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Medicare: Insolvency Projections

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SUMMARY

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Medicare: Insolvency Projections

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 $1.33 trillion, of which $481 billion was paid by Part A. Part A, also known as Hospital Insurance (HI), covers primarily inpatient care at health facilities such as hospitals and skilled nursing facilities. Part A is financed by the HI Trust Fund, which is funded mostly by payroll taxes, taxes on Social Security benefits, and accumulated trust fund assets.

The *2026 Medicare Trustees Report* projects that Medicare Part A expenditures will continue to grow during the next 10 years, primarily because of increases in the number of beneficiaries and the volume and intensity of health services.

The Medicare trustees report notes that since the inception of Medicare in 1966, the HI trust fund has always faced a projected shortfall. If the trust fund runs out of money, it would become *insolvent*. The HI insolvency date has been postponed several times through legislative changes that, for example, have had the effect of restraining growth in program spending. The 2026 trustees report projects that the HI trust fund will transition from a surplus in 2026 to a deficit in 2027. HI is projected to spend down accumulated assets until the trust fund becomes insolvent in 2033, the same year of insolvency as estimated by the trustees in 2025.

There are no provisions in Medicare's authorizing legislation that specify what would happen if insolvency were to occur. In the event of insolvency, policymakers may face decisions regarding increasing revenues, decreasing expenditures, incurring additional debt, or some combination thereof.

The Supplementary 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 financing is updated automatically each year to cover projected expenditures and therefore is not subject to the same solvency concerns. A continuing shift from providing care in inpatient (Part A) settings to outpatient (Parts B and D) settings has resulted in a greater portion of Medicare spending being covered by beneficiary premiums and general revenues than by dedicated payroll taxes. This shift suggests beneficiaries face increased premiums for Parts B and D in the years ahead.

This report describes how the Medicare program is financed, the sources of funding for the program, and the role of trust funds in the financing structure. It also summarizes the history of the trust funds, projections of Part A spending and revenue, and the factors contributing to projected Medicare spending growth, including enrollment growth, inflation, and health care utilization. It reviews historical and future projections of Medicare spending and solvency, based on the annual reports of the Medicare trustees from 1997 to 2026, and alternative projections presented by the trustees. These projections illustrate the long-term financing challenges facing the Medicare program and provide a framework for evaluating potential policy options for adjusting Medicare revenues, expenditures, and trust fund solvency.

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Introduction

Medicare is a federal insurance program that pays for covered health care services of qualified beneficiaries. It was established in 1965 under Title XVIII of the Social Security Act as a federal entitlement program to provide health insurance to individuals aged 65 and older, and it has been expanded over the years to include permanently disabled individuals under the age of 65.

Medicare consists of four distinct components: Parts A through D. Part A covers hospital services, skilled nursing facility (SNF) services, home health visits, and hospice services. Most persons aged 65 and older are automatically entitled to premium-free Part A because they or their spouse paid payroll taxes for at least 40 quarters (10 years) on earnings covered by either the Social Security or the Railroad Retirement systems. Part B covers a broad range of medical services, including physician services, laboratory services, durable medical equipment, and outpatient hospital services. Enrollment in Part B is voluntary; however, most beneficiaries with Part A also enroll in Part B. Part C, Medicare Advantage (MA), provides options to enroll in plans offered by private health insurance companies, such as managed care plans, for beneficiaries who are enrolled in both Part A and Part B. Part D provides optional outpatient prescription drug coverage.[1]

Medicare expenditures are driven by a variety of factors, including the level of enrollment, provider payment rates, the quantity and complexity of medical services provided, health care inflation, and life expectancy. In 2026, Medicare provided benefits to about 70.7 million persons at an estimated total cost of $1.33 trillion, of which $481 billion was paid by Part A.[2]

The Medicare program has two separate trust funds, the Hospital Insurance (HI) trust fund and the Supplementary Medical Insurance (SMI) Trust fund. The Part A program, which is financed mainly through payroll taxes levied on current workers, is accounted for through the HI trust fund. The Part B and Part D programs, which are funded primarily through general revenue and beneficiary premiums, are accounted for through the SMI trust fund.[3] Both funds are maintained by the Department of the Treasury and overseen by the Medicare Board of Trustees, which reports annually to Congress concerning the funds' financial status.[4] Financial projections are made using economic assumptions based on current law, including estimates of consumer price index, workforce size, wage increases, and life expectancy.

From its inception, the HI trust fund has faced a projected shortfall and eventual insolvency. General revenue and premium levels automatically adjust to finance projected SMI spending on Part B and Part D. Because of the way it is financed, the SMI trust fund is unlikely to become insolvent; however, the Medicare trustees have continued to express concerns about the rapid growth in SMI costs.[5]

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

[2] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2026 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, June 9, 2026, Tables V.B1 and V.B3, at https://www.cms.gov/oact/tr/2026 (hereinafter, *2026 Report of the Medicare Trustees*).

[3] Payments are made for beneficiaries enrolled in Part C from the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds based on estimates of HI and SMI spending under Part C.

[4] Medicare trustees reports from 1966 through 1994 are available on the Social Security History webpage at https://www.ssa.gov/history/reports/trust/trustyears.html. More recent reports are available on the CMS web page, "Trustees Report & Trust Funds," at https://www.cms.gov/data-research/statistics-trends-and-reports/trustees-report-trust-funds.

[5] For further information on Medicare financing, see CRS Report R43122, *Medicare's Financial Status*.

Medicare Hospital Insurance Financing

Similar to the Social Security program, the HI portion of Medicare was designed to be financed through dedicated sources of income, rather than by relying on general tax revenues. The primary source of income credited to the HI trust fund is *payroll taxes*, which provided 87% of income to the trust fund in 2025. Medicare payroll taxes are paid by employees and employers; each pays a tax of 1.45% on earnings. The self-employed pay 2.9%. Unlike Social Security, there is no upper limit on earnings subject to the tax.[6] The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) imposed an additional tax of 0.9% on workers' wages that exceed $200,000 for single filers and $250,000 for joint filers, effective for taxable years beginning in 2013.[7]

Additional income to the HI trust fund consists of premiums paid by enrollees who are not entitled to premium-free Medicare Part A through their (or their spouse's) work in covered employment, a portion of the federal income taxes paid on Social Security benefits,[8] and interest on federal securities held by the HI trust fund.

What Is the HI Trust Fund?

The HI trust fund is a financial account in the U.S. Treasury into which all income to the Part A portion of the Medicare program is credited and from which all benefits and associated administrative costs of the Part A program are paid.[9]

HI operates on a "pay-as-you-go" basis, meaning the annual revenues to the HI trust fund, primarily the taxes paid by current workers and their employers, are used to pay Part A benefits for today's Medicare beneficiaries. When the government receives Medicare revenues (e.g., payroll taxes), income is credited by the Treasury to the appropriate trust fund in the form of special issue interest-bearing government debt securities.[10] Interest on these securities is also credited to the trust fund in the form of additional securities. In other words, the trust fund balance is held in the form of Treasury securities rather than in cash. 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 fund of the Treasury and a corresponding amount of securities is deleted from (written off) the HI trust fund.

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[6] Prior to 1991, the upper limit on taxable earnings was the same as for Social Security. The Omnibus Budget Reconciliation Act of 1990 (OBRA 90; P.L. 101-508) raised the limit in 1991 to $125,000. Under automatic indexing provisions, the maximum was increased to $130,200 in 1992 and $135,000 in 1993. The Omnibus Budget Reconciliation Act of 1993 (OBRA 93; P.L. 103-66) eliminated the upper limit entirely beginning in 1994.

[7] For additional detail, see archived CRS Report R41128, *Health-Related Revenue Provisions in the Patient Protection and Affordable Care Act (ACA)*.

[8] Since 1994, the HI trust fund has had an additional funding source; OBRA 93 increased the maximum amount of Social Security benefits subject to income tax from 50% to 85% and provided that the additional revenues would be credited to the HI trust fund.

[9] There are about 200 federal trust funds. 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 on how federal trust funds operate within the context of the federal budget, see CRS Report R41328, *Federal Trust Funds and the Budget*.

[10] Unlike marketable 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.

In years in which the HI trust fund spends less than it receives in income, the fund has a *surplus*. When this occurs, the HI trust fund securities exchanged for any income in excess of spending show up as assets on the trust fund's 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 obligations.[11]

If, in a given year, the HI trust fund spends more than it receives in income, the fund has a *deficit*. In deficit years, Medicare can redeem any government securities accumulated in previous years (including interest). When the securities are redeemed, the government must raise the resources necessary to pay for the securities and the monies are transferred from the Treasury's general fund to the HI trust fund. Should the assets credited to the trust fund reach zero, the fund would be deemed *insolvent*. (See **Appendix A** for a discussion of recent and projected HI balances and for data on historical and projected HI operations through 2035.)

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 (a set amount of money paid upfront) 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 the Centers for Medicare & Medicaid Services (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.[12] Medicare Part D benefits offered through Medicare Advantage prescription drug plans are financed separately through the SMI Trust Fund's Part D account.

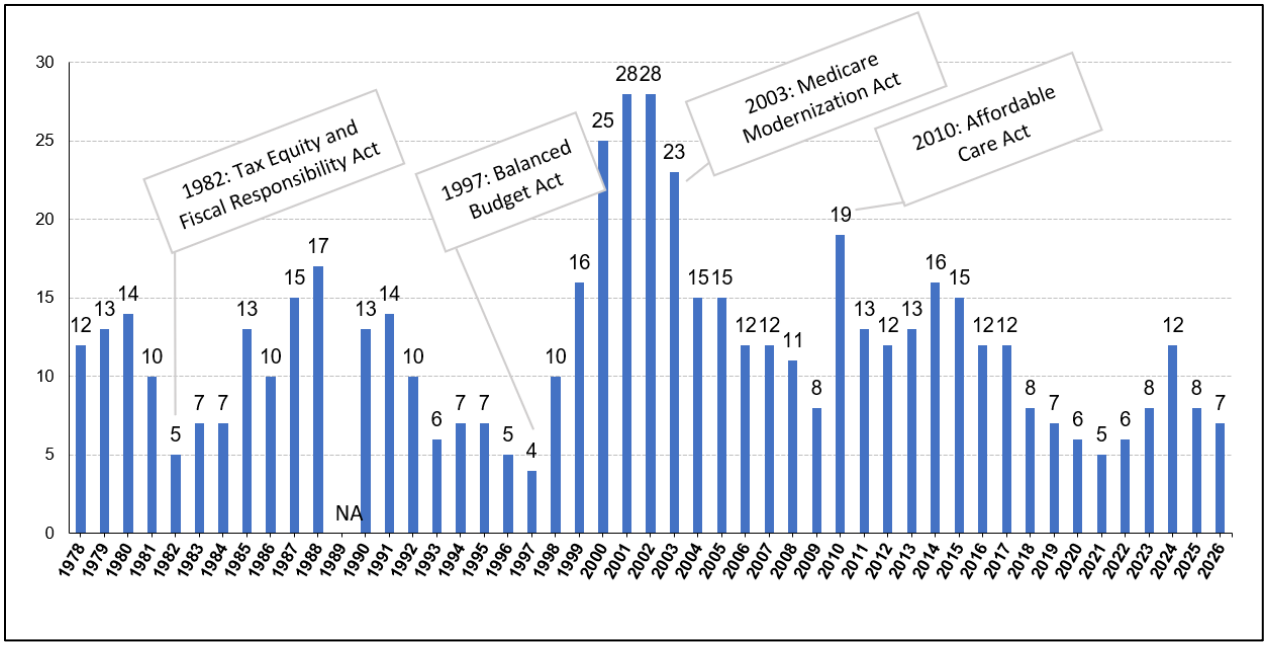
History of HI Trust Fund Solvency Projections

The HI trust fund has never become insolvent. The Medicare Board of Trustees projected insolvency for the HI trust fund beginning with the 1970 report, at which time the trust fund was expected to become insolvent in two years. The insolvency date has been postponed a number of times since the beginning of Medicare through various methods (see **Figure 1** and **Table 1**). For example, Congress has occasionally adjusted the payroll tax rate to maintain the financial adequacy of the HI trust fund, such as the increase in the payroll tax that was enacted in 1982. Other legislative changes also have been made at various times to slow the growth in HI program spending; generally, these measures have been part of larger budget reconciliation laws that attempted to restrain overall federal spending. See **Appendix B** for historical payroll tax rates and **Appendix C** for an overview of legislative, economic, and methodological changes that affected 1997-2026 insolvency projections.

[11] For additional information, see the *2026 Report of the Medicare Trustees*, Appendix F.

[12] *2026 Report of the Medicare Trustees*, p. 163.

Figure 1. Projected Number of Years Until Medicare HI Trust Fund Insolvency and Selected Laws with Impact on Insolvency Date



Sources: Intermediate projections of various Medicare trustees reports, 1978-2026.

Note: No specific estimates were provided by the Medicare trustees for 1989. Many laws have affected solvency. The four laws labeled in **Figure 2** are shown because they resulted in large changes to the solvency date.

Table 1. Year of Projected Insolvency of the Hospital Insurance (HI) Trust Fund in Past and Current Trustees Reports

Year of Trustees Report	Year of Projected Insolvency	Year of Trustees Report	Year of Projected Insolvency	Year of Trustees Report	Year of Projected Insolvency
1970	1972	**1989**	None Indicated	**2009**	2017
1971	1973	**1990**	2003	**2010**	2029
1972	1976	**1991**	2005	**2011**	2024
1973	None Indicated	**1992**	2002	**2012**	2024
1974	None Indicated	**1993**	1999	**2013**	2026
1975	Late 1990s	**1994**	2001	**2014**	2030
1976	Early 1990s	**1995**	2002	**2015**	2030
1977	Late 1980s	**1996**	2001	**2016**	2028
1978	1990	**1997**	2001	**2017**	2029
1979	1992	**1998**	2008	**2018**	2026
1980	1994	**1999**	2015	**2019**	2026
1981	1991	**2000**	2025	**2020**	2026

Year of Trustees Report	Year of Projected Insolvency	Year of Trustees Report	Year of Projected Insolvency	Year of Trustees Report	Year of Projected Insolvency
1982	1987	**2001**	2029	**2021**	2026
1983	1990	**2002**	2030	**2022**	2028
1984	1991	**2003**	2026	**2023**	2031
1985	1998	**2004**	2019	**2024**	2036
1986	1996	**2005**	2020	**2025**	2033
1986 (amended)	1998	**2006**	2018	**2026**	2033
1987	2002	**2007**	2019	—	—
1988	2005	**2008**	2019	—	—

Sources: Intermediate projections of various Medicare trustees reports, 1970-2026.

Note: No specific estimates were provided by the Medicare trustees for years 1973-1977 or 1989.

Current Insolvency Projections

In their 2026 report,[13] the Medicare trustees project that the HI trust fund will become insolvent in 2033, the same year as in their 2025 report. Within 2033, insolvency is projected to occur during the second quarter. The trustees attribute the consistency of their current 2033 insolvency date estimate with that in last year's report to higher Medicare Advantage enrollment and spending that was mostly offset by lower Part A spending in the 2025 base year of the projections.

Historical Projections

Starting in 2008, expenditures in the HI trust fund exceeded income each year through 2015. Although the Medicare trustees reported small surpluses in 2016 and 2017, the HI trust fund again experienced deficits in 2018 and 2019 (see **Table A-1**). In 2020, the HI trust fund experienced a larger deficit, primarily due to accelerated and advance payments made to health care providers during the COVID-19 public health emergency.[14] Providers who received these accelerated and advance payments would have fulfilled these obligations and offset these payments in 2021-2023, resulting in HI trust fund surpluses in those years. In 2024, there was a surplus of $28.7 billion, partly driven by an increase in payroll tax revenue, and the trustees projected insolvency date moved out to 2036. The 2025 surplus dropped to $18.2 billion, with the decrease driven by higher enrollment and spending.

Future Projections

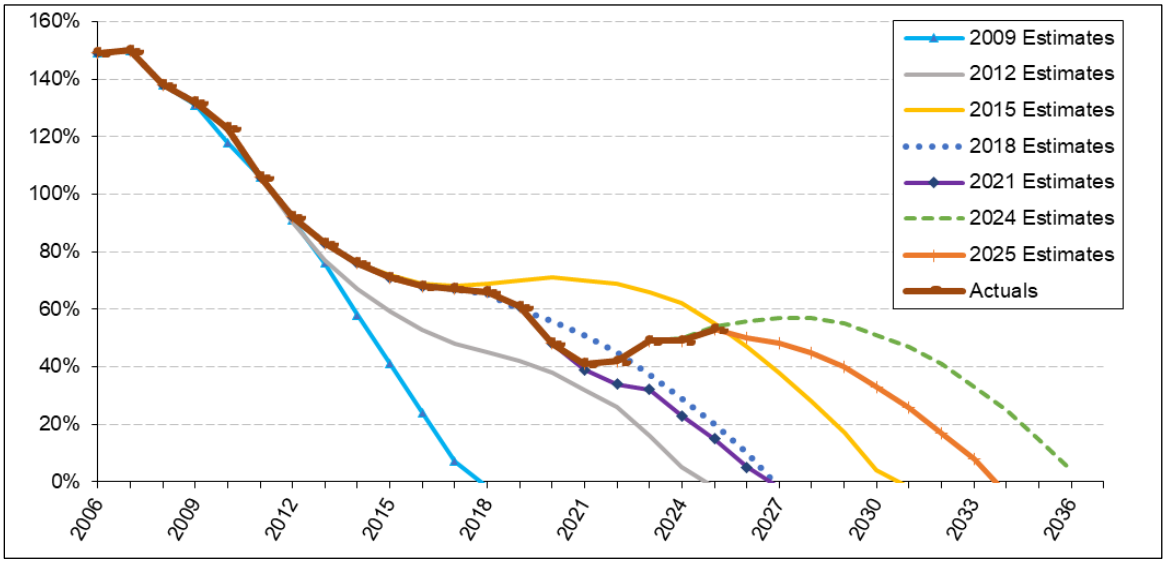
The 2026 trustees report projects that 2026 will be the last year of surpluses. In 2027 and in all following years, the trustees project deficits until the HI trust fund becomes depleted (insolvent) in 2033 (see **Figure 2**).

[13] *2026 Report of the Medicare Trustees*.

[14] Under this program, health care providers were able to receive accelerated or advance payments for services provided or to be provided in the future. In 2020, about $67.1 billion was paid out of the HI trust fund for such payments. For additional information on this program, see archived CRS Report R46698, *Medicare Accelerated and Advance Payments and COVID-19: Frequently Asked Questions*.

Figure 2. HI Trust Fund Assets at Beginning of Year as a Percentage of Annual Expenditures

(estimates from selected 2009-2026 Medicare trustees reports)



Sources: Data from the Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2009 and 2025 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds*, Table II.E1 (2009), Supplementary Tables (2024-2025), and summaries of the applicable 2011 through 2021 Annual Reports of the Social Security and Medicare Boards of Trustees, Chart D (2011) and Chart E (2013, 2015-2021).

Alternative Projections

Each year, beginning in 2010, the CMS actuaries have issued an illustrative alternative scenario that assumes certain ACA changes that reduce Part A provider payments would be phased out gradually.[15] The ACA linked these provider payment reductions to economy-wide productivity growth. Because the differences in assumptions between current law and the alternative scenario are phased in from 2028 to 2042, and therefore have little impact until after 2030, the alternative scenario projects the same 2033 year of HI insolvency as the current law scenario. With the phaseout of the productivity adjustments, the alternative scenario projects a higher spending trajectory that diverges from the trustees' projections under current law from 2028 to 2100.

What Would Happen If the HI Trust Fund Became Insolvent?

A practical function of the HI trust fund is to permit the continued payment of bills in the event of a temporary financial strain (e.g., lower income or higher costs than expected) without requiring legislative action or curtailing health care delivery. As long as the HI trust fund has a balance (i.e.,

[15] Memo from John D. Shatto and M. Kent Clemens, "Projected Medicare Expenditures Under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," June 18, 2025, at https://www.cms.gov/files/document/illustrative-alternative-scenario-2025.pdf.

securities are credited to the fund), the Treasury Department is authorized to make payments for Medicare Part A services. If the HI trust fund cannot pay all current expenses out of current income and accumulated trust fund assets, the HI trust fund would be considered *insolvent*.[16]

To date, the HI trust fund has never become insolvent. There are no provisions in the Social Security Act that govern what would happen if insolvency were to occur. For example, the program has no statutory authority to use general revenues to fund Part A services in the event of such a shortfall, and agencies may not transfer funds unless authorized to do so by Congress.[17]

In their 2026 report, the Medicare trustees project that the HI trust fund will be exhausted in 2033. At that time, there will no longer be sufficient funds to fully cover Part A expenditures. Although the trust fund would continue to receive tax and other income, those funds, according to the trustees, would cover 89% of Part A expenses. The Medicare trustees have suggested that in the event of HI trust fund insolvency, there could initially be delays in payments to plans and providers.[18] Following soon after insolvency, beneficiary access to Part A services could "rapidly be reduced."[19] However, as the Social Security Act does not specify what would happen if the HI trust fund were to become insolvent, it is unclear what actions CMS might take under this circumstance.[20] CMS could choose to pay full benefits on a delayed schedule, although the length of the delay would grow as unpaid benefits from one period reduce the amount of money available to pay benefits for the next period. Alternatively, CMS could choose to make timely but reduced payments to plans and providers. Both options for operating after insolvency are legally untested and could potentially and quickly erode health providers' finances and beneficiaries' access to health care.[21]

Unless action is taken prior to the date of insolvency to increase revenues or to decrease expenditures, or some combination of the two, Congress may face a legislative decision regarding whether, and how, to provide for another source of funding or authorize the assumption of additional debt to make up for the HI trust fund deficits.

To make the HI trust fund solvent for the next 75 years beginning in 2026, the trustees estimate that payroll taxes would have to immediately increase by 0.56 percentage points or benefit spending would have to decrease by 12%.[22] This 0.56 percentage-point payroll tax increase, to achieve solvency, is 0.16 percentage points higher than in the prior trustees report from 2025. This indicates a greater deficit for the HI trust fund during the next 75 years than previously projected. The trustees attribute this larger deficit in the 2026 report to higher spending in the 2025 base year of the projections, reduced taxation of Social Security benefits due to the FY2025

[16] From time to time, it is reported that Medicare is on the verge of "bankruptcy"; however, in the context of federal trust funds, the term "bankruptcy" is not legally meaningful. It is true that a trust fund's expenditures can be greater than its income and that trust funds can have a zero balance, but, unlike private businesses, the federal government is not in danger of "going out of business" or having its assets seized by creditors. The federal government has unique fiscal challenges but also distinctive fiscal powers, such as the power to tax and to issue currency. Insolvency of the HI trust fund would not imply insolvency of the entire federal government or a cutoff of Medicare's other financing sources. As noted, Congress has often taken actions to increase the trust fund's revenues or reduce its expenditures when the Medicare HI trust fund has faced imminent insolvency.

[17] 31 U.S.C. §1532. CRS Report R47600, *Transfer and Reprogramming of Appropriations: An Overview*.

[18] *1998 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund*, p. 16, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/TrusteesReports.

[19] *2026 Report of the Medicare Trustees*, p. 28.

[20] Neither CMS nor the Medicare trustees have committed to specific plans for what would happen after insolvency.

[21] *2026 Report of the Medicare Trustees*, p. 26.

[22] *2026 Report of the Medicare Trustees*, p. 69.

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.[23]

Medicare Financing Issues and Considerations for Congress

Much of the concern about Medicare's financial status tends to focus on the HI trust fund date of insolvency, when Medicare would no longer have the resources to pay for Part A health care services in full. This focus can, however, detract from larger issues confronting the Medicare program as a whole and from the program's current and future impact on the federal budget and on taxpayers. When viewed from the perspective of the entire federal budget, as the number of beneficiaries and per capita health care costs continue to grow, total Medicare spending obligations (HI and SMI spending combined) are expected to place demands on a growing share of the federal budget. The Congressional Budget Office (CBO) projects that Medicare will increase from 17% of federal spending in FY2025 to 25% in FY2056.[24]

Aging of the population and growth in the consumption of health care will likely contribute to the future risk of Medicare's insolvency and spending trajectory. Over the next 10 years, 2026-2035, the trustees project that Part A inflation-adjusted spending will grow primarily because of increases in the number of beneficiaries and the volume and intensity of health services.[25] Under current law, Medicare payment rates are projected to grow more slowly than the Consumer Price Index. New technologies, drugs, and patterns of care contribute to this growth in services. As the population has aged, the ratio of current workers to Medicare beneficiaries declined from 4.0 workers per beneficiary in 1980 to 2.7 workers per beneficiary in 2026. This ratio is projected to further decline to 2.4 in 2035.[26]

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 slightly lag behind the broader Consumer Price Index. After removing the effect of inflation, the volume and intensity of health services are the largest driver of spending. During this longer-term period, enrollment growth has a smaller impact, as population growth is projected to slow, although the trustees project that the ratio of current workers to Medicare beneficiaries will decline further to 2.0 in 2100.

As noted above, because of the way it is financed, the SMI (Parts B and D) portion of Medicare is unlikely to become insolvent. Yet—over time—a crucial underlying phenomenon is likely to challenge policymakers. That is, a continuing shift from providing care in inpatient (Part A) settings to outpatient (Parts B and D) settings has resulted in a greater portion of Medicare spending being covered by beneficiary premiums and general revenues than by dedicated payroll taxes.[27]

[23] 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*.

[24] Congressional Budget Office, "The Long-Term Budget Outlook: 2026 to 2056," February 25, 2026, Tables 1a and 3, https://www.cbo.gov/publication/62044.

[25] *2026 Report of the Medicare Trustees*, Table II.D1.

[26] *2026 Report of the Medicare Trustees*, Supplementary Table III.B4.

[27] See Medicare Payment Advisory Commission, Figure 1-6, "The HI Trust Fund Covers a Declining Share of Total Medicare Spending," in *Report to Congress: Medicare Payment Policy*, March 2021, p. 17, at mar21_medpac_report_to_the_congress_secv2.pdf.

In the future, the Medicare trustees estimate that the portion of total federal personal and corporate income tax revenue needed to fund SMI will increase from about 17.6% in 2025 to about 28.6% in 2040 and 38.3% in 2100.[28]

Congress may face growing pressure to enact changes. The growth of enrollment and the lag of payment rates below inflation may create pressure on policymakers to increase Medicare spending. Meanwhile, the program's growing demands on the federal budget and approaching insolvency may increase pressure to reduce expenditures. A blend of policies could be considered to respond to these competing demands.

To prevent insolvency of Part A, Congress may choose to reduce spending, take on additional debt, or increase revenue. However, these options involve trade-offs. Reducing spending may lower payments to health providers and restrict beneficiaries' access to benefits and services. Increasing taxes or premiums may reduce economic growth and taxpayers' income. Policymakers have repeatedly tried to minimize negative impacts of spending reductions, such as by targeting fraud, low-value care, or empirically identified overpayments (for specific examples of such legislation, see **Appendix C**). Other reforms have changed payment methodologies in ways meant to encourage efficiency, such as prospectively bundling payments for a group of services rather than paying separately for each service. For further resources on Medicare payment and financing reforms, see CBO's Budget Options and the Medicare Payment Advisory Commission's reports to Congress on Medicare payment policy.[29]

[28] *2026 Report of the Medicare Trustees*, Table II.F3. This amount is separate from and in addition to the payroll taxes used to fund the Part A (HI) portion of the program. For an overview of the federal tax system, see CRS Report R45145, *Overview of the Federal Tax System in 2022*.

[29] Congressional Budget Office, "Budget Options," December 2024, https://www.cbo.gov/budget-options, and Medicare Payment Advisory Commission, "Reports," Accessed May 6, 2026, https://www.medpac.gov/document-type/report/.

Appendix A. Operation of the Hospital Insurance Trust Fund

In 2004, Medicare Part A expenditures began to exceed *tax* income (from payroll taxes and from the taxation of Social Security benefits). In 2008, expenditures began to exceed *total* income (tax income plus all other sources of revenue), and Hospital Insurance (HI) assets (the balance of the HI trust fund at the beginning of the year) were used to meet the portion of expenditures that exceeded income. Expenditures have exceeded income every year from 2008 through 2015. In 2016 and 2017, the HI trust fund ran a small surplus, but in 2018 and 2019, the fund again experienced deficits. In 2020, the HI trust fund experienced a larger-than-normal deficit because of accelerated and advance payments made to providers during the COVID-19 pandemic (see the "Current Insolvency Projections" section). These payments were repaid in 2021-2023, resulting in HI trust fund surpluses in those years. In 2024, the surplus continued. In all future years beyond 2026, the trustees' projected expenditure growth is expected to continue to outpace growth in income, and the trust fund's accumulated assets will be drawn down to make up the difference between income and expenditures until the assets are depleted in 2033. At that time, the HI trust fund will no longer have sufficient funds to allow for the full payment of Part A expenditures. (See **Table A-1**, below, for historical and projected Medicare financial data through 2035.)

Table A-1. Operation of the Hospital Insurance Trust Fund, 1970-2035

(in billions of dollars)

	Income			Expenditures			Trust Fund	
Calendar Year	Payroll Taxes	Interest, Transfers, Other[a]	Total	Benefit Payments	Admin. Expenses	Total	Net Change from Prior Year	Balance at End of Year
Historical Data								
1970	$4.9	$1.2	$6.0	$5.1	$0.2	$5.3	$0.7	$3.2
1975	11.5	1.4	13.0	11.3	0.3	11.6	1.4	10.5
1980	23.8	2.1	26.1	25.1	0.5	25.6	0.5	13.7
1985	47.6	3.9	51.4	47.6	0.8	48.4	4.8	20.5
1990	72.0	8.4	80.4	66.2	0.8	67.0	13.4	98.9
1995	98.4	16.7	115.0	116.4	1.2	117.6	-2.6	130.3
2000	144.4	22.9	167.2	128.5	2.6	131.1	36.1	177.5
2005	171.4	28.0	199.4	180.0	2.9	182.9	16.4	285.8
2010	182.0	33.6	215.6	244.5	3.5	247.9	-32.3	271.9
2011	195.6	33.4	228.9	252.9	3.8	256.7	-27.7	244.2
2012	205.7	37.3	243.0	262.9	3.9	266.8	-23.8	220.4
2013	220.8	30.3	251.1	261.9	4.3	266.2	-15.0	205.4
2014	227.4	33.9	261.2	264.9	4.5	269.3	-8.1	197.3
2015	241.1	34.3	275.4	273.4	5.5	278.9	-3.5	193.8
2016	253.5	37.3	290.8	280.5	4.9	285.4	5.4	199.1

	Income			Expenditures			Trust Fund	
Calendar Year	Payroll Taxes	Interest, Transfers, Other[a]	Total	Benefit Payments	Admin. Expenses	Total	Net Change from Prior Year	Balance at End of Year
2017	261.5	37.8	299.4	293.3	3.2	296.5	2.8	202.0
2018	268.3	38.3	306.6	303.0	5.2	308.2	-1.6	200.4
2019	285.1	37.4	322.5	322.8	5.4	328.3	-5.8	194.6
2020	303.3	38.3	341.7	397.7	4.5	402.2	-60.4	134.1
2021	302.5	35.0	337.4	323.6	5.3	328.9	8.5	142.7
2022	352.8	43.8	396.6	337.4	5.3	342.7	53.9	196.6
2023	367.2	48.3	415.3	397.5	5.6	403.1	12.2	208.8
2024	396.5	54.7	451.2	416.3	6.2	422.5	28.7	237.5
2025	403.2	59.2	462.4	438.3	5.9	444.2	18.2	255.7
Intermediate Estimates								
2026	419.6	67.1	486.7	474.3	6.2	480.5	6.2	261.9
2027	441.6	72.8	514.5	518.4	6.5	524.9	-10.5	251.4
2028	464.5	77.7	542.4	556.8	6.9	563.6	-21.3	230.1
2029	488.0	82.6	570.5	596.1	7.2	603.3	-32.8	197.4
2030	512.7	86.9	599.6	636.0	7.5	643.5	-43.9	153.5
2031	538.5	90.7	629.1	677.5	7.9	685.3	-56.2	97.3
2032	564.4	93.9	658.4	719.3	8.2	727.5	-69.2	28.1
2033	591.6	98.5	690.0	766.4	8.7	775.1	-85.0	-56.9
2034	617.4	102.8	720.2	822.4	9.4	831.7	-111.6	-168.5
2035	644.2	104.9	749.2	867.5	9.8	877.3	-128.1	-296.5

Source: Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2026 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, June 9, 2026 (hereinafter, *2026 Medicare Trustees Report*), Table III.B4 and Supplementary Tables.

Notes: Sums may not equal totals due to rounding.

a. Includes income from the taxation of Social Security benefits, Railroad Retirement account transfers, premiums paid by voluntary enrollees, and interest.

Appendix B. Historical Payroll Tax Rates

Table B-1. Tax Rates and Maximum Tax Bases

		Tax Rate (percentage of taxable earnings)	
Calendar Year	Maximum Tax Base	Employees and Employers, Each	Self-Employed
1966	$6,600	0.35%	0.35%
1967	6,600	0.50	0.50
1968-1971	7,800	0.60	0.60
1972	9,000	0.60	0.60
1973	10,800	1.00	1.00
1974	13,200	0.90	0.90
1975	14,100	0.90	0.90
1976	15,300	0.90	0.90
1977	16,500	0.90	0.90
1978	17,700	1.00	1.00
1979	22,900	1.05	1.05
1980	25,900	1.05	1.05
1981	29,700	1.30	1.30
1982	32,400	1.30	1.30
1983	35,700	1.30	1.30
1984	37,800	1.30	2.60
1985	39,600	1.35	2.70
1986	42,000	1.45	2.90
1987	43,800	1.45	2.90
1988	45,000	1.45	2.90
1989	48,000	1.45	2.90
1990	51,300	1.45	2.90
1991	125,000	1.45	2.90
1992	130,200	1.45	2.90
1993	135,000	1.45	2.90
1994-2012	No limit	1.45	2.90
2013 and later[a]	No limit	1.45	2.90

Source: *2026 Medicare Trustees Report*, Table III.B2.

a. Beginning in 2013, workers pay an additional 0.9% of their earnings above $200,000 (those who file individual tax returns) or $250,000 (those who file joint tax returns).

Appendix C. Changes in HI Trust Fund Insolvency Projections: 1997-2026

Although HI trust fund has faced insolvency since its inception, it has never become insolvent. The insolvency date has been postponed several times since the beginning of the Medicare program in 1965 through various methods. For example, in the early years of the program, the payroll tax rate was increased occasionally to maintain the financial adequacy of the HI trust fund. (See **Appendix B** for historical payroll tax rates.)

Other legislative changes have been made at various times to slow the growth in HI program spending, primarily by adjusting Part C plan and Part A provider payment methodologies. Generally, these measures have been part of larger budget reconciliation laws that attempted to restrain overall federal spending. (See **Table C-1** below for a summary of changes each year in the solvency projections of the HI trust fund.)

Table C-1. Summary of Changes in HI Trust Fund Insolvency Projections, 1997-2026

Report Year	Insolvency Projection	Change in Years (– earlier, + later)	Explanation of Change in Solvency Date and Notes
1997	2001	0	Same year of insolvency projected as in prior report.
1998	2008	+7	Enactment of the Balanced Budget Act of 1997 (BBA 97; P.L. 105-33) improved solvency through lower expected expenditures (primarily from modifications in Medicare Part C payments and the establishment of prospective payment systems for certain Part A providers); expanded efforts to combat fraud and abuse; and higher revenues from strong economic growth.[a]
1999	2015	+7	
2000	2025	+10	
2001	2029	+4	Stronger-than-expected economic growth and lower-than-expected program costs due to lower projected enrollment in Medicare Part C, heightened anti-fraud and abuse initiatives, and lower-than-expected increases in health care costs.
2002	2030	+1	
2003	2026	–4	Lower-than-expected HI-taxable payroll and higher-than-expected hospital expenditures.
2004	2019	–7	Slower wage growth (on which payroll taxes are based) and faster growth in inpatient hospital benefits. Enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; P.L. 108-173) added to HI costs primarily through higher payments to rural hospitals and to private plans under the Medicare Advantage program.[b]
2005	2020	+1	Slightly higher income and slightly lower costs in 2004 than previously estimated.
2006	2018	–2	Slightly higher costs and increased utilization of HI services.
2007	2019	+1	Slightly higher payroll tax income and slightly lower benefits than previously estimated.
2008	2019	0	No major changes.
2009	2017	–2	Lower payroll tax income resulting from the December 2007 to June 2009 economic recession (the Great Recession).

Report Year	Insolvency Projection	Change in Years (– earlier, + later)	Explanation of Change in Solvency Date and Notes
2010	2029	+12	Enactment of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) resulted in lower projected Part A payments and higher payroll-tax revenues.[c]
2011	2024	–5	Lower-than-expected payroll taxes stemming from higher-than-expected unemployment, and slower wage growth in 2010.
2012	2024	0	2% reduction in spending required by the Budget Control Act of 2011 (BCA; P.L. 112-25) from 2013 through 2021, offset by higher HI expenditures.[d]
2013	2026	+2	Lower-than-expected expenditures in 2012 and a larger-than-estimated impact of ACA payment methodology changes on Medicare Advantage costs.
2014	2030	+4	Lower expected utilization of and spending for certain Part A services.
2015	2030	0	No major changes.
2016	2028	–2	Lower-than-expected payroll-tax income in 2015 and slower projected wage growth.
2017	2029	+1	Lower-than-expected HI expenditures in 2016 and lower projected utilization of inpatient hospital services.
2018	2026	–3	Lower payroll tax revenue due to lower-than-expected wages in 2017 and projections of slower gross domestic product growth, as well as lower expected income from taxes on Social Security benefits as a result of 2017 legislation that lowered individual income taxes.
2019	2026	0	No major net changes.
2020	2026	0	Lower-than-expected payroll tax revenue, offset by lower-than-expected provider payment updates.[e]
2021	2026	0	Although the COVID-19 pandemic affected Medicare's short-term financing and spending in 2020, with lower income and expenditures that largely offset each other, the trustees did not project that the pandemic would have much effect on the financial status of the HI trust fund beyond 2024.
2022	2028	+2	Higher projected payroll tax revenue and lower HI expenditures in 2021-2023 due to the COVID-19 pandemic.
2023	2031	+3	Higher than expected wage and employment growth, and lower-than-expected expenditures in 2022.
2024	2036	+5	Payroll tax revenue was higher than previously expected. Projected spending was lower because of updated data for hospital and home health payments and the exclusion of medical education from Medicare Advantage benchmark costs.
2025	2033	–3	Higher-than-expected expenditures in 2024 and higher projected utilization of hospital and hospice services.

Report Year	Insolvency Projection	Change in Years (– earlier, + later)	Explanation of Change in Solvency Date and Notes
2026	2033	0	Higher Medicare Advantage enrollment and spending that was mostly offset by lower Part A spending in 2025. Longer-term reductions in tax revenue from the 2025 reconciliation law and updated demographic assumptions did not have a significant impact on the solvency date.

Source: Intermediate projections of various Medicare trustees reports, 1997-2026. Medicare trustees reports are available on the CMS webpage, "Trustees Report & Trust Funds," at https://www.cms.gov/data-research/statistics-trends-and-reports/trustees-report-trust-funds.

a. The Balanced Budget Act of 1997 (BBA 97; P.L. 105-33) established the Medicare + Choice program under Part C. Medicare Part C was changed to Medicare Advantage by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; P.L. 108-173).

b. The Part D outpatient prescription drug program, which was created by the MMA, is funded under SMI; the increased expenditures associated with this new benefit therefore had little impact on projections of Medicare (HI) solvency.

c. The expected spending reductions in the ACA were primarily due to productivity adjustments to Part A provider payment updates and reduced payments to Medicare Advantage plans.

d. Subsequent legislation extended the sequestration reductions in Medicare. For additional information, see and CRS Report R45106, *Medicare and Budget Sequestration*.

e. The *2020 Report of the Medicare Trustees*, April 22, 2020, did not reflect potential economic and health care impacts of the COVID-19 pandemic on the Medicare program.

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