Estimated 10-Year Spending Effects of the DUALS Act of 2024

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In March 2024, a bipartisan group of senators led by Bill Cassidy (R-LA) introduced the Delivering Unified Access to Lifesaving Services (DUALS) Act of 2024 to promote the adoption of integrated plans for individuals dually enrolled in Medicare and Medicaid. The DUALS Act would provide states support to establish integrated plans for dual enrollees.[1] Specifically, the bill would

- mandate that all states implement a program model for providing integrated care for full-benefit duals;
- passively enroll eligible individuals (with an option to opt out and exemptions for those with an out-of-network primary care provider) and provide states the option to implement 12 months of continuous Medicaid eligibility in the new integrated plans;
- establish state offices for integrated care programs and provide grants for enrollee outreach and recruitment;
- create a new duals-specific risk adjustment system to be used for the new integrated plans;
- require states to offer Program of All-Inclusive Care for the Elderly (PACE) services to eligible individuals; and
- expand eligibility for PACE and remove application restrictions on PACE providers.

In this brief, we provide 10-year cost estimates for the DUALS Act. After describing our methodological approach and assumptions, we present findings on enrollment and spending among dual enrollees over the next 10 years if the DUALS Act were enacted. We then discuss alternative scenarios, considering alternatives to our key modeling assumptions, possible modifications to the drafted legislation that are consistent with its broad intent, and potential ways to offset the cost of the legislation without changing our modeling assumptions or the legislation.

Background

Dual Enrollees and Integrated Care Plans

Nearly 13 million individuals in the US are dually enrolled in Medicare and Medicaid (MedPAC and MACPAC 2024). Compared with individuals enrolled only in Medicare or Medicaid, dual enrollees have complex health care needs and high levels of health care spending related to illness, age, and health-related social needs. As reflected in their Medicaid enrollment, most dual enrollees have very low incomes. Although the majority of dual enrollees are 65 and older, nearly 40 percent are younger than 65 and qualify for Medicare because of a disability. Many dual enrollees live with multiple chronic conditions or mental or cognitive impairments, and more than 10 percent of dual enrollees live in nursing homes or other institutional settings.[2] Approximately three-quarters of dual enrollees are considered full-benefit ("full") dual enrollees, meaning they receive the full scope of Medicaid benefits. The remaining partial-benefit dual enrollees qualify for a Medicare Savings Program but not full-scope Medicaid.[3]

The integration of Medicare and Medicaid to better serve dual enrollees has long been a topic of policy importance, given the complexity of coverage rules for those enrolled in both programs, the high levels of need and spending for this population, and the lack of financial incentives for the two programs to coordinate with each other (CBO 2013). Absent program integration, dual enrollees and their providers are left to navigate disjointed Medicare and Medicaid systems, often resulting in duplicative services, delayed or fragmented care, poor outcomes, and unnecessarily high health care spending (MACPAC 2020).

Several types of plans that integrate Medicare and Medicaid benefits—known as integrated care plans—exist for duals, including Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs), Financial Alignment Initiative Medicare-Medicaid plans (MMPs), and PACE.[4] Evidence suggests integrated care models reduce hospitalizations and long-term nursing home stays, but their effects on the use of other health care services and on spending are mixed (Roberts et al. 2024; Smith, Waidmann, and Caswell 2021). Furthermore, less than 10 percent of dual enrollees are enrolled in fully integrated care plans (MACPAC 2020). Rather, most dual enrollees are not in any type of integrated plans but instead receive Medicare coverage through Traditional Medicare (TM), stand-alone Medicare Advantage (MA) plans, or MA coordination-only Dual Eligible Special Needs Plans (D-SNPs)—which provide care coordination services but do not provide Medicaid benefits under the same legal entity (Lakhmani 2023)—and receive Medicaid coverage through standard fee-for-service (FFS) Medicaid or Medicaid Managed Care Organization (MCO) plans.

Overview of the DUALS Act

The DUALS Act intends to expand access to integrated plans for full dual enrollees by creating new integrated plans and expanding the existing PACE program. Under the legislation, states would be required to select a model of integrated care for full dual enrollees from several options that would be published by the Federal Coordinated Health Care Office (also known as the Medicare-Medicaid

Coordination Office) and implement the integrated model within four years. The new integrated plans would provide comprehensive benefits and care coordination services to their enrollees. States would be required to passively (automatically) enroll full dual enrollees into the new integrated plans, with an option for enrollees to opt out and excepting cases where enrollees' primary care provider was not in-network for the integrated plan. States would be given the option to provide 12 months of continuous eligibility and enrollment for enrollees of the new integrated plans, even if changes in enrollees' income or assets would otherwise make them ineligible.

The DUALS Act specifies that the new integrated plans would use a capitated payment structure with Medicare and Medicaid components and that state payments to integrated plans for the Medicaid component would be treated as medical assistance (i.e., would count as Medicaid spending eligible to be matched with federal spending at a specified share). The legislation also calls for the development of a new duals-specific risk adjustment payment model to be used for dual enrollees in the new integrated plans, which would include factors based on individuals' health status.

Under the DUALS Act, states would receive federal funding to establish new dual-eligible integrated care ombudsman offices, provide grants to state and local organizations for outreach and enrollment of duals, carry out administrative functions, and collect and report data.

Finally, the DUALS Act includes several provisions related to PACE. PACE provides comprehensive medical and social services to frail, elderly individuals living in the community who are primarily dual enrollees. Under current law, PACE services are an optional Medicaid benefit. Under the DUALS Act, states would be required to cover PACE as a Medicaid benefit, existing restrictions on PACE enrollment and program expansion would be removed, and PACE eligibility would be extended to include Medicare enrollees younger than 55.

Methods Overview

We first estimated the enrollment, Medicare expenditures, and Medicaid expenditures of full dual enrollees by plan type under current law. We then proposed values for several key parameters necessary to produce 10-year estimates of changes in federal spending associated with the DUALS Act. These parameters included probabilities that enrollees from each plan type would enroll in the new integrated plan or move into the expanded PACE program if the legislation were implemented and expected changes to per enrollee spending if individuals were to transition from their current plan types to the new integrated plans or to PACE. Other key parameters for which we assume values include spending factors that capture how spending changes when beneficiaries move from one type of coverage or plan to another, as well as selection factors that capture the relative costs of care for groups moving out of a coverage or plan type relative to those who remain with their existing coverage or plan under reform. The spending and selection factors for enrollees moving from TM to the new integrated plan were based on evidence for MA enrollees relative to TM under current law. Specifically, we assume that favorable selection (net of risk score) from TM to the integrated plan will be only one-third of what MedPAC currently estimates applies to MA relative to TM because of the passive enrollment provision

of the DUALS Act (MedPAC 2025). We also assume the same degree of upcoding of risk scores of TM enrollees moving to the new integrated plan as MedPAC currently estimates for MA enrollees relative to TM (MedPAC 2025). We assume no risk selection and that the new integrated plans do not yield savings (or additional costs) relative to MA, FIDE-SNPs, coordination only D-SNPs, or MMPs, as there is little evidence that capitated Medicare-Medicaid models reduce Medicare expenditures (MACPAC 2020). We also assume that relative to Medicaid FFS or MMC, the new integrated plans neither increase nor decrease Medicaid spending, based on prior evidence on Medicaid spending in managed long-term services and supports.

We then estimated the cost of the continuous eligibility provision and a "welcome mat" effect (i.e., the enrollment of previously Medicaid-eligible but unenrolled Medicare enrollees who would become dual enrollees for the first time as a result of the legislation). We accounted for other federal spending written explicitly into the legislation, including federal spending for grants to states and local community organizations for outreach and enrollment, payment to states for initial funding for state ombudsman offices, payment to states for general administrative expenses for carrying out the legislation, and payment to states for data collection and reporting.

Adding together each of these components produced an estimate of the cost of the legislation in one year if it were fully implemented. To arrive at 10-year estimates, we applied assumptions of growth in both enrollment and spending of full dual enrollees based on Medicare and Medicaid baseline (current law) estimates published by the Congressional Budget Office (Congressional Budget Office 2023a, 2023b). We assumed the new integrated models proposed by the legislation would be implemented starting in 2027, with full rollout expected by 2031. Finally, we assumed federal Medicaid expenditures would compose approximately 64 percent of total Medicaid expenditures, which represents states' 2023 Medicaid Federal Medical Assistance Percentage weighted by enrollment of full dual enrollees.[5]

In the appendix, we describe additional methodological details on our estimates of baseline enrollment and spending and our modeling of enrollment and spending in the new integrated plans, the effects of PACE expansions, the continuous eligibility provision, and the welcome mat phenomenon.

Results: Primary Scenario

Baseline Enrollment and Spending

Table 1 shows the estimated enrollment and spending of full-benefit dual enrollees by Medicare and Medicaid plan types as of 2023. These figures were the baseline inputs for our model.

TABLE 1

Enrollment and Expenditures of Full Benefit Dual Enrollees under Current Law, by Medicare and Medicaid Plan Type, 2023

	Thousands of full dual enrollees	Total annual spending of full dual enrollees (billions)
Medicare plan type		
TM	4,597	$119.6
MA (not integrated)	1,621	$46.6
C-SNP or I-SNP	158	$5.7
D-SNP (coordination only)	1,976	$57.7
Integrated		
FIDE-SNP	170	$5.0
MMP	426	$11.6
PACE	54	$2.1
Total Medicare	**9,003**	**$248.3**
Medicaid plan type		
FFS	4,208	$115.6
MCO (not integrated)	4,144	$95.5
Integrated		
MCO, FIDE-SNP (exclusively aligned)	85	$2.0
MCO, FIDE-SNP (not exclusively aligned)	85	$2.0
MMP	426	$8.6
PACE	54	$2.0
Total Medicaid	**9,003**	**$225.6**
Total Medicare + Medicaid	**9,003**	**$473.9**

Source: Urban Institute analysis of multiple sources (see Methods Overview and appendix for details).
Notes: TM = Traditional Medicare; MA = Medicare Advantage; C-SNP = Chronic Condition Special Needs Plan; I-SNP = Institutional Special Needs Plan; FIDE-SNP = Fully Integrated Dual Eligible Special Needs Plan; MMP = Medicare-Medicaid Plan; PACE = Program of All-Inclusive Care for the Elderly; FFS = Fee-for-service; and MCO = Managed Care Organization. Exclusive alignment means enrollment in the FIDE-SNP requires enrollees to receive their Medicaid coverage through a D-SNP or MCO plan owned and operated by the same parent company. See Erin Weir Lakhmani, "Definitions of Different Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) Types in 2023 and 2025," (Integrated Care Resource Center, 2023). The calendar year 2023 Medicare Advantage and Part D final rule will require all FIDE-SNPs to operate with exclusively aligned enrollment beginning in 2027.

Estimated 10-Year Spending Effects of the DUALS Act

Table 2 summarizes the DUALS Act's projected impacts. The first set of rows summarizes estimated spending on full dual enrollees for the next 10 years under current law. The second set of rows shows estimated changes in spending on full duals under the DUALS Act. The third set of rows further breaks out the federal spending associated with the DUALS Act into five categories: spending associated with the new integrated plans, expansions to PACE, the continuous eligibility provision, a welcome mat effect, and other federal spending. Finally, the bottom set of rows shows estimated enrollment of full duals in the new integrated plans, increases in PACE enrollment associated with the DUALS Act, and the total change in the number of duals associated with the continuous eligibility provision and a welcome mat effect.

TABLE 2

Estimated Spending Effects of the DUALS Act of 2024

	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	Total 2024–28	Total 2024–33
Spending on full duals under current law, billions of dollars													
Medicare spending	$248.3	$266.4	$285.8	$306.5	$328.8	$352.8	$378.4	$405.9	$435.5	$467.1	$501.1	$1,540.3	$3,728.3
Medicaid spending (federal)	$144.5	$150.6	$157.1	$163.8	$170.8	$178.2	$185.8	$193.8	$202.1	$210.7	$219.7	$820.6	$1,832.6
Total spending (federal)	$392.8	$417.0	$442.9	$470.4	$499.7	$530.9	$564.2	$599.7	$637.5	$677.8	$720.8	$2,360.8	$5,560.9
State Medicaid spending	$81.1	$84.6	$88.2	$92.0	$95.9	$100.0	$104.3	$108.8	$113.5	$118.3	$123.4	$460.8	$1,029.0
Changes in spending on full duals under DUALS Act, billions of dollars													
Medicare spending		$0.0	$0.0	$0.0	$0.9	$2.0	$3.3	$4.3	$5.1	$5.5	$5.9	$3.0	$27.1
Medicaid spending (federal)		$0.0	$0.0	$0.0	$0.5	$1.0	$1.6	$2.0	$2.3	$2.4	$2.5	$1.5	$12.3
Other federal spending		$0.2	$0.2	$0.2	$0.2	$0.2	$0.2	$0.2	$0.2	$0.2	$0.2	$0.9	$1.6
Total change in spending (federal)		$0.2	$0.2	$0.2	$1.6	$3.2	$5.1	$6.4	$7.6	$8.0	$8.5	$5.4	$41.0
State Medicaid spending		$0.0	$0.0	$0.0	$0.3	$0.6	$0.9	$1.1	$1.3	$1.4	$1.4	$0.9	$6.9
Changes in federal spending, by component, under DUALS Act, billions of dollars													
New integrated plans		$0.0	$0.0	$0.0	$0.8	$1.7	$2.7	$3.4	$4.0	$4.3	$4.6	$2.5	$21.4
PACE expansion		$0.0	$0.0	$0.0	$0.2	$0.5	$0.8	$1.2	$1.4	$1.5	$1.6	$0.7	$7.2
Continuous eligibility		$0.0	$0.0	$0.0	$0.1	$0.3	$0.5	$0.6	$0.7	$0.7	$0.7	$0.4	$3.7
Welcome mat		$0.0	$0.0	$0.0	$0.3	$0.6	$0.9	$1.2	$1.3	$1.4	$1.5	$0.9	$7.2
Other federal spending		$0.2	$0.2	$0.2	$0.2	$0.2	$0.2	$0.2	$0.2	$0.2	$0.2	$0.9	$1.6
Total change in spending (federal)		$0.2	$0.2	$0.2	$1.6	$3.2	$5.1	$6.4	$7.6	$8.0	$8.5	$5.4	$41.0
Enrollment of full duals, thousands													
New integrated plan enrollment					629	1,282	1,960	2,398	2,717	2,770	2,824		
Change in PACE enrollment					24	49	75	92	104	106	109		
Total change in number of duals					32	66	101	124	140	143	146		

Source: Urban Institute estimates based on modeling of the DUALS Act of 2024.

Note: In 2023, the total estimated Medicare and Medicaid spending on full duals was $473.9 billion ($392.8 billion + $81.1 billion).

Under current law, federal spending on full dual enrollees from 2024 to 2033 would total an estimated $5.6 trillion, and state Medicaid spending on full dual enrollees would total an estimated $1 trillion. Under the DUALS Act, federal spending on full dual enrollees from 2024 to 2033 would cost an additional $41 billion, and state Medicaid spending would cost an additional $6.9 billion. The $41 billion in additional federal spending breaks out as follows: $21.4 billion associated with the new integrated plans, $7.2 billion from PACE program expansions, $3.7 billion from the continuous eligibility provision, $7.2 billion from a welcome mat effect, and $1.6 billion in other federal spending (e.g., spending to support outreach grants to states and community organizations).

Under the DUALS Act, we expect enrollment of full duals in the new integrated plans to increase steadily from 2024 to 2033, beginning with 629,000 enrollees in 2027 and reaching just over 2.8 million enrollees—or approximately 25 percent of full dual enrollees—by 2033. We expect additional enrollment in PACE (over and above expected enrollment in PACE under current law) to reach nearly 109,000 by 2033. We expect the total number of "new" full dual enrollees associated with the continuous eligibility provision and the welcome mat effect to reach approximately 146,000 by 2033.

Results: Alternative Scenarios

We considered several alternative scenarios for estimating the DUALS Act's spending effects. These scenarios, the key assumptions associated with them, and the corresponding 10-year estimates of changes to federal spending under the DUALS Act are summarized in table 3.

Alternative Scenarios Involving Changes to Modeling Assumptions

In our first alternative scenario, we assume that, in designing the payment and risk adjustment for the new integrated plans, policymakers would not want to replicate the current overpayment problem in MA and would therefore use a higher coding intensity adjustment than the Centers for Medicare and Medicaid Services now applies for MA or would adopt other proposed policies to mitigate or compensate for upcoding (Lieberman and Ginsburg 2025; MedPAC 2024). Thus, for this first alternative scenario, we assume half the degree of overpayment attributable to upcoding of risk scores of TM enrollees moving to the new plans as the Medicare Payment Advisory Committee (MedPAC) currently estimates for MA (our primary scenario assumes the full amount). By assuming a lower degree of overpayment attributable to upcoding in the new plan than is currently estimated for MA relative to TM, and while not considering changes to MA itself in our analysis, we correspondingly assume savings from dual enrollees shifting from MA to the new plan in this scenario. This should be considered a lower-bound estimate, as the resulting payment "wedge" between MA and the new integrated plans would likely lead MA plans to attract duals away from the new integrated plans (or make efforts to retain them).

TABLE 3

Alternative Scenario Assumptions and 10-Year Spending Estimates

Scenario type	Assumptions	10-year spending estimate	Difference relative to primary scenario
Primary scenario	See Methods Overview section of main text and appendix	$41.0B	--
Changes to our modeling assumptions (legislation as written)	A1. Half the degree of upcoding of risk scores for enrollees moving to the new plan from TM as MedPAC estimates for MA compared with TM	$15.3B	-$25.7B
	A2. Same degree of overpayment attributable to both favorable selection and upcoding for enrollees moving to the new plan from TM as MedPAC estimates for MA compared with TM	$48.7B	$7.7B
	A3. New integrated plans save money relative to stand-alone MA	$26.2B	-$14.8B
	A4. Less movement of full dual enrollees into PACE	$35.7B	-$5.3B
	A5. Only half of states adopted the option for continuous eligibility	$39.2B	-$1.8B
	A6. Half as many new dual enrollees associated with the welcome mat effect	$37.4B	-$3.6B
Changes to legislation that are consistent with its broad intent	A7. Payments for dual enrollees in new integrated plans are set lower than for dual enrollees in MA (as in A1), and MA benchmarks for dual enrollees are reduced to ensure payment parity for dual enrollees in MA and new integrated plans (e.g., by imposing the new duals-specific risk adjustment for all duals along with parity in base payments)	-$4.7B	-$45.7B
	A8. Drop PACE provision from legislation altogether	$33.8B	-$7.2B

Source: Urban Institute estimates based on modeling of the DUALS Act of 2024 and authors' analysis of MedPAC (Medicare Payment Advisory Commission), *Report to the Congress: Medicare Payment Policy* (Washington, DC: MedPAC, 2025).
Notes: TM = Traditional Medicare; MedPAC = Medicare Payment Advisory Commission; MA = Medicare Advantage; and PACE = Program of All-Inclusive Care for the Elderly.

In the second alternative scenario, which is significantly more costly, we assume the same estimated degree of overpayment attributable to both favorable selection and upcoding in the new plan as MedPAC estimates exist now in MA relative to TM.

In the third alternative scenario, we consider the possibility that the new integrated plans would save money relative to stand-alone MA plans (rather than assuming per enrollee spending on the new integrated plans would be comparable with stand-alone MA). In modeling this scenario, we furthermore assume that lower payment rates associated with the new plans (resulting from Medicare reducing payment rates to reflect the lower cost) would make them less attractive to managed care organizations and that, as a result, managed care organizations would seek to direct duals to their nonintegrated MA products, thus decreasing overall enrollment in the new integrated plans. This alternative scenario would lead to an estimated $26.2 billion total increase (relative to current law) in federal spending on full duals from 2024 to 2033, or $14.8 billion less than our primary scenario.

Our fourth alternative scenario assumes half as much growth in the PACE program associated with the DUALS Act than is assumed in our primary scenario. Half of the enrollees assumed to move to PACE in our primary scenario would instead stay in their existing plan or move to the new integrated plan. In this scenario, there would be an estimated $35.7 billion increase in federal spending on full duals from 2024 to 2033, or $5.3 billion less than our primary scenario.

Next, we consider a scenario where only half[6] of states adopt the continuous eligibility option written into the DUALS Act (rather than assuming all states would adopt it). In this scenario, there would be an estimated $39.2 billion total change in federal spending on full duals from 2024 to 2033, or $1.8 billion less than our primary scenario.

Finally, we consider a scenario where the welcome mat effect was only half as large as we assume in our primary scenario. In this scenario, there would be an estimated $37.4 billion total change in federal spending on full duals from 2024 to 2033, or $3.6 billion less than our primary scenario.

Alternative Scenarios Involving Changes to the Legislation

Next, we consider possible modifications to the DUALS Act as drafted in March 2024 that are consistent with its broad intent but have implications for the cost of the legislation.

First, we reconsider the possibility that the new integrated plans would save money relative to stand-alone MA plans under current law, and we consider an additional provision to the legislation that would reduce MA benchmarks for dual enrollees in stand-alone MA to guarantee payment parity and avoid incentives for managed care organizations to attract duals to stand-alone MA plans rather than the new integrated plans. For example, this could be achieved by modifying the legislation such that the new risk adjustment model and comparable base payments would be applied to all dual enrollees, including those in stand-alone MA, rather than only to dual enrollees in the new integrated plans. In this scenario, there would be an estimated *savings* of $4.7 billion in federal spending on full duals from 2024 to 2033, or $45.7 billion less than our primary scenario.

Second, we consider a scenario where the PACE provisions of the legislation (i.e., Title IV—PACE) are eliminated, and the PACE program continues to operate as it does under current law (including Medicare payments for PACE-enrolled duals being higher than payments for duals in other plan types). In this scenario, there would be an estimated $33.8 billion total change in federal spending on full duals from 2024 to 2033, or $7.2 billion less than our primary scenario.

Policy Proposals outside the DUALS Act That Could Offset the Cost of the Legislation

There are several possible policy proposals that, if enacted, could offset or more than offset the DUALS Act's estimated 10-year cost. MA plans are broadly understood to be overpaid relative to estimated spending for the same enrollees in TM. MedPAC estimates the total rate of overpayment now to be 20 percent, stemming mainly from higher coding intensity in MA and favorable selection (MedPAC 2025).

Policies to more accurately adjust MA payments for coding intensity could reduce Medicare spending by more than $200 billion estimated from 2021 to 2030.[7] Reducing MA benchmarks would also reduce Medicare overpayments. The Congressional Budget Office (2022) estimates reducing MA benchmarks by 10 percent would save $392 billion from 2023 to 2032. Reforming MA's Quality Bonus Payment program could save an estimated $115 to $170 billion from 2024 to 2033.[8] A more limited change to the Quality Bonus Payment Program that would make employer group waiver plans ineligible for bonus payments (because Medicare enrollees do not "shop" for these restricted plans) would save $20 to $30 billion over the same period.[9] Finally, after annual assessments of the adequacy of Medicare payments to skilled nursing facilities, home health agencies, and inpatient rehabilitation facilities, MedPAC routinely finds payments to these providers in TM are too high. Reducing payments to these three post-acute care providers by 5 percent, as MedPAC had recommended for 2023, would have saved an estimated $2.7 billion in 2021 (Garrett 2023), which, updated and grown over 10 years, would offset a significant portion of the DUALS Act's budgetary impact that we estimate in our primary scenario.

Discussion

We estimate that federal spending on full dual enrollees would increase by $41.0 billion over the next decade under the DUALS Act relative to projected spending under current law. Just over half the projected spending ($21.4 billion) would come from additional spending associated with the new integrated plans themselves, primarily driven by the expected increase in spending on duals moving from TM plans into the new integrated plans and our assumption that payments to the new plans would be similar to payments for dual enrollees currently made to MA plans and would thereby replicate the estimated overpayment of the MA program under current law. Approximately 18 percent of the projected spending ($7.2 billion) would be attributable to growth in the number of full dual enrollees from a welcome mat effect, wherein Medicaid-eligible but unenrolled individuals would enroll in Medicaid as a result of the legislation. Another 18 percent ($7.2 billion) would come from PACE program expansions. Less than 10 percent ($3.7 billion) would come from the continuous eligibility provision, and the remaining $1.6 billion would come from other federal spending.

Ten years following the enactment of the DUALS Act, we estimate that approximately one-quarter of all full dual enrollees would be enrolled in one of the new integrated plans the act introduced and that the PACE program would enroll more than 100,000 additional full dual enrollees relative to growth in the program expected under current law. Under the DUALS Act, nearly 30 percent of full dual enrollees would be enrolled in a fully integrated model by 2033, compared with less than 10 percent today.

As is typical in estimating the effects of new policies where research based on experience from imperfect analogs provides only a rough guide, there is substantial uncertainty in our modeling approach that must be considered when interpreting our estimates. First, our approach draws on analyses of administrative data, previously published estimates and literature, and published growth projections from the Congressional Budget Office, but there are nonetheless several areas where we lack concrete data on which to base our assumptions. In particular, the key areas where we most lacked such data include the extent to which the new integrated plans would save money relative to other plan

types (especially on the Medicaid side, where there is little data available on capitation payments) and the resulting take-up of the integrated models by plans and enrollees; the extent of the welcome mat effect; and how much the PACE program would grow under the DUALS Act. Although we consider the effect of altering assumptions around these issues in our Alternate Scenarios section, it is important to consider these limitations in interpreting our projections.

Second, the DUALS Act, as written, includes several provisions that lack specificity in ways that could have sizable impacts on our estimates. For example, it is unclear how widespread the new integrated models must be for states to comply with the legislation. Moreover, the payment model for the new integrated plans lacks details beyond stating that plans will be paid via risk-adjusted capitated payments with both Medicare and Medicaid components. The legislation states that a new risk adjustment model will be developed specifically for duals enrolled in integrated plans but does not provide any details. These details could considerably impact plan behavior, plan availability and take-up, spending factors, and the cost of the legislation.

Our intention is that these estimates will inform policymakers and stakeholders, including those interested in serving the needs of the dually enrolled population, with a useful benchmark surrounding potential spending over 10 years associated with the DUALS Act. Policymakers and stakeholders should also consider the nonmonetary effects this legislation could have on dual enrollees. For example, to the extent the new integrated plans introduced under the DUALS Act could improve access to high-quality health care for enrollees or the legislation could increase enrollment in Medicaid among eligible but unenrolled populations, there could be meaningful benefits to the health and well-being of dually eligible enrollees associated with the legislation. But, given the mixed evidence to date on the effects of integrated care plans on spending, utilization, and health outcomes, as well as key details that the proposed DUALS Act does not yet provide, additional research on the potential impacts of the DUALS Act and other efforts to expand access to integrated care plans for dual enrollees is warranted.

Appendix. Additional Methodological Details

Baseline Estimates of Enrollment and Spending

For our baseline model inputs, we estimated the number of full dual enrollees and associated expenditures for each combination of Medicare plan (TM, stand-alone MA, C-SNP, I-SNP, FIDE-SNP, coordination only D-SNP, Financial Alignment Initiative MMP, or PACE) and Medicaid plan (FFS, unintegrated MCO, FIDE-SNP, MMP, or PACE) in which full dual enrollees are enrolled under current law. To estimate enrollment by plan type, we used the 2021 Medicare Beneficiary Summary File and Plan Characteristics File.[10] To estimate Medicare and Medicaid expenditures by plan type, we relied on several sources, including data jointly published by MedPAC and the Medicaid and CHIP Payment and Access Commission, analysis of publicly-available MA payment data, analysis of Medicaid administrative data, previous studies on PACE, Financial Alignment Initiative evaluation reports, and Centers for Medicare and Medicaid Services Medicaid expenditure reports (Caswell, Waidmann, and

Wei 2021; Ghosh, Schmitz, and Brown 2014; MedPAC and MACPAC 2022; Murray et al. 2021).[11] We made simplifying assumptions where data were not available. For example, we assumed average per-enrollee Medicare expenditures were the same for full dual enrollees in coordination-only D-SNPs and FIDE-SNPs and that average per-enrollee Medicaid expenditures were the same for full dual enrollees in integrated and nonintegrated MCOs.

Enrollment in New Integrated Plans

Under current law, full dual enrollees are enrolled in various combinations of Medicare and Medicaid plan types. We view the likelihood that a dual enrollee will move from their current plan type to the new integrated plan (i.e., the transition probability) to be a function of their expected opt-out rate—which combines the effects of voluntary opt-out and exemption from passive enrollment because of an out-of-network primary care provider—and the probability that a new integrated plan becomes available to the enrollee in their geographic market. The transition probabilities vary depending on a dual enrollee's current Medicare and Medicaid plan types, with the highest probabilities assumed for dual enrollees already in fully integrated arrangements (i.e., FIDE-SNPs or MMPs), somewhat high probabilities assumed for duals in managed but nonintegrated Medicare and Medicaid plans (e.g., a stand-alone MA plan and an MCO), moderate probabilities assigned to dual enrollees in a managed Medicare or managed Medicaid plan but not both (e.g., TM and a Medicaid MCO), somewhat low probabilities assigned to dual enrollees in TM and FFS Medicaid, and the lowest probabilities assigned to dual enrollees in a C-SNP or I-SNP. We assume enrollees already in PACE will not leave their PACE plan for the new integrated plans. See table A.1 for the specific probabilities we assumed.

Risk Selection and Spending in New Integrated Plan

Our primary scenario assumes that favorable selection (net of risk score) from TM to the integrated plan will be only one-third of what MedPAC currently estimates applies to MA relative to TM because of the passive enrollment provision of the DUALS Act (MedPAC 2025). We assume TM enrollees moving into the new integrated plans will have similar risk scores as current dual enrollees in TM. We also assume the same degree of upcoding of risk scores of TM enrollees moving to the new integrated plan as MedPAC currently estimates for MA enrollees relative to TM (MedPAC 2025). We assume no risk selection and that the new integrated plans do not yield savings (or additional costs) relative to MA, FIDE-SNPs, coordination only D-SNPs, or MMPs, as there is little evidence that capitated Medicare-Medicaid models reduce Medicare expenditures (MACPAC 2020). We also assume that relative to Medicaid FFS or MMC, the new integrated plans neither increase nor decrease Medicaid spending, based on prior evidence on Medicaid spending in managed long-term services and supports arrangements and MMPs (Roberts et al. 2024).[12] See table A.1 for the specific risk selection and spending factors we assumed.

Expansions to PACE

Under current law, PACE services are an optional Medicaid benefit for states. As of 2023, the program covers approximately 56,000 enrollees across 32 states (less than 1 percent of full duals). We anticipate the PACE provisions in the DUALS Act would lead to an additional 1 percent of full duals not currently enrolled in PACE to enroll and that these enrollees would be highly adversely selected because the PACE program is designed to serve individuals who require a nursing home level of care. Given higher payments to PACE plans relative to other Medicare plan types (Skopec 2024), we estimate Medicare and Medicaid expenditures to increase from this growth in the size of the PACE program, with larger increases in expenditures associated with enrollees moving from TM and FFS plans to PACE than with enrollees moving from MA and MMC plans to PACE.

Continuous Eligibility Option for the New Integrated Plans

The legislation provides an option for states to offer 12 months of continuous Medicaid eligibility and enrollment in the new integrated plans. Based on previous estimates of Medicaid "churning" among dual enrollees—such as a recent analysis of Medicare data finding that 5.8 percent of full duals experienced at least one month of Medicaid coverage loss in 2019 (Ma et al. 2024)—we calculate an estimated 29,480 additional person-years of enrollment in the new integrated plans if the continuous eligibility option were to be adopted by all states (Feng, Vadnais, Vreeland, Segelman, et al. 2019; Feng, Vadnais, Vreeland, Haber, et al. 2019). We then multiply this expected increase in enrollment by estimated per enrollee spending in the new integrated plan. All Medicaid spending associated with this increase to dual enrollment is attributed to the cost of the legislation, whereas only a small fraction of the Medicare spending (i.e., the spending associated with the cost of the new integrated plan relative to other Medicare plan types) is attributed to the cost of the legislation because these enrollees would be enrolled in Medicare even absent the policy.

Growth in the Number of Full-Benefit Dual Enrollees from a "Welcome Mat" Effect

Based on analyses of previous expansions to Medicaid programs (Frean, Gruber, and Sommers 2017; Hudson and Moriya 2017; McInerney, Mellor, and Sabik 2017, 2021; Sacarny, Baiker, and Finkelstein 2022; Sommers, Kenney, and Epstein 2014; Sonier, Boudreaux, and Blewett 2013), we assume that approximately 2 percent of Medicare-enrolled individuals who are eligible for but not currently enrolled in Medicaid would enroll in Medicaid for the first time as a result of the state and community outreach grants aimed at increasing enrollment of dual enrollees into integrated plans. We multiply this expected increase in enrollment by estimated per enrollee spending by plan type. All Medicaid spending associated with this increase to dual enrollment is attributable to the cost of the legislation, whereas only a small fraction of the Medicare spending (i.e., the spending associated with the cost of the new integrated plan relative to other Medicare plan types) is attributable to the cost of the legislation because these enrollees would be Medicare enrolled even absent the policy. We expect average Medicaid spending for welcome mat enrollees to be 60 percent of the average Medicaid spending for

non–welcome mat enrollees based on evidence from prior literature on program take-up among eligible but unenrolled individuals following informational interventions (Finkelstein and Notowidigdo 2019).

Limitations

The goal of this analysis was to estimate the cost of the DUALS Act relative to how we would expect spending on full duals to change under current law, all else equal. We made numerous simplifying assumptions and did not account for all possible dynamics related to the distribution of full duals by plan type that could occur absent the DUALS Act. For example, recent literature suggests enrollment of duals in C-SNPs and I-SNPs is increasing, and MMPs are set to fully sunset by the end of 2025 (Gerber and Blom 2022; Stein et al. 2025). But these patterns would ultimately have little effect on our bottom-line estimate for the total cost of the DUALS Act. Furthermore, potential broad cuts to the Medicaid program could have meaningful impacts on enrollment and spending in Medicaid, including among duals (Holahan, O'Brien, and Dubay 2025).[13] We do not account for these potential cuts in our model.

TABLE A.1

Assumed Transition Probabilities, Risk Factors, and Spending Factors for the Movement of Full Dual Enrollees to New Integrated Plans and to PACE under the DUALS Act of 2024

	Movement to New Integrated Plans				Movement to PACE			
Plan types at baseline (Medicare, Medicaid)	Transition probability	Risk selection factor	Spending factor (Medicare)	Spending factor (Medicaid)	Transition probability	Risk selection factor	Spending factor (Medicare)	Spending factor (Medicaid)
TM, FFS	10%	0.9646	1.137	1.0	1%	1.2	1.21	1.21
TM, MCO	20%	0.9646	1.137	1.0	1%	1.2	1.21	1.17
MA, FFS	20%	1.0	1.0	1.0	1%	1.2	1.17	1.21
MA, MCO	40%	1.0	1.0	1.0	1%	1.2	1.17	1.17
C-SNP or I-SNP, FFS	3%	0.95	1.0	1.0	1%	1.2	1.17	1.21
C-SNP or I-SNP, MCO	3%	0.95	1.0	1.0	1%	1.2	1.17	1.17
D-SNP (coordination only), FFS	30%	1.0	1.0	1.0	1%	1.2	1.17	1.21
D-SNP (coordination only), MCO	40%	1.0	1.0	1.0	1%	1.2	1.17	1.17
FIDE-SNP, MCO (not aligned)	50%	1.0	1.0	1.0	1%	1.2	1.17	1.17
FIDE-SNP, MCO (aligned)	70%	1.0	1.0	1.0	1%	1.2	1.17	1.17
MMP	70%	1.0	1.0	1.0	1%	1.2	1.17	1.17
PACE	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Source: Urban Institute modeling assumptions based on analysis of multiple sources (see Appendix).

Note: TM = Traditional Medicare. FFS = Fee-for-service. MCO = Managed care organization. MA = Medicare Advantage. C-SNP = Chronic Condition Special Needs Plan. I-SNP = Institutional Special Needs Plan. D-SNP = Dual Eligible Special Needs Plan; FIDE-SNP = Fully Integrated Dual Eligible Special Needs Plan; MMP = Medicare-Medicaid Plan. PACE = Program of All-Inclusive Care for the Elderly.

Notes

[1] DUALS Act of 2024, S. 3950, 118th Cong. (2024).

[2] Maria T. Peña, Alice Burns, Jeannie Fuglesten Biniek, Nancy Ochieng, and Priya Chidambaram, "A Profile of Medicare-Medicaid Enrollees (Dual Eligibles)," KFF, January 31, 2023, https://www.kff.org/medicare/issue-brief/a-profile-of-medicare-medicaid-enrollees-dual-eligibles/.

[3] Peña et al., "A Profile of Medicare-Medicaid Enrollees."

[4] Maria T. Peña, Maiss Mohamed, Jeannie Fuglesten Biniek, Alice Burns, Juliette Cubanski, and Tricia Neuman, "The Landscape of Medicare and Medicaid Coverage Arrangements for Dual-Eligible Individuals across States," KFF, last updated October 24, 2024, https://www.kff.org/medicare/issue-brief/the-landscape-of-medicare-and-medicaid-coverage-arrangements-for-dual-eligible-individuals-across-states/.

[5] "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier," KFF, accessed July 14, 2025, https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/.

[6] Before 2024, 12-month continuous eligibility policies for children were an option for states. As of 2022, roughly half of states had adopted this policy. See Elizabeth Williams, Bradley Corallo, Jennifer Tolbert, Alice Burns, and Robin Rudowitz, "Implications of Continuous Eligibility Policies for Children's Medicaid Enrollment Churn," KFF, December 21, 2022, https://www.kff.org/medicaid/issue-brief/implications-of-continuous-eligibility-policies-for-childrens-medicaid-enrollment-churn/. Therefore, although our primary scenario assumes all states adopt the optional continuous eligibility provision included in the DUALS Act, it would be reasonable to expect half of states to adopt 12-month continuous eligibility.

[7] "Reducing Medicare Advantage Overpayments," Committee for a Responsible Federal Budget, February 23, 2021, https://www.crfb.org/papers/reducing-medicare-advantage-overpayments.

[8] "Employer Plans in Medicare Advantage: A Flaw in the Quality Bonus System," Committee for a Responsible Federal Budget, March 5, 2024, https://www.crfb.org/papers/employer-plans-medicare-advantage-flaw-quality-bonus-system.

[9] "Employer Plans in Medicare Advantage," Committee for a Responsible Federal Budget.

[10] Kyle J. Caswell, Timothy Waidmann, and Wesley Jenkins, "What We Know about Medicare Enrollment for Dual Enrollees," Urban Institute, May 30, 2024, https://www.urban.org/data-tools/medicare-medicaid-dual-enrollment-available-plans.

[11] See also "Financial Alignment Initiative for Medicare-Medicaid Enrollees," Centers for Medicare and Medicaid Services, last updated December 20, 2023, https://www.cms.gov/priorities/innovation/innovation-models/financial-alignment.

[12] Jill Bruckert, Annie Hallum, and Davis Burge, "Medicaid Long-Term Services and Supports," Milliman, February 1, 2022, https://www.milliman.com/en/insight/Medicaid-long%20term%20services%20and%20supports.

[13] Berkeley Lovelace Jr., "Who Does Medicaid Cover? How Congress' Proposed Budget Cuts Could Be Felt," NBC News, March 2, 2025, https://www.nbcnews.com/health/health-news/medicaid-cover-congress-proposed-budget-cuts-felt-rcna193897.

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