



Reducing Premium Subsidies for High-Income Enrollees in Medicare Part B

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Executive Summary

- The Problem** General revenue funds 48 percent of Medicare. Part B alone will draw \$451 billion from taxpayers in 2026 and grow to \$944 billion by 2035, more than the Congressional Budget Office's projected primary deficit for that year. High-income seniors already pay higher Part B premiums through the Income-Related Monthly Adjustment Amount (IRMAA), but every IRMAA payer still receives a taxpayer subsidy of \$1,460 to \$6,330 a year.
- The Proposal** Replace Part B's five IRMAA tiers with a linear increase rising from 35 percent of program cost at the existing \$111,000 entry point to 100 percent at \$250,000 for singles and \$500,000 for couples. The linear increase removes four premium cliffs with discrete marginal rate spikes and adds no new payers in its first year. Both break points grow with the chained Consumer Price Index. Optionally, replace the two-year income lookback with the same income determination system that the Affordable Care Act uses for its advance premium tax credits (APTCs).
- The Revenue** An additional estimated \$6.0 billion in 2027 and \$113 billion over ten years before behavioral responses, or \$89 billion to \$106 billion after them. Interest cost savings from lower federal borrowing add another \$14.5 to \$17 billion over ten years. Every dollar offsets existing general revenue transfers and lowers federal borrowing.
- The Distributional Impact** Only seniors who currently pay Part B IRMAA premiums would pay more. Their subsidies would fall by as much as \$2,009 per enrollee in 2027. Premiums for the bottom 90 percent of Part B enrollees would remain unchanged.

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INTRODUCTION

Contrary to popular opinion, Medicare is not entirely paid for by payroll taxes, premiums, and beneficiary cost sharing. Dedicated financing covers only 52 percent of Medicare outlays. The other 48 percent comes from general revenue fund transfers.¹ In other words, taxpayers pay for almost half of Medicare spending. Payroll taxes

are dedicated to funding Part A of Medicare and cover around 87 percent of Part A outlays. Parts B and D require seniors to pay monthly premiums, but by statute seniors pay only about 25 percent of the actuarial cost of those services. In 2026, Medicare Part B will require \$451 billion from taxpayers in general fund revenue, growing to \$944 billion by 2035.² For comparison, the Congressional Budget Office (CBO) estimates primary deficits will be \$938 billion in 2035.³

Medicare is highly subsidized for enrollees. A married one-earner couple with average lifetime earnings who turn sixty-five in 2035 will have paid \$126,000 in Medicare payroll taxes and go on to receive an estimated \$911,000 in lifetime Medicare benefits net of premiums. A married two-earner couple, each with maximum lifetime taxable earnings who turn sixty-five that same year, will have paid \$639,000 in Medicare payroll taxes and receive the same \$911,000 in lifetime Medicare benefits.⁴ At the bottom end of the income distribution, roughly one in five Medicare enrollees receives some state or federal assistance to offset the cost of their Medicare coverage.⁵

Seniors are also much better off than they were a few decades ago. In their research, John Cogan

and Daniel Heil find that the median inflation-adjusted income of senior households rose by 85 percent from 1982 to 2018.⁶ Table 1 shows that, adjusting for household size and tax burden, the median senior household is nearly at parity with the median nonelderly household. The increase in seniors' well-being is robust across all segments of senior incomes and demographics.

Parts B and D are the driving forces behind nondedicated revenue financing of Medicare. Both parts already require high-income seniors to pay the Income-Related Monthly Adjustment Amount (IRMAA) to their standard premiums. The 25 percent share of Part B premiums paid by enrollees, for example, rises from 35 percent to 85 percent in discrete jumps depending on their income.

In 2026, the Part B base premium was \$202.90 per month, representing 25 percent of the \$9,739 annual average per capita cost of a Part B enrollee. While most seniors focus on their premium amount, table 2 demonstrates that a senior paying standard premiums is receiving an annual subsidy of \$7,304 for their Part B supplemental medical insurance. Even seniors at the top, making at least half a million dollars a year, are given a \$1,460-per-enrollee annual subsidy funded by taxpayers.

TABLE 1 INCOME AT VARIOUS PERCENTILES FOR SENIORS AND NONSENIORS (2020 DOLLARS)

	25th percentile		Median		75th percentile	
	Seniors	Nonseniors	Seniors	Nonseniors	Seniors	Nonseniors
1982	\$13,300	\$29,400	\$25,500	\$51,700	\$46,200	\$82,400
2018	\$25,700	\$33,200	\$47,000	\$63,700	\$89,300	\$117,900
1982–2018	94%	13%	85%	23%	93%	43%

Sources: John F. Cogan and Daniel L. Heil, "Four Decades of Senior Household Income Growth: New Evidence from the Survey of Consumer Finances," Hoover Institution, February 2023. Data are from the Survey of Consumer Finances (SCF). Income is inflation adjusted using the Personal Consumption Expenditures (PCE) Price Index.

TABLE 2 MONTHLY TAXPAYER SUBSIDY PER PART B ENROLLEE, 2026 (CURRENT LAW)

MAGI (Single/Joint)	Tier	Enrollees	Monthly premium paid	Monthly subsidy	Annual subsidy
<= \$109k / \$218k	25%	58.7 million	\$202.90	\$608.70	\$7,304
\$109-\$137k / \$218-\$274k	35%	2.3 million	\$284.10	\$527.50	\$6,330
\$137-\$171k / \$274-\$342k	50%	1.6 million	\$405.80	\$405.80	\$4,870
\$171-\$205k / \$342-\$410k	65%	0.7 million	\$527.50	\$284.10	\$3,409
\$205-\$500k / \$410-\$750k	80%	1.3 million	\$649.20	\$162.40	\$1,949
> \$500k / \$750k	85%	0.2 million	\$689.90	\$121.70	\$1,460

Note: MAGI = Modified Adjusted Gross Income.

Sources: IRS Statistics of Income (SOI), Table 1.6, Tax Year 2023; and Centers for Medicare and Medicaid Services (CMS), *2026 Medicare Trustees Report*, June 2026.

There are several paths forward for improving Medicare’s fiscal outlook. Congress could increase payroll taxes, but that would only help fund Part A of the program. It could make deeper cuts to provider payments to reduce outlays, but that would risk access for many enrollees. It could continue to borrow more money, but that is costly in a time of higher interest rates. Or it could continue to reduce subsidies for high-income enrollees, as it has already begun doing, to offset growing unfunded outlays.

To reduce subsidies for high-income Medicare enrollees, we propose phasing out the taxpayer subsidy for Part B premiums completely starting at the existing 35 percent IRMAA income tier. Instead of five discrete tiers, we propose a linear phaseout, starting with the IRMAA-eligible enrollees paying 35 percent of Part B premiums and rising to 100 percent of premiums at the top end.

In addition, we propose replacing the two-year income lookback with implementation of IRMAA via the enrollee’s tax return in the same manner as the advance premium tax credits (APTCs) in the Affordable Care Act. If the two-year lookback is replaced, the initial income thresholds should

be increased to compensate for two years of income growth by seniors to prevent increasing the existing number of seniors paying IRMAA premiums the year the policy is adopted.

Once the starting and ending points of the IRMAA income tiers are determined, that logic should be considered for other parts of Medicare cost sharing including Part B deductibles and coinsurance; Part A premiums, deductibles, and coinsurance rates; and Part D premiums, deductibles, and coinsurance rates.

This policy brief only considers details for the Part B IRMAA subsidy reduction. Static scoring suggests a ten-year budgetary impact of \$113 billion in additional premium revenue. Scoring that accounts for behavioral responses suggests a lower ten-year impact, ranging from \$89 billion to \$106 billion depending on how much seniors respond. Additional interest savings on the federal debt would range from \$14.5 billion to \$17 billion.

As Medicare’s fiscal burden grows, subsidies to wealthy seniors should be reduced to help offset the fiscal burden on taxpayers.

EXISTING MEANS TESTING IN MEDICARE PARTS B AND D

High-income seniors pay more for their Parts B and D premiums in the form of IRMAA surcharges. IRMAA provides a clear precedent for means testing high-income seniors. IRMAA was created as part of the 2003 Medicare Modernization Act and implemented in Part B in 2007. The ACA extended it to Part D in 2011. In 2026, seniors are subject to higher premiums if their 2024 modified adjusted gross income (MAGI) was above \$109,000 if single and \$218,000 if married.

Among Part B enrollees, 9.4 percent are expected to pay higher IRMAA premiums for their coverage in 2026. The Medicare trustees project that 13.6 percent of Part B enrollees will pay IRMAA premiums in 2035. Part B IRMAA premiums are expected to raise \$18.8 billion in revenue in 2026 and \$55.8 billion in 2035.⁷

Numerous changes to IRMAA since its creation demonstrate that expanding it is a potential political option. When IRMAA was first created by the Medicare Modernization Act of 2003, there were four tiers paying 35, 50, 65, and 80 percent of program costs, with the income thresholds indexed to the Consumer Price Index for All Urban Consumers (CPI-U). They were phased in over three years (2007 to 2009) and reached about 4 percent of Part B beneficiaries when they began.

The Affordable Care Act (ACA) then froze the income thresholds at their 2010 level from 2011 to 2019, helping to expand the number of seniors subject to higher premiums. The ACA also created the Part D IRMAA premiums, which took effect in 2011.

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 lowered the top two income thresholds starting in 2018. The 80 percent tier threshold for single filers dropped from \$214,000

to \$160,000 and the 65 percent tier fell from \$160,000 to \$133,500. By 2019, 7.7 percent of Part B beneficiaries paid IRMAA premiums.

The Bipartisan Budget Act (BBA) of 2018 then created a fifth tier at 85 percent beginning in 2019. That new tier was also the first time the single and married thresholds were not simply multiples of one another, leading to a slight marriage penalty for very-high-income earners. The BBA also froze top-tier income thresholds until 2028, after which indexing will start up again.

Other expansions to IRMAA have been proposed but not enacted. In 2013, through the Moment of Truth Project, Simpson and Bowles proposed increasing each IRMAA tier share by 15 percent and freezing income thresholds through 2030, expanding eligibility so that 15 percent of seniors paid IRMAA premiums.⁸ President Obama's FY2014 budget proposed increasing the range of income tier percentages to 40 and 90 percent for both Parts B and D, which CBO estimated would raise \$56.3 billion over seven years.⁹ CBO's "Options for Reducing the Deficit" has scored both freezing all income thresholds through 2032 (\$57 billion) and raising the 25 percent enrollee share of premiums up to 35 percent (\$510 billion over ten years).¹⁰

The growing funding requirements of Medicare, combined with rapid income growth by senior households and a clear precedent for reform, suggest that IRMAA expansion is a natural fiscal policy pathway.

ISSUES WITH THE CURRENT IRMAA STRUCTURE

The existing IRMAA income tiers have no phase-in or phase-out provision. Table 3 demonstrates that the resulting cliffs lead to large marginal tax rates, encouraging unproductive economic behavior.

TABLE 3 MARGINAL TAX RATES OF ADDITIONAL \$1,000 MAGI IN EXISTING IRMAA INCOME TIERS, 2026

Crossing (Single / Married)	Annual premium increase upon crossing income threshold	Marginal tax rate of +\$1,000
\$109,000 / \$218,000	\$974	97.4%
\$137,000 / \$274,000	\$1,460	146.0%
\$171,000 / \$342,000	\$1,460	146.0%
\$205,000 / \$410,000	\$1,460	146.0%
\$500,000 / \$750,000	\$488	48.8%

Source: Author's calculations from Centers for Medicare and Medicaid Services, "2026 Medicare Parts A & B Premiums and Deductibles," November 14, 2025. Premium increase equals twelve times the difference in monthly Part B premium between adjacent tiers. Income is modified adjusted gross income from the tax return two years prior (2024 MAGI for 2026 premiums).

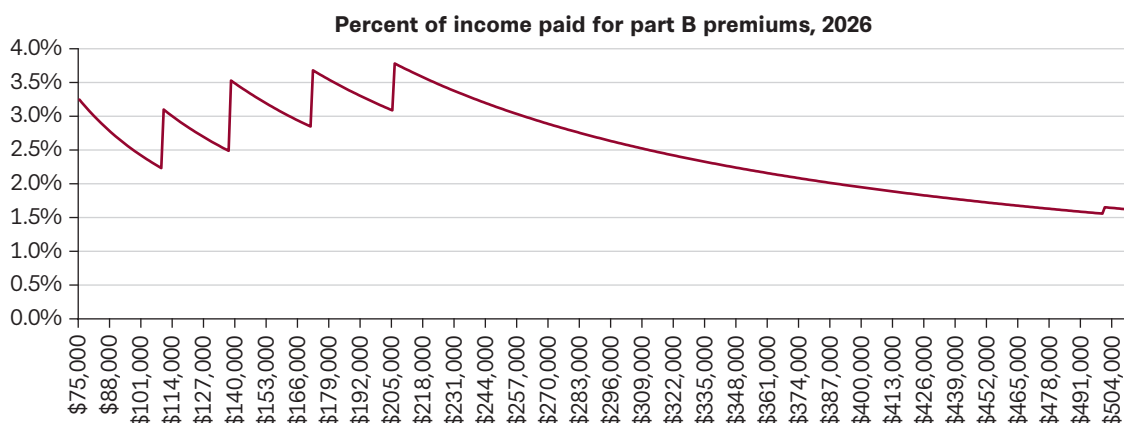
As a result, premiums as a percent of income are uneven across the income distribution (see figure 1). Premiums as a percent of income rise at each threshold and then decrease slowly until the next threshold. The share of premiums paid (shown in figure 2) is set by statute and is the cause of the discrete jumps.

A natural comparison of subsidized insurance that requires enrollees to pay a share of their income is the ACA. The ACA's original advance premium tax credits bounded premiums as a share of a recipient's income between 2 percent and 9.5 percent from 100 percent of the federal poverty guideline up to 400 percent of the FPL (federal poverty level). The expanded ACA tax credits passed as a part of the American Rescue Plan Act of 2021 (ARPA) and extended in the Inflation Reduction Act of 2022 (IRA) lowered those requirements to 0 percent of income up to 8.5 percent and removed the cutoff at 400 percent of poverty until 2026. The 35 percent IRMAA income tier that starts at \$109,000 in 2026 sits at approximately 680 percent of the federal poverty limit for single individuals.

Figure 3 shows premiums as a share of income on the ACA for a forty-year-old and a sixty-four-year-old compared to premiums as a share of income for Parts B and D. Notably, even with IRMAA payments, Part B and Part D premiums are under 5 percent of a single enrollee's income starting at \$63,000 of income, compared to ACA premiums that cost 12 and 28 percent of income for forty-year-olds and sixty-four-year-olds, respectively. Even with the enhanced premium tax credits that expired January 1, 2026, premiums were capped at 8.5 percent of income for ACA enrollees.¹¹

The 2026 Part B monthly premium of \$202.90 represents 25 percent of the program cost, implying a full monthly premium cost of \$811.60. The full premium cost bounds the amount that the highest-income seniors should be charged. Right now, premiums are capped at 85 percent of the cost for single enrollees with MAGIs above \$500,000, representing less than 1 percent of seniors. Additionally, premiums are determined using a two-year income lookback.

FIGURE 1 Percent of income paid for Part B IRMAA premiums, 2026



Note: IRMAA premium thresholds begin at \$109,000 in 2026.

Source: Centers for Medicare and Medicaid Services.

POLICY PROPOSAL: REPLACE IRMAA TIERS WITH A LINEAR PHASEOUT OF PART B SUBSIDIES

This reform proposal has three objectives: first, fix the income tier cliffs to smooth the premium increases and reduce artificially high marginal tax rates that distort economic behavior; second, raise more dedicated revenue to relieve the burden on taxpayers from existing general fund revenue transfers; and third, further reduce subsidies for high-income seniors.

This policy proposes replacing the IRMAA income tiers with a linear increase in premium share required, up to 100 percent of premium costs, beginning with the 35 percent IRMAA tier. Additionally, it proposes adjusting the starting and ending points by the chained CPI-U to gradually increase the number of seniors affected. It also proposes replacing the two-year lookback with a prospective premium payment system akin to the ACA's advance premium tax credits.

The current estimated IRMAA income starting point for 2027 is \$111,000 and the ending point is \$500,000 for single seniors. This proposal would

lower the end points where subsidies phase out to \$250,000 for single enrollees and \$500,000 for married enrollees. Between the new starting and end points, IRMAA premiums would grow by a linear amount to prevent periodic large increases in marginal tax rates. They would also continue past 85 percent and rise all the way to 100 percent of premiums to remove the Part B subsidy for the highest-income seniors. Lowering the end points is necessary to remove the existing income eligibility cliffs.

To calculate the annual premium increase per \$1,000 of income, the formula is as follows:

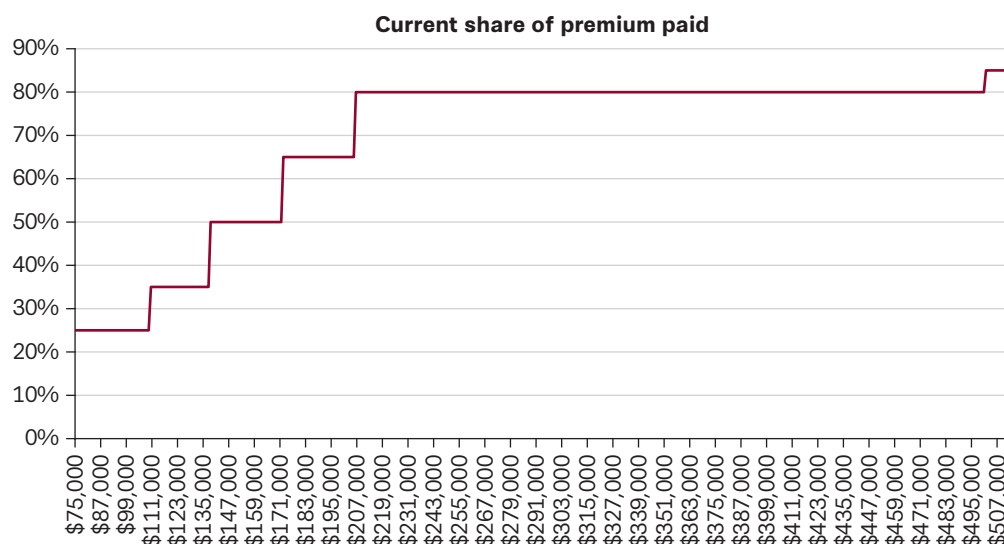
$$(1 - \text{Starting Premium Share}) / (\text{End Point} - \text{Starting Point}) * 1,000 * \text{Full Year Premium}$$

For 2027, the expected values are as shown below:

$$(1 - 0.35) / (\$250,000 - \$111,000) * \$1,000 * \$10,044 = \$46.97$$

Starting at the 35 percent premium share and ending at 100 percent over the new IRMAA income amount leads to a \$46.97 increase per every \$1,000 in income in 2027. The share of premiums paid would increase by 0.47 percentage points per \$1,000 of income.¹²

FIGURE 2 Current share of Part B premium paid by single enrollees, 2026



Notes: Share of premiums paid for single enrollees. Married enrollees pay same rates at twice the income, except for the 85 percent income tier, which begins at \$750,000 MAGI.

Source: Centers for Medicare and Medicaid Services.

The result is that married seniors on Part B who make half a million dollars would no longer receive any Part B premium subsidy. Single seniors who make a quarter million dollars would also no longer receive a Part B premium subsidy. The policy change would represent a \$1,507 subsidy reduction for those at the existing 85 percent IRMAA income tier in 2027.

The percent of seniors who pay IRMAA premiums would remain the same for the first year, although adjusting the 35 percent income tiers by the chained CPI-U would slowly increase the number of seniors who become eligible over time.

The proposed changes are visualized in figures 4, 5, and 6.

REVENUE ESTIMATES

Implementing a linear phaseout of Part B premium subsidies beginning with the 35 percent IRMAA income cutoff would raise an estimated \$6.0 billion

in static revenue in 2027 and \$113 billion from 2027 to 2036. Depending on behavioral effects, ten-year revenue would rise by around \$89 to \$106 billion (see table 4). All revenue would offset existing general revenue transfers.

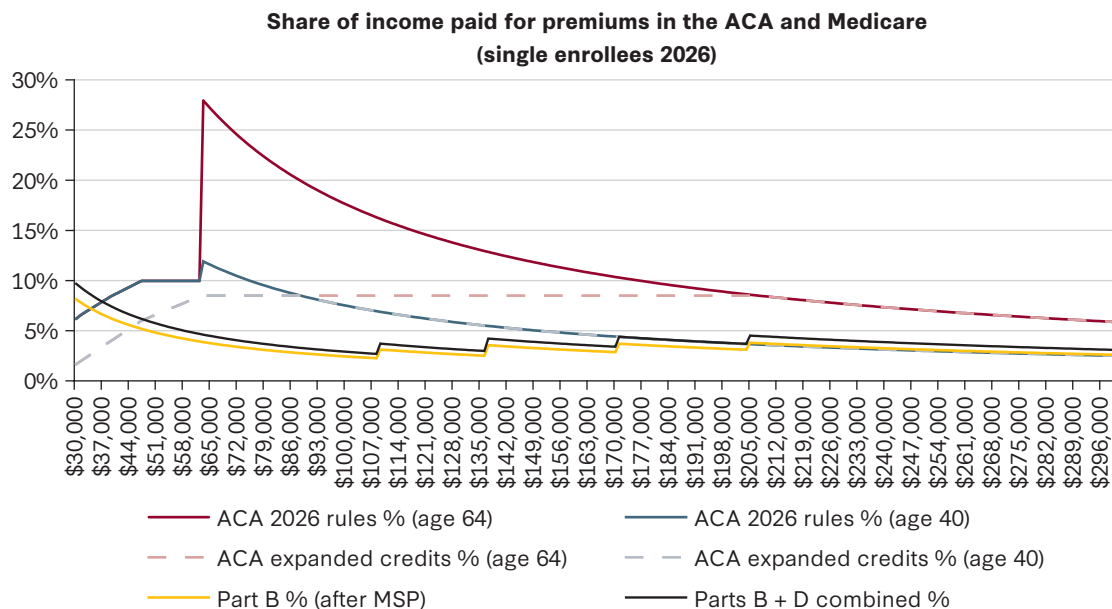
Since federal deficits would fall, interest costs to the government would fall by an estimated \$14.5 to \$17 billion over ten years, depending on the behavioral response exhibited by seniors (see table 5).¹³ CBO's convention is to exclude interest cost reductions when estimating budget effects for singular options but to include them for budget resolutions or comprehensive budget plans.¹⁴ Including them in this option would increase the budget savings by \$14.5 to \$17 billion, depending on the behavioral response.

These estimates are created by using the IRS Statistics of Income (SOI) tables to obtain the number of seniors by adjusted gross income (AGI) band and the income reported within each band, and by marital status. The number of seniors

TABLE 4 STATIC AND BEHAVIORAL RESPONSE REVENUE ESTIMATES (BILLIONS OF DOLLARS)

Year	Static revenue	Behavioral response scenario estimates		
		Low response	Medium response	High response
2027	\$6.0	\$5.7	\$5.3	\$4.9
2028	\$6.9	\$6.5	\$6.0	\$5.6
2029	\$7.8	\$7.3	\$6.8	\$6.2
2030	\$9.0	\$8.4	\$7.8	\$7.2
2031	\$10.1	\$9.4	\$8.7	\$8.0
2032	\$11.3	\$10.6	\$9.8	\$9.0
2033	\$12.9	\$12.0	\$11.1	\$10.1
2034	\$14.5	\$13.4	\$12.5	\$11.4
2035	\$16.3	\$15.2	\$13.9	\$12.7
2036	\$18.3	\$17.0	\$15.6	\$14.2
Total: 2027–36	\$113.1	\$105.5	\$97.5	\$89.3

Sources: Author’s calculations. Senior tax units by income from IRS, “SOI Tax Stats – Statistics of Income,” Table 1.6 (tax year 2023); Part B premiums, IRMAA payer counts, and enrollment from the 2026 *Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, Medicare Boards of Trustees, Tables V.B3 and V.E3. Behavioral scenarios apply elasticities of taxable income of 0.1, 0.25, and 0.4 plus plateau exit of 1, 2, and 4 percent of full-cost payers.

FIGURE 3 Comparison of premiums as a percent of income required, Affordable Care Act (ACA) versus Medicare Part B

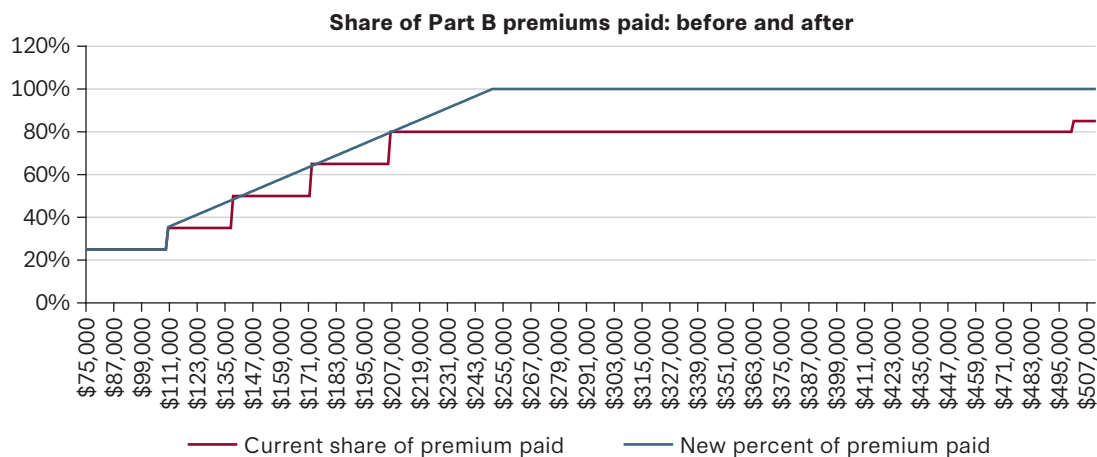
Sources: Author’s calculations from IRS Rev. Proc. 2025-25, IRC §36B, 2025 HHS poverty guidelines, and CMS 2026 Medicare premium and IRMAA announcements. ACA expanded credits reflect the 2021–2025 schedule.

TABLE 5 ESTIMATED INTEREST COST SAVINGS ON LOWER FEDERAL DEBT (BILLIONS OF DOLLARS)

Year	Static estimate	Behavioral response scenario estimates		
		Low response	Medium response	High response
2027	\$0.12	\$0.11	\$0.11	\$0.10
2028	\$0.38	\$0.36	\$0.33	\$0.31
2029	\$0.67	\$0.63	\$0.59	\$0.54
2030	\$1.01	\$0.95	\$0.88	\$0.81
2031	\$1.39	\$1.30	\$1.21	\$1.12
2032	\$1.82	\$1.70	\$1.58	\$1.46
2033	\$2.30	\$2.16	\$2.00	\$1.84
2034	\$2.85	\$2.66	\$2.47	\$2.27
2035	\$3.47	\$3.24	\$3.00	\$2.75
2036	\$4.16	\$3.88	\$3.59	\$3.29
Total: 2027–36	\$18.20	\$17.00	\$15.80	\$14.50

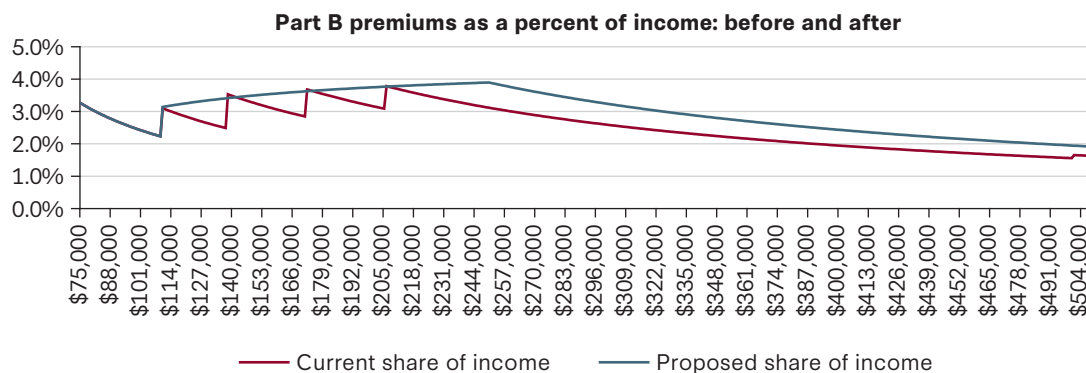
Sources: Author’s calculations. Numbers may not round to precise values. Revenue from table 4 applied to projected interest rates on federal debt from Congressional Budget Office “The Budget and Economic Outlook: 2026 to 2036,” February 2026. Savings assume each year’s revenue reduces borrowing in that year.

FIGURE 4 Share of Part B premium paid by single enrollees, current IRMAA tiers versus linear phaseout, 2026



Sources: Author’s calculations. Current tiers from “2026 Medicare Parts A & B Premiums and Deductibles.” Linear phaseout parameters are as described in the text.

FIGURE 5 Part B premiums as a percent of income, current IRMAA tiers versus linear phaseout, 2026



Sources: Author's calculations. Current tiers from "2026 Medicare Parts A & B Premiums and Deductibles." Linear phaseout parameters are as described in the text.

affected is interpolated within those bands. Premiums are estimated to grow at the trustees' actuarial rate of around 7 percent a year while senior incomes grow at 4 percent a year. Starting and ending points grow at the chained CPI-U. Married households are estimated to have 1.8 Part B enrollees, since not every senior enrolls. As a robustness check, estimates are anchored to administrative data from the Centers for Medicare and Medicaid Services (CMS), leading to a scaling factor of 1.14. Since this policy charges high-income seniors based on percent of premiums, which are a function of estimated Part B outlays, revenue grows alongside Part B's outlays.

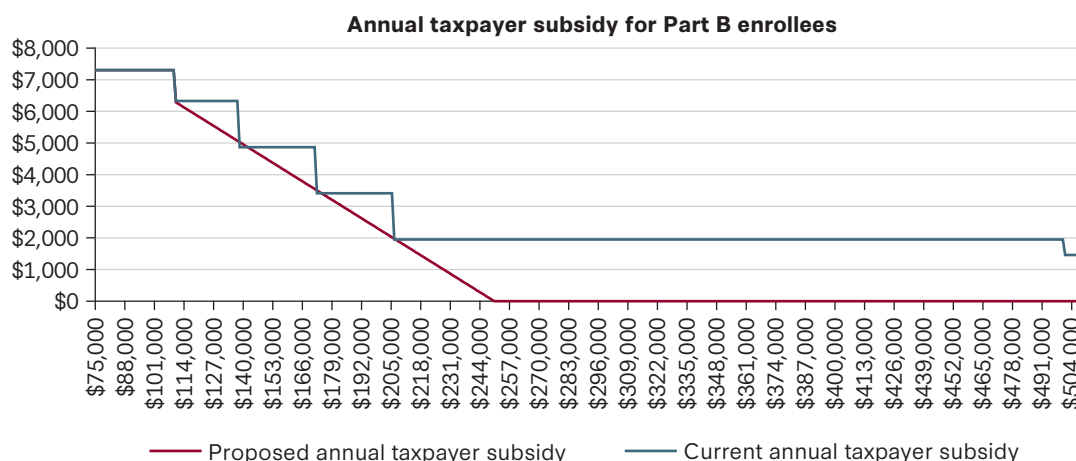
Seniors who qualify for IRMAA premiums would face a new marginal tax rate of 4.7 percent-age points, leading to behavioral changes that reduce their reported MAGI.¹⁵ Seniors facing these marginal tax rates can be expected to change their realizations of Roth IRA conversions, capital gains, and withdrawals from retirement accounts. The reduction in IRMAA premiums paid is estimated using elasticities of 0.1, 0.25, and 0.4 to represent low, medium, and high behavioral responses. Some high-income seniors may also disenroll in Part B due to reductions in premium subsidies, but that effect is likely to be small.

This policy change would not affect the lower three income quintiles. Figure 7 demonstrates that an estimated 83 percent of new IRMAA revenue raised would come from the top 10 percent of seniors. Over half would come from the top 5 percent of seniors. The top 1 percent of seniors would lose a subsidy equal to 15 percent of Medicare Part B premium outlays per capita, or about \$1,507 in 2027. On a per capita basis, all the tax revenue collected would come from the top senior income quintile.

REPLACE THE TWO-YEAR LOOKBACK WITH TAX-TIME COLLECTION

The IRMAA brackets start at \$109,000 for single filers in 2026. Income is calculated using a two-year lookback at a senior's income each year.¹⁶ Income in 2024 determines premiums in 2026. If seniors sell a house or take a large Roth IRA conversion, for example, they can get pushed into the higher IRMAA bracket. The Social Security Administration will only reconsider their premiums if they qualify for and appeal one of eight life-changing events. But the process is lengthy and cumbersome. If seniors are enrolled in Social Security when they sign up for Medicare, their Medicare premiums are deducted

FIGURE 6 Annual federal subsidy per Part B enrollee, current IRMAA tiers versus linear phaseout, 2026



Sources: Author's calculations. Subsidy equals total per-enrollee Part B cost minus the premium paid. Total cost and current premiums from "2026 Medicare Parts A & B Premiums and Deductibles." Linear phaseout parameters are as described in the text.

automatically from their Old-Age, Survivors, and Disability Insurance (OASDI) benefits. But if they don't, CMS bills them directly for IRMAA premiums.

This two-year lookback creates several issues that could be addressed by moving to actual-year income using the same system as the ACA's APTCs. ACA enrollees estimate their current-year income and pay premiums throughout the year based on that estimate. When they file taxes the next year, they end up paying the difference (or receiving a credit) between what they paid and what they should have paid. It would allow seniors with retirement assets to plan for their premium schedule by better timing their retirement asset disbursements, or to handle large one-time events such as home sales.

As more seniors wait until Social Security's full retirement age of sixty-seven, fewer will have their Part B premiums automatically deducted from their Social Security checks and will need to work with CMS directly. Replacing the two-year lookback with the same system as the ACA's APTCs would eliminate most of these issues.

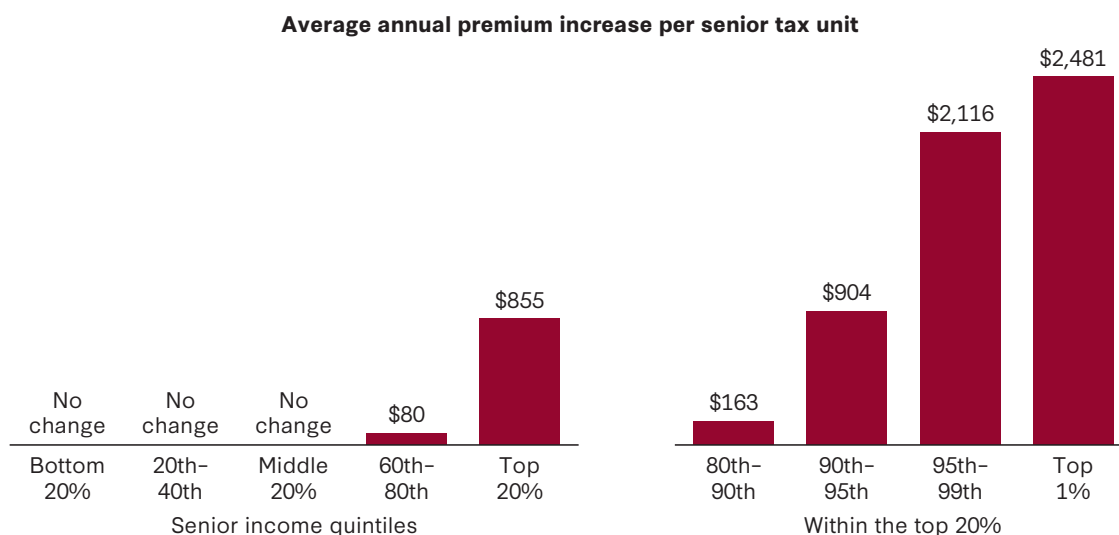
ADDITIONAL IRMAA REFORMS TO CONSIDER

Since one of the primary motivations of this policy recommendation is to reduce subsidies for high-income seniors, additional parts of Medicare's existing cost-sharing structure could adopt its methods as well.

A natural extension of the linear increase in Part B IRMAA premiums is to extend them to Part D's existing IRMAA premium structure. Part D's premiums are much smaller than Part B's monthly premiums, which could make reducing premium subsidies there more palatable. Parts B and D both have cost sharing in the form of deductibles and coinsurance. Consideration should be made to increase either deductibles or the coinsurance rate for higher-income seniors.

While Part A does technically have premiums, almost no one pays them because they are waived for Medicare enrollees with at least forty quarters of covered earnings. Less than 1 percent of Part A enrollees pay premiums, which in 2026 were \$565 a month for those with fewer than thirty quarters of work and \$311 a month for those with thirty to

FIGURE 7 Distribution of proposed Part B IRMAA premiums by income group, 2027



Notes: Senior tax units, single and joint returns pooled, ranked by 2025 modified adjusted gross income (MAGI), the income year that sets 2027 premiums. Averages are per tax unit including unaffected units. Affected fourth-quintile units are single filers above \$111,000. On a person-by-person ranking, the entire increase falls in the top quintile. Per-enrollee reductions never exceed \$2,009. Tax unit averages can exceed that figure because a tax unit may include two enrolled spouses.

Sources: Author’s calculations from IRS SOI, Table 1.6, Tax Year 2023; and *2026 Medicare Trustees Report*. 2027 values.

thirty-nine quarters of work.¹⁷ An IRMAA premium could help prevent the Hospital Insurance (HI) Trust Fund from going bankrupt, or at least delay insolvency depending on the premiums charged to seniors with high incomes.

Part A also has cost sharing in the form of deductibles and coinsurance for hospital stays. Both are set by statute. The inpatient deductible in 2026 is \$1,736 and covers up to the first sixty days of a hospital stay. Days sixty-one through ninety have coinsurance payments of \$434 per day. After ninety days, the coinsurance rate per day rises to \$868. Those coinsurance payments are, respectively, precisely one-fourth and one-half of the deductible (which is rounded each year to the nearest \$4 to allow even division). A stay at a skilled nursing facility (SNF) faces a flat coinsurance rate of \$217 a day for days twenty-one through one hundred, calculated as one-eighth of the year’s deductible.¹⁸ Higher deductibles or coinsurance rates in Part A for those who are

eligible for IRMAA premiums in Parts B and D could also delay the HI Trust Fund’s insolvency date.

CONCLUSION

General fund revenue transfers, mainly due to Parts B and D, currently exceed half a trillion dollars a year and will soon represent half of all Medicare outlays. Congress has to make adjustments to Part A’s HI Trust Fund structure before 2033 to prevent cuts to services paid for by either providers or enrollees. But the warning signs for Parts B and D’s finances are less explicit.

Every Medicare enrollee is subsidized, even the highest-income seniors. Making sure that seniors have quality and accessible medical coverage in their retirement is a worthy policy objective, but subsidizing high-income seniors is a luxury the federal budget is unable to afford.

IRMAA premiums have been expanded several times since their creation and represent a natural way to reduce subsidies at the top of the income distribution. Policymakers should determine where subsidies should begin to phase out and where they should end completely. And if a linear phaseout of IRMAA subsidies were to be adopted in Part B, policymakers should consider immediately extending it to Part D to eliminate income cliffs in that program, too.

Part B's outlays will total \$1.42 trillion in 2036. Dedicated revenues will pay for \$412 billion, and general fund transfers will be required for the remaining \$1 trillion. While the policy recommendation provided in this brief would raise around

\$100 billion over ten years, it would reduce the general revenue draw of Part B by about 1.3 percent.

Congress has repeatedly adjusted the IRMAA thresholds since 2003. If it is unable to ask seniors making a quarter of a million dollars to pay for the cost of their outpatient coverage, it is unlikely to tackle other aspects of Medicare's draw on general fund revenues that increase the federal debt. Reducing subsidies for high-income seniors through Part B IRMAA reform would raise much-needed revenue, remove steep marginal tax rate cliffs, and leave Part B premiums unchanged for roughly the bottom 90 percent of seniors.

ACKNOWLEDGMENTS

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NOTES

1. The definition of "dedicated financing" comes from Section 801 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. It includes five items: payroll taxes for the Hospital Insurance (HI) Trust Fund, Medicare's share of taxes on Social Security benefits, state transfers for Part D (so-called clawback payments), premiums, and gifts to trust funds.
2. Lanhee J. Chen and Tom Church, "Refocusing Medicare Reform on Its Cost to Taxpayers," *JAMA Health Forum* 7, no. 8 (2026): e263867, doi:10.1001/jamahealthforum.2026.3867.
3. Congressional Budget Office, "The Budget and Economic Outlook: 2026 to 2036," February 2026, Table 1–2.
4. C. Eugene Steuerle and Karen E. Smith, *Social Security and Medicare Lifetime Benefits and Taxes: 2025*, Urban Institute, December 2025, Tables 10 and 17.
5. Medicare is robustly subsidized for low-income seniors. Medicaid pays premiums and cost sharing for

low-income seniors who are enrolled in both programs. Medicare Savings Programs pay Part B premiums for seniors up to 135 percent of the designated poverty level and cover all deductibles and cost sharing for those below 100 percent of the poverty level. The Part D low-income subsidy pays premiums, deductibles, and co-pays up to 150 percent of the poverty level. For more, see *December 2025 MedPAC and MACPAC Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid*, MedPAC, December 2, 2025, <https://www.medpac.gov/document/december-2025-medpac-and-macpac-data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid/>.

6. John F. Cogan and Daniel L. Heil, "Four Decades of Senior Household Income Growth: New Evidence from the Survey of Consumer Finances," Hoover Institution, February 2023.

7. *Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, Medicare Boards of Trustees, June 9, 2026, Tables V.E3 and V.E4.

8. A Bipartisan Path Forward to Securing America's Future, Moment of Truth Project, April 2013, https://www.crfb.org/sites/default/files/media/documents/Securing%20America%27s%20Future_Full.pdf.
9. Congressional Budget Office, "Estimated Effects on Direct Spending and Revenues for Health Care Programs of Proposals in the President's 2014 Budget," May 17, 2013, https://www.cbo.gov/sites/default/files/cbofiles/attachments/44247_APB_HealthCarePrograms.pdf.
10. Congressional Budget Office, "Options for Reducing the Deficit, 2023 to 2032," Option 4, December 7, 2022, <https://www.cbo.gov/publication/58164>; Congressional Budget Office, "Options for Reducing the Deficit: 2025 to 2034," Option 7, December 12, 2024, <https://www.cbo.gov/publication/60557>.
11. Premiums are adjusted by age according to a community rating limit of 3 to 1. Sixty-four-year-olds may have premiums that are three times as large as premiums for twenty-one-year-olds. Forty-year-olds provide a clean middle estimate.
12. If the two-year income lookback were replaced with an APTC-type prospective premium payment system, the starting income tiers should be increased to account for expected income growth by seniors, holding the expected share of IRMAA-eligible seniors constant. Since senior incomes are expected to grow by about 4 percent, the new starting point would be \$120,000 (rounded to the nearest \$1,000) instead of \$111,000, the end point would instead be \$270,000 for seniors, and the annual premium increase per additional \$1,000 of income would fall to \$43.52.
13. Each dollar of deficit reduction requires lower interest payments. A flat rate of 4 percent, slightly below CBO's projected 10-year Treasury rate, is used to estimate the reduction in interest payments, with new savings counted for half a year. Cost savings are reported separately and not included in base revenue estimates.
14. CBO, "Options for Reducing the Deficit: 2025 to 2034," p. 4, says: "The estimated budgetary effects of the options do not reflect the extent to which the options would reduce interest payments on federal debt. Those savings may be included as part of a comprehensive budget plan (such as a Congressional budget resolution), but CBO does not generally make such calculations for individual pieces of legislation or for individual options of the type discussed here."
15. If the two-year income lookback were replaced, marginal tax rates would fall slightly to account for a higher initial starting point to qualify for IRMAA premiums.
16. Congressional Research Service, "Medicare Part B: Enrollment and Premiums," updated May 19, 2022, 19-20.
17. Centers for Medicare and Medicaid Services, "2026 Medicare Parts A & B Premiums and Deductibles," November 14, 2025, <https://www.cms.gov/newsroom/fact-sheets/2026-medicare-parts-b-premiums-deductibles>.
18. Social Security Act, Section 1813(b) for deductible, 1813(a)(1) for hospital-stay coinsurance, and 1813(a)(3) for SNF coinsurance.



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32 31 30 29 28 27 26 7 6 5 4 3 2 1

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Hoover's Healthcare Policy Working Group develops and promotes innovative market-based health policy proposals that are capable of both reducing costs and expanding access to healthcare. The policy proposals include reforms to introduce competitive forces across the sector and improve consumer-directed healthcare. The working group collaborates with healthcare experts and other stakeholders to identify actionable policies that will improve America's healthcare system.

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