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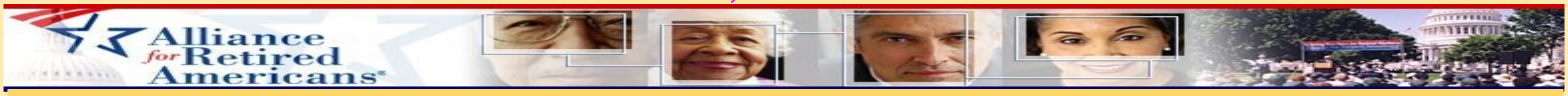


Friday Alert Message from the Alliance *for* Retired Americans Leaders

Shakeups at Social Security Administration Cause More Turmoil for Retirees and Staff

Robert Roach, Jr
President, ARA

The Trump Administration kicked off this week with major changes at the Social Security Administration (SSA) that threaten to further weaken the agency. On Monday, U.S. Treasury Secretary Scott Bessent **announced** that SSA Commissioner Frank Bisignano will now also serve as CEO of the Internal Revenue Service (IRS). **Alliance Executive Director Richard Fiesta blasted the move** – which essentially treats the position of SSA Commissioner as a side gig – in a statement.

The Washington Post reported that the Administration is also considering changing the Social Security disability criteria. Currently SSA reviews disability claims by looking at a person's age, work history, and education to decide whether they can adjust to other kinds of work. Applicants over 50 generally have a higher chance of qualifying, since age is recognized as a factor that can make it harder to adapt to new types of jobs.

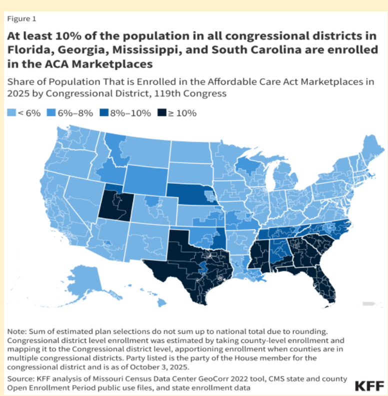
The SSA is considering raising the age threshold to 60 years or **completely eliminating** age as a factor altogether. If the changes take effect, advocates say thousands of older people with disabilities will need to find work, or if they are 62, claim their Social Security retirement benefits early, significantly reducing their monthly benefit amount.

"After cutting thousands of staff members and replacing them with AI chatbots, the Administration has decided to deepen the chaos at SSA by giving Bisignano another job and cutting older disabled beneficiaries off from their benefits," said **Robert Roach, Jr., President of the Alliance**. "Older Americans have earned their benefits over a lifetime of hard work. They deserve better from the Administration."

Older Enrollees and Patients Living in Red States Will Be Hurt Most If ACA Subsidies Lapse

Americans between the ages of 50 and 64 and those living in **Republican congressional districts** will be the hardest hit if the current Affordable Care Act tax credits are not renewed by Congress, according to new analyses from KFF.

The tax credits expanded eligibility for subsidies so that more middle-income Americans could get help paying health insurance premiums. Fifty-one



percent of these enrollees are 50 to 64 years old. They are not eligible for Medicare and do not have health insurance through their employment. Since insurers are already allowed to charge older patients up to three times as much for ACA plans, if subsidies expire, this group would be hit with a "double whammy," where they could no longer get help paying for premiums but also would face the steepest increases.

Americans living in states that have not expanded Medicaid or have high rates of uninsured and/or low-income residents are also more likely to be enrolled in an ACA Marketplace plan and take advantage of subsidized coverage. More than half of ACA enrollees live in Republican congressional districts, especially in Southern states. At least 10 percent of residents in every congressional district in Florida, Georgia, Mississippi, and South Carolina are enrolled in a Marketplace plan.

The five congressional districts with the most ACA enrollees are all in Florida: FL-27, FL-24, FL-28, FL-09, and FL-26. At least 30% of residents in each of these districts are enrolled in an ACA plan.

The ACA tax credits will expire on December 31, 2025. If Congress does not take action, on January 1, health insurance premiums **will skyrocket** by as much as 114 percent for 22 million Americans who rely on ACA Marketplace plans. Democrats attempted to get an extension included in a government funding bill last week, but Republicans pushed a "clean" bill that would keep spending at previous levels for seven weeks instead.

Rich Fiesta,
Executive
Director, ARA

"This new research highlights how devastating it will be for millions of Americans across the country," said **Richard Fiesta, Executive Director of the Alliance**. "It's time to fund the government and extend ACA subsidies to avert a preventable health care catastrophe."

KFF Health News: Health Centers Face Risks as Government Funding Lapses
By Paula Andalo

About 1,500 federally funded health centers that serve millions of low-income people face significant financial challenges, their leaders say, as the government shutdown compounds other cuts to their revenue.

Some of these community health centers may have to cut medical and administrative staff or reduce services. Some could eventually close. The result, their advocates warn, may be added pressure on already crowded hospital emergency rooms.

"This is the worst time in all the years I have been working in health care," said Jim Mangia, president and CEO of St. John's Community Health, a network of 28 clinics that serves more than 144,000 patients in Los Angeles, Riverside, and San Bernardino counties in California. "We are facing federal cuts and extreme state cuts that will impact services."

St. John's and other federally qualified health centers offer primary care and a wide range of other services free of charge or on a sliding fee scale. Nationwide, they see nearly 34 million patients in the country's most underserved areas.

The federal funds come through two primary routes, both of which face challenges: grants paid in part through the **federal Community Health Center Fund** and reimbursements for patients' care through programs like Medicaid, which provides health insurance for low-income people and people with disabilities. Medicaid is jointly funded by states and the federal government.... **Read more here**.

Will the Government Shutdown Affect the 2026 COLA?

Tens of millions of seniors may have to wait longer to find out how much their Social Security checks will rise next year.

The **Social Security Administration** (SSA) is expected to announce the 2026 cost-of-living adjustment (COLA) on Oct. 15, the same day the Bureau of Labor Statistics (BLS) planned to release September's inflation data. But with most BLS employees furloughed amid the government shutdown, economic reports — including the inflation update — could be delayed, **USA Today reported.**

The SSA cannot calculate the annual COLA without the **inflation report**, according to USA Today.

Although the COLA announcement may be delayed, Social Security payments will continue as usual, since its funding is not tied to **Congress' annual** budget process, according to USA Today.

"A government shutdown could potentially delay an announcement of the COLA, but remember, the data is for September and that has already been collected," Mary Johnson, an independent Social Security and Medicare policy analyst, told USA Today.

The only time a COLA announcement has been delayed was in October 2013, according to USA Today.

Last month, the Senior Citizens League (TSCL) estimated that the Social Security COLA would be 2.7% when it is unveiled in mid-October. That would raise the average monthly benefit for retired workers by $54 from $2,008 to $2,062.

Social Security's COLA is used to adjust the amounts paid to beneficiaries to account for inflation pushing prices higher. The COLA for 2025 was 2.5% and took effect at the start of the year.ddx

The Social Security Administration did not immediately respond to FOX Business' request for comment.

Will TrumpRx simply be a rebranded GoodRx?

Most Americans are aware of GoodRx, a service that delivers drug discounts at the pharmacy. Heather Landi reports for **FierceHealthcare** that GoodRx's value is increasing as it builds its reach in partnership with Kroger. Now, GoodRx hopes to power TrumpRx.

GoodRx stock was up 14 percent in a week. The company believes it will benefit from TrumpRx, possibly from a partnership with it. GoodRx already is set up to do what TrumpRx plans to do–offer prescription drug discounts at point of sale.

GoodRx gives people the ability to compare drug prices as well as to offer coupons to lower people's drug costs at the pharmacy. About 30 million people use GoodRx each year. The company does not see TrumpRx as a competitive threat but rather as an opportunity for even more business.

GoodRx believes that pharmaceutical companies will decide which pharmacies they want to use to provide drug discounts through TrumpRx. In order to do that, GoodRx is well poised to serve as the middleman. That's what GoodRx does today.

At the same time, GoodRx is helping the Trump administration understand that Americans do not want to rely on just a few pharmacy options. Americans want to be able to get their drugs at whatever pharmacy they please. GoodRx can make that happen with discounted prices.

Today, GoodRx works with more than 70,000 pharmacies across the US, including CVS, Costco, Walgreen's and Walmart. It also has a program through Kroger–RxSmartSaver–that offers discounts on brand-name drugs. The program is available in 35 states at 2,200 pharmacies.

GoodRx makes deals with pharmaceutical companies that bring down the cost of some high-priced drugs. For example, in partnership with Novo Nordisk, GoodRx offers Ozempic and Wegovy at $499 a month.

This all said, the prescription drug market is so complex and uncompetitive that sometimes you're better off using your insurance to buy your drugs and sometimes you spend less than you would on your copay if you buy the drug without insurance. Sometimes, **Costco mail-order might be the best deal**, sometimes it's **Mark Cuban's Cost-Plus Pharmacy**, and sometimes you're best off buying your drugs from a **verified pharmacy abroad**.

Of course, if the pharmaceutical companies did not have a stranglehold on our elected officials, the US would be negotiating prices for all drugs for everyone in the country, as every other wealthy nation does for their residents. Drug costs for all Americans would be at the same level as they are in France and the UK. Drugs don't work if people can't afford them.

Forcing people to go through multiple hoops in order to fill a prescription at lower cost is insane. It keeps people from getting the drugs they need, particularly the most vulnerable people.

Will Congress cut Medicare Advantage waste to end the government shutdown?

The Democrats want the government to invest money in health care to end the government shutdown. Eliminating Medicare Advantage waste, which totals more than **$1 trillion over the next decade**, would free up tens of billions of dollars a year for health care. A bipartisan bill, the No UPCODE Act, would end about 12.5 percent of that waste and could become law, reports Chris Dickerson for **Legal Newsline.**

Senators Bill Cassidy (Rep. Louisiana) and Jeff Merkley (Dem. Oregon) introduced the No UPCODE Act (No Unreasonable Payments, Coding or Diagnoses for the Elderly Act) earlier this year. It is designed to change the way insurers do health risk assessments. At the same time, it would make it harder for insurers to add additional codes to patients' medical records and, in the process, reduce their overpayments.

Estimates are that the No Upcode Act would end $124 billion in Medicare waste over ten years. It would keep insurers from claiming that their enrollees have greater health needs than they really do. That said, experts find that the government is overpaying the insurers in Medicare Advantage about $80 billion a year, so cutting $12.4 billion still leaves a lot of fat.

As a result of eliminating waste, the No Upcode Act also would reduce Medicare Part B and D premiums and strengthen the Medicare Trust Fund.

To be sure, insurers game the Medicare Advantage program in a multitude of ways. They leave markets that are unprofitable, as many are doing at the end of this year. They have their sales agents steer people to their most profitable plans, plans that might not serve their health care needs.

Insurers also don't compete to treat the people with Medicare who have the greatest health care needs. Have you ever seen an ad from an insurer saying they have the best cancer and stroke program. You never will. They don't want you if you have cancer or a failing heart. The more they can minimize the amount of costly care they provide to people with complex conditions, the more they profit.

Insurers establish PACs that appear to be grassroots-based in order to block needed reforms. Not surprisingly, one of their PACs misleadingly claims that the No UPCODE Act will raise costs and reduce benefits for older adults. The goal is to make anyone in Congress who supports the Act appear not to support people with Medicare.

4 Things To Do If Your Social Security Checks Aren't Big Enough

If you're not happy with the size of your **Social Security** check, you're not alone. A recent Senior Citizens League survey of 1,920 U.S. seniors (ages 62 and up) found that just 10% were satisfied with their benefits amount. Nearly 2 in 3 respondents (63%) reported feeling dissatisfied, while 27% had more neutral feelings about how much they receive each month.

In August 2025, the **Social Security Administration** reported that the average benefit amount for retirees was just over $2,000. The average check for those on survivor benefits was significantly lower at $1,575.

If your Social Security checks aren't enough, here are **a few ways to supplement them.**

Earning passive income doesn't need to be difficult. **You can start this week.**

Get a Side Gig or Part-Time Job

Every dollar counts when you're on a fixed income, but when the money you're receiving isn't enough to cover the bills, the best thing to do might also be the hardest — and that is to **pick up some extra work on the side.**

"A lot of people I know are picking up gig work like driving for Uber or Lyft, doing deliveries with DoorDash, walking dogs or pet sitting through apps like Rover," said Joseph Camberato, CEO of **National Business Capital.** "The nice thing is, you can do it on your schedule and stop whenever you need a break."

Other options include part-time consulting or picking up seasonal or holiday work. According to Indeed, the average seasonal associate earns $15.99 an hour in the U.S.

Suspend or Delay Benefits

If you're willing and able, **consider delaying benefits** for a few more years. This does mean working longer, but it can also give you a little more financial security down the line.

"Continuing to work and earn a higher income can potentially increase your benefits," said Hanna Grichanik, private wealth advisor at **Northwestern Mutual**. "The Social Security Administration recalculates your benefits periodically to account for any additional earnings, especially if those earnings are among your highest years."

The full retirement age is either 66 or 67, depending on your birth date. But if you voluntarily suspend Social Security, you'll earn delayed retirement credits. Wait until you're 70 to collect, and your paycheck will be at its highest possible amount.

Set Up Passive Income

Passive income can save you from having to work beyond what you already planned. Plus, it can supplement those lower-than-desired paychecks. Combine **passive income** with reducing expenses, and you might find yourself in a much better financial position.

"You can rent a room or basement apartment or consider renting your entire house while downsizing into something smaller," Camberato said.

For **renting out your home** or a room, you can use short-term vacation rental sites like Airbnb or Vrbo. If this doesn't sound appealing, you could always rent out a vehicle using Turo or personal items like equipment or tools with a site like RentMyTool or Fat Llama.

Other passive income ideas — like selling homemade goods on Etsy or getting into affiliate marketing — might take longer to set up, but the earnings potential could be worth your while.

Check Into Other Benefits

Continuing to work isn't for everyone, but have you looked into other benefits? You might qualify for things you didn't know existed.

"If you're facing financial difficulties, check if you qualify for Supplemental Security Income (SSI), which provides additional financial support to eligible individuals with limited income and resources," Grichanik said.

Currently, the maximum SSI payment is $967 per individual. It's $1,450 for couples.

You might also qualify for other benefits, like spousal or **survivor benefits**. Depending on how much you're getting now, these other options could mean a higher check.

"If you were married 10 years or longer and your ex-spouse is eligible to begin collecting, you are entitled to one-half of your ex's benefit," Grichanik said. "You must also not be currently married in order to receive a divorced spousal benefit."

Final Rule and New Special Enrollment Period Will Aid Those Misled by Provider Directories

Earlier this month, **we flagged important changes** coming to **Medicare Plan Finder (MPF)** for the upcoming **Fall Open Enrollment period**, including the addition of Medicare Advantage (MA) provider directories. Now we commend the Centers for Medicare & Medicaid Services (CMS) for recently announced steps to further integrate the directories and MPF. These improvements will do more to ensure the information is accurate and accessible.

Background on Directory and MPF Integration

In late 2024, the Biden-Harris administration proposed a rule requiring MA plans to submit directory information for incorporation into MPF. We **strongly supported this change in our comments**, as well as related guardrails, like requiring plans to attest to the accuracy of the directory information. The Trump administration initially declined to finalize these provisions.

First Set of Changes

In August, CMS **announced that it would update** MPF to allow beneficiaries to search by provider and see directory information on the site. Some plan types would be included automatically (with no submission necessary), while others would be permitted, but not required, to provide directory information. At that time, CMS made no mention of the attestation provision from the original proposed rule.

New Final Rule

In **our initial report**, we urged CMS to go further and require plans to do more to ensure the directories are accurate. We are pleased that CMS has now done so, in the newly **finalized MPF provisions in the proposed rule.** All MA plans will now be required to submit directory information to CMS in a format that can be integrated into MPF, to keep their directories up to date within 30 days of a known change, and to attest at least annually that their data are accurate.

All MA plans will now be required to submit directory information to CMS in a format that can be integrated into MPF.

Important New Special Enrollment Period (SEP)

To go along with these changes and the likelihood that people will rely on the directories in MPF to make crucial enrollment decisions, CMS has created a new temporary "**Special Election Period for Incorrect Medicare Plan Finder Medicare Advantage (MA) Provider Directory Information**." This SEP will offer relief for people who trust the MPF directory information to choose a plan but later discover that the directory was wrong.

This temporary SEP will be available to individuals who made MA enrollments with effective dates of 1/1/26 through 12/1/26.

To qualify for the SEP, individuals must

- Rely on MPF provider directory information,
- Enroll in an MA plan through MPF,
- Within 3 months of coverage starting, discover that their preferred provider was not actually in the MA plan's provider network, and
- Call 1-800-MEDICARE for help.

People using the SEP will be able to switch to a new MA plan or return to Original Medicare (adding a Part D plan if necessary)….**Read More**.

4 Social Security Loopholes Most People Miss

Social Security was originally created to help keep seniors from poverty. Today, many retirees rely heavily on it to supplement or even fully support their **retirement years**. As per the Social Security Administration (SSA), 90% of people ages 65 and up receive Social Security. Social Security also makes up 31% of these individuals' total monthly income.

Considering how vital Social Security is to many people's finances, you may want to take advantage of these built-in loopholes. Doing so could earn you thousands.

Earning passive income doesn't need to be difficult. **You can start this week.**

Voluntary Payment Suspension

You can generally start collecting benefits at age 62, but you might already be aware that waiting until you reach the **full retirement age** (FRA) — either 66 or 67, according to the SSA — means a higher benefit amount.

But did you know that waiting until you're 70 will get you the highest paycheck?

"**Claiming your benefit too early** can be pretty costly. Every year someone waits to claim beyond their full retirement age, there are an additional 8% in benefits," said Krisstin Petersmarck, investment advisor representative at **New Horizon Retirement Solutions.**

After reaching the FRA, you can voluntarily suspend your Social Security payment until you're 70. For every year you delay benefits, your monthly paycheck could increase by 8%, per the SSA. Payments automatically start the month you turn 70.

12-Month Do-Over Rule

Did you know that you can get a "do-over" if you start collecting benefits and later decide you want to stop?

"If you claim your Social Security benefits and then wish to 'undo' it, you can within the first year you claimed. However, if you do this, you'll have to pay back any money you received," Petersmarck said.

Why would you want to do this? It might be because you want a higher Social Security check. Or it might be because you thought you were retired for a few months, such as if you were laid off from work at age 62, but then find another job.

Whatever the case, you'll need to formally withdraw your application for Social Security using Form SSA 521.

Survivor Benefit and Ex-Spousal Benefit Loophole

Under the SSA, you could qualify for a survivor benefit if any of the following apply:

- You're 50 and have a disability
- You're 60
- You have a dependent under age 16 or who became disabled before they turned 22
- You're a widow or widower and remarry after turning 60

As a survivor, you could collect the survivor benefit while letting your primary benefit grow. This might be worthwhile if the survivor benefit is currently higher than your primary benefit.

Say you're a 65-year-old survivor and you're eligible for either a $2,000 survivor benefit or a $1,800 primary benefit. Claiming the survivor benefit means a higher paycheck now while your benefit continues to increase each year (up until you turn 70).

Once you turn 70, you could switch to your primary benefit. Given the potential 8% annual increase (from the FRA to 70), it may be substantially higher than the $2,000 survivor benefit. As a note, there's also an ex-spousal benefit you might be eligible for.

"If you were married for at least 10 years and have not remarried (or remarried after age 60 or older), you can claim benefits off of your ex-spouse," Petersmarck said.

This can be helpful if your ex-spouse's benefit amount is higher than your own.

Tax Loophole

The SSA uses a "combined income" formula to determine whether you must pay taxes on your benefits. Combined income includes your:

- Adjusted gross income (AGI)
- 50% of Social Security income
- Tax-free income from municipal bond interest

Your AGI includes any taxable income — like your **401(k) plan**, IRA, dividends, interest, **capital gains,** wages and other income (including self-employment). Some things that aren't taxable — like qualified Roth distributions — don't count in your AGI.

If you're someone who's going to have to pay taxes on your Social Security, you may want to contribute to a Roth account rather than a 401(k). With **a Roth**, you pay taxes upfront but let the money grow tax-free. With a 401(k), you pay taxes on withdrawals. Both options will affect the size of your Social Security benefit, but the Roth option could save you on taxes.

How retirees can stop fake debt collector scams

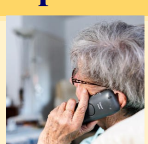
You pick up the phone and hear a stern voice claiming you owe money. Maybe it's for a credit card you don't recognize, a loan you never took out or some old bill you thought was long gone. Panic sets in, especially if the caller threatens arrest, wage garnishment or lawsuits.

Unfortunately, this scenario is becoming all too common. Scammers are posing as debt collectors, and retirees are among their favorite targets. Even legitimate debt collection companies have crossed the line. One such company was ordered to pay over $8 million for harassing people into **paying fake debts.**

The good news? With a little knowledge and some practical steps, you can spot these calls, protect yourself and stop them before they get too close for comfort.

Scammers don't call at random. Retirees often make ideal marks because:

- **Less frequent monitoring:** Many retirees check credit reports and bank accounts less often, making it easier for fraud to go unnoticed.
- **Accumulated assets:** Retirement savings, pensions and home equity make seniors look "cash-rich" to scammers.
- **Trust factor:** Politeness and trust on the phone can be exploited.
- **Less tech-savvy:** Some retirees feel less comfortable with online verification.



This combination creates a perfect storm for **fake debt collection scams.**

Recognizing the signs can stop scammers in their tracks.

- **Immediate threats or pressure:** Real collectors cannot threaten arrest or use abusive language under the Fair Debt Collection Practices Act (FDCPA).
- **Unusual payment methods:** Gift cards, wire transfers and cryptocurrency are red flags. Legitimate collectors use checks, debit or bank payments.
- **Refusal to verify debt:** If they won't send written proof, hang up.
- **Mismatch with public records:** Fake companies often use official-sounding names that don't exist.

Requests for unrelated personal information: Collectors don't need your Social Security number or bank logins

Even if a call raises red flags, it's essential to verify the information before taking action. Here's how:

Under the FDCPA, you have the right to ask for a debt validation letter. This document should include:

- The **creditor's name**
- **Original amount owed**
- **Verification** that the collector is legally authorized to collect the debt.….**Read More**

5 Ways the Trump Administration Is Changing Social Security in the Next 3 Years

Social Security is a lifeline for millions of retirees, and the rules around it are shifting again.

Under the Trump administration, changes in how people access services and prove eligibility are beginning to take shape. Some adjustments are already in effect, while others may be coming soon.

To **make the right money moves,** retirees will need to understand the new rules and prepare for extra hurdles when managing benefits. Here are the key changes you need to know about.

1. Requiring people to show up at offices in person for certain tasks©li/Adobe

The Social Security Administration (SSA) has been rolling back what can be handled remotely. Some tasks that were once possible by phone or mail may now require an in-person visit, such as applying for benefits or verifying your identity.

That can be inconvenient for retirees who live far from a field office, have mobility issues, or lack a sufficient means of transportation.

2. Stricter requirements regarding documentation©Downloads/Adobe

The SSA has increased its documentation standards, making it harder to complete applications or verify identity without original records. Photocopies or partial paperwork are often no longer accepted. Additionally, you now only have 10 to 15 days to submit the requested documentation or information, instead of weeks.

This means retirees should keep critical documents, such as birth certificates and marriage records, readily available. Having organized records can help avoid delays in processing benefits.

3. Reducing what can be done over the phone©panitan/Adobe

Telephone services have been scaled back, limiting how much retirees can resolve through a call center. Instead, the SSA is directing more people to either visit a local office or use the my Social Security website.

While the online portal may be a viable option for many, it can be challenging for those uncomfortable with technology. Retirees may need help from family members or trusted advisors to complete tasks digitally.

4. Reducing Social Security staffing©ngstock/Adobe

The SSA has announced plans to cut 7,000 staff positions, down to 50,000 positions from 57,000. There may also be closures of certain field offices as well. With fewer employees, field offices may face longer wait times, reduced hours, and slower processing.

Retirees could find it harder to get assistance with complex issues. Those who anticipate needing help should consider booking appointments as far in advance as possible.

5. No more paper benefit checks©Crystal/Adobe

Another shift is the end of paper Social Security checks. With the SSA looking to implement further cost-saving measures, on Sept. 30, 2025, all benefits began being distributed electronically through direct deposit or prepaid debit card.

While this change may increase security and reduce fraud, it may also create challenges for retirees who prefer paper checks or lack easy access to banking. If you haven't done so already, be sure to set up direct deposit in advance to ensure benefits arrive without disruption.

Steps you can take to navigate Social Security changes©Kenishirotie/Adobe

Retirees can take practical steps to stay ahead of these changes. First, set up and familiarize yourself with a my Social Security online account, which allows you to manage many tasks digitally.

Second, keep essential documents secure but easily accessible so you can respond quickly to requests for originals. Finally, stay proactive by scheduling appointments early, confirming benefit details, and considering professional guidance if rules become too complex.

Bottom line©pikselstock/Adobe

Social Security is shifting toward fewer staff and more digital services, which may complicate how retirees access benefits. At the same time, stricter documentation rules and the end of paper checks make preparation more important than ever.

By planning early and keeping good records, you can limit the stress these changes bring without negatively impacting your **retirement plan.**

Federal Government Shuts Down Over Health Care Subsidies

The federal government is currently in a **shutdown triggered by a lack of bipartisan agreement** on government funding and access to health care coverage.

Congressional Democrats have **pledged not to vote on a budget extension** and end the government shutdown unless Congress extends subsidies for **Affordable Care Act Marketplace plans**.

Fall Open Enrollment Creating Urgency

Many Republicans in Congress **argue that there is plenty of time** before the end of the year to extend the subsidies, if they should be extended at all. But Marketplace open **enrollment begins November 1**. This gives little time for Congress to clarify what subsidies will be available before people begin shopping for coverage. **People who shop for plans before the decisions are made** could leave without enrolling and it may be hard to reach them later once the prices are updated.

Spikes in Marketplace Plan Costs Expected Unless Congress Acts

Earlier this fall, KFF **outlined the dramatic increases** in premiums that are expected to result if the subsidies expire. They found that "expiration of the enhanced premium tax credits is estimated to more than double what subsidized enrollees currently pay annually for premiums—a 114% increase from an average of $888 in 2025 to $1,904 in 2026." This increase is even higher than previously estimated because of rising 2026 premiums and separate changes by the administration to the way tax credits are calculated.

"…expiration of the enhanced premium tax credits is estimated to more than double what subsidized enrollees currently pay annually for premiums…" *-KFF*

A family of four earning 75,000, for example, would pay $2,498 for coverage if the enhanced subsidy was extended but will pay $5,865—$3,367 dollars more—when they expire. KFF found that premium increases will impact enrollees across the income spectrum: "On average, a 60-year-old couple making $85,000 (or 402% FPL) would see yearly premium payments rise by over **$22,600** in 2026, after accounting for an annual premium increase of 18%. This would bring the cost of a benchmark plan to about a quarter of this couple's annual income, up from 8.5%. Meanwhile, a 45-year-old earning $20,000 (or 128% FPL) in a non-expansion state would see their premium payments for a benchmark plan rise from $0 to $420 per year, on average, from the loss of enhanced premium tax credits."

Other Contentious Health Care Issues

Some in the caucus have also called for the repeal of some of the Medicaid changes included in the **2025 budget reconciliation bill**, HR 1, passed earlier this year. These include cuts in Medicaid payment and changes to eligibility rules.

UnitedHealth's Medicare Advantage Cuts: What It Means for 2026

As 2026 approaches, **financial concerns** loom for many Americans, particularly those relying on **Medicare Advantage** for healthcare coverage. UnitedHealth, the largest healthcare provider in the U.S., has announced substantial cuts to its Medicare Advantage plans, affecting hundreds of thousands of beneficiaries. These changes are expected to increase personal expenses and reduce the scope of care, posing significant challenges for those dependent on these plans.

UnitedHealth's decision to cut back on Medicare Advantage plans stems from a need to balance rising medical costs with decreasing federal reimbursements. The company plans to withdraw from 109 counties, impacting approximately 180,000 members. This move is part of a broader strategy to maintain the sustainability of its offerings amid financial pressures, particularly in rural areas where healthcare access is already limited.

Currently covering over 10 million seniors, UnitedHealth will reduce its coverage from 2,896 counties in 2025 to 2,787 in 2026. This reduction primarily affects Preferred Provider Organization (PPO) plans, potentially forcing many members to switch to Health Maintenance Organization (HMO) plans, which offer more restricted and structured care options.

The funding for Medicare is projected to decrease by up to 20% compared to 2023, compelling UnitedHealth to make difficult adjustments to ensure the program's viability. Despite these cuts, the company remains a dominant player, continuing to offer Medicare Advantage plans in 48 states and the District of Columbia, adapting to an increasingly challenging regulatory and economic environment.

UnitedHealth attributes its decision to the increased utilization of medical services and reduced payments from the Centers for Medicare & Medicaid Services (CMS). The U.S. government has been progressively cutting funds for Medicare Advantage since 2024 to curb public spending, adding pressure to a program already strained by high medical costs and demand.

Bobby Hunter, UnitedHealth's director of government programs, stated,

“The combination of funding cuts, rising costs, and increased utilization has created obstacles that no organization can ignore.”

This highlights the complex challenges facing Medicare Advantage providers in the current healthcare landscape.

Despite these adjustments, UnitedHealth emphasizes its commitment to offering coverage to about 94% of eligible Medicare beneficiaries. The company assures that most members will still have access to $0 premium plans, particularly in HMO options, which include additional benefits like over-the-counter medication credits and comprehensive dental coverage. UnitedHealth is modernizing its offerings in response to rising healthcare costs, focusing on preserving essential benefits for its members. From $0 copays to quality care access, the company aims to help individuals live with confidence and well-being, even amid financial and regulatory challenges.

As the healthcare landscape evolves, beneficiaries must stay informed about changes to their Medicare Advantage plans. Understanding these adjustments and exploring available options will be crucial for managing healthcare needs and financial stability in the coming years.

States Already Cutting Medicaid, Massive Federal Cuts Yet to Come

The budget reconciliation bill, HR 1, **contained drastic cuts to states’ Medicaid funding and coverage**. While most of these cuts have not yet gone into effect, many states are already fearing **economic downturns or recession** spurred in part by rising costs and tariffs. In response, some of these states have **already started cutting Medicaid spending**, leading to access issues for people who get vital coverage from the program. In many areas, finding Medicaid providers can be difficult. **Medicaid’s payment rates are lower than Medicare’s** or other insurance and may **drive some providers away from treating patients with Medicaid coverage**.

Medicaid’s payment rates are lower… and may drive some providers away from treating patients with Medicaid coverage. This is the risk in North Carolina where the Medicaid program is cutting provider pay by a **minimum of 3%,** citing funding gaps. Similarly, Washington is **cutting hundreds of millions** from its Medicaid program, though state officials claim that the cuts will not reduce eligibility or coverage.

States Cannot Weather Economic Downturns Without Cutting Programs

Unlike the federal government, states are generally unable to weather economic downturns without cutting major programs. Medicaid is among the largest state expenditures. For example, in Nevada, **Medicaid accounts for 25% of the state’s budget.** And state spending on Medicaid has **grown in the past few years.**

While all states maintain **rainy day funds** that can help mitigate revenue losses in the short term, they are not enough to cover big, long-term gaps in funding.

Bigger Cuts on the Horizon

Not every state is cutting Medicaid yet, but they eventually will. Most of the provisions in the 2025 budget reconciliation bill—HR 1—**have yet to go into effect a**nd these cuts will have a devastating impact on state budgets. **KFF analysis** shows that HR 1 will cut federal Medicaid spending by $1 trillion over ten years. States might be able to pick up some of those costs, but not all.

States might be able to pick up some of the $1 trillion over ten years, but not all.

The effects will not be even across states. **Another KFF analysis** shows that expansion states with large numbers of rural residents will be hit the hardest. Medicaid covers 1 in 4 adults in rural areas, a higher share than in urban areas, and plays a large part in financing rural health care services.

States facing huge Medicaid shortfalls may be forced to cut **optional Medicaid services** or eligibility. Of particular concern are **the Home- and Community-Based Services (HCBS) that allow people to age in place safely.** These benefits **have been targeted in the past** when state budget pressures arose.

Administrative Costs Will Also Rise

Because HR 1 puts new administrative barriers like work reporting requirements in place, state costs will also rise. States will be paying millions of dollars to establish new processes for potential Medicaid enrollees to report their work or exemptions. These processes are extremely expensive to create and maintain; for example, Georgia’s recent implementation of such a requirement has spent **twice as much on administration—$54 million—as on providing actual Medicaid coverage** according to the watchdog **Government Accountability Office (GAO).**

Georgia’s recent implementation of such a requirement has spent twice as much on administration as on providing actual Medicaid coverage.

It Is Not Too Late to Change Course

Amidst the serious economic news, rising health care costs, and looming Medicaid cuts, we urge policymakers to shore up Medicaid programs nationwide, reverse the devastating cuts HR 1 has set in motion, and encourage rather than discourage providers to participate in the program.

How to Set Up Your Home for Aging in Place

Whether your loved one is planning to stay in their own home or move in with an adult child or other relative, these tips can help ensure everyone's safety, sanity and satisfaction.

To set up your home for aging in place, focus on safety, accessibility and independence by making modifications such as installing grab bars and ramps, improving lighting, clearing pathways of clutter and upgrading to lever handles and rocker switches.

Aging in place is the preferred way to get older for many adults.

In fact, numerous surveys and studies – including a **2022 study** in the Delaware Journal of Public Health – show that a majority of adults prefer to stay in their homes for as long as possible.

However, simply remaining in the home where you've always lived may not be feasible for all seniors. In some cases, stairs and other physical characteristics of the home can make it more difficult to move around and stay

in place long term.

Here are 12 things you can do to make your home safer and more comfortable for **aging in place**.

1. Start Planning Early for Aging in Place
2. Eliminate Fall Hazards to Create a Safer Home
3. Upgrade Lighting for Better Vision and Safety
4. Reduce Strain With Aging-Friendly Modifications
5. Improve Bathroom Accessibility
6. Make the Kitchen Safer
7. Widen Doorways for Mobility Devices
8. Add Ramps for Home Entry
9. Use Smart Home Technology to Support Aging in Place
10. Install a Home Monitoring System
11. Choose Adjustable Furniture for Senior Comfort
12. Control Moisture to Reduce Illness Risk to Seniors….Read More on these 12 and more.

Social Security benefits do not meet the needs of most older Americans with disabilities

.When the Social Security Act was passed in 1935, it came on the heels of the Great Depression. A large cohort of older Americans were struggling to cover the cost of even basic needs. But, even after Social Security benefits began to flow, for more than two decades, many older Americans continued to struggle financially, reports David Weaver for **Real Clear Markets**.

Back in 1959, with Social Security, **more than a third of older adults were living in poverty**. Social Security still offered limited benefits. Benefits were smaller than state-based programs designed to help older Americans back in 1950.

Then, over the course of ten years, the federal government expanded Social Security coverage and benefits. Now, fewer than 10 percent of older adults live in poverty.

So, is there a retirement crisis? Some economists on the right argue no. Other economists believe that there is a retirement crisis. Weaver argues that the retirement crisis for some older adults is related to disability.

People with disabilities lose their Social Security Disability Income (SSDI) when they turn 67, their full retirement age. They receive Social Security benefits based on their age, not their disability. The amount of their benefits does not change. About fifteen percent of older adults receiving Social Security benefits received Social Security benefits before they turned 67.

The cost of living is far higher for people with disabilities over 67 who receive Social Security benefits. As a result, they are more likely to live in poverty or near poverty. Nearly 60 percent of them are poor (17 percent) or near poor (40.4 percent). In stark contrast, just over 20 percent of everyone else receiving Social Security lives in poverty (5.7 percent) or near poverty (14.8 percent).

Nearly three in ten people with disabilities over 67 struggle to afford basic needs, including food, housing, electric and more. That's almost three times the proportion of other people receiving Social Security who struggle paying for basic needs (11 percent).

The contrast in wealth among people with disabilities over 67 and everyone else is exceptionally stark. People over 67 who did not have Social Security Disability Income have more than six times as much wealth ($236,000) as people who were receiving SSDI before turning 67 ($38,000). It is more than likely that people's disabilities earlier in life keep them from accumulating wealth.

Expanding Social Security is crucial to moving millions of older Americans out of poverty. People with disabilities over 67 are in particular need of expanded benefits. To end poverty among older Americans and people with disabilities, policymakers could also strengthen the Supplemental Security 10.3

***Dear Maeci**: What do supplemental benefits cover?*

Dear Marci,
I'm new to Medicare and trying to decide if I should get a plan with supplemental benefits. What do supplemental benefits cover?
– Caroline (Medford, OR)

Dear Caroline,

Supplemental benefits are just one factor to consider when choosing your Medicare plan. Though they are the focus of a lot of marketing, they usually should not be your primary consideration. Supplemental benefits, which provide coverage for services that aren't included in Original Medicare, can include:

- Dental care
- Vision care
- Hearing services
- Gym memberships or fitness programs

Dear Marci

Most supplemental benefits offered by Medicare Advantage Plans are available to everyone in the plan, and they must be primarily health-related. These benefits can either be:

- **Optional**, meaning that they are offered to everyone who is enrolled in a plan, and you can choose to buy the benefits for an additional premium, or
- **Mandatory**, meaning that they are covered for everyone enrolled in a plan and you can't decline the coverage. The plan premium (if any) includes the premium cost for these services.

Supplemental benefits for chronic conditions

Additionally, Medicare Advantage Plans can also cover supplemental benefits that are not primarily health-related for people who have chronic illnesses. These benefits are meant to address social determinants of health. A social determinant of health is part of your life that can affect your health in some way, such as not having access to transportation.

Plans can offer benefits such as:

- Meal delivery
- Transportation for non-medical needs

Air cleaners

In order to be eligible for these benefits, you must be chronically ill and meet any plan requirements for the specific benefit. Hope this answers your question!

-Marci

RI ARA HealthLink Wellness News

Please Note: All Articles In This Section Are For Information Only And Not Medical Advice

HealthLink Wellness "Taking Control"

Healthy Aging Month: Aging With Dignity Takes a Village

This Healthy Aging Month, we at Medicare Rights are highlighting the importance of comprehensive medical and community care to healthy and happy aging for older adults.

Preventive Care

Keeping up with **regular preventive care appointments** is one of the most important aspects of maintaining health and minimizing the risk of more dangerous illnesses down the line. For those regularly taking medication or living with a chronic condition, consistent preventive care is especially important to manage and maintain their health.

As with all stages of life, older adulthood can bring its own challenges, commonly prompted by physical, environmental, and behavioral changes. As a result, doctors often focus on **particular areas** in preventive care for older adults, including bone and dental health, memory and brain health, eye health, and hearing loss.

Mental health care is also essential to combat the toll of loneliness and bereavement**; nearly 15% of adults aged 50 and older** have a mental health disorder, and this number is expected to increase.

Older adulthood can bring its own challenges, commonly prompted by physical, environmental, and behavioral changes.

Medicare covers a wide range of physical and mental health preventive services, **many without cost sharing** for the patient if the provider is a **participating provider** (for Original Medicare) or an **in-network provider** (for Medicare Advantage). Preventive care recommended by the **U.S. Preventive Services Task Force** is free at the point of service for beneficiaries if they meet the relevant eligibility requirements and guidelines.

Services from providers who are out of network or do not participate in Medicare may not be completely covered, so it is important to check what your options are if you have recently changed providers or plans.

In some cases, a preventive care visit may lead to additional diagnostic care if a provider discovers something that needs further investigation. Costs and coverage for diagnostic care are determined by different rules, and Medicare may bill beneficiaries for **separate diagnostic services** that arise from a preventive care visit.

Aging on Your Own Terms

When surveyed, older adults consistently respond that they would prefer to live **independently in their communities** as they age, as opposed to living in institutions. Older adults enrich their communities and are supported by them in turn; they are valued friends and mentors whose age only strengthens their ties to the community. Robust community living services are therefore essential to helping people age on their own terms and to sustaining a society that embraces its older adults.

Robust community living services are essential to helping people age on their own terms and to sustaining a society that embraces its older adults.

Community living as a standard for healthy aging provides a **less expensive option** than institutional care for most older adults, and it makes **culturally competent care** more accessible by keeping the beneficiary integrated within their community. And it is also the law; the landmark **Olmstead case** established the rights of those with disabilities to receive care in community-integrated settings.

States across the country have created **"livable communities"** that meet the needs of older adults and make spaces safe and more accessible for the whole community.

The **AARP initiative** to create exercise facilities for older adults to promote brain health provides a successful example of providing concrete physical and mental health care while keeping older adults in their communities.

….**Read More**

Popular Painkiller Less Effective, More Risky Than Thought, Evidence Review Says

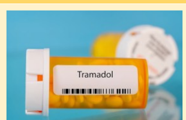
A widely prescribed opioid painkiller is not all it's cracked up to be, a new evidence review has concluded.

The opioid painkiller **tramadol** does little to reduce moderate to severe pain, according to results published Oct. 7 in the journal ***BMJ Evidence Based Medicine*.**

At the same time, tramadol increases a person's risk of serious side effects, including heart disease and pre-cancerous cells, researchers found.

The drug's use should be minimized, and guidelines that recommend it reconsidered, the research team concluded.

"The potential harms associated with tramadol use for pain management likely outweigh its limited benefits," wrote the research team led by **Jehad Ahmad Barakji** of the Center for Clinical Intervention Research at Rigshospitalet in Copenhagen, Denmark.



Tramadol is a dual-action opioid, researchers said in background notes. It works on the usual opioid receptors in the brain, much like morphine, but also acts like an antidepressant by inhibiting brain chemicals like serotonin and adrenaline.

Tramadol use has surged in recent years, and it's now among the most commonly prescribed opioids in the U.S., researchers said. It's seen as a safer, less addictive option than more powerful opioids like morphine, oxycontin or fentanyl.

For the review, researchers pooled data from 19 clinical trials involving more than 6,500 patients with chronic pain. Five studies looked at the use of tramadol on nerve pain; nine on osteoarthritis; four on low back pain; and one on fibromyalgia.

Results showed that tramadol's pain-relieving effects were minimal, falling below what would be considered clinically effective.

At the same time, tramadol users had double the risk of serious side effects compared to placebo groups, including heart-related events like chest pain, heart disease and heart failure. The risk also was driven by a higher proportion of pre-cancerous growths called neoplasms.

Other side effects included nausea, dizziness, constipation and sleepiness.

Researchers noted that these findings likely overestimate tramadol's beneficial effects and underestimate its harmful effects, based on how the studies were done.

The team also cited the risk of opioid addiction and overdose as a reason to turn away from the drug.

"Approximately 60 million individuals worldwide experience the addictive effects of opioids. In 2019, drug use was responsible for approximately 600,000 deaths, with nearly 80% of these fatalities associated with opioids and approximately 25% resulting from opioid overdose," the researchers wrote.

"In the United States, the number of opioid-related overdose deaths increased from 49,860 in 2019 to 81,806 in 2022," the team continued. "Given these trends and the present findings, the use of tramadol and other opioids should be minimized to the greatest extent possible."

Six Surgeons General Fire Editorial Grenade at RFK Jr.

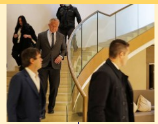
In a blistering opinion piece published Tuesday in ***The Washington Post***, six former U.S. surgeons general said Health and Human Services Secretary **Robert F. Kennedy Jr.** is putting the nation's health at risk.

"Never before have we issued a joint public warning like this," the six wrote. "But the profound, immediate and unprecedented threat that Kennedy's policies and positions pose to the nation's health cannot be ignored."

The piece is signed by doctors **Jerome Adams**, **Richard Carmona**, **Joycelyn Elders**, **Vivek Murthy**, **Antonia Novello** and **David Satcher**. The authors were appointed by every Republican and Democratic president since George H.W. Bush.

"Over recent months, we have watched with increasing alarm as the foundations of our nation's public health system have been undermined," they wrote, adding that morale in U.S. health agencies has plummeted and talent is fleeing because science and expertise have taken a backseat to ideology and misinformation.

At the same time, they warned that threats posed by resurgent infectious diseases and worsening chronic illnesses pose growing threats.



"Repairing this damage requires a leader who respects scientific integrity and transparency, listens to experts and can restore trust to the federal health apparatus," they wrote. "Instead, Kennedy has become a driving force behind this crisis."

They pointed to Kennedy's history of spreading discredited claims about vaccines and misrepresentation about the safety of mRNA technology and **COVID** vaccines, despite their lifesaving impact during the pandemic.

The commentary also noted that earlier this year, during the nation's worst measles outbreak in more than three decades, he directed agency resources toward unproven vitamin therapies and de-emphasized vaccination.

"Discrediting vaccines undermines one of the most important public health tools in American history," the former health chiefs wrote.

"Yet Kennedy continues to ignore science and the public's wishes," they added, noting he most recently proposed new warning labels on products containing acetaminophen. In so doing, Kennedy cited a discredited link between its use during pregnancy and autism, they said.

"Rather than combating the rapid spread of health misinformation with facts and clarity, Kennedy is amplifying it," the commentary said. "The consequences aren't abstract. They are measured in lives lost, disease outbreaks and an erosion of public trust that will take years to rebuild."

The former surgeon generals pointed to the exodus — both forced and voluntary — of hundreds of public health professionals, who describe "a culture of intimidation, where scientific findings are censored, evidence is disregarded and career officials are pressured to rubber stamp conclusions that are not backed by science."

They urged Americans to consider what is at risk:

The National Institutes of Health (NIH) pursues groundbreaking research. The U.S. Centers for Disease Control and Prevention (CDC) leads in emergencies, and the U.S. Food and Drug Administration (FDA) holds Big Pharma to account and approves lifesaving drugs. HHS agencies work to address issues with substance use disorders, mental health and primary care shortages, as well health coverage for millions of disabled individuals, seniors and low-income Americans, they wrote.

"Secretary Kennedy is entitled to his views," the former chiefs wrote. "But he is not entitled to put people's health at risk. He has rejected science, misled the public and compromised the health of Americans. The nation deserves a health and human services secretary who is committed to scientific integrity and can restore morale and trust in our public health agencies."

Early reaction on *The Post*'s website to the commentary was generally supportive.

"Thank you to the six Surgeons General for speaking out," wrote reader Ken Olsh, who identified himself as a physician.

"Pretty powerful stuff," wrote another reader, identified as TheLast Moderate.

Added another, using the handle Franklyspeaking: "I agree completely with this letters. Like others I ask what can we do about this nightmare of 'leadership'. He's got to go. How can we make it happen?"

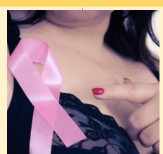
Rare, Dangerous Type Of Breast Cancer On The Rise In The U.S.

. in a A rare but dangerous form of **breast cancer** is on the rise in the United States, a new report says.

Lobular breast cancer rates are rising three times as fast as all other breast cancers combined, 2.8% per year versus 0.8% per year, researchers reported Oct. 7 in the journal ***Cancer***.

"Although lobular breast cancer accounts for a little over 10% of all breast cancers, the sheer number of new diagnoses each year makes this disease important to understand," said lead researcher **Angela Giaquinto**, an associate scientist for cancer surveillance research at the American Cancer Society (ACS).

"Also, survival rates beyond seven years are significantly lower for (lobular breast cancer) than the most common type of breast cancer, highlighting the pressing need for prevention and early detection strategies targeting this subtype to be brought to the forefront," Giaquinto added in a news release.



Lobular breast cancer develops in the milk-producing glands of the breast, which are called lobules, researchers said in background notes.

This form of breast cancer is typically lumped in with the most common subtype, ductal carcinoma — cancer that develops in the milk ducts, researchers said.

However, it appears and grows in ways different from other breast cancers, researchers said.

For example, lobular cancers grow in a dispersed pattern instead of forming a lump typical of other breast cancers, potentially delaying diagnosis.

For the new report, researchers analyzed data from cancer surveillance programs and registries to track lobular breast cancers in the U.S. The researchers found that the steepest rise in lobular breast cancer cases is among Asian American/ Pacific Islander women, with an increase of 4.4% per year.

White women have the highest case rate of lobular breast cancer, nearly 15 cases per 100,000 women, compared to 11 per 100,000 among Black women.

Compared to ductal cancer, lobular cancer has a slightly higher survival rate in the first seven years after diagnosis, as well as for cancers detected before they've spread, researchers said.

However, the 10-year survival rate is lower for women whose lobular breast cancer has spread to the lymph nodes or surrounding organs (78% versus 76%), or if their cancer has spread to farther parts of the body (20% versus 12%), results showed.

"Invasive lobular breast cancer is very understudied, probably because of a very good short-term prognosis. But at 10 years, these women with metastatic disease are half as likely to be alive as their counterparts with ductal cancer, probably because of the unique spread and resistance to therapy," said senior researcher Rebecca Siegel, senior scientific director for cancer surveillance research at the ACS.

"Our study underscores the need for much more information on lobular cancers across the board, from genetic studies to clinical trial data, so we can improve outcomes for the increasing number of women affected with this cancer," Siegel concludednews release.

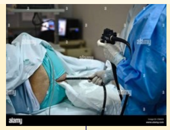
Rectal Bleeding Strongest Predictor of Colon Cancer Under 50

A new study finds patients under 50 who experience rectal bleeding are 8.5 times more likely to be diagnosed with colorectal cancer

Rectal bleeding may be one of the strongest warning signs of colon cancer in younger adults.

Researchers are urging people in their 30s and 40s to take the often overlooked symptom more seriously.

In a **new study**, they reviewed recent colonoscopy records from more than 400 patients under the age of 50. Those who had rectal bleeding were **8.5 times more likely** to be diagnosed with colorectal cancer, according to the results.



Other key findings: 70% of those diagnosed had **no family history** of the disease— and **nearly 90%** only got a colonoscopy because of symptoms, not routine screening.

The senior author says these findings reveal a care gap for younger adults— too young for routine screening yet facing rising colon cancer rates.

Her advice to clinicians: ***"If a person below the screening age comes in with rectal bleeding, you should seriously consider a colonoscopy."***

The study also found that lifestyle factors like smoking may raise risk, while genetics played a smaller role than expected.

Experts Warn The IV Hydration Craze May Be Putting You at Risk

IV hydration spas are popping up across the United States, offering pricey vitamin infusions that promise energy, detox or immune support, but experts warn the science doesn't back up those claims.

A study published Oct. 6 in ***JAMA Internal Medicine*** found that the IV hydration industry operates with almost no regulation and little medical evidence to support its supposed health benefits.

These businesses are operating "almost completely without evidence," study co-author **Dr. Peter Lurie**, president of the Center for Science in the Public Interest, told *NBC News*. "As a result, there's a real danger to consumers."

Hydration clinics and medical spas offering IV vitamin drips, cosmetic treatments and skin procedures have exploded into a $15 billion wellness industry, according to the **American Med Spa Association.**

Despite their popularity, "this is a medical system that exists largely outside of conventional medicine," Lurie said.

There are no federal regulations or national safety standards for their operation.

Of 50 states, only 32 have any kind of rule or policy related to IV hydration services. And just four — Alabama, North Carolina, South Carolina and Vermont — have what researchers called "comprehensive oversight."

"This is a medical system that exists largely outside of conventional medicine," Lurie told *NBC News*.

"We're worried that people will spend their money on these without reason to expect benefits," he said. "We're also worried that there will be adverse effects related to this."

That risk includes infection, allergic reactions and contamination, especially when IVs are given by untrained providers.

Alex Thiersch, CEO of the American Med Spa Association, said many owners of these businesses may not realize they're practicing medicine.

"We have had folks who are surprised by that," Thiersch said. "They thought, 'I'm just doing an IV. It's different. It's vitamins.' If you're putting a needle in someone's vein, that's 100% medical practice."

The study included an analysis of 255 clinic websites and a "secret shopper" investigation involving 87 randomly selected spas.

More than half the websites advertised IV treatments with vague health claims such using as magnesium for headaches or glutathione to "boost immunity," *NBC News* reported.

Only two sites cited scientific sources for their claims, and none mentioned risks like infection or allergic reaction.

When researchers posed as customers, more than 85% of clinics recommended specific IV cocktails for symptoms like fatigue or colds often without asking about medical history.

Only 1 in 4 clinics required a medical consultation beforehand and fewer than 25% warned about possible side effects.

The U.S. Food and Drug Administration (FDA) has previously issued warnings about med spa injections marketed to dissolve fat, citing cases of infection and scarring linked to unapproved shots.

Does Medicare Cover Foot Care?

.Navigating Medicare coverage for podiatry can be complex. Learn when Medicare Part B covers medically necessary foot care, exceptions for chronic conditions like diabetes and how Medicare Advantage plans might offer additional benefits for podiatry services.

Our feet are the unsung heroes of everyday activities. **Painful or injured feet** can limit your ability to walk, run or even stand, affecting your independence and hampering daily life. As we get older, we need to take steps to take better care of our feet.

"Many pre-existing conditions – such as flat feet, bunions and hammertoe deformities – can worsen with age," says says Dr. Jacqueline Prevete, a podiatrist at New York-Presbyterian Hospital in New York. That's why, "when being evaluated for these deformities, it's better to address them sooner rather than later."

Incorporating **regular foot care** into your routine can help ensure your feet remain healthy, functional and free from pain, contributing to your overall well-being and quality of life.

What Foot Care Does Medicare Cover?

Medicare covers podiatry services for medically necessary treatments of foot injuries, diseases or systemic conditions. These podiatry services are covered under Medicare Part B.

A doctor must deem the treatment **medically necessary**. The most common conditions that Medicare Part B covers include:

- Foot injuries, such as fra
- ctures, sprains, etc.
- Limb-threatening ulcers
- Ingrown toenail surgery
- Reconstructive surgery, such as bunion and hammertoe correction
- Wound and foot ulcers
- **Plantar fasciitis**
- Heel spurs

However, Medicare does not typically cover routine foot care. This includes:

- Cutting or removing calluses and corns
- Hygienic maintenance, such as cleaning and soaking the feet
- Trimming, cutting or clipping nails

If you receive foot care while you're admitted to the hospital, it will be covered under Part A. As with Part B coverage, the foot care in the hospital must be considered medically necessary to be covered.

Exceptions are made if the patient has certain chronic conditions, such as **diabetes**, that require these foot care services to prevent complications or worsening of symptoms. ...**Read More**