One half of Medicare can go broke. The other half can only get expensive.

The 2026 Trustees Report covers two trust funds with completely different failure modes — and almost every argument about Medicare comes from confusing them. Here is each one, read from the kitchen table and from the committee room.

> **Two funds, two rules. HI** (Hospital Insurance, Part A) is funded by payroll tax and *can* run out of money. **SMI** (Supplementary Medical Insurance, Parts B and D) is refilled every year by law from general revenue and beneficiary premiums, so it *cannot* run out — the cost simply moves onto taxpayers and onto you.

THE HALF WITH A DEADLINE

2033

Second quarter. That is when the Hospital Insurance trust fund — the part that pays for your hospital stays — is projected to run out of reserves. It moved **one quarter earlier** than last year's report.

HOSPITAL INSURANCE (PART A)

Q2 2033

Then 89% of scheduled benefits are payable — a figure that recovers to 93% by 2100 rather than sliding further.

PARTS B & D (SMI)

Never

Financed by law each year from general revenue and premiums. It cannot deplete — which is not the same as being affordable.

HI SHORT-RANGE ADEQUACY TEST

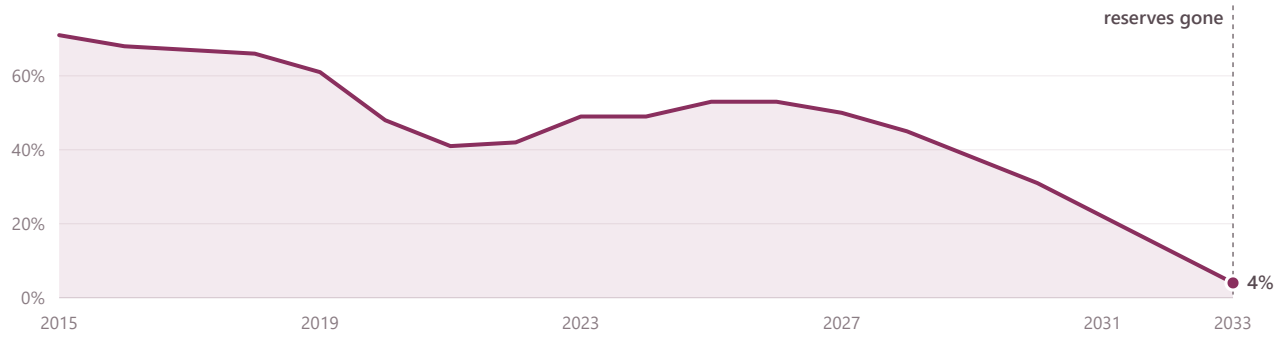
Failed

The fund does not meet the Trustees' own 10-year test. They call this “an indication that action is necessary.”

Source: 2026 Medicare Trustees Report, Overview p. 8; §III.B pp. 61–62.

Hospital Insurance reserves, measured against one year of spending

Trust fund ratio: assets at the start of the year as a percent of that year's expenditures. The Trustees' own test wants this at 100% or above.



Source: Medicare TR2026, table III.B6, p. 62.

AT THE KITCHEN TABLE

Part A is the hospital half — inpatient stays, skilled nursing, hospice. If nothing changes, from 2033 it can only cover **89%** of what it owes providers.

You would not be dropped from Medicare. The squeeze would land first on what hospitals are paid, which is a slower and less visible problem than a benefit cut — right up until it affects which facilities take you.

IN THE COMMITTEE ROOM

The date moved because of a **revenue** change, not a spending one. Over 2026–2035 HI income is **$51.6 B lower** (about 0.8%) than last year's projection; expenditures are only **$4.3 B higher** (0.1%).

The Trustees attribute the income drop to lower taxation of Social Security benefits under the OBBBA. A tax cut scored elsewhere pulled a quarter off Medicare's clock.

THE HALF WITH NO DEADLINE

"Adequately financed" is the most misread phrase in the report.

The Trustees write that SMI — Parts B and D — is adequately financed indefinitely. That is true, and it is not reassurance. It is a description of a mechanism: whatever Parts B and D cost next year, the premium and the government's contribution are simply *reset to cover it*. There is no trust fund to run dry because the bill is re-sent every year.

Government contributions — general taxpayer revenue
Beneficiary premiums
Interest and other (remainder)

Source: Medicare TR2026, "Medicare Data for Calendar Year 2025," p. 13. Shares are of SMI program cost in 2025.

AT THE KITCHEN TABLE

“Medicare can't go bankrupt” is technically true of Parts B and D — because your premium is the shock absorber. When costs rise, the premium rises. That is the design, not a failure of it.

It is deducted from your Social Security payment before you see it, which is why the increase is easy to miss and hard to avoid.

IN THE COMMITTEE ROOM

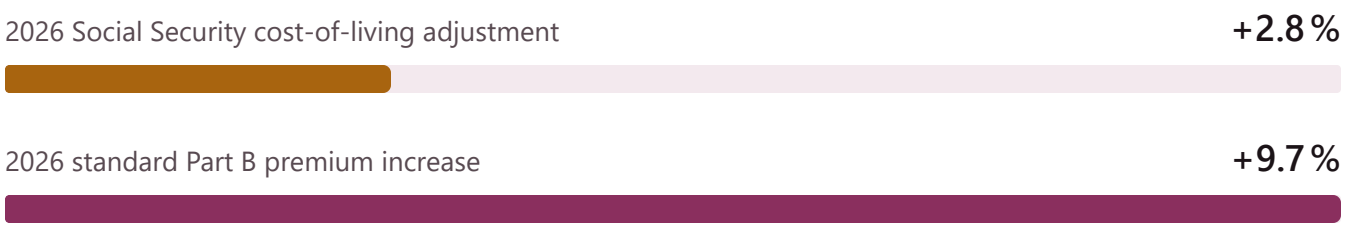
SMI's unfunded obligation is **$0** by construction. HI's is **$4.2 trillion**. Comparing the two as if they measured the same thing is a category error the report itself warns against.

Because 75% of SMI is general revenue, Part B and Part D growth is a claim on the same appropriations pool as everything else — it shows up in the deficit, not in a depletion date.

THE PART YOU FEEL

In 2026 your premium rose about three and a half times faster than your raise.

The Social Security cost-of-living adjustment for 2026 is **2.8%**. The standard Part B premium — deducted from that same check — rose **9.7%**. Both numbers come from the two Trustees Reports, and together they are the single most consequential fact on either page.



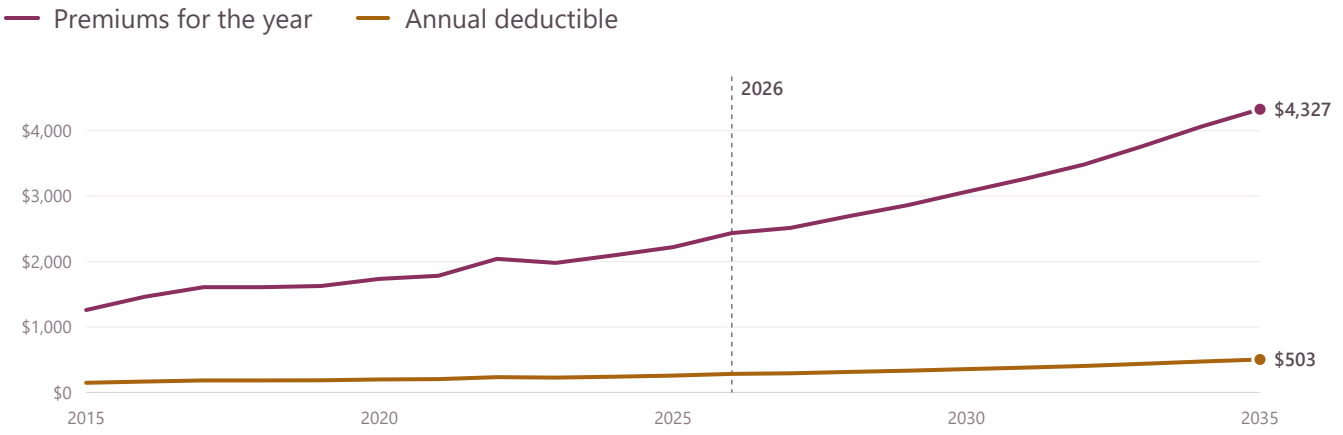
Sources: Premium from Medicare TR2026 table III.C2, p. 83: $185.00 in 2025 → $202.90 in 2026. COLA from OASDI TR2026 table V.C1 — note that table lists each increase against the year it is *payable for December of*, so the raise arriving in January 2026 sits on the row labelled 2025. The same offset puts the familiar 8.7 % on the row labelled 2022.

WHAT IT COSTS	2025	2026	CHANGE
Part B standard monthly premium Most enrollees; deducted from your Social Security payment	$185.00	$202.90	+9.7%
Part B annual deductible Before Part B starts paying	$257	$283	+10.1%
Part A inpatient hospital deductible Per benefit period, not per year	$1,676	$1,736	+3.6%
Part D out-of-pocket cap The drug-spending ceiling introduced in 2025, now indexed	$2,000	$2,100	+5.0%
Part D base beneficiary premium Before plan-specific pricing	$36.78	$38.99	+6.0%

Source: Medicare TR2026, tables V.E1 (p. 206) and V.E2 (p. 207).

What Part B costs you in a year

Premiums annualised (twelve monthly payments) so both lines are the same unit over the same period. Actual through 2026, projected to 2035.



Source: Medicare TR2026, table V.E2, p. 207. The report publishes the premium monthly; it is multiplied by twelve here. The table view shows both forms.

AT THE KITCHEN TABLE

The standard Part B premium is projected to reach **$360.60 by 2035** — **nearly double** the 2025 figure. The deductible roughly doubles too, from $257 to $503.

If your income is above **$109,000** filing single or **$218,000** jointly, you pay more on top. At the highest tier in 2026 that surcharge is **$487.00 a month** — on top of the $202.90.

IN THE COMMITTEE ROOM

6.1 million beneficiaries pay the income-related surcharge in 2026, contributing **$18.8 billion**. That is a means test already operating inside a universal program.

The $200,000 / $250,000 threshold for the additional 0.9% Medicare payroll tax has never been indexed. Every year of wage growth quietly widens who pays it — a tax increase that requires no vote.

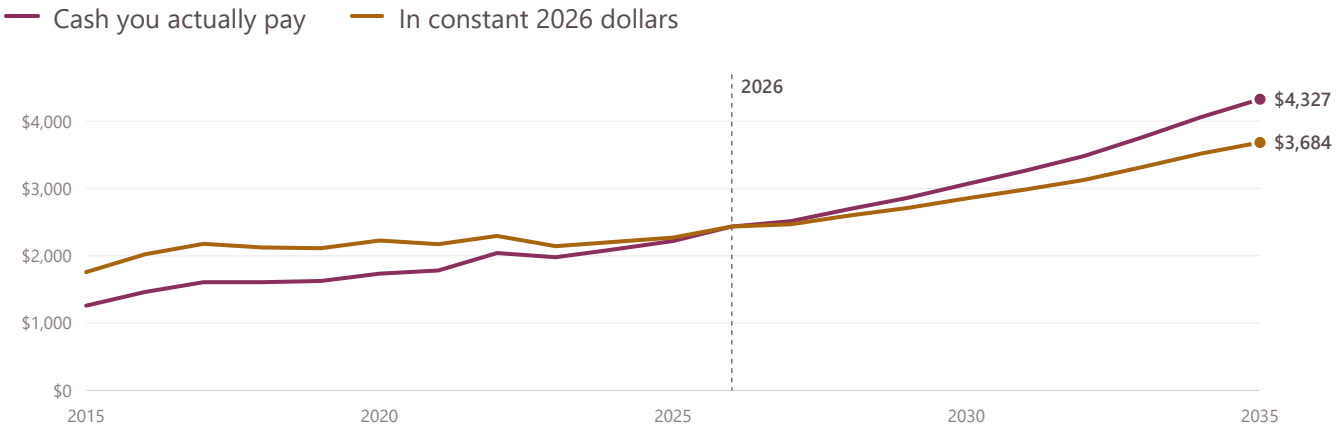
IN TODAY'S MONEY

After inflation, the Part B premium still rises by half.

A projection in future dollars always overstates the pain, so here is the same price list with inflation taken out. Between 2026 and 2035 the Trustees project general prices to rise **17.5%**. The Part B premium rises **77.7%**. Deflate one by the other and you are still left with a **51%** real increase — this is not a price-level illusion.

A year of Part B premiums, before and after inflation

The distance between the two lines is pure inflation. The lower line is what the premium costs in constant 2026 dollars — and it still climbs.



Source: Medicare TR2026 table V.E2 for the premiums; deflated using the Trustees' own CPI projection, OASDI TR2026 table VI.G1 (*Selected Economic Variables*, adjusted CPI, indexed to 2026 = 100).

2026 → 2035	NOMINAL	REAL	REAL Δ
Part B standard monthly premium $202.90 today	$360.60	$306.97	+51.3%
Part B annual deductible $283 today	$503	$428	+51.3%
Part A inpatient hospital deductible $1,736 today	$2,296	$1,955	+12.6%
Part D out-of-pocket cap $2,100 today	$2,650	$2,256	+7.4%

Real = the 2035 amount expressed in 2026 dollars. **Real Δ** = change against the 2026 amount after inflation. General prices rise 17.5 % over the same period.

AT THE KITCHEN TABLE

Your Social Security payment rises with consumer prices; that is what the COLA does. So the honest question is never "does my premium go up," it is **does it go up faster than my raise**. For Part B the answer is yes, by roughly half again over the next nine years.

The good news is narrower than it looks but it is real: the **hospital deductible and the drug cap grow only about 8 to 13% in real terms**. The squeeze is concentrated almost entirely in the Part B premium.

IN THE COMMITTEE ROOM

The real growth sits in **exactly the half of Medicare that cannot become insolvent**. Part A — the half with the 2033 headline — is close to flat once you deflate it. Part B, which never makes a headline because it can never run out, is where the money actually goes.

That inverts the usual framing. The depletion date is the urgent problem; Part B growth is the large one.

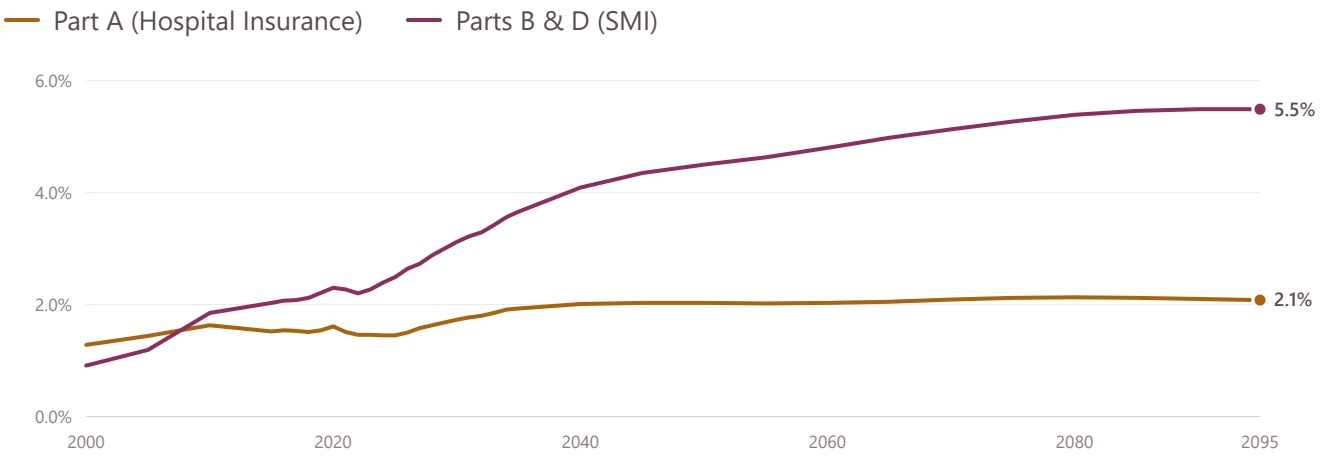
THE TRAJECTORY

Medicare roughly doubles as a share of the economy. Almost all of the growth is Parts B and D.

This is the chart that reframes the whole argument. Hospital Insurance — the half with the scary depletion date — barely grows as a share of GDP. The half that *cannot* go insolvent is the half that grows.

Medicare spending as a share of GDP

Incurred expenditures. Historical through 2025, projected after; five-year intervals beyond 2035.



Source: Medicare TR2026, table V.B2, p. 188. Parts B and D combined; each row cross-checks against the report's printed total.

TOTAL MEDICARE SPENDING, 2025	SHARE OF GDP, 2025	PEOPLE ENROLLED, 2025	IN MEDICARE ADVANTAGE
$1,210.1 B	**3.9 %**	**69.3 M**	**51 %**
income was $1,226.2 B	rising to 7.5 % by 2100	62.2 M aged, 7.1 M disabled	now the majority of enrollees

Source: Medicare TR2026, Overview pp. 7 and 11, “2025 in Review.”

THE ARITHMETIC

Closing the hospital fund's gap is a small number attached to a hard vote.

The report states the two ways to erase the 75-year HI shortfall outright. Compared with Social Security's gap, these are modest — which is exactly why the political economy, not the arithmetic, is the binding constraint.

UNDER CURRENT LAW

Close the HI gap

Raise the Medicare payroll tax

2.90 % → 3.46 %

Or cut Part A spending, immediately

−12 %

75-year HI actuarial deficit

0.56 % of taxable payroll

IF THE LAW'S COST CONTROLS DON'T HOLD

Illustrative alternative

Raise the Medicare payroll tax

2.90 % → 4.28 %

Or cut Part A spending, immediately

−25 %

75-year HI actuarial deficit

1.38 % of taxable payroll

Source: Medicare TR2026 §III.B, p. 33 and footnote 35. The alternative scenario assumes the physician and productivity-adjusted payment updates written into current law are not sustained — the Trustees publish it precisely because they doubt those updates hold.

AT THE KITCHEN TABLE

You currently pay **1.45%** of every paycheck to Medicare and your employer pays another 1.45%. Closing the gap means about **28 cents more per $100** of wages from each of you.

Self-employed? You pay both halves — 2.90% today, 3.46% under that fix.

IN THE COMMITTEE ROOM

The gap is **0.56% of taxable payroll** — roughly an eighth of Social Security's 4.42%. It is the cheapest of the entitlement problems to fix and the one closest to its deadline.

The alternative scenario more than doubles it to 1.38%. The difference between those two columns is entirely a question of whether Congress lets scheduled provider payment restraint actually take effect.

CURRENT INFO · MOVED SINCE THE 2025 REPORT

The depletion date moved a quarter. The deficit moved a third.

HI trust fund depletion One quarter earlier than last year's report	Q3 2033 → Q2 2033
HI 75-year actuarial deficit Share of taxable payroll needed to close the gap	0.42% → 0.56%
HI income, 2026–2035 Versus last year's projection, chiefly from OBBBA's effect on the taxation of Social Security benefits	−$51.6 B
Total Medicare as a share of GDP Higher than the 2025 report, on higher projected drug spending and lower projected GDP	revised up

Source: Medicare TR2026, Overview p. 8; §III.B p. 62; §V.B p. 187.

AT THE KITCHEN TABLE

Nothing about your coverage changes this year because of any of the above. The dates in this report are forecasts, and they have moved before — in both directions.

What has already changed is the price list further up this page. That part is not a projection.

IN THE COMMITTEE ROOM

The Trustees close with an unusually direct line: *"The sooner solutions are enacted, the more flexible and gradual they can be."* They recommend Congress and the executive branch "work closely together to quickly address these challenges."

Seven years remain before the HI date. Social Security's is eight. The two reports are effectively one deadline.

SOURCES — EVERY FIGURE ON THIS PAGE

Medicare TR2026 — 2026 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. Overview pp. 2–14; §III.B pp. 30–62; §V.B p. 188; appendix tables V.E1–V.E3 pp. 206–209; table III.C2 p. 83.

OASDI TR2026 — table V.C1, for the 2026 cost-of-living adjustment used in the premium comparison.

All projections are the Trustees' *intermediate* assumptions — their central estimate. The report also publishes an illustrative alternative that assumes current-law payment restraint does not hold; where that scenario is used it is labelled. Nothing here is medical, financial, or enrollment advice; it is a reading of one public document, with page and table numbers attached so you can check any figure yourself.