American Academy of Actuaries

Issue Brief

Medicare's Financial Condition: Beyond Actuarial Balance

SEPTEMBER 2026

Key Points

Medicare faces three distinct financing challenges:

- The Federal Hospital Insurance trust fund expenditures will exceed income starting 2027. The 2026 Trustees Report projects trust fund depletion in Q2 2033—one quarter earlier than last year's estimate. At that time, only 89% of scheduled benefits could be covered.*
- The Supplementary Medical Insurance trust fund has no depletion date since premiums/federal contributions adjust annually, but rising costs still strain beneficiary and federal budgets.
- Total Medicare spending is projected to grow from 3.9% of GDP (2025) to 7.5% (2100), raising long-term fiscal concerns.

Corrective action remains necessary—delay risks larger future burdens on beneficiaries, providers, and taxpayers. Any reforms should weigh impacts on care access and affordability alongside financing goals.

* "2026 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds" (2026 Medicare Trustees Report), Sections II.A and II.E; Centers for Medicare & Medicaid Services; June 9, 2026.

American Academy of Actuaries
1850 M Street NW, Suite 300
Washington, DC 20036
202-223-8196 | www.actuary.org

Geralyn Trujillo
Senior Director, Public Policy

Julia Lerche
Senior Actuary, Health

Each year, the Boards of Trustees of the Federal Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) Trust Funds submit the statutorily required report to Congress on the Medicare program's financial condition. The federal Medicare program is operated through these two trust funds. The HI trust fund, which finances Medicare Part A, pays primarily for inpatient hospital services, hospice, skilled nursing facility services, and certain home health services. The SMI trust fund includes the Medicare Part B account, which covers physician, outpatient hospital, and other services, and the Medicare Part D account, which covers prescription drugs. Medicare Advantage (MA) plans, which cover Part A and Part B services, receive capitated payments financed through both the HI and SMI Part B accounts.[1]

The Medicare Trustees Report is the federal government's principal current-law actuarial assessment of Medicare's short- and long-range financial condition. The 2026 report reflects the intermediate assumptions adopted by the trustees and the analyses prepared by the federal actuaries who support the report. Its most visible result is the projected depletion of the HI trust fund in the second quarter of 2033. That date, however, captures only one dimension of Medicare's financial condition. The report also projects growing SMI costs, rising beneficiary and federal budget burdens, and Medicare expenditures that are projected to increase substantially as a share of the economy.[2]

In this issue brief, the American Academy of Actuaries' Medicare Committee examines the trustees' findings through two related lenses. Solvency refers to whether a trust fund can pay scheduled benefits when due under scheduled financing. Financial sustainability is broader and considers

1 2026 Medicare Trustees Report, Introduction and Overview; Centers for Medicare & Medicaid Services; June 9, 2026.
2 2026 Medicare Trustees Report, Sections I and II.G.; Centers for Medicare & Medicaid Services; June 9, 2026.

the burden Medicare spending places on beneficiaries, taxpayers, providers, the federal budget, and the economy. Actuarial balance refers to the difference between summarized income and cost rates over a valuation period, expressed as a percentage of taxable payroll; a negative actuarial balance is an actuarial deficit. The distinction is important: HI solvency, SMI affordability, and the overall fiscal burden of Medicare are connected, but they are not interchangeable measures.[3]

Medicare HI Trust Fund Income Falls Short of the Amount Needed to Fund HI Benefits

Medicare's trust funds account for program income and expenditures. Payroll taxes, premiums, federal contributions, and other income are credited to the trust funds and used to pay benefits and administrative costs. Income not immediately needed for expenditures is invested in special-issue U.S. Treasury securities. From the trust fund perspective, these securities are assets available to finance future benefits; from the Treasury perspective, they represent borrowing by the Treasury from the trust funds. The HI trust fund is financed primarily through earmarked payroll taxes.

Under the trustees' intermediate assumptions, the HI trust fund is projected to be depleted in the second quarter of 2033, the same calendar year as projected in last year's report but a quarter earlier. The 75-year HI actuarial deficit increased from 0.42% of taxable payroll in the 2025 report to 0.56% in the 2026 report, an increase of roughly one-third over the prior estimate. Short-range HI income is lower than projected last year, while expenditures are projected to remain relatively close to last year's estimates.[4]

3 2026 Medicare Trustees Report, Section III.B.3.; Centers for Medicare & Medicaid Services; June 9, 2026. The report describes actuarial balance as the difference between summarized income and cost rates over the valuation period, with the calculation including the target trust fund balance.
4 2026 Medicare Trustees Report, Sections II.E and III.B.2, Table II.E1; Centers for Medicare & Medicaid Services; June 9, 2026.

The members of the Medicare Committee: Derek Skoog MAAA, FSA (Chairperson); Emily Bartel, MAAA, ASA; Andrew Bourg, MAAA, ASA; Ryan Brake, MAAA, ASA; Bradley Budnick, MAAA, ASA; Eric Buzby, MAAA, FSA; Veronika Chervenska, MAAA, FSA; Marshall Forest, MAAA, FSA; Tyler Grossi, MAAA, FSA; Michael Nordstrom, MAAA, ASA; William Olaprath, MAAA, ASA; Bradley Paulis, MAAA, ASA; Ryan Pestka, MAAA, ASA; Bruce Pyenson, MAAA, FSA; Neela Ranade, MAAA, FSA; Brian Regan, MAAA, FSA; Dianne Schmidt, MAAA, FCA, ASA; David Scholl, MAAA, ASA; Annoria Shah, MAAA, ASA; Paul Spitalnic, MAAA, ASA; Glynn Villadavis, MAAA, ASA; Todd Wanta, MAAA, FSA

Special thanks to: Derek Skoog, Bradley Budnick and Michael Nordstrom

What changed in 2026? Compared with the 2025 report, HI cost-rate projections are mostly consistent through 2050 and higher thereafter, while projected income rates are lower. The One Big Beautiful Bill Act (OBBBA) reduced projected HI income by lowering the amount of federal income tax expected to be collected on Social Security benefits and credited to the HI trust fund. Revised demographic assumptions, most notably lower projected fertility, also weaken the long-range outlook by reducing projected taxable payroll and GDP. On the expenditure side, changes in projected payments to private health plans and certain fee-for-service providers affect the year-by-year results, although favorable 2025 experience partially offsets these pressures.[5]

The demographic pressure is visible in the number of workers supporting each HI beneficiary: 4.6 workers per beneficiary in 1970, roughly 4.0 from 1980 through 2000, a projected 2.5 in 2030, and a projected 2.0 by 2075. This ratio is not a complete measure of Medicare financing, but it provides a simple illustration of how population aging increases pressure on payroll-tax-financed benefits.[6]

- After a small projected surplus in 2026, annual HI deficits are projected to return beginning in 2027 and to persist for the remainder of the projection period. From the trust fund perspective, these deficits require redemption of the special-issue Treasury securities held as assets. From the federal budget perspective, the Treasury must finance the associated cash requirement through current revenues, reductions in other federal spending, or additional borrowing from the public. The redemption itself is an intragovernmental transaction and should not be treated as equivalent to a change in the unified budget deficit; the trust fund and budget perspectives answer different questions.[7]

- The HI trust fund is projected to be depleted in the second quarter of 2033. In the year of depletion, ongoing non-interest income is projected to cover 89% of scheduled HI expenditures. That share is projected to decline to 85% in 2050 and then increase to about 93% by 2100. Current law does not provide an automatic general-revenue transfer to cover the shortfall. For purposes of illustrating the size of the financing gap, the trustees' projections continue to show scheduled expenditures after depletion rather than reducing payments to the level supportable by incoming revenue.[8]

5 2026 Medicare Trustees Report, Section II.G, section III.B.3, Figure III.B6, and Table III.B10; Centers for Medicare & Medicaid Services; June 9, 2026.
6 2026 Medicare Trustees Report, Expanded and Supplementary Tables and Figures, Ratio of HI Covered Workers to HI Beneficiaries; Centers for Medicare & Medicaid Services; June 9, 2026.
7 2026 Medicare Trustees Report, Section V.F, Medicare and Social Security Trust Funds and the Federal Budget; Centers for Medicare & Medicaid Services; June 9, 2026.
8 2026 Medicare Trustees Report, Sections II.E and III.B.2-3; Centers for Medicare & Medicaid Services; June 9, 2026.

- The 2033 depletion date is a central estimate, not a date known with precision. Medicare projections are sensitive to economic growth, demographic trends, health care utilization, technological change, and provider-payment assumptions. Under the trustees' high-cost assumptions, depletion would occur in 2030. Under the low-cost assumptions, HI assets would increase throughout the projection period. The trustees also caution that actual experience could fall outside the range illustrated by these scenarios.

The projected 75-year HI actuarial deficit is 0.56% of taxable payroll. To illustrate the magnitude of the gap, the trustees estimate that eliminating the deficit through an immediate change would require increasing the standard HI payroll tax rate from 2.90% to 3.46%, reducing scheduled HI expenditures by 12%, or adopting a combination of revenue increases and expenditure reductions. These figures illustrate the size of the shortfall; they are not policy recommendations. If action is delayed until depletion, larger changes would be concentrated over fewer years and generations.[9]

The current-law projections may understate the seriousness of Medicare's financial condition if statutory provider-payment constraints prove difficult to sustain. Payment updates for most non-physician providers are reduced to reflect economy-wide productivity improvements, even though health care providers historically have achieved lower productivity growth. Physician payment updates are specified in statute and, over the long range, are projected to remain below physician input-cost growth. The CMS chief actuary notes that, if payment rates become inadequate for any service, beneficiary access to or quality of care could deteriorate over time, or future legislation could increase program costs above current-law projections.[10]

At the trustees' request, the CMS Office of the Actuary (OACT) prepared an illustrative alternative analysis. The alternative assumes that payment updates for providers subject to the economy-wide productivity adjustment would transition to updates reflecting health-sector productivity and that physician updates would transition toward the Medicare Economic Index. The alternative is not the trustees' official best estimate and should not be interpreted as an endorsement or prediction of future legislation. Its purpose is to illustrate the possible magnitude of cost understatement if current-law payment constraints are not sustained.

9 2026 Medicare Trustees Report, Section II.E, Addressing the Long-Range Financial Imbalance; Centers for Medicare & Medicaid Services; June 9, 2026.
10 2026 Medicare Trustees Report; Centers for Medicare & Medicaid Services; June 9, 2026.

Under the illustrative alternative, the HI depletion date remains 2033. However, the projected 75-year actuarial deficit increases to 1.38% of taxable payroll, compared with 0.56% under current law. Eliminating that deficit through an immediate change would require increasing the standard HI payroll tax rate from 2.90% to 4.28%, reducing scheduled HI expenditures by 25%, or adopting a combination of both.[11]

Growth in SMI Costs Increases Pressure on Beneficiary Household Budgets and the Federal Budget

The SMI trust fund includes separate accounts for Medicare Part B and Part D. Unlike HI, SMI does not face a comparable trust-fund depletion date under current-law financing. Part B and Part D beneficiary premiums and federal contributions are reset annually to meet projected program costs and, for Part B, maintain a contingency reserve. The trustees therefore expect the SMI accounts to remain adequately financed. The central SMI challenge is affordability: as costs grow, required financing increases for beneficiaries and the federal government.[12]

In 2025, federal government contributions covered about three-quarters of total SMI costs, while beneficiary premiums financed roughly one-quarter. The shares vary between Parts B and D and across beneficiaries because premiums are income-related and because low-income subsidies and state payments finance portions of Part D.[13]

Part B expenditures as a percentage of GDP are lower in the short range than in last year's report, primarily because of the assumed effect of 2026 payment-policy changes for skin substitutes, which are categorized as physician-administered drugs. Medicare Part B spending for skin substitutes increased from $0.8 billion in 2021 to $14.1 billion in 2025. The trustees project that the 2026 physician fee schedule policies will reduce this spending by more than 90% in 2026. This unusually large policy assumption materially affects the near-term Part B projection. Faster projected growth for other Part B drugs causes projected Part B spending to exceed last year's projection by 2048.[14]

11 2026 Medicare Trustees Report, section V.C, Table 1; Centers for Medicare & Medicaid Services; June 9, 2026.
12 2026 Medicare Trustees Report, Sections II.F and III.C-D; Centers for Medicare & Medicaid Services; June 9, 2026.
13 2026 Medicare Trustees Report, ServiTable II.B1 and Section II.B.; Centers for Medicare & Medicaid Services; June 9, 2026. Premium shares vary by account and beneficiary circumstances.
14 2026 Medicare Trustees Report, Sections II.A and II.G; Centers for Medicare & Medicaid Services; June 9, 2026.

Part D expenditures as a percentage of GDP are higher than in last year's report in all years. The principal near-term drivers are increased utilization of GLP-1 drugs and expensive specialty drugs in 2025, higher projected cost trends, and lower projected direct and indirect remuneration (DIR), which ordinarily reduces plans' net costs. Lower DIR therefore increases projected net Part D costs. These changes occur as the Inflation Reduction Act's Part D redesign shifts the distribution of costs among beneficiaries, plans, manufacturers, and the federal government. In the long range, revised demographic assumptions and lower projected GDP further increase Part D spending as a share of the economy.[15]

Because SMI financing is reset annually, higher expenditures are reflected in higher beneficiary premiums and federal contributions rather than in a depletion date. SMI government contributions are projected to increase from 1.9% of GDP in 2025 to 3.7% by 2100 under current law. This is a projected financing requirement, not a fixed statutory schedule, and it represents a growing claim on federal revenues.[16]

The Medicare funding warning provides a statutory measure of Medicare's reliance on general revenues. A determination of excess general revenue Medicare funding is required when the difference between total Medicare expenditures and specified dedicated financing sources is projected to exceed 45% of expenditures within the first seven fiscal years of the projection. In the 2026 report, the threshold is projected to be exceeded in fiscal year 2026. This is the tenth consecutive report with such a determination and the ninth consecutive report to trigger a funding warning, which requires a presidential legislative proposal and expedited congressional consideration.[17]

Rising SMI costs also affect beneficiary affordability. As an illustrative measure, average beneficiary expenses for Parts B and D premiums and cost sharing combined are projected to increase from 27% of the average retired-worker Social Security benefit in 2026 to 41% by 2100. Individual experience will vary substantially by income, health status, supplemental coverage, and use of services. The measure also does not include Part A cost sharing or premiums for supplemental coverage.[18]

15 2026 Medicare Trustees Report, Sections II.A and II.G.; Centers for Medicare & Medicaid Services; June 9, 2026. Direct and indirect remuneration (DIR) refers to post-point-of-sale price concessions that generally reduce plans' net costs
16 2026 Medicare Trustees Report, Section II.D; Centers for Medicare & Medicaid Services; June 9, 2026.
17 2026 Medicare Trustees Report, sections II.A and V.B; Centers for Medicare & Medicaid Services; June 9, 2026.
18 2026 Medicare Trustees Report, Figure II.F2.; Centers for Medicare & Medicaid Services; June 9, 2026. The comparison uses the average Old-Age and Survivors Insurance retired-worker benefit

Total SMI expenditures are projected to increase from 2.5% of GDP in 2025 to 5.5% by 2100 under current law. The increase reflects both growth in spending per beneficiary and the changing size and composition of the Medicare population. Under the OACT illustrative alternative, SMI spending would be higher, particularly in the long range, because of higher assumed physician and other provider-payment updates. Total SMI expenditures would reach 6.7% of GDP in 2100, compared with 5.5% under current law.[19]

Growth in Total Medicare Spending Raises Long-Term Fiscal Sustainability Concerns

A broader question is whether the economy can sustain Medicare spending over time. The share of GDP consumed by Medicare is a useful measure of fiscal burden because it places program expenditures in the context of the economy available to support them. It is not, however, a threshold that determines whether Medicare is sustainable. Rather, a rising share indicates increasing pressure on taxpayers, beneficiaries, the federal budget, and other public and private priorities.

Under current law, total Medicare expenditures are projected to increase from 3.94% of GDP in 2025 to 6.53% in 2050 and 7.53% in 2100. Under the OACT illustrative alternative, total expenditures would reach 6.97% of GDP in 2050 and 9.79% in 2100.[20]

Table 1. Total Medicare Expenditures as a Percentage of GDP

Calendar Year	2026 Report (Current Law)	2026 Illustrative Alternative Projection
2025	3.94%	3.94%
2030	4.84	4.85
2040	6.10	6.25
2050	6.53	6.97
2060	6.83	7.59
2070	7.22	8.35
2080	7.51	9.04
2090	7.59	9.51
2100	7.53	9.79

Values are displayed to two decimals to avoid rounding ambiguity; values are affected by economic cycles.[21]

19 2026 Medicare Trustees Report, Figure II.F1 and Table II.A2; CMS Office of the Actuary illustrative alternative projections; Centers for Medicare & Medicaid Services; June 9, 2026.
20 CMS Office of the Actuary, Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers, Table 4; Centers for Medicare & Medicaid Services; June 9, 2026.
21 CMS Office of the Actuary, Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers, Table 4; Centers for Medicare & Medicaid Services; June 9, 2026.

Future Policy Considerations

The 2026 report presents projected outcomes under current law and the trustees' intermediate assumptions. Those projections are conditional: they describe what would occur if current-law financing and payment provisions remain in place and the assumptions are realized. The illustrative alternative highlights one important source of uncertainty, but it does not capture the full range of possible future health care costs, utilization, delivery-system changes, or legislative responses.

The trustees emphasize the value of timely action. Earlier changes generally can be phased in more gradually and allow beneficiaries, providers, taxpayers, and other affected parties more time to adjust. As the trustees state, "[t]he sooner solutions are enacted, the more flexible and gradual they can be." The trustees also recommend that Congress and the executive branch work together to address these challenges.[22]

Medicare's challenges are not solely financial. The beneficiary population includes people with diverse health care needs, limited incomes, and substantial health care needs. Traditional Medicare Parts A and B do not include an annual out-of-pocket maximum absent supplemental coverage, while Medicare Advantage and Part D operate under different cost-protection rules. Accordingly, the effects of any financing or benefit change should be evaluated not only in aggregate but also across beneficiary groups, generations, providers, and sources of financing. Policymakers should consider whether changes preserve access to appropriate, high-quality care and whether they encourage cost-effective use of services.[23]

Conclusion

The 2026 Medicare Trustees Report continues to show serious but distinct financial challenges. HI annual deficits are projected to resume in 2027, and the HI trust fund is projected to be depleted in 2033. SMI is expected to remain adequately financed under its automatic financing structure, but its cost growth will increase beneficiary premiums and federal contributions. Total Medicare spending is projected to consume a substantially larger share of the economy over time.

22 2026 Medicare Trustees Report, Section II.G.; Centers for Medicare & Medicaid Services; June 9, 2026.
23 Medicare & You 2026; Medicare.gov; June 9, 2026. Original Medicare has no annual out-of-pocket limit unless the beneficiary has supplemental coverage, while Medicare Advantage plans include annual limits for covered services. Medicare Part D includes its own annual out-of-pocket cap for covered Part D drugs.

These measures should be considered together rather than in isolation. A change that improves HI solvency may shift costs to beneficiaries, providers, SMI, or the federal budget; a change that reduces federal spending may affect access to care or affordability. Actuarial analysis can clarify these trade-offs and the distribution of costs across current and future beneficiaries and taxpayers. Consistent with the Academy's role as an objective, independent resource, this issue brief is diagnostic and does not recommend specific policy changes. Continued actuarial analysis and engagement among policymakers, program staff, beneficiaries, providers, and other stakeholders will be important in evaluating the consequences of both action and inaction.

The American Academy of Actuaries is a 20,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 60 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

This paper was developed thanks to the work of the Academy's volunteers. To learn more about becoming a volunteer, please visit actuary.org/volunteer.