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Medicare's Financial Status

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SUMMARY

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Medicare's Financial Status

Medicare, the federal health insurance program that pays for covered health services for enrolled beneficiaries, provided coverage to approximately 70.7 million beneficiaries in 2026 and incurred total expenditures of approximately $1.30 trillion. The Hospital Insurance (HI) trust fund, which finances Medicare Part A, is funded primarily through payroll taxes and accumulated trust fund assets. The Supplemental Medical Insurance (SMI) trust fund, which finances Medicare Parts B and D, is funded primarily through beneficiary premiums and transfers from the general fund of the Treasury. Unlike the HI trust fund, the SMI trust fund's finances are updated automatically each year to cover projected expenditures and therefore is not subject to the same solvency concerns.

The 2026 Medicare Trustees Report projects that Medicare expenditures will continue to increase as a share of the economy over the long term. The trustees estimate that the present value of Medicare's total unfunded obligations over the 75-year projection period increased from $60.3 trillion in the 2025 report to $65.3 trillion in the 2026 report. The trustees project that the HI trust fund will remain solvent through 2032 and that accumulated trust fund assets will be exhausted in 2033 under current law. At that time, incoming revenues are projected to be sufficient to cover approximately 89% of scheduled Part A expenditures. These projections illustrate the long-term financing challenges facing the Medicare program under current law and provide a framework for evaluating potential policy options for adjusting Medicare revenues, expenditures, and trust fund solvency.

This report provides an overview of Medicare financing and the financial status of the Medicare program based primarily on the findings of the 2026 Medicare Trustees Report. It describes the structure of Medicare, the sources of financing for the HI and SMI trust funds, and the operation of the trust funds. In addition, the report summarizes Medicare spending and trust fund operations in 2025, reviews the trustees' projections for future revenues and expenditures, and discusses selected measures used to evaluate Medicare's long-term financial outlook.

The report also discusses historical examples in which Congress enacted legislation to improve the financial status of the HI trust fund through revenue increases, expenditure reductions, or both; describes the factors contributing to projected Medicare spending growth, including enrollment growth, inflation, and increases in spending per beneficiary associated with changes in health care utilization, service intensity, medical technologies, and prescription drugs; and reviews projections of Medicare spending as a share of gross domestic product (GDP), estimates of Medicare's long-term unfunded obligations, and alternative projections presented by the trustees.

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Overview of the Medicare Program

Medicare is the federal health insurance program that pays for covered health services for enrolled beneficiaries: most persons aged 65 years and older and certain permanently disabled individuals under the age of 65.[1] As a health insurance program, Medicare pays health care providers and suppliers, such as hospitals, physicians, and medical equipment companies, for the services and products they provide to Medicare beneficiaries.

There are no specific aggregate caps on the annual amount of Medicare spending. Spending under the program (except for a portion of administrative costs) is mandatory spending and is not subject to the appropriations process. Medicare is prohibited by law from interfering in the practice of medicine or controlling how medical services are provided. In addition, Medicare is required to pay for covered services provided to eligible persons so long as specific criteria are met. As a result, the growth in per-person Medicare expenditures largely reflects the medical practices, use of technology, and underlying costs in the broader health care system.

Since its enactment in 1965, the Medicare program has undergone considerable change. Spending and enrollment have grown rapidly. Between 2005 and 2026, expenditures increased by 285%, to a total of $1.30 trillion in 2026, and enrollment grew 66%, to a total of 70.7 million beneficiaries.[2] Growth in enrollment has been driven largely by the aging of the baby boom generation, while spending growth has reflected increased enrollment, rising health care costs, and benefit expansions such as enactment of the Part D prescription drug benefit in 2003. Because of its rapid growth, both in terms of aggregate dollars and as a share of the federal budget, the Medicare program has been projected to exhaust the balance of its Hospital Insurance Trust Fund and to increase fiscal pressures on the general fund of the Treasury. The program has been a major focus of deficit reduction legislation passed by Congress.[3] With a few exceptions, reductions in program spending have been achieved largely through freezes or reductions in payments to health providers, primarily hospitals and physicians, and by making changes to beneficiary premiums and other cost-sharing requirements. For example, the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) made numerous changes that modified provider reimbursements and established incentives to improve the quality and efficiency of care.[4]

Four Parts of Medicare

Medicare consists of four distinct parts, A through D:

- **Part A** covers inpatient hospital services, skilled nursing care, hospice care, and some home health services. Most persons aged 65 and older are entitled to premium-free Part A because they or their spouse paid payroll taxes for at least

[1] For additional information on the Medicare program, see CRS Report R40425, *Medicare Primer*.

[2] Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *The 2026 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, June 9, 2026 (hereinafter, the 2026 Report of the Medicare Trustees), Table V.B3 and V.H4, https://www.cms.gov/oact/tr/2026.

[3] For a brief history of changes to the Medicare program, see CRS Report R40425, *Medicare Primer*.

[4] For details on individual Medicare provisions in the Patient Protection and Affordable Care Act (ACA; 111-148, as amended), see CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*.

40 quarters (10 years) on earnings covered by either the Social Security or the Railroad Retirement systems.[5]

- **Part B** covers a broad range of medical services, including physician services, outpatient laboratory services, durable medical equipment, and outpatient hospital services. Enrollment in Part B is optional, and most beneficiaries with Part A also enroll in Part B.
- **Part C** (Medicare Advantage, or MA) is a private plan option for beneficiaries that covers all Parts A and B services, except hospice. MA plans may offer additional benefits not covered by Parts A and B. Individuals choosing to enroll in Part C must be eligible for Part A and must also enroll in Part B. About 51% of Medicare beneficiaries are enrolled in MA.[6]
- **Part D** covers outpatient prescription drug benefits. Like Part C, Part D is optional. About 82% of Medicare beneficiaries are enrolled in Medicare Part D or have coverage through an employer retiree plan subsidized by Medicare.[7]

Beneficiary Costs

In addition to paying premiums for Medicare Parts B and D,[8] beneficiaries may pay other out-of-pocket costs, such as deductibles and coinsurance, for services provided under all parts of the Medicare program. There is no limit on beneficiary out-of-pocket spending for Parts A and B. As a result, most beneficiaries have some form of supplemental insurance through private Medigap plans, employer-sponsored retiree plans, or Medicaid to help cover a portion of their Medicare premiums, deductibles and coinsurance, or both.

Beneficiary liability for out-of-pocket costs varies depending on the type of Medicare coverage. For example, Medicare Advantage plans are required to include an annual maximum out-of-pocket limit for Part A and Part B services, while Medicare Part D prescription drug coverage includes an annual cap on beneficiaries' out-of-pocket spending for covered prescription drugs. Consequently, beneficiaries' financial exposure can differ substantially depending on their source of supplemental coverage and which Medicare Part(s) they choose to enroll in.

Provider and Plan Payments

Under traditional Medicare, Parts A and B, the federal government generally pays providers directly for services on a *fee-for-service* basis using different prospective payment systems, or fee schedules.[9] Under Parts C and D, Medicare pays private insurers a monthly *capitated* per-person

[5] The number of quarters of coverage required depends on whether the person is filing for Part A based on age, disability, or end-stage renal disease (ESRD).

[6] The 2026 Report of the Medicare Trustees, Table V.B3. https://www.cms.gov/oact/tr/2026.

[7] Ibid.

[8] Beneficiaries enrolled in a Medicare Advantage (MA; Part C) plan must pay Part B premiums as well as any additional premium required by the MA plan. Individuals who have not reached the requirements for full Part A eligibility may also pay a premium for Part A.

[9] Under a *prospective payment system* (PPS), Medicare payments are made using a predetermined, fixed amount based on the classification system for a particular service or bundle of services. The Centers for Medicare & Medicaid Services (CMS) uses separate PPSs to reimburse acute inpatient hospitals, home health agencies, hospice, hospital outpatient departments, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities. A *fee schedule* is a listing of fees used by Medicare to pay doctors or other providers/suppliers. Fee schedules are used to pay for physician services; ambulance services; clinical laboratory services; and durable medical equipment, prosthetics, orthotics, and supplies in certain locations.

amount to provide coverage to enrollees. The capitated payments are risk adjusted to reflect differences in the relative cost of sicker beneficiaries with different risk factors, including age, diagnoses, and end-stage renal disease.

Medicare Trust Funds and Sources of Revenue

Medicare is administered by the Centers for Medicare & Medicaid Services (CMS). The Medicare program is financed through two separate trust funds: the Hospital Insurance (HI) trust fund, which finances Part A, and the Supplementary Medical Insurance (SMI) trust fund, which finances Parts B and D.[10] Both the HI and SMI trust funds are maintained by the Department of the Treasury and overseen by a Medicare Board of Trustees that reports annually to Congress concerning the current and projected financial status of the trust funds.[11] By law, the Medicare Trustees Report focuses on the financial status of the program's trust funds and does not examine the impact of Medicare spending on the overall federal budget. Financial projections are made using economic assumptions based on current law, including estimates of consumer price index (CPI), workforce size, wage increases, and life expectancy.

The Medicare trust funds are financial accounts in the U.S. Treasury into which all income to the program is credited and from which all benefits and associated administrative costs of the program are paid. As long as a trust fund has a positive balance, the Department of the Treasury is authorized to make payments for the trust fund from the U.S. Treasury.

Hospital Insurance Trust Fund

Medicare Part A benefits are financed through the Hospital Insurance trust fund. Although the HI trust fund receives revenue from several sources, payroll taxes account for the majority of trust fund income.

Sources of HI Revenue

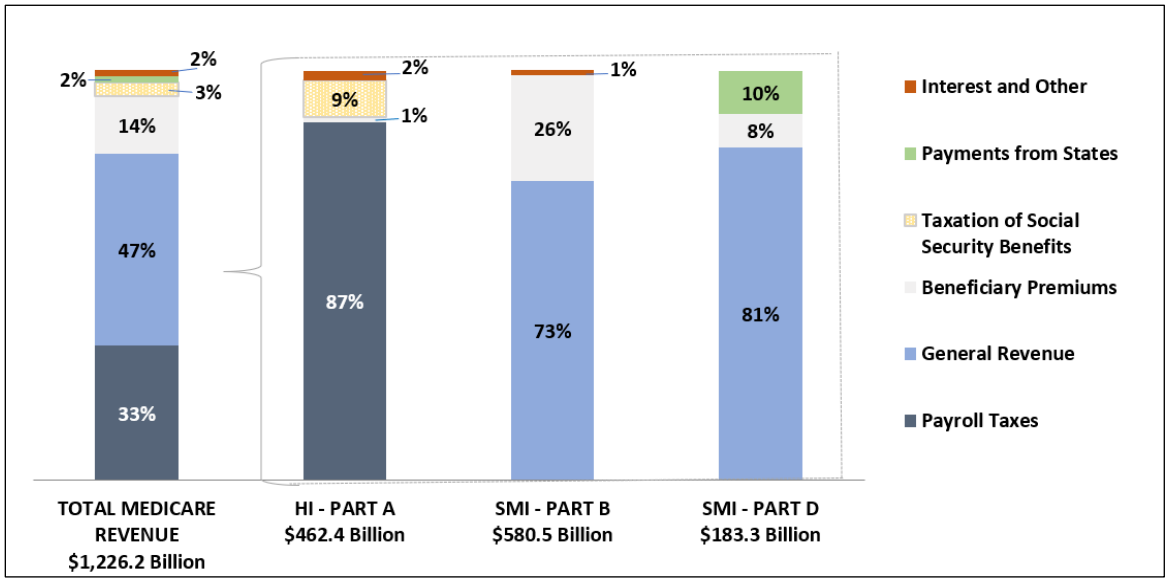
The HI trust fund is funded primarily by a dedicated payroll tax of 2.9% of earnings, shared equally between employers and workers (see **Figure 1**). Unlike Social Security, there is no upper limit on wages subject to Medicare payroll taxes. Beginning in 2013, the ACA imposed an additional tax of 0.9% on high-income workers with wages over $200,000 for single tax filers and over $250,000 for joint filers. Other sources of income to the HI trust fund total less than 15% of receipts. These sources include premiums paid by enrollees who are not entitled to premium-free Medicare Part A, a portion of the federal income taxes paid on Social Security benefits, and interest on federal securities held by the trust fund.[12]

[10] Many government programs are financed through trust funds. Despite the name, federal trust funds are not the same as private-sector trust funds. A trust in the private sector is a fiduciary relationship in which one person (the trustee) holds property for the benefit of another (the beneficiary); the trustee must follow the express terms of the trust instrument and administer the trust for the benefit of the beneficiary. Most federal trust funds are not based on a legal fiduciary relationship. Congress creates trust funds that involve a commitment to use monies for a specific purpose, but it can alter the terms (e.g., receipts, outlays, or purpose) of the trust fund at any time. For additional information, see CRS Report R41328, *Federal Trust Funds and the Budget*.

[11] These reports are available at CMS, "Trustees Report and Trust Funds," at https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/reportstrustfunds.

[12] Under the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66), 85% of Social Security benefits are taxable for individuals with taxable income, after deductions, above a certain threshold, with revenue from 35% of the taxable portion of benefits going to the HI trust fund and the remainder of the revenue going to the Social Security trust funds. For additional, information, see CRS Report RL32552, *Social Security: Taxation of Benefits*.

Figure 1. Sources of Medicare Revenues: 2025



Source: 2026 Report of the Medicare Trustees, June 9, 2026, Table II.B1.

Notes: Totals may not add to 100% due to rounding. HI = Hospital Insurance; SMI = Supplementary Medical Insurance.

Part C (Medicare Advantage) is not shown because it is funded by HI and SMI based on CMS estimates of the proportion of total traditional Medicare spending for Part A and Part B services. In 2024, 39.5% of MA payments were drawn from the HI trust fund and 60.5% were drawn from the SMI trust fund.

HI Trust Fund Mechanics

The HI trust fund operates on a pay-as-you-go basis. Income to the fund, primarily in the form of the taxes paid by current workers and their employers, is used to pay Part A benefits for today's Medicare beneficiaries. When the government receives Medicare revenues, income is credited by the Treasury to the HI trust fund in the form of special-issue interest-bearing government securities.[13] Interest on these securities also is credited to the trust fund. The tax income exchanged for these securities then goes into the general fund of the Treasury and is indistinguishable from other cash in the general fund; this cash may be used for any government spending purpose. When payments for Medicare Part A services are made, the payments are paid out of the general treasury and a corresponding amount of securities is redeemed from the HI trust fund. In other words, the HI trust fund does not maintain a large cash balance. Instead, it holds accumulated credits of special Treasury securities that are redeemed for cash when the trust fund needs to make payments.

In years in which the trust fund spends less than the income it receives, the trust fund securities exchanged for any income in excess of spending are recorded as *assets* on the financial accounting balance sheets and are available to the system to meet future obligations. The trust fund surpluses are not reserved for future Medicare benefits but are simply bookkeeping entries that indicate how much Medicare has lent to the Treasury (or alternatively, what is owed to Medicare by the Treasury). From a unified budget perspective, these assets of the trust fund are offset by liabilities to the general fund of the Treasury because they represent future budget

[13] Unlike marketable Treasury securities, special issues can be redeemed at any time at face value. Investment in special issues gives the trust funds the same flexibility as holding cash.

obligations. If the HI trust fund is unable to pay all current expenses out of current income and accumulated trust fund assets, it is considered to be *insolvent*.[14]

Supplementary Medical Insurance Trust Fund

The SMI trust fund consists of two accounts: Part B and Part D.

Sources of SMI Revenue

Unlike the HI trust fund, the SMI trust fund was not designed in the authorizing legislation to be financed through dedicated payroll taxes. Instead, Medicare Part B and Part D rely on general tax revenues and beneficiary premiums as revenue sources (see **Figure 1**).[15]

The Part B portion of SMI is funded mainly through beneficiary premiums (set at 25% of estimated program costs for the aged),[16] and general revenues finance most of the remaining costs. In 2026, the standard monthly Part B premium is $202.90. However, certain low-income enrollees receive assistance with their premiums from Medicaid (joint federal-state funding). In addition, since 2007, high-income enrollees have paid higher Part B premiums through income-related monthly adjustment amounts (IRMAA). As of 2011, additional revenues from an annual fee imposed on certain manufacturers and importers of branded prescription drugs are also credited to the SMI trust fund.[17]

Part D is financed through a combination of beneficiary premiums (generally set at 25.5% of the estimated cost of the standard benefit), general revenues, and state transfer payments (to cover a portion of the costs of beneficiaries enrolled in both Medicare and Medicaid—the *dual-eligibles*; see **Figure 1**.) Actual Part D premiums may vary depending on which plan an enrollee selects. Low-income enrollees may receive premium assistance through the Part D low-income subsidy (all federal funding); higher-income enrollees have paid higher premiums since 2011.

SMI Trust Fund Mechanics

The level of SMI funding is automatically updated each year to cover expenditures in the upcoming year. If actual costs exceed those estimated when the funding was set, the amount of financing in the next year (i.e., general revenues and beneficiary premiums) may be increased to recover the shortfall. Similarly, if actual costs are less than expected in a given year, general revenue and premium levels needed for the next year may be adjusted downward. Because of these beneficiary premiums and general revenue annual adjustments to meet expected program expenditures, the SMI trust fund is kept in balance and is not subject to the same solvency concerns as the HI trust fund.

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[14] Medicare is periodically reported to be on the verge of *bankruptcy*; however, in the context of federal trust funds, this term is not meaningful. Although a federal trust fund's spending can be greater than its income and trust funds can have a zero balance, unlike private businesses, the federal government is not in danger of "going out of business" or having its assets seized by creditors.

[15] Some reports claim that Medicare beneficiaries receive more from the program than what they have paid into it throughout their working years in payroll taxes. However, as noted above, unlike Part A, the costs of Medicare Parts B and D were designed in the original statute to be subsidized by the government and not through dedicated taxes.

[16] Part B premiums were initially set to cover 50% of estimated costs at the inception of the Medicare program. Beginning in 1972, several laws decreased the share of beneficiary premiums as a percentage of estimated Part B costs, and the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) permanently set the Part B premium at 25% of estimated Part B costs. For additional information, see CRS Report R40082, *Medicare Part B: Enrollment and Premiums*.

[17] This revenue source is included in "Interest and Other" for Part B in **Figure 1**.

HI and SMI Trust Funds Jointly Finance Part C

Medicare Advantage (Part C) does not have its own trust fund. Instead, MA is financed by the HI and SMI trust funds. Medicare pays private health plans monthly capitated per-person payments to provide the equivalent of Part A and Part B coverage to beneficiaries enrolled in MA. These MA payments are drawn in appropriate percentages from the HI and SMI trust funds based on CMS estimates of spending for Part A and Part B services. In 2025, 39.5% of MA payments were drawn from the HI trust fund and 60.5% were drawn from the SMI trust fund.[18] This percentage split is an aggregate estimate by CMS. The actual percentages of MA payments spent between Part A and Part B services vary by MA beneficiary and are not publicly reported by most MA plans. Medicare Part D benefits offered through Medicare Advantage prescription drug plans are financed separately through the SMI trust fund's Part D account.

Medicare Spending in 2025[19]

In CY2025, Medicare provided benefits to about 69.3 million people (62.2 million people aged 65 and older and 7.1 million disabled people under the age of 65), at an estimated total cost of $1,226 billion.[20] Most of that amount, about $1,198 billion (99%), was spent on program benefits, with the remaining amount used for program administration (see **Table 1**).

2025 HI Operations

At the beginning of CY2025, the HI trust fund had an asset balance of $237.5 billion. During 2025, Part A expenditures reached $444.2 billion; about $403.2 billion of that amount was funded by payroll taxes, and $59.2 billion was funded by interest income and other revenue sources (see "Sources of HI Revenue"). Because income exceeded expenditures, the balance in the HI trust fund increased by $18.2 billion. At the end of 2025, the HI trust fund had a total asset balance of $255.7 billion. This means that if or when HI spending exceeds income in future years, the trust fund will be able to spend a total of $255.7 billion in addition to what it receives in income.

2025 SMI Operations

In CY2025, total spending for Part B was $584.3 billion, with general revenues financing $422.9 billion of that amount and premiums covering most of the remainder. Total spending for Part D reached $181.5 billion in 2025, with $148.8 billion of that amount paid for by general revenues. In addition, $14.9 billion was covered by beneficiary premiums and $19.1 billion was covered by state transfer payments. Although Part D premiums are set at a rate to cover 25.5% of the costs of standard Part D benefits, the program pays for the premiums of about one-third of enrollees because they qualify for a low-income subsidy. As a result, Part D premiums paid directly by beneficiaries represented about 8% of Part D revenues in 2025, with state transfer payments covering an additional 10% (see **Figure 1**).

[18] The 2026 Report of the Medicare Trustees, p. 163.

[19] All data are from the 2025 Report of the Medicare Trustees, Table II.B1.

[20] This amount reflects Medicare total spending regardless of revenue source; it does not net out nonfederal income (e.g., premiums, state transfers).

Table 1. Medicare Expenditures and Enrollment: CY2025

	HI	SMI		
	Part A	**Part B**	**Part D**	**Total**
Expenditures (billions)				
Benefits	$438.3	$578.4	$181.0	$1,197.8
Hospital	159.8	77.8	—	237.7
Skilled Nursing	30.7	—	—	30.7
Home Health Care	6.2	10.4	—	16.6
Physician Services	—	72.4	—	72.4
Private Plans (Part C)	209.6	321.3	—	530.9
Prescription Drugs	—	—	181.0	181.0
Other	31.9	96.5	—	128.4
Administrative Expenses	5.9	5.9	0.5	12.3
Total Expenditures	**$444.24**	**$584.3**	**$181.5**	**$1,210.1**
Enrollment (millions)				
Aged	62.0	56.8	50.8	62.2[a]
Disabled	7.1	6.6	6.0	7.1
Total Enrollment	69.1	63.4	56.8	69.3
Average Benefit Expenditures per Enrollee	**$6,344**	**$9,117**	**$3,190**	**$18,650**

Source: 2026 Report of the Medicare Trustees, Table II.B1.

Notes: Totals do not necessarily equal the sums of rounded components. HI = Hospital Insurance; SMI = Supplementary Medical Insurance.

a. Number of beneficiaries with HI and/or SMI coverage.

Estimated Date of HI Trust Fund Insolvency

Under their most recent projections, the Medicare trustees estimate that the HI trust fund will become insolvent in the second quarter of 2033.[21] Specifically, the Medicare trustees reported deficits (expenditures exceeded income) in 2018 and 2019 of $1.6 billion and $5.8 billion, respectively, requiring the trust fund to draw on accumulated assets to finance a portion of Part A benefits.

In 2020, the HI trust fund experienced a larger deficit, primarily due to the accelerated and advance payments made to providers during the COVID-19 public health emergency. These payments were repaid in 2021 through 2023. The HI trust fund recorded surpluses in those years.[22] In 2024, there was a surplus of $28.7 billion, partly driven by an increase in payroll tax revenues. Following 2025, the trustees project a continuation of annual surpluses in 2026. In 2027 and in all following years, the trustees project deficits until the HI trust fund becomes depleted (insolvent) in 2033. At that time, there would no longer be sufficient funds to fully cover Part A expenditures. Although the HI trust fund would continue to receive tax revenue and other income, the funds would cover only 89% of projected Part A expenditures in 2033. The trustees suggest

[21] For additional information on HI trust fund solvency, see CRS Report RS20946, *Medicare: Insolvency Projections*.

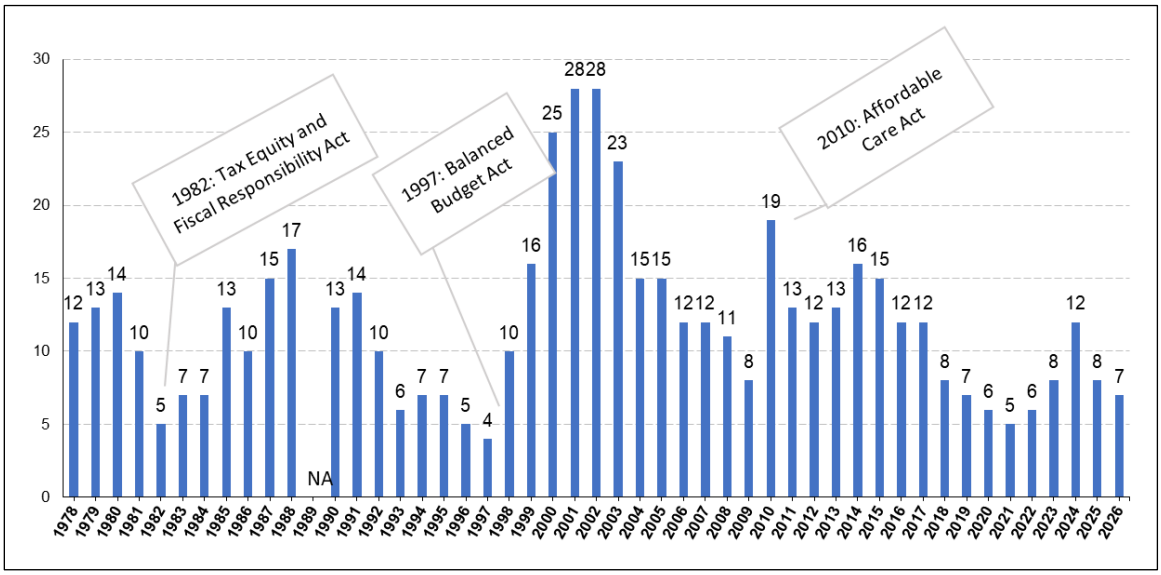
[22] For additional information on the impact of the COVID-19 pandemic on HI financing, see CRS Report RS20946, *Medicare: Insolvency Projections*. For details on Medicare accelerated and advance payments, see CRS Report R46698, *Medicare Accelerated and Advance Payments and COVID-19: Frequently Asked Questions*.

that, under these circumstances, beneficiary access to Part A services "could rapidly be reduced."[23]

Almost from its inception, the HI trust fund has faced a projected shortfall and eventual insolvency, with insolvency dates ranging from two years to 28 years from the year of the projection (see **Figure 2**). However, to date, the HI trust fund has never become insolvent.

Congress and the President have enacted legislation several times to avert insolvency by increasing revenues and reducing expenditures. For example, when insolvency was projected to be five years away in 1982, P.L. 97-248 was enacted, which increased the Medicare payroll tax to its current level of 1.45%. In 1997, the estimated insolvency dropped to four years away, and Congress passed the Balanced Budget Act of 1997 (P.L. 105-33), which reduced projected Medicare expenditures by $112 billion.[24] From 2010 to 2011, the estimated years to insolvency increased from eight to 19 after the ACA included, among other provisions, a new Medicare tax on high-income individuals that raised $87 billion and reductions to post-acute care spending and Medicare Advantage benchmarks that lowered Medicare spending by $304 billion.[25]

Figure 2. Projected Number of Years Until Hospital Insurance Trust Fund Insolvency and Selected Laws with Impact on Insolvency Date



Source: Intermediate projections of various Medicare Trustees Reports, 1978-2026.

Notes: The trustees did not provide specific estimates for 1989. Many laws have affected solvency. The three laws labeled in **Figure 2** are highlighted because they resulted in long extensions to the solvency date.

If insolvency were to occur, no provisions in the Social Security Act govern what would happen. For example, no legal authority exists for the program to use general revenues to fund Part A services in the event of such a shortfall. Unless action is taken prior to the expected date of

[23] The 2026 Report of the Medicare Trustees, p. 28.

[24] Congressional Budget Office, "Budgetary Implications of the Balanced Budget Act of 1997," September 1, 1997, https://www.cbo.gov/sites/default/files/105th-congress-1997-1998/costestimate/summary.pdf.

[25] Joint Committee on Taxation, "Estimated Revenue Effects Of The Manager's Amendment To The Revenue Provisions Contained In The Patient Protection And Affordable Care Act," December 19, 2009, https://www.jct.gov/publications/2009/jcx-61-09/. Congressional Budget Office, Letter to Senator Harry Reid Regarding Budgetary Effects of the Patient Protection and Affordable Care Act, March 11, 2010. https://www.cbo.gov/system/files/2022-02/reid_letter_hr3590.pdf.

insolvency to increase HI revenues or decrease expenditures, Congress may face a decision regarding the provision of additional funding to make up for these deficits and to allow for full and on-time payments to Part A providers.

The Social Security Act requires that income from general revenue and premiums to the SMI trust fund are updated automatically each year to ensure that the program has enough money to continue operating. Therefore, the SMI trust fund is kept in balance and is always solvent. However, the Medicare trustees continue to express concerns about the rapid growth in SMI (Parts B and D) costs.[26]

Projected Medicare Spending Growth

Medicare expenditures have increased rapidly throughout most of the program's history. For the period of 1985 through 2025, program spending grew at an average annual rate of 7.3%.[27]

Although the 2021 Medicare Trustees Report noted a slowing in the growth of U.S. national health expenditures from 2008 to 2020,[28] the trustees still project that U.S. health care expenditures, including Medicare expenditures, will grow, on average, faster than gross domestic product (GDP) in most future years.[29] For Medicare, the projected growth in the prices of health services, plus anticipated increases in utilization rates and in the complexity of services, are expected to contribute to rising costs of Medicare relative to GDP. The aging of the baby boom population is also expected to contribute to significant increases in benefit expenditures.[30] CBO estimates that spending growth from 2026 to 2036 can be allocated among three sources: 23% from higher enrollment, 31% from inflation, and 47% from the growth of inflation-adjusted spending per beneficiary.[31] In other words, the largest single driver of Medicare spending growth during the next decade is expected to be higher volume and intensity of health care services. New technologies and drugs contribute to this growth in services. Over the longer term in 2051-2100, the trustees project inflation to be the largest driver of Medicare spending growth, with Medicare prices projected to closely track the broader Consumer Price Index. Volume and intensity of health services are the next-largest driver and are the largest factor after removing the effect of inflation. During this longer-term period, enrollment growth is expected to have a smaller impact, as population growth is projected to slow.[32]

The trustees project that from 2026 through 2035, Medicare expenditures will grow by an average of 7.7% per year. During that time, total Medicare expenditures are projected to increase from $1.3 trillion (in 2026) to almost $2.5 trillion (in 2035).[33] Of that $2.5 trillion, about $877 billion is expected to be spent on Part A services, $1.3 trillion on Part B services, and $347 billion on Part D services (see **Figure 3**).

[26] The 2025 Report of the Medicare Trustees, p. 36.

[27] The 2026 Report of the Medicare Trustees, p. 186.

[28] 2021 Report of the Medicare Trustees, p. 5.

[29] 2021 Report of the Medicare Trustees, p. 5, and 2026 Report of the Medicare Trustees, p. 15.

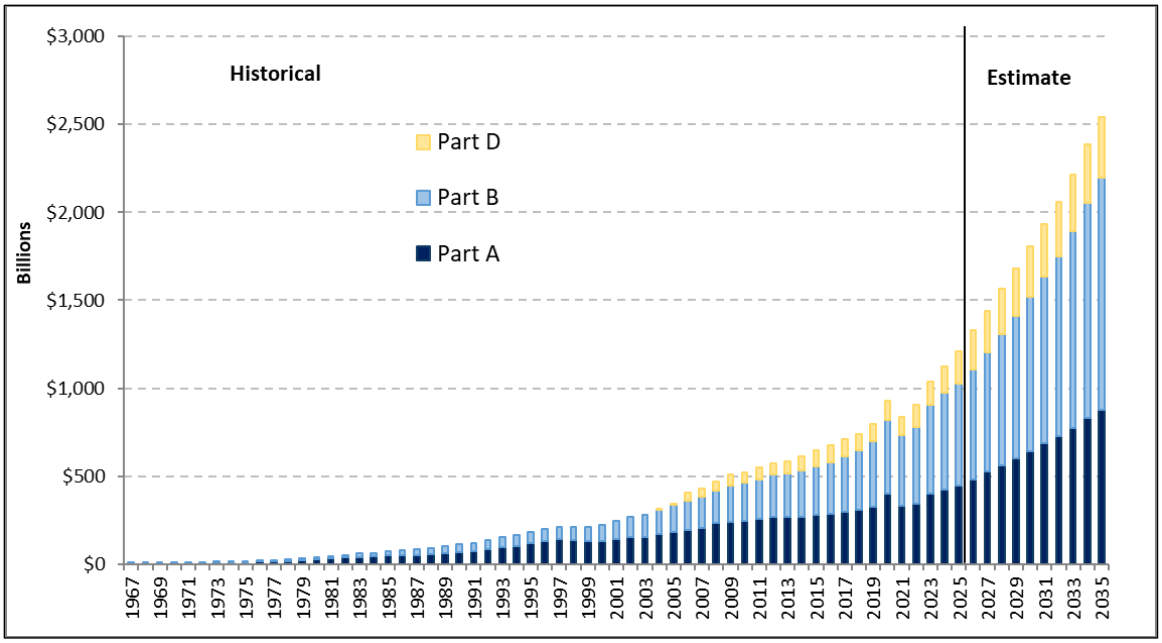
[30] When Medicare first began in 1966, there were about 19 million beneficiaries. This number has grown to over 69 million enrollees in 2025 and is expected to increase to about 81 million in 2035 and close to 103 million in 2095. (2026 Report of the Medicare Trustees, Table V.B3, p. 190.)

[31] Congressional Budget Office, "The Budget and Economic Outlook: 2026 to 2036," February 2026, Table 3-3, https://www.cbo.gov/publication/62105.

[32] 2026 Report of the Medicare Trustees, Table II.D1.

[33] In nominal dollars.

Figure 3. Historical and Projected Medicare Expenditures



Sources: 2026 Report of the Medicare Trustees, Expanded and Supplementary Tables.

Note: Not adjusted for inflation. The spike in spending in 2020 is primarily due to the accelerated and advance payments made to providers during the COVID-19 pandemic during 2020. These payments were repaid in 2021-2023.

Part C (Medicare Advantage) expenditures, which are financed by contributions from Part A and Part B, are projected to increase from $586 billion in 2026 to $1.3 trillion in 2035, which CRS calculates is an average annual growth rate of 9.2%. This rapid growth in Part C is partly driven by a projected shift in enrollment from 51.6% of total beneficiaries in Part C in 2026 to 56.0% in 2035.[34]

Growth in Medicare Expenditures Relative to GDP

A comparison of total Medicare expenditures to GDP provides a measure of the amount of financial resources that will be necessary to pay for Medicare services relative to the output of the U.S. economy. The trustees expect that, under current law, total Medicare expenditures will increase from 3.9% of GDP in 2025 to about 6.5% of GDP by 2050, mainly due to the rapid growth in the number of beneficiaries, and then to about 7.5% of GDP in 2100 (see **Figure 4**).[35]

Over the next 75 years, general revenues and beneficiary premiums are expected to provide a growing share of the program's income. For example, the level of general revenues needed to fund SMI is expected to increase from 2.1% of GDP in 2026 to an estimated 3.9% in 2100 under current law.[36] Similarly, income from beneficiary premiums is expected to increase from 0.6% of GDP in 2026 to 1.5% in 2100. The Medicare trustees estimate that about 17.6% of federal personal and corporate income taxes collected in 2025 were used to fund the general revenue

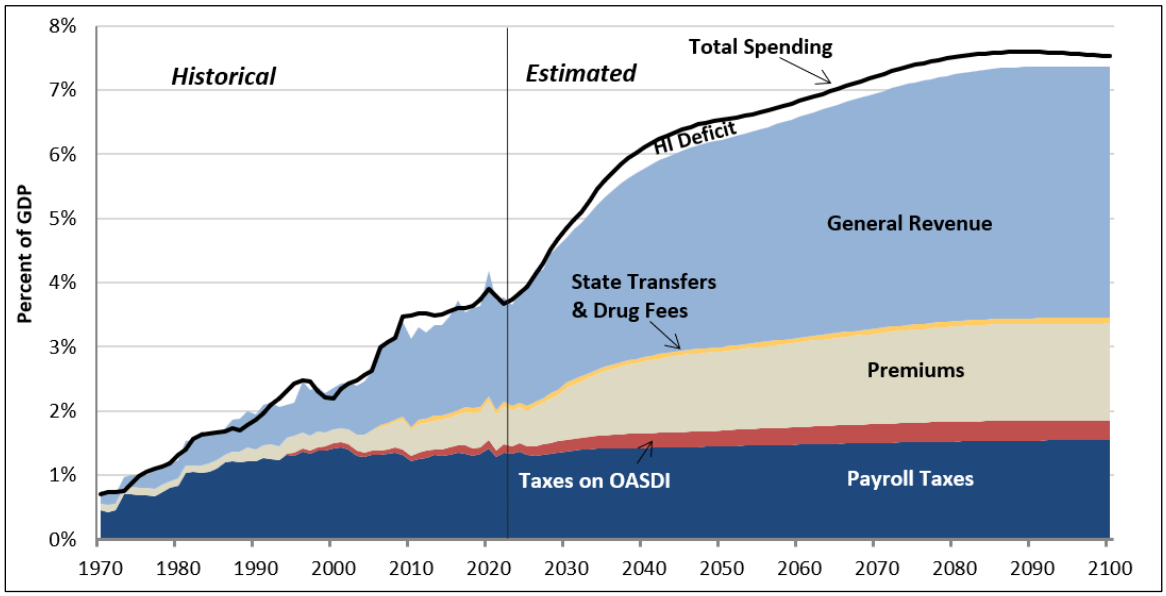
[34] 2026 Report of the Medicare Trustees, Table IV.C1.

[35] 2026 Report of the Medicare Trustees, p. 21.

[36] Total Part B outlays are expected to be about 2.0% of GDP in 2026, and the Medicare trustees project those outlays will grow to about 4.5% of GDP by 2100. The trustees also estimate that total Part D outlays will increase from about 0.5% of GDP in 2026 to close to 1.0% of GDP in 2100.

portion of SMI, and the trustees project that this portion will increase to 28.6% in 2040 and to 38.3% in 2100.[37] This percentage is *in addition to* the payroll taxes used to fund Part A (HI).

Figure 4. Medicare Non-Interest Income and Spending, by Source as a Percentage of GDP



Source: Summary of the 2026 Annual Reports of the Social Security and Medicare Boards of Trustees, Chart C, at http://www.ssa.gov/oact/TRSUM/index.html.

Notes: OASDI is Old Age Survivors and Disability Insurance benefits, also known as Social Security.

Unfunded and General Revenue Obligations

The Medicare Trustees Report provides estimates of the present value of the HI deficit—the *unfunded obligation*—over the next 75 years, 2026-2100 (see **Table 2**). This cumulative unfunded obligation represents the dollar amount by which expenditures would need to be reduced or revenue increased to maintain the financial soundness of the program over this 75-year period. The trustees estimate that the present value of funding needed to cover the expected difference between income to the HI trust fund and expenditures over the next 75 years is $4.2 trillion.[38] The trustees note that this financial imbalance could be addressed by immediately increasing payroll taxes to 3.46% (from the current 2.9%), or by immediately decreasing expenditures by 12%, or by some combination of the two.[39] From a budgetary standpoint, the accumulated assets in the trust fund are considered liabilities, as the redemption of the assets represents a formal budget commitment. Therefore, the starting balance of about $0.2 trillion in the HI trust fund needs to be added to the unfunded obligation of $4.2 trillion for a present value of $4.4 trillion shortfall in dedicated revenues.

The Trustees Report also provides estimates of the present value of future SMI spending. Although SMI is funded automatically and does not face a shortfall, the general revenue portion represents obligated federal spending. The present value of expected general revenues needed to

[37] 2026 Report of the Medicare Trustees, Table II.F3.

[38] 2026 Report of the Medicare Trustees, Table V.F2.

[39] 2025 Report of the Medicare Trustees, p. 33.

pay for Medicare Parts B and D over the next 75 years is $60.9 trillion. Summing the HI unfunded obligation estimate and the present value of future SMI spending for the 75-year period yields a total unfunded obligation of $65.3 trillion.[40] In other words, about $65.3 trillion in current dollars would be needed to cover the cost of Medicare not funded through dedicated sources over the next 75 years. For comparison, this unfunded obligation of $65.3 trillion is about 3.5% of the present value of GDP over the next 75 years.[41]

Table 2. Present Value of Estimated Medicare Unfunded Obligations and General Revenue Spending: 2025-2099

Present Value of HI Deficit		Present Value of SMI General Revenues		
	Part A		Part B and Part D	Total
Unfunded obligations through 2100	$4.4 trillion[a]	General revenue contributions through 2100	$60.9 trillion	$65.3 trillion

Source: 2026 Report of the Medicare Trustees, Table V.F2.

a. Budgetary and trust fund accounting rules differ in the treatment of trust fund assets. From a budgetary standpoint, the accumulated assets in the trust fund are considered liabilities, as the redemption of the assets represents a formal budget commitment. The starting balance of $0.2 trillion in the HI trust fund is thus included in this figure. Under trust fund accounting methods, which exclude the asset balance, the unfunded HI obligation for the 75-year projection period would be $3.1 trillion.

Comparison to Prior-Year Estimates

Projections of total Medicare spending in the 2026 Trustees Report are similar to those in the 2025 report. The specific changes in each Part are broken out below:

- **Part A:** Projected spending is relatively flat compared to the projections in the 2025 Trustees Report. The trustees estimate that HI expenditures in 2035 will be 1.9% of GDP, which is 0.01 percentage points higher than in last year's report. The estimated depletion date of the HI trust fund is 2033, the same year as in the 2025 report. At the end of the 75-year projection period, expenditures are projected to be 2.0% of GDP, which is 0.16 percentage points higher than in the 2025 report. The estimated HI actuarial deficit (the amount that would need to be added to the payroll tax to maintain HI solvency for the 75-year period) increased by 0.14 percentage points—from 0.42% of taxable payroll in the 2025 report to 0.56% of taxable payroll in the 2026 report. The trustees attribute the slightly higher spending and larger actuarial deficit in the 2026 report, compared with the 2025 report, to several factors, including higher spending in the 2025 base year of the projections, reduced taxation of Social Security benefits due to the FY2025 reconciliation law (P.L. 119-21), and lower projected fertility and immigration, which are estimated to reduce the number of wage-earning workers during the next 75 years.[42]

[40] The trustees note that while SMI general revenue transfers represent formal budget commitments under current law, no provision exists for covering the HI trust fund deficit once assets are depleted.

[41] 2026 Report of the Medicare Trustees, Table V.F2.

[42] The specific factors contributing to the change in the 75-year actuarial balance projections from 2025 to 2026 are listed in Table III.B10 and described on page 74 of the 2026 Report of the Medicare Trustees.

- **Part B:** Projected spending is up. At the end of the 75-year projection period, the trustees estimate that Part B expenditures will be 4.5% of GDP, which is 0.2 percentage points higher than in the 2025 report.[43] This increase in 2100 spending compared with the 2025 report is due to higher projected expenditures for physician-administered drugs, which are partly offset by lower spending on skin substitutes due to recent regulatory payment limitations.[44]
- **Part D:** Projected spending is up. The trustees estimate that at the end of the 75-year projection period in 2100, Part D expenditures will be 1.0% of GDP, which is 0.37 percentage points higher than in last year's report. This increase in spending is due to higher utilization of glucagon-like peptide (GLP)-1 drugs and lower rebates than previously assumed.[45]

In total, these changes to spending in Parts A, B, and D net out to an increase of 0.8 percentage points of GDP in 75 years, primarily driven by higher spending in Part B and Part D. When projected spending is compared with projected income, the present value of total unfunded obligations over 75 years increases by $5.0 trillion, from $60.3 trillion in the 2025 Trustees Report to $65.3 trillion in the 2026 Trustees Report.

Alternative Projections

Throughout the 2026 report, the Medicare trustees caution that actual costs may be higher than their intermediate projections. For example, because the trustees are required to base their estimates on current law, their projections assume that physician payments will be updated according to levels set forth in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10, as amended). This act set annual payment updates for years after 2025 of 0.75% for physicians in advanced alternative payment models and 0.25% for physicians in the merit-based incentive payment system.[46] In addition, the trustees assume that, under current law, several types of nonphysician providers, including hospitals, will continue to be affected by statutory decreases to annual payment updates that reflect economy-wide productivity growth. The trustees identify these payment provisions as "potentially unsustainable elements of current law" because they perennially push payment increases to be less than the average growth rate of health care costs.[47]

In response to concerns about the likelihood of the current-law projections, the Medicare trustees asked the CMS Office of the Actuary to prepare an alternative projection based on the assumptions that annual physician payment updates will transition from current law to 2.05% from 2028 to 2042, and that the provider productivity adjustments will be phased down beginning in 2028.[48] Under this alternative scenario, long-term Medicare costs are projected to reach about

[43] 2026 Report of the Medicare Trustees, supplemental data for Figure II.D1.

[44] 2026 Report of the Medicare Trustees, p. 6.

[45] 2026 Report of the Medicare Trustees, p. 6

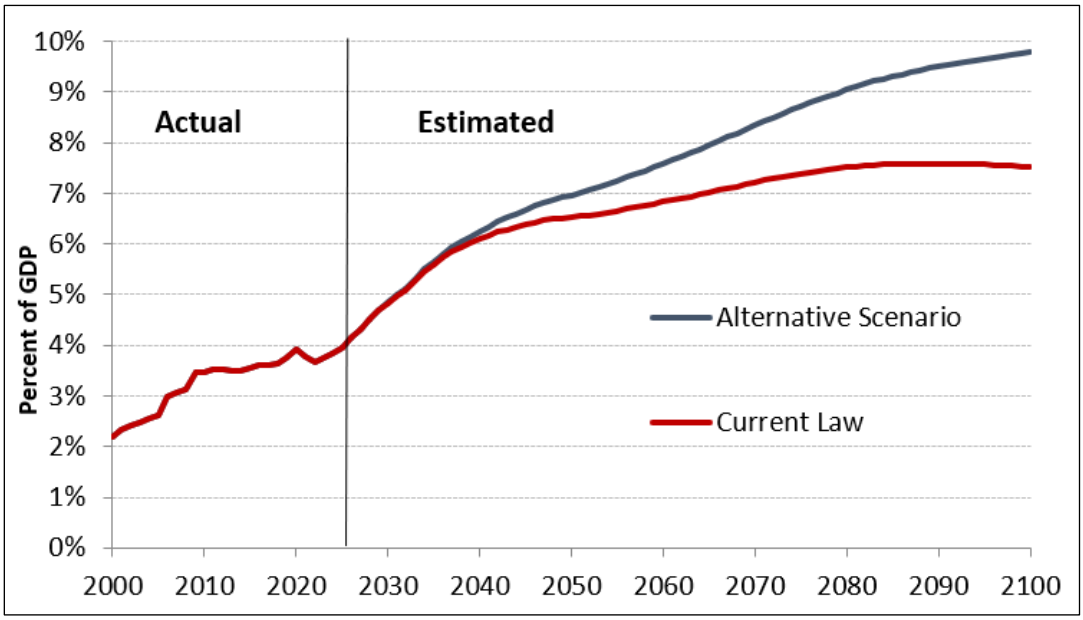
[46] 2025 Report of the Medicare Trustees, p. 14. For more inflation about physician payment updates, see CRS Report R43962, *The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10)*.

[47] 2026 Report of the Medicare Trustees, p. 220.

[48] John D. Shatto and M. Kent Clemens, "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," June 18, 2025, https://www.cms.gov/files/document/illustrative-alternative-scenario-2025.pdf. CBO also publishes long-term projections of Medicare spending. Similar to the trustees' alternative scenario, CBO's projections assume higher annual payment updates after 2035. Other than those higher annual payment updates, CBO and the trustees have similar assumptions rates of long-term GDP growth and Medicare cost growth. CBO's projected level of total Medicare expenditures in 2056—6.9%—is 0.2 percentage points of GDP (continued...)

9.8% of GDP in 2100, instead of 7.5% under the trustees' current-law projections. Additionally, under the alternative scenario, the HI actuarial deficit would be 1.388% of taxable payroll (compared with 0.56% under the current-law projection), which could be addressed by immediately increasing payroll taxes to 4.28%, by immediately decreasing expenditures by 25% (compared with 3.46% and 12% under current law), or some combination of the two. Because the differences in assumptions between current law and the alternative scenario are phased in from 2028 to 2042, the alternative scenario projects the same year of HI insolvency, 2033.

Figure 5. Comparison of Medicare Expenditure Projections Based on Current Law and an Alternative Scenario



Source: 2026 Report of the Medicare Trustees, Supplementary Table I.1 and V.C1.

Note: The alternative scenario assumes phasing out limits to annual physician payment increases set in MACRA and payment reductions based on productivity adjustments for many non-physician providers.

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higher than the trustees' current law projection and 0.3 percentage point lower than the trustees' alternative projection. CBO projects the HI trust fund will become insolvent in 2040. CBO's long-term projections are available at "The Long-Term Budget Outlook: 2026 to 2056," February 25, 2026, https://www.cbo.gov/publication/62044. CBO's solvency data estimate is available at "CBO's Updated Projections of the Hospital Insurance Trust Fund's Finances," February 23, 2026, https://www.cbo.gov/publication/62165.

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This report was originally authored by former CRS Specialist in Health Care Financing Patricia A. Davis and was updated in 2021 by CRS Specialist in Health Care Financing Jim Hahn.

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