor at the Georgetown Public Policy Institute at Georgetown University. Richard W. Johnson, Ph.D., is a principal research associate at the Urban Institute. They gratefully acknowledge Jeffrey Rohaly for modeling the income tax surcharge and for helpful discussions. Financial support came from the Georgetown University Long-Term Care Financing Project, through a grant from the Robert Wood Johnson Foundation. The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders.

# Contents

|  |    |
|--|----|
| Abstract.....  | 1  |
| Introduction .....   | 1  |
| The Current System for Financing Long-Term Care Services .....               | 3  |
| Medicaid .....   | 4  |
| Medicare .....   | 7  |
| Private Long-term Care Insurance.....  | 7  |
| Limitations of the Current System .....                                      | 9  |
| Expanding Medicare to Provide Comprehensive Long-Term Care Services<br>..... | 13 |
| Medicare Part E.....   | 13 |
| Financing.....   | 16 |
| Transition Period.....   | 20 |
| Strengths and Limitations of Our Proposal.....                               | 22 |
| References.....  | 25 |
| Tables.....  | 29 |

# **A Proposal to Finance Long-Term Care Services through Medicare with an Income Tax Surcharge**

Leonard E. Burman and Richard W. Johnson

## **Abstract**

We propose a new system of financing long-term care services in the United States. Our plan expands Medicare to cover comprehensive long-term care services, including home care and custodial nursing home care. Beneficiaries would share in the cost of services through deductibles and copayments, but the program would include stop loss coverage and special protections for low-income adults. By providing long-term care insurance that actually protects the assets of older adults, our proposal would eliminate the disincentive to save inherent in the means-tested Medicaid system. Our plan would also remove the bias in the current system for institutional care, enabling more persons with disabilities to remain at home where most prefer to live. We propose to finance this expansion of Medicare benefits with a surcharge on federal income taxes. Unlike the regressive payroll tax that finances Medicare's hospitalization coverage, the surcharge we propose would not increase tax burdens for low-income individuals or families. All of the revenue generated by the tax would be dedicated to a special Medicare trust fund that would finance future long-term care services.

## **Introduction**

The financing of long-term care services for elderly adults is a critical public policy issue. As baby boomers age, the number of older Americans will soar over the next few decades. Between 2000 and 2040, the population aged 65 and older will almost double, to 77.2 million, while the population aged 85 and older will more than triple, to 14.3 million (U.S. Census Bureau 2000). Despite recent improvements in health at older ages (Manton and Gu 2001; Freedman et al. 2004), many elderly Americans will continue to need assistance with basic

personal care. The Congressional Budget Office (1999, 2004) estimates that the number of Americans aged 65 and older with long-term care needs will increase from 8.8 million in 2000 to at least 12.1 million in 2040.

The family has traditionally been an important provider of care to the frail elderly. Most older persons with disabilities live in the community, not in nursing homes (Feder, Komisar, and Niefeld 2000), and receive care from spouses and adult children (Johnson and Wiener 2006). The availability of informal care is a critical factor in enabling frail elders to live independently in the community (LoSasso and Johnson 2002). However, it is unlikely that family caregivers alone can meet the expected rise in long-term care needs. Women are much more likely than men to provide care to their parents (Mui 1995), but many are being forced to reduce the amount of time they devote to caregiving activities as more and more women enter the labor force. And declining fertility rates may limit the number of adult children who will be available to provide care to their parents in the future. As a result, an increasing number of older adults may rely on paid helpers in the next few decades, either at home or in institutions, to meet their long-term care needs.

Despite the growing importance of formal long-term care services in the United States, there are significant problems with the way in which they are now financed. Most nursing home costs are paid by the public sector today. Although this is clearly a boon for frail elderly Americans, the availability of public funds for long-term care services discourages individuals from preparing for their own long-term care needs when they are young and healthy. Medicaid eligibility rules impose a nearly 100 percent tax on income and assets for nursing home residents. This implicit tax may be an important factor behind the alarmingly low savings rate for middle-class Americans. The current system also favors institutional care over home- and community-based services, which are not as heavily subsidized as nursing home services.

Private insurance is available for long-term care expenses, but coverage rates are very low. Adults may be reluctant to purchase long-term care policies because Medicaid will pay for expenses that exceed their financial resources. Other problems with the private market for long-term care insurance include benefits that often turn out to be inadequate to cover future expenses, high load factors, large year-to-year premium increases and resultant high nonrenewal rates, and serious adverse selection problems.

To remedy the problems with the current system, we propose expanding Medicare to cover comprehensive long-term care services, including home care and custodial nursing home care. Beneficiaries would share in the cost of services through deductibles and copayments, but the program would include stop loss coverage and special protections for low-income adults. By providing long-term care insurance that actually protects the assets of older adults, our proposal would eliminate the disincentive to save inherent in the means-tested Medicaid system. Our plan would also remove the bias in the current system in favor of institutional care, enabling more persons with disabilities to remain at home where most prefer to live. We propose to finance this expansion of Medicare benefits with a surcharge on federal income taxes. Unlike the regressive payroll tax that finances Medicare's hospitalization coverage, the surcharge we propose would not increase tax burdens for low-income individuals or families. All of the revenue generated by the tax would be dedicated to a special Medicare trust fund that would finance future long-term care services.

### **The Current System for Financing Long-Term Care Services**

The cost of long-term care is high and growing. Nursing home care in a semi-private room now costs \$183 per day on average, or nearly \$67,000 per year

(Metlife Mature Market Institute 2006).<sup>1</sup> Spending from all public and private sources for long-term care totaled about \$207 billion in 2005 (Komisar and Thompson 2007). Real nursing home and home health costs nearly quadrupled between 1980 and 2005 (Levit et al. 2002; Poisal et al. 2007), and a recent study projects that costs could quadruple again by 2050 (Tilly, Goldenson, and Kasten 2001). These figures exclude the value of informal care from family and friends, who provide most of the help received by those with disabilities. According to one estimate, annual long-term care spending would increase by about \$200 billion if paid helpers provided the services now offered by informal caregivers (Arno, Levine, and Memmott 1999).

## **Medicaid**

A combination of public and private sources finance long-term care services. Medicaid is the single largest payer of long-term care costs, financing 49 percent of total expenses in 2005 (Komisar and Thompson 2007). It covers institutional care and home health services for eligible adults who cannot pay the full cost themselves. All states also offer Medicaid beneficiaries home- and community-based care services, which provide a variety of nonmedical and social services and supports designed to enable persons with disabilities to remain in the community. These Medicaid services, provided under waiver authority granted by the Department of Health and Human Services, have grown rapidly in recent years.<sup>2</sup> In 2003, spending for the waiver programs reached \$19 billion, nearly double the amount spent in 1998 (Government Accountability Office 2005). Nonetheless, most Medicaid spending for the aged and disabled is still devoted to institutional care, not care received at home or

---

<sup>1</sup> Costs are even higher in some parts of the country. In New York City, for example, the annual cost of a semi-private room in a nursing home averaged about \$120,000 in 2006 (Metlife Mature Market Institute 2006).

<sup>2</sup> Under section 1915(c) of the Social Security Act, states may request waivers of certain federal requirements to develop Medicaid-financed community-based treatment alternatives. The first home and community-based waiver program was established in 1981, and there are currently about 287 programs in effect, covering every state except Arizona, which provides similar Medicaid services to its eligible residents through a federal demonstration program (CMS 2007).

in the community. In 2005, 63 percent of Medicaid long-term care expenditures paid for services in nursing homes and intermediate care facilities (Summer 2007).

Although Medicaid provides fairly comprehensive long-term care services, individuals must meet strict income and asset tests to qualify for coverage. The eligibility rules are complex and vary by state. In most states aged or disabled adults who receive Supplemental Security Income (SSI) automatically qualify for Medicaid. In 2007, the federal SSI limits for individuals are \$623 per month in countable income and \$2,000 in countable assets.<sup>3</sup> (For couples, the monthly limits are \$934 in income and \$3,000 in assets.) Some states impose even more stringent limits for Medicaid participation, corresponding to the eligibility rules for cash assistance programs for the aged and disabled in place before the introduction of the SSI program in 1972.

In most states, individuals who do not qualify for SSI may still receive long-term care services through Medicaid. Federal regulations allow state Medicaid programs to pay for long-term care services for individuals with incomes up to 300 percent of the federal SSI benefit (or \$1,869 per month in 2007). The “300 percent rule” for nursing home care exists in 31 states, and another four states use income thresholds for Medicaid-financed nursing home care that are between 100 percent and 300 percent of the federal SSI benefit (Kassner and Shirey 2000). In a few states, an individual may have more than \$2,000 in assets and still qualify for long-term care services. Most states apply the same limits to determine eligibility for home- and community based services.

---

<sup>3</sup> Countable income excludes \$20 per month in unearned income, \$65 per month in earnings plus one-half of monthly earnings in excess of \$65, the value of food stamps and rent subsidies, and state and locally funded need-based assistance. Countable assets generally exclude the value of owner-occupied housing, an automobile used to obtain medical treatment, certain burial funds, and up to \$2,000 in personal effects.

Individuals with incomes and assets too high to qualify for long-term care services may “spend down” to Medicaid eligibility and receive benefits. In fact, about one-third of discharged nursing home residents admitted as private pay residents had spent down to Medicaid by the time of their discharge (Wiener, Sullivan, and Skaggs 1996). Most state Medicaid programs include medically needy provisions, which exclude medical and long-term care expenses from income when determining program eligibility. However, the income thresholds in medically needy cases are lower than the SSI income thresholds. Medicaid applicants who live in states that do not offer medically needy programs and whose pension and social security incomes exceed the Medicaid eligibility standards can still qualify for long-term care services by assigning their incomes to special trusts, called qualified income trusts or Miller trusts. These trusts release to the applicants income equal to one dollar less than the income eligibility threshold and directs the remainder of the payment to the facility or care provider.

Medicaid pays for long-term care services only after eligible users have exhausted almost all of their resources on their long-term care costs. Aside from income they may protect for a community-dwelling spouse, Medicaid nursing home residents may keep only a small personal needs allowance. By federal law, this allowance must be at least \$30 per month, and may not exceed \$90 per month. Participants in waiver programs that provide home- and community-based services may keep substantially more of their income to cover the expense of living in the community. The maintenance needs allowance, as it is called, varies by state, ranging from 100 percent to 300 percent of the SSI benefit amount (Kassner and Shirey 2000).

Medicaid law requires states to protect the income and assets of spouses of Medicaid nursing home residents. Community-dwelling spouses are entitled to all of the income received in their own names and half of the income they receive jointly with their spouses, plus half of the value of assets held by both

spouses combined. However, states must also establish minimum levels of assets and income that the community spouses can keep even if their resource shares fall short of these levels. The 2007 minimum monthly income allowance for spouses must be at least \$1,650, about twice the federal poverty level for single people, while the minimum asset allowance is \$20,328. States can raise minimum allowances for spouses, but they cannot exceed \$2,541 in monthly income or \$101,640 in assets (in 2007).

### **Medicare**

Some public funding for long-term care comes from Medicare, but it plays a relatively small role, paying only about 20 percent of the nation's long-term care expenses in 2005 (Komisar and Thompson 2007). Medicare covers only temporary stays in certified skilled nursing facilities that follow hospitalizations. It does not cover custodial care. In addition, Medicare coverage ends after 100 days of nursing home care. Medicare does not charge beneficiaries copayments for the first 20 days, but requires daily copayments of \$124 (in 2007) for the last 80 days of coverage.

Medicare also provides limited home health care benefits. It covers medically necessary skilled nursing care, physical therapy, speech language services, and occupational therapy for homebound beneficiaries. Beneficiaries do not need to make copayments. Medicare home health care spending peaked at \$17.9 billion in 1997, more than double the 1992 level, but then declined to \$8.7 billion in 2001 after cost-cutting initiatives in the 1997 Balanced Budget Act and efforts to reduce fraud and abuse (MEDPAC 2006). Spending has rebounded somewhat in recent years, rising to \$12.5 billion in 2005.

### **Private Long-term Care Insurance**

Private insurance is also available to cover long-term care expenses. It generally pays up to a specified amount for nursing home and home health care, typically about \$100 per day (LifePlans Inc. 2000). Policyholders must, however, meet the

policy's disability criteria before they can receive benefits. Nearly all plans now sold allow policyholders to collect payments only if they are severely cognitively impaired or need assistance with at least two activities of daily living (America's Health Insurance Plans 2004). Policies differ in terms of the duration of benefits they provide, the length of the waiting period before benefits are paid, the availability of partial benefits for policyholders who let their coverage lapse, and the availability of inflation escalators. Inflation protection can be especially important for those who purchase their policies in midlife, perhaps 25 or more years before they are likely to incur long-term care costs. However, only about 4 in 10 new policyholders purchased inflation protection in 2000 (Cohen, Weinrobe, and Miller 2002).

Long-term care insurance premiums can be substantial and increase rapidly with age at time of issue. For example, for a policy providing up to four years of benefits, with a \$150 daily benefit and a 90-day waiting period but no inflation protection, the 2002 average annual premium was \$422 for 40-year-old purchasers (America's Health Insurance Plans 2004). The average annual premium for the same policy was \$564 at age 50, \$1,337 at age 65, and \$5,330 at age 79. Once a plan is purchased, premiums do not increase with age, although an insurer can raise premiums for an entire class of policyholders based on their claims experience. Taxpayers who itemize deductions may deduct long-term care insurance premiums for qualifying policies from taxable income to the extent that they (plus other unreimbursed medical expenses) exceed 7.5 percent of adjusted gross income. Premiums may also be paid from health savings accounts on a tax-free basis.

Private long-term care insurance coverage has grown rapidly in recent years. About 9 million policies had been sold by the end of 2002, up from fewer than 1 million in 1987 (America's Health Insurance Plans 2004). Nonetheless, coverage rates remain low. Only about 9 percent of Americans aged 55 and older had private long-term care insurance coverage in 2002 (Johnson and

Uccello 2005). Some employers, including the federal government, offer workers the opportunity to purchase long-term care insurance at group rates, but employers do not generally contribute toward premiums and few employees participate. According to one study, the median participation rate among active employees across a random sample of firms offering long-term care insurance was only 3 percent in 1998 (Lutzky, Corea, and Alecxih 2000). In 2005, private insurance paid only 7 percent of long-term care costs (Komisar and Thompson 2007).

Because of limited public and private benefits, many long-term care costs are paid out of pocket by care recipients and their families. In 2005, out-of-pocket payments accounted for 18 percent of all long-term care costs (Komisar and Thompson 2007). These out-of-pocket payments can be a significant burden. According to data from the Health and Retirement Study (HRS), the median out-of-pocket payment to nursing homes during the two-year period between 2000 and 2002 totaled \$15,000 among nursing home residents who made payments.<sup>4</sup> One-quarter of residents who make out-of-pocket payments spent more than \$52,000.

## **Limitations of the Current System**

The current system does not finance long-term care services in an efficient or fair way. Many families would be better off if they could insure themselves against the risk of catastrophic long-term care expenses. However, many adults with long-term care needs are forced to rely on Medicaid, which provides benefits only after they have exhausted all of their financial resources. Recent Medicaid reforms have increased the level of income and assets that are reserved for spouses, in an effort to provide better financial security for the community-dwelling husbands and wives of nursing home residents, but the

---

<sup>4</sup> Estimates are based on the authors' tabulations. For more information on the HRS, a nationally representative survey of older Americans visit <http://hrsonline.isr.umich.edu/>.

available evidence suggests that these reforms have not substantially improved the economic security of spouses remaining in the community (Norton and Kumar 2000). Moreover, the program is not designed to protect the assets of those receiving long-term care services. It leaves them with nothing to pass on to their heirs and impoverishes those who return to the community after temporary nursing home stays.

Medicaid penalizes those who save for their old age, because it imposes a 100 percent tax on most assets for those who receive long-term care through the program (Hubbard, Skinner, and Zeldes 1995). The savings rate in the U.S. is among the lowest of all industrialized nations. In 2005 and 2006, the U.S. personal savings rate was negative, with personal outlays exceeding disposable personal income (Bureau of Economic Analysis 2006). And most Americans do not accumulate much non-housing wealth outside of Social Security and employer-sponsored retirement plans. For example, median household financial wealth excluding retirement plans for adults aged 55 to 64 was only \$12,000 in 2004.<sup>5</sup>

Another disadvantage of the current system is that Medicaid can distort the choice between home- and institutional-based care. Most older adults prefer to remain in their own homes, instead of moving to nursing homes (AARP 2003). But despite recent improvements, Medicaid rules still make it difficult for frail older adults to receive subsidized care at home. The growth in waiver programs that provide home- and community-based services has expanded long-term care options for many adults with disabilities, but federal law stipulates that the introduction of these programs must not increase Medicaid spending. This condition has forced states to limit eligibility for Medicaid-financed home- and community-based care and impose other requirements to limit costs. As a result, some enrollees in the waiver program cannot afford to

---

<sup>5</sup> Estimates are based on the authors' tabulations.

remain in the community because the monthly stipend that the program allows is too small to cover their living expenses.

The current system also imposes substantial burdens on state governments. Medicaid is a joint federal-state program, with the federal government paying most of the costs. Nonetheless, states end up financing a sizable portion of Medicaid expenses. Medicaid is the second-largest category of state spending from general funds, behind elementary and secondary education, accounting for about 17 percent of total fiscal year 2005 general fund expenditures (National Association of State Budget Officers 2006).<sup>6</sup> According to a 2002 survey, many state Medicaid directors attribute a substantial portion of the recent increase in Medicaid spending to the rising cost of long-term care (Smith et al 2002).<sup>7</sup> The same survey reported that a number of states are considering steps to reduce long-term care costs, including changing facility bed hold policies, instituting new reimbursement methodologies, shutting down nursing homes, and requiring that long-term care facilities have dual Medicare and Medicaid certification.

Private long-term care insurance has a number of attractive features which, if coverage became more widespread, might address many of the problems with the current system. For example, unlike federal and state governments, private insurers must set aside financial reserves to cover future claims. As a result, higher levels of long-term care insurance coverage would increase the pool of savings available to pay for future long-term care services. In addition, competition among insurance companies could keep premiums at a reasonable level. With proper reforms, private insurance would better protect

---

<sup>6</sup> However, Medicaid is the largest category of state spending overall, accounting for nearly 23 percent of all fiscal year 2005 expenditures (National Association of State Budget Officers 2006). Federal funds cover a large share of state Medicaid costs.

<sup>7</sup> Survey respondents most often cited increases in the cost of prescription drugs as a significant factor in the growth in Medicaid expenditures.

the income and assets of recipients of long-term care. Legislation might be needed, however, to mandate that policies provide inflation protection.

Despite these advantages, however, it seems unlikely that private insurance could ever finance long-term care for more than a small minority of older Americans. Many older adults are simply unable to afford long-term care insurance. For example, in 2004 21 percent of married couples aged 55 to 61 had incomes below \$40,000, and 40 percent of unmarried adults had incomes below \$25,000 (Social Security Administration 2006). It is unlikely that these adults could afford to purchase long-term care insurance. Affordability is an even more serious problem for those who delay purchasing coverage until older ages, when annual premiums are much higher. Among those aged 70 to 74, 60 percent of unmarried adults had incomes below \$25,000 in 2000. Some studies have found that only 10 to 20 percent of older adults could afford to purchase long-term care coverage (General Accounting Office 2000).

Many who can afford to purchase coverage discover later that they are unable to maintain their premium payments and let their policies lapse after a few years. Plans often lack nonforfeiture benefits, which provide partial benefits for those who let their policies lapse. As a result, some who fail to renew their policies receive nothing in return for their premium payments, because most policyholders do not use long-term care services until very late in life.

Those with health problems have special difficulty purchasing long-term care insurance. Medical underwriting of policies increases premiums for those in poor health, making their coverage even less affordable. Some in especially poor health may be unable to purchase coverage at any price.

A related problem is adverse selection, which can undermine the private insurance market. At a given premium level, those who expect to use many services are more likely to purchase coverage than those who anticipate lower

usage. As high-cost users dominate the pool of policyholders, insurers need to raise premiums to cover their claims. But raising premiums discourages more low-cost users from purchasing coverage, leading to even higher premiums. This “death spiral,” as it is sometimes called, can cause private insurance markets to break down. A single payer system, such as Medicare, eliminates this problem.

A final challenge for a system of voluntary private insurance is how to treat those who elect not to purchase coverage. Some type of safety net, such as Medicaid, is vital, because a compassionate society demands that every frail adult receive at least a minimal level of care. The presence of a safety net, however, discourages some people from purchasing costly private insurance. This “free rider problem” raises important fairness issues about who receives free care in a system of voluntary private insurance.

## **Expanding Medicare to Provide Comprehensive Long-Term Care Services**

To overcome many of the limitations of the current system, we propose expanding Medicare to cover comprehensive long-term care services. It would provide benefits to all disabled Americans and those aged 65 and older who need long-term care services, and would include special protections for low-income adults. It would be financed by a surcharge on individual income taxes that would be paid by all taxpayers once the plan is fully phased in.

### **Medicare Part E**

Our plan would add a new component to the Medicare system, which we call Medicare Part E. It would cover all nursing home care, including skilled nursing and rehabilitation care as well as custodial care that provides assistance with activities of daily living. It would also cover home care, including both medical services (as currently provided) and custodial care. Our proposal would move

coverage of home health care and skilled nursing facility care that Medicare currently provides out of Parts A and B and into Part E.

Coverage under Part E would begin at age 65 or the age at which younger individuals with disabilities qualify for Medicare Part A. Like Part A, but unlike Part B, coverage would not require monthly premiums, because beneficiaries would have already contributed to their coverage through an income tax surcharge paid throughout most of their adult lives (as described in more detail below). Because the long-term care benefits would be financed through an income tax, not a payroll tax, eligibility would not depend on one's work history or a spouse's work history. Thus Part E would cover all Americans aged 65 and older, including the few elderly adults without Part A coverage.

Our proposal restricts benefits to those who can demonstrate a medical need for supportive services at home or in a nursing home. To qualify for services, beneficiaries would need medical certification that they are severely cognitively impaired or that they have limitations in at least two activities of daily living. Our proposal eliminates the current restriction that beneficiaries must be homebound to qualify for Medicare-financed home health care. Because the program would be phased in over time and all adults currently on Medicare would continue to qualify for the current package of benefits, no one currently receiving long-term care through Medicare would lose benefits. We would not limit the type, amount or duration of services that beneficiaries could receive in a nursing home. Part E would cover all reasonable types of home care services, but would pay for no more than 100 hours of services per month.

We propose an annual deductible of \$500 for all Part E services combined. The deductible would rise each year by the percentage change in the Consumer Price Index (CPI), rounded to the nearest \$50. In addition, beneficiaries would be responsible for 20 percent copayments for Medicare Part E services. However, our proposal also includes stop loss coverage to protect

those with significant long-term care needs, since expenses for nursing home and home care services can mount quickly. We propose to cap copayments at \$5,000 per year. This spending limit would be indexed for inflation based on the CPI.

Many low-income adults could not afford the cost-sharing requirements we propose, even with stop loss protection. However, they could receive help with deductibles and copayments from state Medicaid offices through the current Qualified Medicare Beneficiaries (QMB) program, available to Medicare beneficiaries with incomes below the federal poverty level (or \$851 per month for single adults and \$1,141 per month for married couples in 2007) and countable assets below 200 percent of the SSI limits (currently \$4,000 for single adults and \$6,000 for married couples). Since this program is already in place, it provides an administratively simple way of extending special protections to low-income adults with long-term care needs. One drawback, however, is that relatively few eligible beneficiaries currently participate in these programs (Moon, Brennan, and Segal 1998).

As under the current system, our proposal envisions a mix of private and public health care providers offering long-term care services and receiving reimbursement from Medicare. We anticipate a prospective payment system for long-term care services, similar to that currently in place for skilled nursing facilities and home health agencies that provide Medicare-financed services. Under our plan, nursing homes would receive a set per diem rate for each Medicare patient, adjusted for local wages and the level of services the patient is likely to require, based on the level of impairment. Home care providers would receive a fixed payment for each type of home visit, with adjustments for local labor market conditions.

An expansion of the Medicare program to cover more long-term care services would generate a windfall for state governments. Shifting many long-term care costs out of the Medicaid system would substantially reduce health

care bills paid by the states. Under the current system, states assume responsibility for up to one-half of long-term care costs incurred by virtually all low-income elderly and disabled individuals. Under our proposal, states would pay long-term care costs for only those low-income individuals who do not qualify for Medicare—primarily individuals with developmental disabilities—and they would pay Medicare deductibles and copayments for low-income people in the QMB program. States would welcome a reduction in their Medicaid costs, given the problems they cause for state budgets, but the long-term federal budget outlook is also quite bleak, so this shift in burden may not be feasible.<sup>8</sup> Congress could offset states' long-term care savings by raising the share of costs paid by the states for other Medicaid services.

## **Financing**

The goal of our financing scheme is to fully fund the portion of long-term care costs that would currently be paid by the private sector in a way that approximates the current distribution of expected long-term care costs over a lifetime, and do it in a way that does not discourage people from saving. At present, low-income people pay relatively little for their long-term care costs because most are paid by Medicaid. Middle- and upper-income people pay a share of those costs that tends to increase with income because of the spend-down provisions to qualify for Medicaid. High-income people pay all or most of their costs, either directly or via private long-term care insurance, because they have too much assets and income to qualify for Medicaid.

We propose to finance Medicare Part E from a combination of general revenues (to pay for the portion of such expenditures currently paid by the public sector) and an income tax surcharge (to pay for the currently private

---

<sup>8</sup> The Congressional Budget Office (2005) projects that outlays for Medicare, Medicaid, and Social Security will rise from 9 percent of GDP in 2007 to 19 percent in 2050 under its intermediate spending scenario (which assumes slower growth in health care costs). By comparison, federal tax revenues have averaged about 18 percent of GDP over the past 50 years.

portion). In principle, one could design a surcharge that, over a lifetime, very closely matched each individual's expected long-term care costs, but it would not be practical. Such a tax scheme could be quite complex, depending on age, income, family status, and assets. And there is no good evidence on what younger individuals can expect to spend for their long-term care costs over their lifetime. We contend, however, that a simple flat-rate surcharge appears to be a fair proxy for expected out-of-pocket costs under current law, and it would be simple to administer.<sup>9</sup>

For illustrative purposes, our proposal includes an across-the-board increase in individual tax rates equal to one percentage point. The actual rate would have to be set so as to achieve long-run actuarial balance. Were our plan in place for the 2007 tax year, the lowest marginal tax rates, for taxable income below \$7,825 for single households and \$15,650 for married households filing jointly, would rise from 10 percent to 11 percent, while the top marginal rate, for taxable income in excess of \$349,700, would rise from 35 percent to 36 percent. The surcharge would also apply to the special lower tax rates on capital gains and dividends, currently capped at 15 percent. They would increase to a maximum of 16 percent under the proposal.

If this surcharge were fully phased-in in 2007, it would have generated about \$55 billion in revenue, based on the Tax Policy Center microsimulation model.<sup>10</sup> The trust fund financed by the income tax surcharge would also generate additional revenue. By comparison, total private long-term care costs (not counting the value of caregivers' time) was about \$58 billion in 2005 (Komisar and Thompson 2007), and not all of that would have been reimbursed

---

<sup>9</sup> There are some complexities for the Treasury Department, which would be required to estimate the share of income tax receipts attributable to the surcharge and make transfers to the long-term care trust fund in real time. Those complexities, however, are no more daunting than Treasury's current obligation to estimate revenues from the taxation of Social Security benefits, which are allocated to the Social Security and Medicare trust funds.

<sup>10</sup> Official revenue estimates for the proposal would be lower, because government estimators would assume that the higher tax rates would lead to more tax avoidance and thus produce some offsetting

by our proposal, so the one-percent surcharge appears to be in the right ballpark.

A federal income tax surcharge would be more equitable than the current payroll tax that is used to finance Social Security and Medicare Part A. The current payroll tax is split between employers and employees, with each party paying 6.2 percent of earnings to the Social Security trust fund and 1.45 percent of earnings to the Medicare Part A trust fund. Most economists believe that workers bear the entire burden of the payroll tax, meaning that employers reduce wages to offset the payroll taxes they pay to the government. Thus, the existing payroll tax reduces wages by a total of 15.3 percent. Other types of income, such as capital gains, profits from businesses, and interest, dividend, and rental income, are exempt from this tax. With a federal income tax surcharge, most sources of income would be subject to the special tax, spreading the burden of funding long-term care services more equally across the population.<sup>11</sup>

The current payroll tax is regressive, in that the average tax rate falls with income. High-income taxpayers derive a relatively large share of their income from non-wage sources, such as assets, which are not subject to the payroll tax. In addition, under current rules, annual earnings in excess of a certain amount are not subject to Social Security taxes (although they are subject to the Medicare tax). This threshold, which increases each year by the percentage change in the average wage, is \$97,500 in 2007. Because high wages are exempt from the tax, low-wage workers pay a larger share of their earnings in Social Security taxes than high-wage workers. In fact, three-quarters of filers pay more in payroll tax than in income tax (Gale and Rohaly 2003). An income tax surcharge would be more progressive. Even though all income groups would

---

revenue leakage. This behavioral response, however, would be largely irrelevant to the estimate of how much money should be allocated to the trust fund.

<sup>11</sup> However, the federal income tax does exempt some types of income, such as fringe benefits, contributions and earnings of retirement plans, and public assistance.

face the same increase in tax rate bracket, the individual federal income tax excludes the first several thousand dollars of income from taxation.<sup>12</sup> With an income tax surcharge, then, those better able to pay would make larger contributions to the financing of long-term care services.

Overall, the bottom 40 percent of households would owe very little tax. (See Table 1.<sup>13</sup>) Assuming that the tax had been in place forever in 2007—so that everyone is subject to it—one-third would owe no additional tax at all. The bottom quintile would pay virtually nothing, because few of them owe income tax. The second quintile would contribute about 2 percent of overall revenues, paying an average tax of \$38 per year. The middle quintile would contribute more—8 percent—but the overall contribution would amount to only one-half of one percent of their income (an average of \$147 per year). The fourth quintile would contribute slightly less than their proportional share—almost 19 percent—but the tax would still amount to only 0.7 percent of income (or \$344 on average). In contrast, the top quintile pays 71 percent of the tax. The average tax for the top 1 percent of households would be about \$10,196. This pattern is appropriate as high-income households have the most to gain from a system that does not require them to exhaust their assets before qualifying for governmental assistance to pay for long-term care, but it will probably exceed the amount that they expect to gain, especially for those with very high incomes. Thus, this financing mechanism includes some redistribution from the very wealthy to the middle class.

Because they have less taxable income and qualify for a larger standard deduction, more than 57 percent of households headed by someone aged 65 or

---

<sup>12</sup> In 2007, a single filer could earn \$8,750 before owing tax; a married couple, \$17,500; and a couple with two children, \$24,300 (Tax Policy Center 2007). Filers aged 65 and over qualify for an additional standard deduction of \$1,150 for a single older filer and \$1,050 for each spouse filing a joint return who is at least 65 years of age (\$2,100 for a qualifying couple). Tax credits can raise the filing threshold further for some households, especially those with children (Burman, Maag, and Rohaly 2002).

<sup>13</sup> For more detail, as well as estimates by dollar income classes (rather than percentiles), see tables T07-0103 and T07-0104 for all households and tables T07-0105 and T07-0106 for households headed by someone aged 65 or over, available at <http://www.taxpolicycenter.org/estimates>.

over would owe no additional tax under the fully phased in proposal (table 2). The average tax for senior citizens would be \$264 per year, 29 percent less than the average tax collected from the whole population.

Because Part E benefits would replace some benefits provided under Parts A and B, our proposed Medicare expansion could allow lawmakers to reduce the taxes and premiums that finance the existing Medicare system. Nursing home and home health costs accounted for 15.6 percent of total Part A payments in 2002 and 5.2 percent of total Part B payments (CMS 2006). Thus, by moving all of these costs to Part E, our proposal could lead to a reduction in the Hospital Insurance payroll tax that funds Part A from 1.45 percent (paid by both employers and employees) to 1.22 percent. Or lawmakers could choose to maintain the current tax rate to improve the trust fund's long-run solvency. Our proposal would similarly allow Congress to reduce the monthly premiums that beneficiaries pay for Part B coverage, or use the additional revenues to add years of solvency to the program.

Revenue raised by the income tax surcharge would be set aside in a special trust fund, dedicated to financing Medicare Part E services. The trust fund would be invested in nongovernmental securities, so that revenues raised would be exactly offset by outlays and could thus not be used to mask budget deficits. Income earned on trust fund balances would also be totally outside budgetary accounts, and therefore less susceptible to diversion. This trust fund would create a pool of savings that could be used to meet future long-term care needs, something that is missing from the current system.

### **Transition Period**

We propose to phase in our reforms gradually over time. This would allow the Part E trust fund to accumulate substantial reserves before it begins to make payouts. It also would treat different birth cohorts fairly. For example, members of earlier birth cohorts who have already purchased private long-term

care insurance should not also have to contribute to a public insurance program, while those who never contributed to the public system should not receive its benefits.

Our proposal would cover those younger than age 55 at the time the plan first goes into effect.<sup>14</sup> For example, if the income tax surcharge begins in 2008, it would apply only to those born after 1953. Older adults would not be subject to the surcharge, and they would continue to rely on the current system of Medicaid, Medicare Part A, private long-term care insurance, and out-of-pocket payments to meet their long-term care needs. Since very few people purchase private long-term care insurance before age 55, our plan would exclude almost all adults who already have private coverage. Persons with disabilities who qualify for Medicare before age 65 could begin to receive Medicaid Part E benefits five years after the tax surcharge begins.

Our plan would give adults aged 55 to 59 at the time the plan is first implemented the option of enrolling in Medicare Part E. However, they would face higher income tax surcharge rates than younger individuals. Instead of a one percentage point income tax surcharge, those age 55 when the plan began would be subject to a 2 percentage point surcharge for the rest of their lives (or until they no longer receive enough taxable income to pay federal income taxes). The surcharge would increase by one-third of a percentage point for each yearly birth cohort, until age 59. Thus, those aged 57 when the plan began would face an income tax surcharge of 2.67 percentage points if they elect to participate in Medicare Part E, while those age 59 would face a surcharge of 3.33 percentage points.<sup>15</sup> Including this voluntary transition group would add

---

<sup>14</sup> Special transition rules would need to be developed for older people married to younger spouses. A 65-year-old taxpayer would be exempt from the tax during the transition period, whereas her younger spouse would be subject to it. Since income tax is calculated based on joint income, this creates a complication. One possible solution would be to average the tax rate that would apply to each spouse. Thus the couple just described would pay a 0.5 percent tax rate and only the younger spouse would be covered.

<sup>15</sup> Because Part A of Medicare is funded primarily on a pay-as-you-go basis, with today's taxpayers financing benefits for today's older adults, the Hospital Insurance payroll tax rates could not be lowered

complexity to the proposal, because the IRS would have to make sure that individuals who had opted into Medicare Part E paid a higher tax for the rest of their lives.

## **Strengths and Limitations of Our Proposal**

We believe our proposal to reform the long-term-care financing system has a number of important advantages. It provides coverage for comprehensive long-term care services, including home care, for all Americans with disabilities who qualify for Medicare. It reduces distortions between the choice of home- and institutional-based care by covering both service modalities at the same rate. To keep program costs down, our proposal requires cost sharing by beneficiaries, but also provides protections for low-income adults. It insures individuals and families against the risk of catastrophic expenses after the onset of frailty, and protects the assets of those who need care. As a result, it substantially reduces the implicit tax on savings caused by current Medicaid rules, and may encourage more Americans to save for their old age.

By relying on a surcharge on federal income taxes, our plan distributes the burden of financing the proposed expansion of the Medicare program widely across the population. Unlike a payroll tax, it does not exempt nonwage income from taxation. Yet it shields from additional taxes low-income adults and families with the least ability to pay. By creating a mandatory program that requires all taxpayers to contribute to the cost of financing long-term care services, our proposal eliminates the free rider problem inherent in a voluntary private insurance program. It also avoids raising taxes on most people who currently receive subsidized long-term care from Medicaid. And it could provide important budgetary relief for state governments, which now spend

---

immediately after the creation of Part E. For the same reasons, we also do not anticipate that funds could be moved out of the Part A trust fund.

about one-sixth of their budgets on Medicaid. Alternatively, it could help reduce the long-term imbalances in the Medicare program.

The proposal would raise national savings two ways. First, it would eliminate the strong disincentives to save created by the existence of highly subsidized long-term care services under Medicaid and the asset spend-down rules to qualify for those services. Second, by advance funding future long-term care costs via a trust fund that is invested in private nongovernmental assets, the proposal would directly increase national savings (assuming that the trust fund is not offset by larger public deficits). Higher national saving would improve the nation's ability to cope with the long-run fiscal imbalances that will start with the retirement of the baby boom generation.

However, our plan does not solve every problem confronting the way in which we now finance long-term care in this country. For one thing, our proposal does very little to help the current cohort of older Americans pay their long-term care bills. Because we phase in our program slowly over time, and the oldest potential participants are currently less than 60 years old, it will take about 20 years for the plan to have a major impact on the way in which long-term care services are financed. In the meantime, those in need of long-term care would continue to run the risk of catastrophic long-term care expenses and the loss of a lifetime of savings. If implemented quickly, however, our plan would provide mandatory coverage for half of baby boomers and optional coverage for most of them. The real long-term care crisis will not emerge until about 2030, when disability rates are likely to surge within this large cohort of Americans, born between 1946 and 1964 (Knickman and Snell 2002).

Another potential problem with our plan is that it will hurt the private insurance industry. If enacted, our proposal would gradually eliminate the market for private long-term care insurance, a rapidly growing product for an influential industry. The industry's opposition could impede efforts to implement the plan. In principle, a system of private insurance could be

designed along the lines of this plan. The federal government could make an annual payment to the insurer of choice, ideally with adjustments for difference in health status and thus expected utilization. The long-term care insurance industry would have to invent a system of totally portable insurance with protection from health care cost inflation, guaranteed issue and renewability, and a uniform set of minimum benefits. An accurate form of risk assessment would be necessary to deter cherry-picking, by which insurers cover the lowest risk persons to maximize profits.

The principal political drawback of our proposal may be that it calls for a substantial expansion of a public program and an income tax surcharge at a time when many have concerns about the size of the public sector and the burden of federal taxes. The recent trend has been to cut taxes, not increase them. In addition, the expansion of Medicare to include coverage of prescription drugs may complicate efforts to add comprehensive long-term care services to Medicare. Given concerns about Medicare's long-term financial health, lawmakers may be reluctant to embrace another expansion of the program to cover even more services.

## References

- AARP. 2003. "Beyond 50 2003: A Report to the Nation on Independent Living and Disability." Washington, DC: AARP.
- America's Health Insurance Plans. 2004. "Long-Term Care Insurance in 2002." Washington, DC: America's Health Insurance Plans.
- Arno, Peter S., Carol Levine, and Margaret M. Memmott. 1999. "The Economic Value of Informal Caregiving." *Health Affairs* 18(2): 182-88.
- Bureau of Economic Analysis. 2006. "Personal Income and Its Disposition." <http://www.bea.gov/national/nipaweb/TableView.asp?SelectedTable=58&FirstYear=2004&LastYear=2006&Freq=Qtr>.
- Burman, Leonard, Elaine Maag, and Jeffrey Rohaly. 2002. "The Effect of the 2001 Tax Cut on Low- and Middle-Income Families and Children." *Tax Policy Discussion Paper No. 1*. Washington, DC: Tax Policy Center.
- Centers for Medicare and Medicaid Services. 2006. *Health Care Financing Review: Medicare and Medicaid Statistical Supplement, 2004*. Baltimore, MD: Centers for Medicare and Medicaid Services.
- . 2007. "HCBS Waivers Section 1915(c)." Baltimore, MD: Centers for Medicare and Medicaid Services. [http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/05\\_HCBSWaivers-Section1915\(c\).asp](http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915(c).asp).
- CMS. See Centers for Medicare and Medicaid Services.
- Cohen, Marc A., Maurice Weinrobe, and Jessica Miller. 2002. "Inflation Protection and Long-Term Care Insurance: Finding the Gold Standard of Adequacy." AARP Public Policy Institute Report No. 2002-09. Washington, DC: AARP.
- Congressional Budget Office. 1999. "Projections of Expenditures for Long-Term Care Services for the Elderly." *CBO Memorandum*. Washington, DC: Congressional Budget Office.
- . 2004. "Financing Long-Term Care for the Elderly." Washington, DC: U.S. Government Printing Office. <http://www.cbo.gov/ftpdocs/54xx/doc5400/04-26-LongTermCare.pdf>.
- . 2005. *The Long-Term Budget Outlook*. Washington, DC: U.S. Government Printing Office.
- Feder, Judith, Harriet L. Komisar, and Marlene Niefeld. 2000. "Long-Term Care in the United States: An Overview." *Health Affairs* 19(3): 40-56.

- Freedman, Vicki A., Eileen Crimmins, Robert F. Schoeni, Brenda C. Spillman, Hakan Aykan, Ellen Kramarow, Kenneth Land, James Lubitz, Kenneth Manton, Linda G. Martin, Diane Shinberg, and Timothy Waidmann. 2004. "Resolving Inconsistencies in Trends in Old-Age Disability: Report from a Technical Working Group." *Demography* 41(3): 417-41.
- Gale, William G., and Jeffrey Rohaly. 2003. "Three-Quarters of Filers Pay More in Payroll Taxes Than in Income Taxes." Washington, DC: The Urban-Brookings Tax Policy Center.  
[http://www.taxpolicycenter.org/commentary/taxfacts/payroll\\_income.pdf](http://www.taxpolicycenter.org/commentary/taxfacts/payroll_income.pdf).
- General Accounting Office. 2000. "Long-Term Care Insurance: Better Information Critical to Prospective Purchasers." Testimony Before the Special Committee on Aging, U.S. Senate. Report No. GAO/T-HEHS-00-196. Washington, DC: General Accounting Office.
- Government Accountability Office. 2005. "Long-Term Care Financing: Growing Demand and Cost of Services Are Straining Federal and State Budgets." GAO-05-564T. Washington, DC: Government Accountability Office.  
<http://www.gao.gov/new.items/d05564t.pdf>.
- Hubbard, R. Glenn, Jonathan Skinner, and Stephen P. Zeldes. 1995. "Precautionary Savings and Social Insurance." *Journal of Political Economy* 103(3): 360-99.
- Johnson, Richard W., and Cori E. Uccello. 2005. "Is Private Long-Term Care Insurance the Answer?" Issue in Brief No. 29. Chestnut Hill, MA: Center for Retirement Research at Boston College.  
[http://www.bc.edu/centers/crr/ib\\_29.shtml](http://www.bc.edu/centers/crr/ib_29.shtml).
- Johnson, Richard W., and Joshua M. Wiener. 2006. "A Profile of Frail Older Americans and Their Caregivers." Washington, DC: The Urban Institute.  
<http://www.urban.org/publications/311284.html>.
- Kassner, Enid, and Lee Shirey. 2000. "Medicaid Financial Eligibility for Older People: State Variations in Access to Home and Community-Based Waiver and Nursing Home Services." AARP Public Policy Institute Report No. 2000-06. Washington, DC: AARP.
- Knickman, James R., and Emily K. Snell. 2002. "The 2030 Problem: Caring for Aging Baby Boomers." *Health Services Research* 37(4): 849-84.
- Komisar, Harriet L., and Lee Shirey Thompson. 2007. "National Spending for Long-Term Care." Washington, DC: Georgetown University Long-Term Care Financing Project.  
<http://ltc.georgetown.edu/pdfs/natspendfeb07.pdf>.

- Levit, Katharine, Cynthia Smith, Cathy Cowan, Helen Lazenby, and Anne Martin. 2002. "Inflation Spurs Health Spending in 2000." *Health Affairs* 21(1): 172-81.
- LifePlans, Inc. 2000. "Who Buys Long-Term Care Insurance in 2000: A Decade of Study of Buyers and Nonbuyers." Washington, DC: Health Insurance Association of America.
- LoSasso, Anthony T., and Richard W. Johnson. 2002. "Does Informal Care From Adult Children Reduce Nursing Home Admissions for the Elderly?" *Inquiry* 39(3): 279-97.
- Lutzky, Steven, John Corea, and Lisa Alecxih. 2000. "A Survey of Employers Offering Group Long-Term Care Insurance to Their Employees." Final Report to the Office of Disability, Aging, and Long-Term Care Policy, U.S. Dept. of Health and Human Services.  
<http://aspe.hhs.gov/daltcp/reports/ltcinsfr.htm>.
- Manton, Kenneth G., and XiLiang Gu. 2001. "Changes in the Prevalence of Chronic Disability in the United States Black and Nonblack Population Above Age 65 From 1982 to 1999." *Proceedings of the National Academy of Sciences* 98(11): 6354-59.
- MEDPAC. 2006. "A Data Book: Healthcare Spending and the Medicare Program." Washington, DC: Medicare Payment Advisory Commission.  
[http://medpac.gov/publications/congressional\\_reports/Jun06DataBook\\_Entire\\_report.pdf](http://medpac.gov/publications/congressional_reports/Jun06DataBook_Entire_report.pdf).
- MetLife Mature Market Institute. 2006. "MetLife Market Survey of Nursing Home and Home Care Costs." New York: Metropolitan Life Insurance Company.  
<http://www.metlife.com/WPSAssets/21052872211163445734V1F2006NHHCMarketSurvey.pdf>.
- Moon, Marilyn, Niall Brennan, and Misha Segal. 1998. "Options for Aiding Low-Income Medicare Beneficiaries." *Inquiry* 35: 346-56.
- Mui, Ada C. 1995. "Caring for Frail Elderly Parents: A Comparison of Sons and Daughters." *The Gerontologist* 35(1): 86-93.
- National Association of State Budget Officers. 2006. *Fiscal Year 2005 State Expenditure Report*. Washington, DC: National Association of State Budget Officers.  
<http://www.nasbo.org/Publications/PDFs/2005%20State%20Expenditure%20Report.pdf>.
- Norton, Edward C., and Virender Kumar. 2000. "The Long-Run Effect of the Medicare Catastrophic Coverage Act." *Inquiry* 37(2): 173-87.

- Poial, John A., Christopher Truffer, Sheila Smith, Andrea Sisko, Cathy Cowan, Sean Keehan, Bridget Dickensheets, and the National Health Expenditure Accounts Projections Team. 2007. "Health Spending Projections Through 2016: Modest Changes Obscure Part D's Impact." *Health Affairs Web Exclusive* w242-53.
- Smith, Vernon, Eileen Ellis, Kathy Gifford, Rekha Ramesh, and Victoria Wachino. 2002. *Medicaid Spending Growth: Results From a 2002 Survey*. Washington, DC: The Henry J. Kaiser Family Foundation.
- Social Security Administration. 2006. *Income of the Population 55 or Older, 2004*. Washington, DC: Social Security Administration.
- Summer, Laura. 2007. "Medicaid and Long-Term Care." Washington, DC: Georgetown University Long-Term Care Financing Project. <http://ltc.georgetown.edu/pdfs/medicaid2006.pdf>.
- Tax Policy Center. 2007. "Personal Exemption and Standard Deduction 2001-2007." <http://www.taxpolicycenter.org/TaxFacts/TFDB/TFTemplate.cfm?Docid=389>.
- Tilly, Jane, Susan Goldenson, and Jessica Kasten. 2001. "Long-Term Care: Consumers, Providers, and Financing." Washington, DC: The Urban Institute.
- U.S. Census Bureau. 2000. "Projections of the Total Resident Population by 5-Year Age Groups, and Sex with Special Age Categories: Middle Series, 2025 to 2045." <http://www.census.gov/population/projections/nation/summary/np-t3-f.pdf>.
- Wiener, Joshua M., Catherine M. Sullivan, and Jason Skaggs. 1996. "Spending Down to Medicaid: New Data On the Role of Medicaid in Paying for Nursing Home Care." AARP Public Policy Institute Report No. 9607. Washington, DC: American Association of Retired Persons.

## Tables

**Table 1**  
**Distribution of One Percentage Point Individual Income Tax Surcharge**  
**Fully Phased in, by Cash Income Percentile, 2007**<sup>1</sup>

| Cash Income Percentile <sup>2,3</sup> | Percent of<br>Tax Units<br>with Tax<br>Increase <sup>4</sup> | Average Tax<br>Change (\$) | Percent of<br>After-Tax<br>Income <sup>5</sup> | Share of<br>Total<br>Federal Tax<br>Change |
|---------------------------------------|--|----------------------------|--|--|
| <b>Lowest Quintile</b>                | 9.1  | 2                          | 0.0  | 0.1  |
| <b>Second Quintile</b>                | 46.6   | 38                         | -0.2   | 2.1  |
| <b>Middle Quintile</b>                | 81.0   | 147                        | -0.5   | 7.9  |
| <b>Fourth Quintile</b>                | 96.7   | 344                        | -0.7   | 18.5                                       |
| <b>Top Quintile</b>                   | 98.7   | 1,323                      | -0.9   | 71.4                                       |
| <b>All</b>                            | 66.4   | 371                        | -0.7   | 100.0                                      |
| <b>Addendum</b>                       |  |                            |  |  |
| <b>Top 10 Percent</b>                 | 99.3   | 2,106                      | -1.0   | 56.8                                       |
| <b>Top 5 Percent</b>                  | 99.2   | 3,387                      | -1.0   | 45.7                                       |
| <b>Top 1 Percent</b>                  | 99.2   | 10,196                     | -1.1   | 27.5                                       |

Source: Urban-Brookings Tax Policy Center Microsimulation Model (version 1006-1).

(1) Calendar year. Baseline is current law. Proposal would increase individual income tax rates from 10, 15, 25, 28, 33, and 35 percent to 11, 16, 26, 29, 34, and 36 percent. Alternative minimum tax rates would increase from 26 and 28 percent to 27 and 29 percent. Rates on long-term capital gains and qualifying dividends would increase from 15 to 16 percent (from 5 percent to 6 percent

(2) Tax units with negative cash income are excluded from the lowest income class but are included in the totals. For a description of cash income, see

(3) For the income levels at each quintile and the top income percentiles used in this table, see <http://www.taxpolicycenter.org/TaxModel/percentiles.cfm>

(4) Includes both filing and non-filing units but excludes those that are dependents of other tax units.

(5) After-tax income is cash income less: individual income tax net of refundable credits; corporate income tax; payroll taxes (Social Security and Medicare); and estate tax.

**Table 2**  
**Distribution of One Percentage Point Individual Income Tax Surcharge**  
**Tax Units with Head Aged 65 and Over**  
**Fully Phased in, by Cash Income Percentile, 2007<sup>1</sup>**

| Cash Income Percentile <sup>2,3</sup> | Percent of<br>Tax Units<br>with Tax<br>Increase <sup>4</sup> | Average Tax<br>Change (\$) | Percent of<br>After-Tax<br>Income <sup>5</sup> | Share of<br>Total<br>Federal Tax<br>Change |
|---------------------------------------|--|----------------------------|--|--|
| Lowest Quintile                       | 0.9  | 0                          | 0.6  | 0.0  |
| Second Quintile                       | 18.1   | 12                         | 1.9  | 1.2  |
| Middle Quintile                       | 41.7   | 55                         | 3.7  | 3.6  |
| Fourth Quintile                       | 92.1   | 299                        | 14.3   | 19.9                                       |
| Top Quintile                          | 98.1   | 1,362                      | 79.3   | 75.3                                       |
| All                                   | 42.7   | 264                        | 100.0  | 100.0                                      |
| <b>Addendum</b>                       |  |                            |  |  |
| Top 10 Percent                        | 99.1   | 2,172                      | 66.9   | 60.1                                       |
| Top 5 Percent                         | 99.0   | 3,194                      | 57.4   | 50.3                                       |
| Top 1 Percent                         | 99.7   | 8,670                      | 37.3   | 31.8                                       |

Source: Urban-Brookings Tax Policy Center Microsimulation Model (version 1006-1).

(1) Calendar year. Baseline is current law. Proposal would increase individual income tax rates from 10, 15, 25, 28, 33, and 35 percent to 11, 16, 26, 29, 34, and 36 percent. Alternative minimum tax rates would increase from 26 and 28 percent to 27 and 29 percent. Rates on long-term capital gains and qualifying dividends would increase from 15 to 16 percent (from 5 percent to 6 percent for lower-income taxpayers).

(2) Tax units with negative cash income are excluded from the lowest income class but are included in the totals. For a description of cash income, see <http://www.taxpolicycenter.org/TaxModel/income.cfm>

(3) For the income levels at each quintile and the top income percentiles used in this table, see <http://www.taxpolicycenter.org/TaxModel/percentiles.cfm>

(4) Includes both filing and non-filing units but excludes those that are dependents of other tax units.

(5) After-tax income is cash income less: individual income tax net of refundable credits; corporate income tax; payroll taxes (Social Security and Medicare); and estate tax.