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Celebrating 60 Years of Medicaid: Dually Eligible Beneficiaries in Medicare and Medicaid

History

Alongside Medicaid, President Johnson also signed Medicare law on July 30, 1965, with the program going into effect the following year.[1] Medicare provides healthcare coverage to adults aged 65 and older. In the beginning, Medicare was divided into two parts, Part A and Part B. Part A covers hospital stays, hospice, and other acute care needs at no cost to the beneficiary. Individuals are automatically enrolled in Part A when they turn 65 with no cost sharing requirements. Part B covers physician services, laboratory services, durable medical equipment, and other non-acute care. Part B coverage requires individuals to enroll into coverage and charges a premium, with rates varying based on income. Since its inception, Medicare has grown into a more complex system made up of multiple parts.

In 1972, Medicare was authorized to enter contracts with health maintenance organizations (HMOs) to provide benefits through capitated payments.[2] Congress also expanded Medicare to cover individuals under the age of 65 if they had qualifying disabilities or End-Stage Renal Disease (ESRD).[3] Then, in 1997, Medicare Part C was

[1] A brief history of Medicare in America | medicareresources.org
[2] Microsoft Word - 2. [Formatted] Medicare Advantage History - Legislative Milestones 7.13.23.docx
[3] A brief history of Medicare in America | medicareresources.org

created through the Balanced Budget Act. Originally, this was called Medicare+Choice but is now referred to as Medicare Advantage (MA).[4] This expanded the ability of private insurance companies to contract with the federal government to provide benefits to enrollees who now had the ability to choose their health plan. The most recent piece of Medicare, called Part D, was enacted in 2003 through the Medicare Modernization Act (MMA). Part D provides prescription drug plans to enrollees if they choose to enroll. The MMA also created two additional Part C plans, Regional Preferred Provider Organizations (RPPOs) and Special Needs Plans (SNPs).[5] MA plans offer the combined benefits of Parts A, B, and D to enrollees along with other supplemental benefits or incentives that are not available to individuals receiving Original Medicare (OM). However, MA plans are more limited in their provider networks, whereas enrollees in OM can see any doctor that accepts Medicare.[6]

Original Medicare provides a much more limited scope of benefits and coverage than Medicaid. Part B does not cover items like hearing aids, vision care, or most dental work, which many states elect to cover in their Medicaid programs or must cover due to medical necessity.[7] Part A, which covers hospital stays, has limits on the number of days it will cover. MA plans can provide more expansive coverage, opting to cover the cost of needed items like hearing aids or glasses alongside other value-added services like grocery benefits and transportation services.[8] Most importantly, Medicare, including Medicare Advantage, does not cover the cost of long-term care. However, an estimated 70% of older adults will need long-term care at some point in their lives.[9] Medicaid is the single largest payer of long-term care in the U.S.[10]

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[4] Ibid.
[5] Ibid.
[6] Comparing Original Medicare vs. Medicare Advantage
[7] What's not covered? | Medicare
[8] Medicare Advantage Value-Based Insurance Design Model | CMS
[9] What Is the Lifetime Risk of Needing and Receiving Long-Term Services and Supports? | ASPE
[10] What Long-term Care (LTC) is Covered by Medicaid? - Medicaid 101 | KFF

In addition to enrolling in Medicare, older adults and other Medicare-eligibles may also be eligible for and enroll in Medicaid, either based on income or medical condition, such as a disability. Once enrolled in Medicaid, older adults can receive cost-sharing assistance with Part B premiums, prescription drugs, and other needed services that would not otherwise be available to them under Original Medicare. These Medicaid-funded services are known as "wrap-around" services. Individuals who are jointly enrolled in Medicare and Medicaid are often referred to as "dual-eligibles." Some individuals qualify for full Medicaid coverage, while others only receive partial benefits due to higher income, referred to here as partial dual-eligibles.

Current State

In May 2025, total Medicare enrollment was 68.9 million with over half, 51.2%, enrolled in an MA plan.[11] MA enrollment has increased steadily since 2010, though the pace of enrollment slowed in 2025. Enrollment in special-needs plans under MA has increased rapidly, from 1.25 million enrollees in 2010 to 7.27 million in 2025.[12] There are currently 11.9 million dual-eligibles enrolled in both Medicare and Medicaid. Of these, 8.5 million, or 72%, receive full Medicaid benefits while the remaining 3.4 million are partial dual-eligibles.[13] This population comprises 16% of Medicare enrollment and 14% of Medicaid enrollment on the national level.[14] On average, full dual-eligibles live on very low, fixed incomes, with nearly 90% living on an annual income of less than $20K.[15] Dual-eligibles are more likely to self-report having fair to poor health compared to Medicare-only enrollees and about half of dual-eligibles have at least one limitation on activities of daily living, like bathing, dressing, or

[11] Medicare Enrollment Dashboard | CMS Data
[12] Medicare Advantage in 2025: Enrollment Update and Key Trends | KFF
[13] U.S. Enrollment and Spending for Dual-Eligible Individuals
[14] Ibid.
[15] A Profile of Medicare-Medicaid Enrollees (Dual Eligibles) | KFF

toileting.[16] Women are also more likely to be dual-eligibles. Partial dual-eligibles have worse outcomes compared to Medicare-only enrollees but generally fare better than full dual-eligibles.[17] In 2025, just under half of all dual-eligibles were people of color.[18] According to data from 2021, slightly less than 10% of adults aged 65 and older lived in poverty.[19]

Data from 2021 shows that full-benefit dual-eligibles had the highest cost of care compared to partial dual-eligibles and Medicare only individuals.[20] On average, a full-benefit dual-eligible cost Medicare over $24K per year, compared to just under $10K for Medicare-only enrollees. Medicaid spending on dual-eligibles was slightly lower than Medicare. However, full-benefit dual-eligibles remained the costliest population to cover, with these individuals receiving over $19K per year compared to just under $6K for Medicaid-only enrollees.

Recent Developments

Integrated care models are of particular importance for this population, as dual-eligibles are more likely to have chronic illness, disabilities, and long-term care needs. These services are known to be costly and complex, and coordinated, integrated care is intended to improve health outcomes and lower healthcare spending.[21]

In general, there are two groups of integrated care models for dual-eligibles: special needs plans (SNPs) and the Program of All-Inclusive Care for the Elderly (PACE).Special Needs Plans can be divided into three types: a Coordination-only Dual Eligible Special Needs Plan (CO D-SNP), Highly Integrated Dual Eligible Special Needs

[16] A Profile of Medicare-Medicaid Enrollees (Dual Eligibles) | KFF; Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)
[17] Ibid.
[18] A Profile of Medicare-Medicaid Enrollees (Dual Eligibles) | KFF
[19] Majority of Older Adults in Poverty in 2021 Lived Alone
[20] U.S. Enrollment and Spending for Dual-Eligible Individuals
[21] Chapter 2 Integrating Care for Dually Eligible Beneficiaries

Plan (HIDE-SNP), or Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP).[22] These models provide various levels of integrated care for enrollees in Medicare and Medicaid, with FIDE-SNPs having the most coordination. All SNPs require the MCO to contract both with CMS and the state Medicaid program, as mandated by the Bipartisan Budget Act of 2018.[23] FIDE-SNPs are single managed care entities that provide both Medicare and Medicaid coverage, coordinates both sets of benefits, and integrates communication and enrollment materials. For example, this may look like an enrollee having one ID card to represent their Medicare and Medicaid coverage instead of two separate plans.

HIDE-SNPs provide Medicaid benefits to dual-eligibles through a contract with the state Medicaid agency. Enrollees in the HIDE-SNP may have a different health plan that covers their Medicare benefits and may not receive all of the benefits that an enrollee in a FIDE-SNP would. CO D-SNPs meet minimum CMS requirements but do not have the same level of service integration that HIDE and FIDE-SNPs must have. However, these plans are required to share important health information on enrollees with the state Medicaid agency.

PACE is a separate program that offers services to individuals in the community who otherwise need a nursing-facility level of care.[24] Individuals must apply to their local PACE program and be approved to receive services. Participants can receive both Medicare and Medicaid benefits, as well as any other service or support that is medically necessary to maintain or improve their health.[25] Enrollees do not necessarily have to be dually enrolled in both Medicare and Medicaid, nor do they need to meet any financial eligibility requirements.[26] This is a highly integrated model where an interdisciplinary team of professionals provides coordinated care to participants and

[22] Definitions of Different Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) Types in 2023 and 2025
[23] Definitions of Different Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) Types in 2023 and 2025
[24] Program of All-Inclusive Care for the Elderly | Medicaid
[25] Eligibility Requirements | NPA | National PACE Association
[26] Ibid.

can include a range of services, from nursing services to nutritional counseling, mental and behavioral health care, and more.[27] Financing for PACE is integrated, receiving both Medicare and Medicaid funds on a capitated basis.[28]

Finally, Medicaid waivers can also provide older adults with an option to receive needed care, including those who are dual eligibles regardless of their enrollment in OM or MA. 46 states and the District of Columbia operate at least one 1915(c) waiver for specific populations like individuals with disabilities, including physical and intellectual disabilities.[29] These provide home and community-based services, like private duty nursing, companion care, or personal care attendants, in addition to other supports like transportation, durable medical equipment, and home delivered meals.[30] Generally, people enrolled under a waiver must meet the nursing facility level of care for their state and maintain Medicaid eligibility. Services can be delivered through managed care or fee-for-service.[31] In some cases, acute care needs for individuals may be provided outside of the waiver.

Outlook

House Resolution 1 (H.R.1), passed earlier this year, creates significant changes to the healthcare system, largely focused on Medicaid.[32] However, dual eligibles may still be impacted. The budget reconciliation bill made changes to the limit on home equity that could hinder some older adults trying to apply for Medicaid. As mentioned earlier, many older adults seek Medicaid to cover the cost of long-term care but first need to meet certain financial requirements, including asset limits. Most homes are

[27] PACE Services | NPA | National PACE Association
[28] Program of All-Inclusive Care for the Elderly | Medicaid
[29] Compendium: Medicaid Payment Policies for Home- and Community-Based Services in Section 1915(c) Waivers - MACPAC
[30] Home- and community-based services - MACPAC
[31] Compendium: Medicaid Payment Policies for Home- and Community-Based Services in Section 1915(c) Waivers - MACPAC
[32] H.R.1 - 119th Congress (2025-2026): One Big Beautiful Bill Act | Congress.gov | Library of Congress

excluded from the asset limit provided that they are under the state's home equity interest limit.[33] In some states, like California, Maine, Hawaii, Massachusetts, New Jersey, and New York, this value exceeds $1M.[34] However, H.R.1 caps the maximum home equity limit to $1M effective January 1, 2028, and does not account for inflation.

H.R. 1 also limits Medicare coverage to American citizens and certain eligible immigrants. It places a 10-year moratorium on the implementation of the final CMS rule "Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment." The final rule was intended to simplify the enrollment process for Medicare Savings Programs (MSPs) that provide financial assistance for cover premiums and cost sharing requirements, with many dual-eligibles qualifying for assistance.[35]

The Trump Administration is also seeking ways to update and revise Medicare outside of lawmaking. In June 2025, CMS Administrator Dr. Oz announced a new model in the CMS Innovation Center, the Wasteful and Inappropriate Service Reduction (WISeR) Model.[36] It aims to reduce unnecessary or inappropriate care in Original Medicare through partnerships with companies that provide enhanced technology, including artificial intelligence, to streamline prior authorization processes.[37] The WISeR model will focus on services and items that have been identified as high risk for fraudulent activities. The model excludes emergency and in-patient services, as well as other care that would pose a substantial risk if significantly delayed. [38]

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[33] Home Ownership & Its Impact on Medicaid Eligibility
[34] Ibid.
[35] Federal Register :: Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment
[36] CMS Launches New Model to Target Wasteful, Inappropriate Services in Original Medicare | CMS
[37] Ibid.
[38] Ibid.

Finally, there have been several revisions to federal regulations regarding Original Medicare and Medicare Advantage. In 2022, CMS finalized a rule that ended the Financial Alignment Initiative (FAI) that was intended to increase the financial alignment of Medicare and Medicaid and better integrate services for dual eligibles.[39] Most states that participated in the initiative developed Medicare-Medicaid Plans (MMPs), which were a three-way contract between CMS, the state agency, and the health plan.[40] With the FAI ending, states moved their MMP populations to D-SNPs. All MMP transitions must be completed by the end of 2025.[41] In April 2025, CMS finalized a rule that requires D-SNPs that are applicable integrated plans to have integrated member ID cards and conduct integrated health risk assessments for Medicare and Medicaid, extending the coordination requirements that were previously reserved for HIDE and FIDE-SNPs.[42]

The 65+ population is expected to grow by nearly 50% by 2050.[43] Additionally, the share of people aged 65 and older is becoming more racially and ethnically diverse compared to previous generations.[44] This is also coupled with the fact that the share of children in the population decreased from 25% in 2004 to 21.5% in 2024.[45] In 2024, there were 11 states where older adults outnumbered children compared to only three states in 2020.[46]

This gap between the amount of people paying into the program and the number of enrollees creates significant concerns about the financial health of Medicare. The Medicare trustees predict that the Hospital Insurance Trust Fund will

[39] Medicare-Medicaid Plan Transition - MACPAC
[40] Ibid.
[41] Ibid.
[42] Federal Register :: Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly
[43] Fact Sheet: Aging in the United States | PRB
[44] Ibid.
[45] Older Adults Outnumber Children in 11 States, Nearly Half of Counties
[46] Ibid.

run out of money by 2036.[47] Spending from the Trust on Part A benefits exceeded income by just over $12B in 2023.[48] In addition to addressing financial solvency, some lawmakers have expressed interest in reforming prior authorization requirements and upcoding in MA.[49]

[47] Medicare go-broke date extended to 2036, but warning bells continue ringing | Healthcare Dive
[48] Ibid.
[49] Senators reintroduce bill that seeks to reform prior authorization in Medicare Advantage; Cassidy, Merkley Introduce Bill to Stop Overpayments in the Medicare Advantage Program | U.S. Senator Bill Cassidy