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## October 19, 2025 E-Newsletter

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## Friday Alert For October 17th Wasn't Available At The Time Of Publishing This E-Newsletter

### Big Changes Hit Medicare Open Enrollment

Medicare's annual enrollment period is in full swing despite the federal government shutdown.

Nearly 70 million Americans who are enrolled in the federal health insurance program because of their age or qualifying disability can now make changes to their health insurance plans through Dec. 7.

This enrollment season in particular, experts are urging enrollees to pay careful attention to their health benefits due to several policy changes from both private insurers and the federal government.

"It's really important for people to take a close look at the options available in their area," says Gretchen Jacobson, vice president of Medicare policy at the nonprofit Commonwealth Fund, "Especially this year."

According to the nonprofit health research organization KFF, about 70% of Medicare enrollees don't compare their coverage options during open enrollment, although the group strongly encourages folks to do so.

"Medicare Advantage and Medicare prescription drug plans typically change from one year to the next and may vary in many ways," KFF researchers wrote in a brief released **Thursday**.

On top of that, next year's premiums for traditional Medicare and prescription coverage are jumping higher than normal, and several major private insurers are paring down their Medicare Advantage Plans, a shift that is estimated to change coverage for at least 1 million Americans.

**Medicare open enrollment: changes for 2026**

During this enrollment period, Medicare enrollees in Part A (for hospital insurance) and Part B (for medical insurance) can switch to private insurance plans that meet Medicare standards — known as Part C or Medicare Advantage Plans. They can also add or change their prescription drug benefits through Part D.

Likewise, people who are already enrolled in a Medicare Advantage Plan can switch back to traditional Medicare, or choose from dozens of other private Medicare Advantage Plans. Any changes will go into effect Jan. 1.

Traditional Medicare enrollees may want to brace for sticker shock. Premiums for Part B insurance are expected to jump by nearly 12% to $206.50, according to the **Centers for Medicare & Medicaid Services**, or CMS. Premiums for Part D may also rise.

The limit on out-of-pocket expenses on prescription drugs through Part D is rising to $2,100 next year, up from $2,000 currently. Jacobson notes that folks will have fewer Part D plans to choose from this year, across the board.

"We're seeing in every state that there are fewer standalone prescription drug plans available this year than last year," she says, "and it's been fewer plans every year for the past several years."

In general, folks who make no selections during open enrollment will be re-enrolled in their current plans.

However, that won't be the case for a portion of people enrolled in Medicare Advantage Plans through Aetna, Humana and UnitedHealth.

**Private insurers pull back on Medicare**

Combined, those three largest private providers are reducing Medicare Advantage coverage in hundreds of counties and several states across the U.S.

An **estimated 1.2 million Americans** enrolled in Medicare Advantage plans may lose their current coverage as a result, according to Healthpilot, a Medicare plan marketplace. Insurance companies say that the retrenchment is due to a combination of funding cuts from the federal government, health care inflation and other financial constraints.

Those who are affected by the changes should have received an Annual Notice of Change in the mail by Sept. 30.

It's not all bad news, though, according to Jacobson.

"There's potentially a silver lining there," she says, noting that people who lose their Medicare Advantage coverage have a unique opportunity to obtain Medigap coverage.

Medigap plans are available to those who are enrolled in traditional Medicare, and the plan works to supplement what isn't covered by the government program. Usually, there are limited enrollment windows and medical underwriting restrictions that vary by state, making it confusing for enrollees to get Medigap coverage. However, federal rules relax those requirements when people get kicked off their private plans.

**Where to get help choosing Medicare coverage**

Amid a flurry of changes this year, experts say it's important to lean on the free assistance programs to make sense of it all.

One prime example: State Health Insurance Assistance Programs, or SHIPs. They are available nationwide and offer free advice for enrollees.

"Federally funded advisors are available in every state to provide one-on-one help," Jacobson says.

Medicare.gov also offers a user-friendly **coverage comparison tool**, and the 1-800-Medicare hotline is available to offer advice and troubleshooting assistance as well.

Jacobson notes that Medicare.gov was updated before the government shutdown, and the hotline and SHIPs have funding to continue operations.

"Those resources should not be affected by the shutdown," she says.

### After Weeks of 'Final' Deadlines, the Government Is Now Quietly Walking Back Its Plan to End All Social Security Paper Checks

The Government Has Some Bad News for Everyone Born in 1959 – Your Full Retirement Age Has Just Increased, and Here's What It Means for Your Checks

A Select Group of Americans Can Now Officially Cut the Line for Social Security Benefits – The Government Has Just Released the Official List of Who Qualifies

After weeks of final deadlines, the government is now quietly walking back its plan to end all Social Security paper checks, just days after the official deadline passed. The softening of its stance on eliminating paper checks follows growing concern that thousands of seniors and disabled individuals could be left struggling to access their monthly checks.

A Push Toward Digital Payments

As of September 30, 2025, the Social Security Administration (SSA) officially stopped issuing physical paper checks for most retirees. This move marked the end of an era for mailed payments that began in 1940, when the first Social Security paper check was sent to the first recipient, **Ida May Fuller**…..**Read More**

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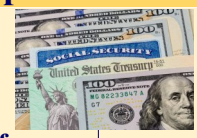
# Social Security announces 2026 COLA update as recipients wonder how much checks will rise

Social Security recipients have been patiently awaiting the cost-of-living-adjustment (COLA) announcement to know how much their checks will rise next year. The COLA is announced every year in October, which details what the **increase in monthly benefits** will be that reflects the change in inflation. The 75 million Americans who collect **Social Security** were expecting the announcement to come on Wednesday, but the news was **delayed due to the government shutdown.**

The adjustments are determined based on the Bureau of Labor Statistics (BLS) inflation report, but all of the bureau's 2,055 employees were furloughed except one. The government shutdown has hit day 13, and there could be more layoffs on the horizon. It comes after **Social Security officials warn of new scam that could cost seniors thousands of dollars.**



A Social Security Administration (SSA) spokesperson, however, has finally confirmed when the COLA news will come.

**When will the 2026 COLA be announced?**

The 2026 COLA announcements will be made on Oct. 24.

A spokesperson told **Newsweek**: "The Bureau of Labor Statistics (BLS) has announced they will issue the September 2025 Consumer Price Index (CPI) on October 24. The Social Security Administration will use this release to generate and announce the 2026 cost-of-living adjustment on October 24 as well.

"Social Security and Supplemental Security Income (SSI) benefits for 75 million Americans will be adjusted per the 2026 COLA, beginning January 1, 2026, without any delay due to the current government lapse in appropriation."

**What will the COLA be?**

The latest estimate based on August inflation data was 2.8%, which would represent about a $52 increase in the average benefits.

In 2022, the COLA was set at 5.9 percent, and in 2023, seniors experienced an 8.7 percent increase in the COLA due to widespread inflation.

**Has the COLA ever been delayed before?**

The COLA was only ever delayed once before, and it was in 2013 during a government shutdown. That time, the government was closed for 16 days over a similar funding issue related to the Affordable Care Act.

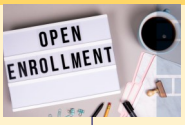
This year, the shutdown is related to enhanced subsidies for the Affordable Care Act.

It comes after it was revealed **how the government shutdown could affect October Social Security payments.**

# How to Make the Most of Medicare Open Enrollment

In order to ensure you are getting the best health and drug coverage for the upcoming year, you should **review your current Medicare health and drug coverage** and compare it with the available options. If you currently have Original Medicare, consult the ***Medicare & You* 2026** handbook for your coverage and costs for next year. If you currently have a Medicare Advantage or Part D plan, you should receive an Annual Notice of Change and/or Evidence of Coverage document outlining coverage and costs, including any changes for next year. Everyone is different, so keep in mind your individual health needs when comparing plans, such as the providers and specialists you frequently see and the costliest prescription drugs for you. Even if you are satisfied with your current coverage, it is a good idea to check if there are options in your area that are more affordable, have fewer coverage restrictions, or are otherwise better suited to your needs.

The best way to enroll in a new plan is via the **Medicare Plan Finder** website or by calling 1-800-MEDICARE (1-800-633-4227). Plan Finder can help you compare Medicare Advantage and prescription drug costs across plans in your area, taking into consideration the drugs you take and the pharmacies you use. To confirm plan information you read online, call the plan directly and always write down everything about the conversation, including the date, name of the representative you spoke to, and any outcomes. Enrolling directly through these official Medicare platforms can protect you in case you receive incorrect information from Medicare sources or run into problems with your plan. In 2026, to account for changing plan information on Plan Finder, people who enroll directly through the online platform will be given a Special Enrollment Period if they have been given incorrect network information by Plan Finder.




**Other Enrollment Periods**

Open Enrollment is the Medicare enrollment period that covers the most expansive range of beneficiaries and plans, as you can make any number of changes to Original Medicare, Medicare Advantage, or Part D coverage. But there are also other enrollment periods that may be important for you to know about.

The **Medicare Advantage Open Enrollment Period** begins on January 1 and ends on March 31. If you choose a Medicare Advantage Plan during Open Enrollment and are dissatisfied with it when it goes into effect, you have the option to switch Medicare Advantage plans or switch to Original Medicare. However, if you entered the year with Original Medicare, you will not be able to use the Medicare Advantage Open Enrollment Period. If you received notice that your **Medicare Advantage Plan is terminating at the end of the year,** you will have an additional Special Enrollment Period from December 8, 2025, to February 28, 2026. Any changes you make will go into effect on the first of the following month, so you should aim to make important health and drug coverage changes by December 31 so that you are not subject to a gap in coverage once your current coverage ends.

**How We Can Help**

At the Medicare Rights Center, our helpline (**800-333-4114**) is ready to help you navigate Open Enrollment. Our expert counselors can walk you through plan comparisons with a Plan Finder appointment, explain new and changing benefits, and help you troubleshoot enrollment problems as they arise. Last year, we completed over 200 Plan Finders with beneficiaries across the country, helping callers find the best, most affordable Medicare Advantage and Part D plans according to their personalized coverage and prescription drug needs.

Among these Plan Finder callers in 2024 was Mark P., who was unsure whether he should change his prescription drug coverage during Open Enrollment. He, like many people just getting started with plan comparisons, had found the process "confusing and daunting." When he called the Medicare Rights Center for a Plan Finder appointment, one of our counselors thoroughly reviewed his specific prescriptions and helped him evaluate in detail several plans' coverage, cost, and reviews. "She gave me all the time I needed to understand the information and took my call back a few days later to answer additional concerns," Mark said. "She made it clear and gave me confidence about making a decision.

**Medicare Interactive,** our online educational platform, also houses an Open Enrollment toolkit filled with detailed resources. **Your Guide to Medicare Open Enrollment**, written by Medicare Rights experts, can help you understand your options and feel confident about making enrollment decisions. This resource explains key upcoming changes to Medicare, includes expert advice from our counselors, and helps you avoid confusing or misleading marketing. Log in or register for free at Medicare Interactive to access the guide and numerous other downloadable and interactive educational resources. You can also follow us on **Facebook**, **Bluesky**, and **YouTube** to keep up with Open Enrollment news and see tips and reminders from our team during this key period.

## Prescription drug costs are skyrocketing. Will Medicare Part D bring relief?

**Prescription drug costs are skyrocketing. Will Medicare Part D bring relief?**

The law of supply and demand dictates that when competition is scarce, prices will inevitably skyrocket. In the health care realm, this often means that patients facing high drug costs are often forced to forgo care, a decision that can lead to health complications. For Medicare beneficiaries in particular, soaring specialty drug prices and seemingly outrageous out-of-pocket expenses have created a tension point in U.S. health policy.

Back in 2022, though, the introduction of the **Inflation Reduction Act** offered a partial remedy that began at the start of 2025: Medicare Part D. This limited out-of-pocket spending to $2,000 for covered prescription drug use that fell under Part D.

However, patients still remain vulnerable amidst rising alternative costs for drugs not under Part D and a host of other factors. **CheapInsurance.com** p ulled together the data from accredited sources ranging from the National Library of Medicine, CMS Newsroom, the Pan Foundation, and more to do a deep dive into Medicare Part D.

**The $2,000 out-of-pocket cap: Immediate relief for millions**

As outlined by **the U.S. Department of Health and Human Services**, an estimated 11 million individuals enrolled in Part D were impacted by the spending cap at the start of the year. These enrollees are currently estimated to see an average out-of-pocket savings of $600 per person, with that value being even higher (about $1,100) for those who don't receive financial assistance. The impact of this cap covers three primary areas….**Read More**

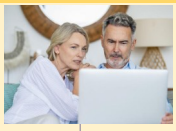
## What to Do About These Three Medicare Changes During Open Enrollment

When the **Medicare open-enrollment season for 2026** starts on October 15, brace yourself for some big, and potentially costly, changes.

Premium hikes for both medical and drug coverage, shrinking benefits on some private insurers' **Medicare Advantage** plans and a few rule changes mean it will be especially wise to research your choices to protect your health and save money.

Yet, nearly seven out of 10 Medicare beneficiaries don't compare plan options, according to a study last year by health policy and research firm **KFF.** That can be an expensive error — even if you're satisfied with your current coverage.

"Medicare Advantage and Part D plans often change from one year to the next, so people may see changes to their premiums, cost-sharing, coverage of their medications, and their health provider or pharmacy networks," says Alex Cotrill, a senior policy analyst at KFF.



As always, during open enrollment this year you'll be able to sign up for either government-run original Medicare or a Medicare Advantage (Part C) plan from a private insurer; switch from original Medicare to Medicare Advantage or vice versa; replace your Medicare Advantage plan with a different one; and choose or change a Part D prescription-drug plan.

Here's a rundown of the key changes and tips to pick the best coverage for your needs.

**New restrictions on Medicare coverage**

Experts expect many Medicare Advantage plans to trim benefits, hike costs or both for 2026, due to the financial squeeze insurers are facing. In addition, some insurers — including UnitedHealthcare, the largest provider — will not offer all the plans they did in 2025.

"These companies are trying to find their way to profitability," says David Lipschutz, co-director of the **Center for Medicare Advocacy**.

The biggest news for original Medicare is that some beneficiaries will now need to get **prior authorization to** receive certain treatments. This rule applies to residents in Arizona, New Jersey, Ohio, Oklahoma, Texas and Washington and is limited to 17 medical needs, including pain management and help for urinary incontinence.

The basic choice between the two types of coverage, though, remains the same. Although original Medicare is usually more expensive than Advantage (due to the need to supplement coverage with a Part D prescription-drug plan and a **medigap policy)**, it lets you go to any doctor or hospital that takes Medicare.

By contrast, Medicare Advantage plans typically have restrictive physician and hospital networks and require prior authorization to see a specialist. Many, however, offer benefits original Medicare doesn't (such as dental, vision and hearing coverage) and typically include Part D coverage…..**Read More**

## US health agency releases 2026 quality ratings for Medicare plans

(Reuters) -The U.S. government announced quality ratings for 2026 Medicare health and prescription drug plans on Thursday, which help determine bonus payments from the government to health insurers.

CVS Health's Aetna unit has more than 81% of members in top-rated programs. UnitedHealth has 78%, Elevance 55% and Humana about 20%, figures from the regulator and companies showed.

Overall, 64% of people currently enrolled in Medicare Advantage plans that cover prescription drugs are covered by plans rated four or five stars, according to a research note from Oppenheimer.

The U.S. Centers for Medicare & Medicaid Services, which is part of the HHS, issues star ratings for the plans from one to five — with five being the highest performing — to help beneficiaries choose among them.

The agency evaluates different factors to rate the plans, including customer satisfaction, access to care and performance on cancer screenings and management of chronic conditions, among others.

Plans with higher star ratings mean bigger payments from the government to the insurer, and the bonus payments can be worth hundreds of millions or billions of dollars. The ratings will impact insurers' revenues in 2027.

"Overall, the results were not very surprising given the various company pre-announcements over recent weeks," said Oppenheimer analyst Michael Wiederhorn.

CVS Health added that its Aetna business also has over 63% of Aetna Medicare Advantage members in a 4.5-star plan for next year.

Humana and UnitedHealth's star ratings were in line with the companies' earlier announcements, analysts said.

UnitedHealth said that it has 78% of its members in 4-star plans or higher and 40% are in 4.5-star plans for 2026.

Humana said last week that it has about 20%, or 1.2 million, of its members in high-rated plans.

levance said it now has 55% of membership in plans rated 4 stars and higher, up from 40% a year ago. Elevance was among the largest gainers in quality ratings, analysts said.

# All the Rules for Social Security in 2025

The Government Has Officially Rewritten All the Rules for Social Security in 2025 – Here's the Full Guide to the Dozens of New Changes That Affect Your Check

2025 has been a roller coaster for Social Security. The year began with the Social Security Fairness Act being signed into law and effectively restoring the full benefits to millions of public sector workers. Following the Trump Administration's election to office, the Department of Government Efficiency (DOGE) had been deployed at the Social Security Administration (SSA) to enact cutbacsk — and spark persistent criticism from former SSA officials, lawmakers, and advocates.

Currently, there are well over 70 million beneficiaries in the Social Security program, however, these tens of millions of vulnerable individuals may soon be hit with hefty cuts to their benefits due to the projected and accelerating shortfall of a major trust fund, as per the annual report from the Social Security Board of Trustees. Lawmakers are being urged to make some sort of sustainable change to the program in the present to prevent the projected insolvency.

While major sustainable change is required to maintain the financial health of the program in the long-run, an array of changes have already been occurring throughout the course of this year. Here is a breakdown.

Social Security under the Trump Administration

The One Big Beautiful Bill Act

One of the most notable of changes affecting Social Security in 2025 would be the One Big Beautiful Bill Act. Under the OBBBA, seniors aged 65 or older will qualify for an additional tax deduction of $6,000 for single filers, and $12,000 for couples, provided their income does not exceed a $75,000 threshold for single files, and $150,000 for joint filers.

This tax relief will only be in place for a temporary period starting in 2025 and ending in 2028. Due to the changes in income threshold, this tax deduction will result in the majority of seniors being exempt from paying taxes on the benefits, and as a result, the White House had been framing this tax relief as the elimination of tax on Social Security for almost all seniors. It is, however, important to note that tax on benefits has not been eliminated.

No paper checks

A March executive order has stipulated that the use of paper based payments will be phased out of the broader federal government as of September 30th, and this includes federal agencies such as the SSA. The SSA has, however, shared confirmation that **paper checks** will still be disbursed to those who require it. Even before the executive order, more than 99% of beneficiaries had already been receiving their benefits electronically. As such, the remaining >1% of paper check recipients are encouraged to switch over to either a Direct Deposit or a Direct Express Card.

Overpayments

As of July 24th, the SSA has started to withhold 50% of the check of a beneficiary with an overpayment balance. Notices informing beneficiaries of the withholding rate were sent out on April 24th. Recipients then had 90 days to take action against the notice by either filing an appeal, applying for a waiver of repayment, or negotiating a lower rate of withholding.

Low staffing and office closures

In February, the SSA announced its plans to reduce staff from 57,000 employees to around 50,000, with several field offices also slated for closure. While the SSA has affirmed that the closures of these offices are not permanent, the agency is still currently running with its lowest staff count on record in decades. SSA Commissioner Frank Bisignano previously shared that he hopes to make the SSA a "digital first organization" and has been updating the technology and systems at the agency to ensure customer service is not interrupted.

Identity verification

In August, the SSA was meant to implement an anti-fraud measure that would remove the option of verifying one's identity over the phone. Instead, callers would be required to provide a one-time pin from their online account when trying to conduct routine tasks over the phone. This change sparked backlash from advocates and lawmakers and the agency subsequently reversed these plans stating the OTP verification was optional.

OLA announcement delay

The Cost of Living Adjustment announcement which is usually made during October will be delayed this year due to the ongoing government shutdown. The COLA is an increase implemented to benefits on a yearly basis in order to counter the effects of inflation. The COLA is calculated using data released by the Bureau of Labor Statistics, however, due to the current shutdown, the BLS has ceased operations. As such, the COLA announcement will be delayed indefinitely.

# Health Care Consolidation Continues to Raise Concerns

A **recent literature review** from a government watchdog shows that physician consolidation is on the rise. The nonpartisan Government Accountability Office (GAO) found that patterns like practices being acquired by other entities are increasing, leading to fewer doctors working in independent or private practices.

To conduct this analysis, which was requested by Congress, GAO examined peer-reviewed studies from January 2021 through July 2025 and talked with a range of stakeholders.

Physicians are increasingly consolidating with other entities, including hospital systems, private equity firms, and insurers.

Among GAO's key findings is that physicians are increasingly consolidating with other entities, including hospital systems, private equity firms, and insurers. Hospitals play a sizable role. In 2024, at least 47% of physicians were employed by or affiliated with a hospital system, up from less than 30% in 2012. Private equity owns a small but growing share of the market. From 2019 to 2023, these firms were responsible for 65% of all physician practice acquisitions. Today, nearly 7% of physician practices are owned by private equity, up from about 5% in 2022.

While estimates of consolidations with health insurers vary, in part due to lack of transparent ownership reporting requirements, GAO found that the 10 largest health insurers in the country have acquired physician practices in recent years, suggesting an increase in this type of consolidation.

**Profit-Driven Consolidation Is Common**

GAO looked at the reasons behind these consolidations. With hospital systems, they cite the potential for more revenue, as "consolidation between hospitals and physicians can result in higher payments for certain physician services when provided in a hospital outpatient department."

Acquiring physician practices can give Medicare Advantage plans "additional influence over how physicians document patient conditions and how insurers assess patient risk."

Health insurers, in particular Medicare Advantage plans, may also have profits in mind. As GAO explains, acquiring physician practices can give the plans "additional influence over how physicians document patient conditions and how insurers assess patient risk. For example, Medicare Advantage organizations have a financial incentive to ensure that their physicians record all possible patient diagnoses because adding them can result in higher payments for enrolled Medicare beneficiaries."...**Read More**

# Medicare update: Open enrollment starts this week amid government shutdown

**Open enrollment** for Medicare begins on October 15, and millions of seniors are likely to reevaluate their **health insurance options.**

**Why It Matters**

Nearly 70 million Americans rely on Medicare for their health insurance coverage, and the open enrollment period allows beneficiaries to make changes to their plans. That can entail switching between original Medicare to the privatized Medicare Advantage options or adding on Medicare Part D for prescription drugs.

As the government shutdown remains underway, beneficiaries may be concerned about how this affects open enrollment.

*Newsweek* reached out to the Centers for Medicare and Medicaid Services for comment via email.

**What To Know**

Open enrollment takes place from October 15 to December 7.

The government shutdown, meanwhile, began on October 1 and has so far been unresolved, affecting some aspects of the Centers for Medicare and Medicaid Services' (CMS) operations.

For instance, updates to information on the Medicare.gov site could be delayed, but key services are supposed to continue even amid the shutdown, according to a CMS statement shared with MarketWatch.

"The government shutdown is not going to affect Medicare or the plans that are being presented. However, seniors should expect delays in the processing of applications if they are looking to make a change this AEP (annual enrollment period)," Chris Fong, a Medicare specialist and the CEO of Smile Insurance Group, told *Newsweek.*

"This AEP some seniors who are losing their Medicare Advantage plan will be given an opportunity to be guaranteed approval for a Medigap policy. But, I would suggest seniors to consult with a Medicare insurance agent to go through their options."

While overall Medicare shouldn't experience many issues due to the shutdown, seniors should be aware of delays regarding website information or customer service staffing, said Kevin Thompson, the CEO of 9i Capital Group and the host of the *9innings* podcast.

"Website updates or customer service staffing will be reduced, so everyone just needs to be aware of delays," Thompson said. "Telehealth implemented a 10-business day hold on claims, so there will need to be some patience."

**What People Are Saying**

**Alex Beene, a financial literacy instructor for the University of Tennessee at Martin, told *Newsweek*:** "Most aspects of open enrollment should be unchanged, even if the government shutdown persists for the next several weeks. While there have been some concerns about potential delays to updates beneficiaries may make during the shutdown, the Department of Health and Human Services has said they plan for most services to run as usual."

**Medicare specialist Chris Fong told *Newsweek*:** "Traditional Medicare falls under the mandatory spending for the government, which should not affect coverage. But we are expecting a delay on the processing of claims if the government shutdown continues."

"We don't expect the government shutdown to affect claim processing for Medigap or Medicare Advantage plans."

**9i Capital Group CEO Kevin Thompson told *Newsweek*:** "The longer-term effects should be minimal, but this change will impact those who need more hands-on guidance within the program. To be brutally honest, I sometimes struggle with the system myself, and I'm a financial professional. So, I can only imagine how confusing and frustrating this process must feel for elderly applicants trying to navigate it on their own."

**What Happens Next**

The private version of Medicare, Medicare Advantage, will hold its open enrollment period between January 1 and March 31.

"Ultimately, the only true concern Medicare recipients should have is ensuring the plan they choose during the open enrollment period best meets their needs," Beene said. "The federal government has always understood the popularity and importance of the program for millions of Americans, and keeping Medicare active even during a shutdown is viewed as essential."

# Prescription Drug Coverage Options Are Shrinking for Medicare Shoppers

Fewer choices may be on the menu again as Medicare patients shop for prescription coverage this fall.

The number of available, stand-alone drug plans has fallen for a few years, and that trend will continue for 2026. Most markets will still have several choices, but some options are becoming particularly sparse for shoppers with low-income subsidies. And help may be harder to find because some insurers no longer pay brokers commissions for new business.

Shoppers have from Oct. 15 to Dec. 7 to find new coverage that starts in January.

Some things to consider:

**Here's Who Needs a Medicare Part D Plan**

Regular Medicare, which most people qualify for after turning 65, does not come with prescription coverage, known as Part D. People must choose that separately.

About 23 million people with regular Medicare have this standalone coverage, according to the non-profit KFF, which studies healthcare.

Another roughly 34 million people have Medicare Advantage plans, which are privately run versions of Medicare that often come with prescription coverage.

**How Medicare Part D Plans Are Changing**

A typical shopper will be able to choose a standalone drug plan from among eight to 12 options for 2026, according to KFF Medicare expert Juliette Cubanski, PhD. That's down from 12 to 16 options in 2025.

Shoppers had nearly 30 choices as recently as 2021, according to the Commonwealth Fund's Gretchen Jacobson, PhD.

Depending on the state, a range of one to four plans will be available at no premium to people who qualify for low-income subsidies, according to KFF. Eight were available in 2021.

Some insurers are reducing their presence in standalone Part D plans, while the Blue Cross-Blue Shield carrier Elevance is leaving the market entirely. Insurers and analysts who follow the industry note that the **Inflation Reduction Act**, which will cap annual out-of-pocket drug costs at $2,100 in 2026, puts more financial pressure on insurers. The same law now allows patients to spread the cost of prescriptions over the year.

**There Are Still Many Medicare Part D Options**

Most markets will have several choices. But experts say Medicare Part D customers don't like to shop, especially if they already have a plan that covers their medications. Finding affordable coverage for multiple prescriptions can be tricky.

"I think there's a lot of inertia and, frankly, people may be concerned that if they switch, they're going to end up worse off," Cubanski said.

More people are being pushed to shop. Nearly 11% of those with standalone prescription drug coverage lost their plan in 2024, according to research published recently in *JAMA*.

Before 2023, that figure was often under 1%, said Christopher Cai, MD, one of the researchers involved in the study.

**Here's How Medicare Part D Prices Are Changing**

Monthly premiums, or coverage prices, will fall nearly 10% on average to $34.50, CMS **announced** last month….**Read More**

# Significant Social Security, Medicare changes backed by most Republicans

A majority of Republicans support making significant changes to **Social Security** and **Medicare** to ensure their costs are lower, according to a new Gallup **survey.**

The poll found that 56 percent of Republicans backed making the changes compared to just 18 percent of Democrats.

**Why It Matters**

The health care and financial support programs are facing a funding shortfall that may hit as early as the mid-2030s.

The programs, which serve around 70 million Americans each, also contribute to the larger U.S. federal deficit, which has reached roughly $2 trillion.

**What To Know**

While Republicans were far more likely to support Social Security and Medicare changes to get the federal deficit down, nearly half of U.S. adults said Congress should reduce the deficit either "mostly" (27 percent) or "only" (22 percent) by cutting spending.

That was compared to 17 percent who favor relying mostly or only on tax increases. Another 27 percent said they prefer an equal mix of spending cuts and tax hikes.


The findings are based on Gallup's September 2-16 poll of 1,000 U.S. adults.

Most Americans supported increasing income tax rates for upper-income Americans (63 percent) and increasing tax revenues by making major changes to the federal tax code (54 percent), but the support was largely concentrated among Democrats and independents, not Republicans.

More than 70 million Americans rely on Social Security payments each month, and nearly 40 percent of people over age 65 are estimated to be living in poverty if they went without the government support program.

In 2034, the Social Security Administration will face an automatic 19 percent cut to benefits based on the current money supply. That would translate to seniors losing around $4,573 a year, dramatically lowering the quality of life for many.

**What People Are Saying**

**Alex Beene, a financial literacy instructor for the University of Tennessee at Martin, told *Newsweek*:** "It should come as no surprise that many Republicans favor spending cuts over tax increases when considering how to fund major social welfare programs going forward. However, this latest polling actually does see some support among party members for tax increases on high-income earners, breaking with decades of aversion to an increase of taxes on Americans of any income level.

"It speaks to a growing number of working class Republicans who see the value and need for these programs they themselves will one day rely on and believe if they are willing to accept cuts to some of the services they would receive, wealthier Americans should be willing to pay more to fund them, as well."

**Kevin Thompson, the CEO of 9i Capital Group and the host of the *9innings* podcast, told *Newsweek*:** "Republicans have long been told that waste, fraud, and abuse exist within the system and that a broad overhaul would finally root out those inefficiencies. The belief is that by 'cleaning up' the system, the savings could offset future funding shortfalls."

**What Happens Next**

Thompson said even if the United States removed the Social Security wage cap and taxed every dollar of income, it would only solve about 50 to 54 percent of the funding problem.

"What's worse is that the policies we have implemented, like raising the deductible for seniors over 65 and removing the GPO/WEP [Government Pension Offset and Windfall Elimination Provision], work against the long-term health of the system. They may sound good politically, but they take more out of the program without addressing the real issue," Thompson said.

# Dave Ramsey, AARP raise red flag on Medicare; changes coming soon

The Annual Enrollment Period (AEP) for Medicare, which runs from Oct. 15 to Dec. 7, is the designated time for individuals already enrolled in Medicare to review their coverage.

During this window, beneficiaries can make changes to their existing plan or switch to a different one.

ve Ramsey has a warning for Americans: This is not the time to sign up for Medicare for the first time. Instead, he explains that people should use the AEP to evaluate whether their current plan still meets their health and financial needs, especially since coverage details and costs can change from year to year.

**Medicare** first-time enrollment should occur when people turn 65 during their initial Enrollment Period or any year after that during a General Enrollment Period that runs from Jan. 1 to March 31.

Ramsey points out an important way Medicare is different from regular health insurance.

"Unlike regular health insurance, Medicare doesn't have plans for couples or families — it only covers individuals," **he wrote**. "Medicare comes in what are called 'parts' ... and then a Medicare supplement. Each part is like a little mini plan that helps cover a different aspect of health care."

**What each Medicare 'part' covers**

- **Medicare Part A** provides coverage for inpatient hospital care, including overnight stays, as well as services received in a skilled nursing facility, hospice care, and certain types of home health care. It's designed to help with the costs associated with more intensive medical situations that require admission or specialized support.
- **Medi Medicare Part B** focuses on outpatient medical services. This includes visits to doctors and other health care providers, outpatient procedures, home health care, and durable medical equipment such as wheelchairs, oxygen tanks, and hospital beds. It also covers a wide range of preventive services, including screenings, immunizations, and annual wellness exams.
- **Medicare Advantage, or Part C,** combines hospital, medical, and often drug coverage into one plan offered by private insurers. Many plans include extras such as dental and vision. Separate premiums are paid for Part B and an Advantage plan, and out-of-pocket costs vary. Coverage is limited to in-network providers, and referrals may be required for specialists. Plans may not auto-renew. Though it seems simpler, one has less control than with Original Medica care Part A provides coverage for inpatient hospital care, including overnight stays, as well as services received in a skilled nursing facility, hospice care, and certain types of home health care. It's designed to help with the costs associated with more intensive medical situations that require admission or specialized support.
- **Medicare Part D** is the prescription drug component of Medicare. It helps pay for medications prescribed by a doctor and also covers many recommended vaccines and immunizations. People enrolled in Original Medicare need to add Part D separately. However, most Medicare Advantage plans include drug coverage as part of their benefits.
- Medical Supplemental Insurance, also known as Medigap, is offered by private insurers. It helps pay expenses not covered by Original Medicare. It's especially useful for those facing frequent medical bills. If one enrolls in a Medigap plan, they will pay a separate premium for it, along with their regular Medicare Part B premium. Most Original Medicare users benefit from having it.

# 2026: Insurers predict that most people with Medicare will be enrolled in traditional Medicare

For the first time since its inception, insurers predict that Medicare Advantage enrollment will drop in 2026 and that most people with Medicare will be enrolled in traditional Medicare, which the federal government directly administers. Unlike corporatized Medicare Advantage, traditional Medicare (TM) guarantees you the choice of care from the best doctors and hospitals. And, TM provides easy access to reliable care.

In stark contrast, there's nothing reliable about Medicare Advantage. Choosing a Medicare Advantage (MA) plan–an HMO or PPO run by a corporate health insurer– means gambling with your life. Medicare Advantage plans can keep you from seeing the best doctors and hospitals and wrongly delay and deny care that Traditional Medicare covers.

Insurers are ending many of their Medicare Advantage plans because they are not profitable. They are also cutting additional benefits. People with Medicare will still have far too many choices of Medicare Advantage plans. Each plan is different, with different provider networks, prior authorization rules and costs, but the information is not available for people to avoid the Medicare Advantage plans that wrongly delay and deny care.

Insurers are saying that their costs are rising at the same time that the government has cut payments a little. To be clear, the data show that the government is still overpaying the insurers offering Medicare Advantage more than $80 billion a year. But, the insurers recognize that they can maximize profits if they pull out of certain markets and pare back on certain extra benefits like dental and vision care.

Elevance ended dental, vision and hearing benefits in many Medicare Advantage plans.

Insurers want to avoid the enrollees who are not profitable. Offering fewer PPOs, which cover care outside of the insurers' network, is one way for them to boost their profits. Sicker people won't sign up. Some insurers also stopped paying commissions to brokers who enrolled people in PPOs, another way to keep people out of PPOs and boost their profits.

Insurers have also raised out-of-pocket maximums and deductibles, forcing people with costly conditions to spend more before their care is fully covered.

# 15 Common Medicare Mistakes and How to Avoid Them

Medicare insures millions of older Americans, but it's a complex program that requires seniors to research their options when first enrolling and every subsequent year during the renewal period.

Because this task can be so daunting, you might be tempted to put it off for as long as possible. However, procrastinating can be a costly error.

We've outlined the top 15 mistakes people tend to make during **their Medicare enrollment period** and how to avoid them.

**Costly Medicare Mistakes**

1. **Not signing up on time**
2. **Not signing up during the special enrollment period**
3. **Not enrolling in a stand-alone Medicare Part D prescription drug plan with original Medicare**
4. **Not getting supplemental coverage on time**
5. **Not understanding how Medicare coordinates with your current coverage**
6. **Assuming your spouse is covered under your Medicare plan**
7. **Not educating yourself on the differences between original Medicare and Medicare Advantage**
8. **Not reading the small print on Medicare Advantage plans**
9. **Not checking the insurer's formulary**
10. **Selecting the wrong drug plan**
11. **Not researching which hospitals and providers are covered by Your plan**
12. **Signing up for automatic renewal**
13. **Overlooking out-of-pocket expenses**
14. **Thinking Medicare is too expensive for you**
15. **Doing it alone**

# Negotiated Prices Take Effect for Ten Drugs in 2026

The Inflation Reduction Act (IRA) of 2022 created a new ability for Medicare to negotiate prices for the most expensive drugs the program covers. The **first set of negotiated drug prices will go into effect in** 2026 and **are estimated to save $1.5 billion** in annual out-of-pocket costs for Medicare beneficiaries while saving the Medicare program $6 billion per year. The negotiated prices are a **minimum of 38% off the 2023 list price.**

**Ten Important and Costly Drugs**

Drugs selected for negotiation must be brand-name drugs that don't have competition and must be among those that drive the most Medicare spending. These are the ten drugs for 2026:

**• Eliquis • Jardiance • Xarelto • Januvia • Farxiga • Entresto • Enbrel • Imbruvica • Stelara • NovoLog**

These medications treat serious chronic illnesses like cancer, diabetes, blood clots, heart failure, autoimmune conditions, and chronic kidney disease. In 2022, **Part D spent around $46.4 billion on just these drugs,** 19% of all Part D spending, and beneficiaries paid $3.4 billion out of pocket for them. Evaluating based on total spending allows for the inclusion of medications that are extremely expensive on a per-patient basis as well as those that are very widely prescribed to beneficiaries.

**The Negotiation Timeline**

All eligible Medicare beneficiaries will have access to these prices and new drugs will be added to the negotiated list each year. The next set of negotiated prices, for 15 additional drugs including **blockbuster diabetes drugs like Ozempic,** will go into effect in 2027.

- 2023—CMS announced **the first 10 Part D drugs to be negotiated**.
- 2024—CMS published **the negotiated prices**.
- 2025—Medicare **negotiating prices for 15 more Part D drugs.**
- 2026—Negotiated prices for the first 10 Part D drugs will take effect. This is the first year people with Medicare will see the direct impacts of negotiation. CMS will select another 15 drugs—under Part D or Part B—for negotiation.
- 2027—Negotiated prices for the 15 Part D drugs selected in 2025 will kick in. CMS will announce 20 more Part B or Part D drugs for negotiation.

In subsequent years, CMS will continue negotiating prices for additional drugs, which will take effect two years later. Each round is cumulative, continuing to add to the total number of drugs with negotiated prices.

**Reconciliation Bill Restricts Negotiation Program's Potential**

Unfortunately, the 2025 budget reconciliation bill—HR 1—reduced the efficacy of the IRA's negotiation program by **further limiting what drugs can be negotiated.** KFF estimates that this change will increase Medicare spending by at least $5 billion. As always, increases in Medicare spending mean increases in out-of-pocket costs for beneficiaries.

**Build on the Inflation Reduction Act**

At Medicare Rights, we condemn efforts to pull back on the IRA's negotiation framework. We believe more drugs should be subject to negotiation, not fewer. Other cost-saving aspects of the law should also be built out to **lower costs for those covered by other forms of insurance.**

# RI ARA HealthLink Wellness News

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

HealthLink Wellness "Taking Control"

## Prior Authorizations Draining Time, Energy From Many Cancer Patients

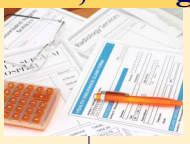
Cancer patients aren't just battling a deadly disease — part of their time and energy can also be spent fighting the system intended to cure them, a new **study** says.

Half of cancer patients who needed prior insurance authorization for their **care** had to directly involve themselves in the process, researchers reported at the American Society of Clinical Oncology's Quality Care Symposium last weekend in Chicago.

The results, researchers said, included treatment delays, financial strain and personal stress that could potentially affect their odds of survival.

"Cancer patients and their families are being pulled into the insurance prior authorization process, at the expense of their time, health and well-being," lead researcher **Alexandra Zaleta,** vice president of research and insights at CancerCare, a professional support service for cancer patients, said in a news release.

"While doctors and care teams often take the lead, half of patients told us they also had to roll up their sleeves by personally making calls, filing paperwork or chasing down approvals," Zelata said.



For the new study, researchers surveyed 1,200 recent cancer patients age 26 or older, of whom 74% needed at least one prior authorization for their cancer care.

Half of those reported direct involvement by themselves or a family member in obtaining their most recent prior authorization. The other half said prior authorization was fully handled by their health care team.

Of those who had to get involved in obtaining a prior authorization:

- 50% spent up to one business day working on it.
- 29% spent up to three business days.
- 12% spent a full business week or more.
- Personal involvement in prior authorization differed based on the type of cancer treatment:
- Targeted therapies (73% personally involved versus 27% handled completely by health care team)
- Supportive medications (64% versus 36%)
- Radiation therapy (40% versus 60%)
- Imaging (40% versus 60%)

Certain groups were more likely to become personally involved in obtaining prior authorization, including:

- People younger than 65 on employer-provided insurance (3.7 times greater odds) or Medicare (2 times greater odds)
- Men (2 times greater odds compared to women)
- Patients with advanced cancer (2 times greater odds)
- Patients with delays in diagnosis (66% higher odds) or treatment (54% higher odds)

Cancer patients who had to get involved in their prior authorizations were 23% more likely to report worse physical, emotional and financial well-being, researchers found.

They also were 21% more likely to report scrimping on medication to save money.

"This study makes clear what many of us in oncology have suspected: Prior authorization isn't just an administrative hurdle for clinicians, it's a hidden second job for patients," Dr. Macin Chwistek, director of supportive oncology and palliative care at Fox Chase Cancer Center in Philadelphia, said in a news release.

"This study found that patients with cancer, particularly younger patients and those with advanced disease, often have to personally navigate the authorization process, leading to delays in treatment and financial and emotional strain," noted Chwistek, who was not involved in the research.

Researchers plan to continue digging deeper into the study data, to better understand the unique challenges faced by people with employer-provided insurance plans.

Findings presented at medical meetings should be considered preliminary until published in a peer-reviewed journal.

## Common Hospice Meds Increase Death Risk For Alzheimer's, Dementia Patient

Hospice drugs commonly handed out to people with **Alzheimer's disease** and dementia might be hastening their deaths, a new study says.

Benzodiazepines and antipsychotics given to hospice patients with dementia appear to increase their risk of earlier death, compared to similar patients who weren't prescribed those drugs, researchers reported Oct. 14 in ***JAMA Network Open***.

Dementia patients who began taking benzodiazepines were 41% more likely to die within six months, and those on antipsychotics 16% more likely to die, researchers found.

"Dementia is now the most common qualifying condition among hospice enrollees, yet many of these patients are not imminently dying," said lead researcher **Dr. Lauren Gerlach**, a geriatric psychiatrist at the University of Michigan.

"Because prognosis in dementia is so difficult to determine, nearly 1 in 5 patients will outlive the six-month eligibility window for hospice," she said in a news release. "This makes it critical that medications used during this period enhance, rather than diminish, quality of life."

Hospice care was originally developed to help people dying from cancer, but has since expanded to ease the passing of people with other terminal diseases like **dementia**.

The proportion of hospice patients with Alzheimer's disease or dementia has increased from less than 1% in 1995 to 25% in 2023, researchers said in background notes.

However, Alzheimer's and dementia follow a more prolonged and unpredictable trajectory than cancer, making it uncertain that a patient in hospice will necessarily die soon.

In fact, 20% of those patients outlive the six-month prognosis required for hospice eligibility and will be discharged from the program, researchers said.

"The Medicare hospice benefit was designed when most patients enrolling had cancer and short, predictable trajectories," Gerlach said. "For people with dementia, whose disease course can span years, we need care models and prescribing guidance that better reflect their experience."

Benzodiazepines and antipsychotics are commonly prescribed to hospice patients to manage agitation, anxiety and delirium, researchers said.

However, they also increase risks of falls, confusion and sedation, potentially affecting patients' quality of life.

For the new study, researchers analyzed national Medicare data between July 2015 and September 2018, during a period when hospice facilities were required to report prescriptions.

None of the 139,000 Alzheimer's or dementia patients had received either benzodiazepines or antipsychotics in the six months prior to entering hospice, researchers found.

Despite this, nearly half (48%) received a new benzodiazepine prescription and 13% an antipsychotic after hospice enrollment — most within days of admission, results showed….**Read More**

# Fentanyl-Linked Overdose Deaths Among Seniors Soar 9,000% in 8 Years

**Fentanyl** overdose deaths are surging among seniors, particularly in cases where the powerful opioid is mixed with stimulants like cocaine or methamphetamine, a new study says.

Fentanyl-stimulant overdose (OD) deaths skyrocketed by an astonishing 9,000% during the past eight years, approaching rates found in younger adults, researchers reported Saturday at an American Society of Anesthesiologists' meeting in San Antonio, Texas.

"A common misconception is that opioid overdoses primarily affect younger people," lead researcher Gab Pasia, a medical student at the University of Nevada-Reno School of Medicine, said in a news release.

"Our **analysis** shows that older adults are also impacted by fentanyl-related deaths and that stimulant involvement has become much more common in this group," Pasia said. "This suggests older adults are affected by the current fourth wave of the opioid crisis, following similar patterns seen in younger populations."

America's opioid epidemic has unfolded in four distinct waves, researchers explained in background notes.

Prescription opioids started the crisis in the 1990s, followed by heroin beginning in 2010 as prescribing standards tightened, researchers said. A third wave involving fentanyl began in 2013, followed by the current fourth wave of fentanyl mixed with stimulants that began around 2015.

Fentanyl is a hundred times more powerful than morphine and 50% more powerful than heroin, making it a serious risk for overdose. Illicitly produced fentanyl is sold alone or combined with heroin and other substances.

Seniors are especially vulnerable to overdoses because many live with chronic health problems that require taking several different medications daily, researchers said. As people age, they also tend to process drugs more slowly, potentially increasing their impact.

For the new study, researchers analyzed data from nearly 405,000 death certificates issued between 1999 and 2023 that listed fentanyl as a cause of death. Older adults represented more than 17,000 of the deaths.

Overall, annual fentanyl-related deaths increased by 1,470% between 2015 and 2023 for seniors 65 and older, and by 660% among younger adults 25 to 64, results show.

There also was a disturbing increase in the number of overdose deaths related specifically to fentanyl mixed with stimulants.

Among seniors 65 and older, fentanyl-stimulant overdose deaths increased from less than 9% of fentanyl-related OD deaths in 2015 to 50% of deaths in 2023 – a 9,000% increase.

Younger adults 25 to 64 also experienced a spike in fentanyl-stimulant deaths, rising from 21% of OD deaths in 2015 to 59% of deaths in 2023, or a 2,115% increase.

Fentanyl-stimulant deaths among seniors began to sharply rise in 2020, while deaths linked to other substances either remained stable or declined, researchers found.

Cocaine and methamphetamine were the most common stimulants paired with fentanyl among seniors, surpassing co-use with other substances like alcohol, heroin or benzodiazepines.

"The findings underscore that fentanyl overdoses in older adults are often multi-substance deaths — not due to fentanyl alone — and the importance of sharing drug misuse prevention strategies to older patients," Pasia said.

However, the study could not explain why this trend is occurring, Pasia noted.

Doctors, pain medicine specialists and pharmacists should be aware of the risk of multiple substance use among seniors, and be cautious when prescribing opioids, the research team said.

"Older adults who are prescribed opioids, or their caregivers, should ask their clinicians about overdose prevention strategies, such as having naloxone available and knowing the signs of an overdose," said researcher **Dr. Richard Wang**, an anesthesiology resident at Rush University Medical Center in Chicago.

"With these trends in mind, it is more important than ever to minimize opioid use in this vulnerable group and use other pain control methods when appropriate," Wang said in a news release. "Proper patient education and regularly reviewing medication lists could help to flatten this terrible trend."

Findings presented at medical meetings should be considered preliminary until published in a peer-reviewed journal.

# Have you gotten a bone density test?

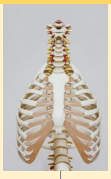
.According to the **CDC,** 16 percent of women over 50 and four percent of men over 50 have osteoporosis of the femur, neck or lumbar spine. The **percentage grows significantly for people over 65**—24.8 percent of women and 5.6 percent of men. A bone density test or bone mass measurement can diagnose osteoporosis. Have you gotten one?

Patients with osteoporosis have thin and brittle bones as well as a high likelihood of breaking their bones. Osteoporosis tends to worsen as you grow older. For these reasons, **Medicare covers the full cost of a bone density test** every two years for women, if the doctor prescribes it, because:

1. You are estrogen-deficient at risk for osteoporosis based on medical history or other evidence;
2. An X-ray shows vertebral abnormalities;
3. You have been getting steroid treatments for at least three months;
4. You are diagnosed with hyperparathyroidism;

You are on a drug for osteoporosis.

For full Medicare coverage, you must see a doctor who takes assignment—accepts Medicare's rate in full if you have traditional Medicare. You should see an in-network provider if you are in a Medicare Advantage plan. However, if you take the test at the same time as you are getting examined for a range of issues, you will still bear the deductible and coinsurance costs of your doctor's exam if they are applicable.



Women should get a bone density scan at age 65. Medicare also covers follow-up bone-mass measurement or more frequent screenings for osteoporosis if your doctor prescribes them. If you have osteoporosis, you can take a drug to preserve your bones and even strengthen them.

While osteoporosis is more common in women, men also can have osteoporosis. And, 25 to 30 percent of men with osteoporosis who have a serious osteoporotic fracture of a bone are likely to die within a year, a much higher death rate than women or than from prostate cancer.

Men should consider getting a bone density scan at age 70, especially if they have had a bone fracture after the age of 50. But, the US Preventive Services Task Force does not recommend the osteoporosis test for men, claiming the evidence does not suggest efficacy. So, Medicare won't cover a screening unless men have suffered a fracture. And, since osteoporosis is asymptomatic, men who don't pay out of pocket for the test won't know whether they have osteoporosis.

In addition to hip fractures, risk factors for osteoporosis include: rheumatoid arthritis, Parkinson's disease, smoking and alcohol.

**Osteoporosis treatment:** Fosamax or Actonel, Reclast, Forteo, Tymlos or Prolia all are effective treatments for osteoporosis**….Read More**

# FDA Clears New Blood Test to Help Rule Out Alzheimer's Disease


The U.S. Food and Drug Administration (FDA) has cleared another blood test that could help doctors identify whether a patient's memory problems are likely caused by **Alzheimer's disease**.

The new test, called Elecsys pTau181, was developed by **Roche Diagnostics** in partnership with **Eli Lilly**. It's designed for adults 55 and older who are showing early signs of cognitive decline.

"By bringing Alzheimer's blood-based biomarker testing into primary care, we can help patients and their clinicians get answers sooner to support them earlier in their journeys," **Brad Moore**, president and CEO of Roche Diagnostics North America, told *CNN*.

The Elecsys test measures levels of pTau181, a protein found in blood plasma. Higher levels of this protein are linked to Alzheimer's and other brain diseases.

In a study involving 312 people, the test correctly ruled out Alzheimer's disease 97.9% of the time, according to Roche.

"When the test result is negative, there's a very high likelihood the person does not have Alzheimer's-related pathology," said **Laura Parnas**, director of medical and scientific affairs at Roche Diagnostics.

"However," she added in a *CNN* report, "it's important to note that for patients with a positive result, further clinical investigations and confirmatory testing for the amyloid pathology is needed for the final diagnosis of Alzheimer's."...**Read More**

# FDA Approves At-Home Version of Lasix for Heart Failure Care

A new at-home version of a common heart failure drug could make treatment easier for millions of Americans.

The U.S. Food and Drug Administration (FDA) has approved Lasix ONYU (furosemide injection), a new drug-device combination developed by **SQ Innovation, Inc.**, for treating edema caused by chronic **heart failure**.

The approval will allow certain patients to receive the treatment at home through subcutaneous (under-the-skin) infusion, rather than in a hospital.

"Lasix ONYU has the potential to be transformative in the care of patients experiencing worsening heart failure due to fluid overload," **Dr. Pieter Muntendam**, president and CEO of SQ Innovation, said in a news release.

"Treating selected patients at home offers important benefits to patients, health systems and payers," he added, noting that the company expects to launch Lasix ONYU with leading health systems by year's end.

About 6.7 million Americans live with heart failure, and that number could rise to 8.7 million by 2030, the company said. Heart failure is also a leading cause of hospitalization for people over 65, with 1.2 million hospital stays each year.

Lasix ONYU delivers the same medication found in traditional Lasix IV treatments, but through a small, wearable device.

The system includes a reusable unit that lasts for 48 treatments and a single-use component that is discarded after each session.

The company said this two-part design lowers production costs and could make the therapy more affordable.

In a clinical study, Lasix ONYU showed 112% bioavailability compared to IV Lasix, meaning the body absorbed it fully. It also produced similar results in terms of urine output (115%) and sodium loss (117%), showing that at-home use may be as effective as hospital-based treatment.

"Heart failure is the most common serious medical condition in the U.S. and affects about 1 in 4 Americans during their lifetime," said **Dr. Javed Butler**, professor of medicine at the University of Mississippi and president of the Baylor Scott & White Research Institute in Dallas.

"The number of patients affected is expected to double over the next 20 years and we currently already often lack adequate resources to take care of the 6.7 million patients affected presently — there are not enough beds, clinicians and funds," he added in a news release.

Others also praised the innovation.

"Decongestion through use of IV diuretics has been the cornerstone of treatment for reducing edema and hypervolemia in heart failure patients for over five decades," said **S. Craig Thomas**, past president of the American Association of Heart Failure Nurses.

"The availability of accessible, affordable and novel options that do not require the presence of a health care professional allows for transformative new clinical care-delivery," he added. "This means patients who now would typically need to be hospitalized for several days of IV treatment can instead remain home, supported by periodic or remote monitoring."

He said the significance of this shift away from inpatient care cannot be overstated.

Lasix ONYU will be distributed through leading pharmaceutical distributors starting this quarter, making it available at certain hospitals and retail pharmacies nationwide.

# When it comes to Medicare, don't trust AARP


There was once a time when AARP fought for the interests of older and disabled Americans with Medicare. Then, AARP made a deal with UnitedHealth to market UnitedHealth products to its members. Now, AARP is largely silent when it comes to the often deadly nature of Medicare Advantage and the major issues with **UnitedHealth's Medicare Advantage plans**. Don't trust AARP.

Adriel Bettelheim reports for **Axios** that UnitedHealth paid AARP $9 billion in royalties last year. AARP's silence regarding grave concerns with Medicare Advantage is chilling at a time when UnitedHealth and many other insurers are engaged in widespread and persistent inappropriate delays and denials of care for their Medicare Advantage enrollees. Choosing a Medicare Advantage plan, including one's with AARP branding, can mean gambling with your life.

AARP's deal with UnitedHealth has enormous bearing on its policies and advocacy. Its silence whenever a new serious issue with UnitedHealth comes to light tells you everything you need to know. If AARP were speaking out for the interests of its members, it would be explaining that traditional Medicare (TM) guarantees people get the care they need from the best doctors and hospitals and that, with Medicare Advantage, people are gambling with their lives.

Keep in mind that Medicare Advantage plans can keep you from seeing the best doctors and not cover the care you need. They wrongly deny care that Medicare covers. The insurers profit more the more care they deny. They profit most when they deny complex and costly care or keep you from using a cancer center of excellence or other high quality hospital or specialist. That's why they will never compete for members with serious health conditions.

Older Americans need the easy access to reliable care they get in Traditional Medicare, not the hassles and denials of care they get in Medicare Advantage. AARP should be leading the call for easy access to needed care for everyone with Medicare, but they are silent.