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RI ARA

Affiliated with the Rhode Island AFL-CIO
"Fighting for the future of our members."
"NOW, more than ever!!!"

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House Group Works to Cut Social Security and Medicare Behind Closed Doors

On Monday a bipartisan group of 60 House members, evenly divided among Republicans and Democrats, sent a **letter** to House leadership calling for measures to be included in the next coronavirus relief package to tackle the growing deficit.

The proposed committees, the brainchild of Sen. **Mitt Romney** (UT), would bypass the committees of jurisdiction over Social Security and Medicare — the House Committees on Ways and Means and Energy and Commerce and the Senate Committee on Finance.

The letter was written as economic experts are urging Congress **to keep spending** to meet the needs of the pandemic and the economic crisis while interest rates on federal borrowing are low.

The House members are requesting that the Government Accountability Office produce an annual report on the country's fiscal health. They also called for the inclusion of the TRUST Act (H.R. 4907) that would create the special congressional "rescue committees" to keep trust funds afloat. In reality, the TRUST Act creates **closed-door commissions to cut Social Security and Medicare**. Once the respective Rescue Committees approve a trust fund bill, the legislation would receive expedited consideration in the House and Senate.

Rich Fiesta, Executive Director, ARA

"This deficit demagoguery is just a smokescreen to achieve the dangerous goal of destroying our hard-earned Medicare and Social Security benefits," said **Richard Fiesta**, Alliance Executive Director. "That is the last thing we need during a public health and economic crisis. Americans overwhelmingly want and need these programs expanded."

Workers First Day of Action

Join the Rhode Island Labor Movement on **Wednesday, June 17, 2020 at 3:00PM** in a ***rolling caravan*** to call attention to the importance of the United States Postal Service and America's 5 Economic Essentials. The caravan will start at the West River Street/Corliss Street intersection and proceed around the postal center, with stops at the Providence Teachers Union Hall and the Stop & Shop on West River Street. We will then travel down Branch Avenue to parade by a non-union construction site where concerns have been raised about worker safety.

*Please RSVP to the link provided **https://actionnetwork.org/events/rhode-island-afl-cio-workers-first-caravan** and we look forward to seeing you on Wednesday the 17th!

AMERICA'S 5 ECONOMIC ESSENTIALS FOR CARES 2

1. Keep front-line workers safe.
2. Keep workers employed and protect earned pension checks.
3. Keep state and local governments, public schools and the U.S. Postal Service solvent and working.
4. Keep America healthy—protect and expand health insurance for all workers.
5. Keep America competitive—hire people to build infrastructure.

AFL-CIO

Sign and send the petition to the U.S. Senate: We must have funding for Vote by Mail

The coronavirus pandemic is deeply impacting our elections, as states move to protect voters' health during this crisis.

We are less than six months away from Election Day 2020, and Americans still struggle with access to the ballot box. Multiple roadblocks can impede access, **even without a global pandemic!**

In order to ensure every voice is heard this election, we must expand mail-in voting, absentee voting and other expanded voting options. **We must properly fund Vote by Mail.**

Alliance *for* Retired Americans®

Wisconsin is a particularly regrettable example of in-person voting amid COVID-19. On April 7, Wisconsin held its primary elections in the midst of the pandemic, putting its voters and poll workers at risk of infection and forcing some people—particularly vulnerable populations such as the elderly and immunocompromised—to skip voting altogether. As a result of the in-person election, **52 people** who worked or voted in the election contracted coronavirus.

Vote by Mail offers a way to vote without fear of contracting coronavirus COVID-19.

Additionally, Vote by Mail has been proven to encourage greater participation in our democracy. States that have enacted Vote by Mail have seen a **15 percent higher** median turnout than polling-place-centric states during the 2018 primary.

Several states have already successfully enacted Vote by Mail including Oregon, Washington, Colorado, Utah, California, and Hawaii -- and these states are seeing a higher voter turnout as a result.

In the wake of this pandemic, we must urge the Senate to pass legislation funding stronger election safety measures, including Vote by Mail.

Sign and send the petition: Demand the Senate properly fund Vote by Mail.

Elimination of the Unfair GPO and WEP Provisions of the Social Security Act

Penalties

Your benefits may be cut by many thousands of dollars even though you and/or your spouse have paid the required minimum or more in Social Security contributions. It is not uncommon to be penalized by both GPO and WEP.

Government Pension Offset Provision (GPO)

Spousal benefits (must be spouse for a minimum of 10 years) are penalized by the Government Pension Offset (GPO) when you begin to collect your pension from a "non-covered" public position. Because of the GPO:

- Dependent spouses will probably lose all the benefits due them — a non-working spouse normally receives an SS payment equal to half that of the SS earner.
- Widows/widowers will lose at least part of or, more often, all of the Social Security retirement.

Windfall Elimination Provision (WEP)

If you have had two jobs: one in which you paid Social Security taxes and therefore earned your own Social Security credits and a public sector job in which you did not pay Social Security taxes (referred to as "non-covered" public employment), you are penalized by the Windfall Elimination Provision (WEP), and may lose up to 60% of your earned Social Security retirement benefits.

Medicare premiums are higher if you lose all Social Security benefits. You will be denied the $255 burial payment sent by the Social Security Administration to other bereaved families, if you are a widow/ widower with a government pension.

What is unjust:

Both the GPO/WEP are based on faulty assumptions. The offsets were based on a decision to treat pensions from certain public positions as if they were the same as Social Security benefits, despite the fact that these "non-covered" state and local positions have nothing to do with Social Security.

- Error #1. These pensions were earned separately and differently from Social Security, yet they are used to reduce the amount of Social Security benefits that a worker receives during retirement. When participation is required by both Social Security and also State and local pensions, the public pension is earned and collected separately. Therefore, it should have no effect on Social Security benefits earned elsewhere.
- Error #2. Social Security and public agency pension benefits are treated differently by Federal tax law. While federal income tax is collected on public agency pensions, Social Security benefits are sheltered, often completely, from this tax. State community property laws may treat them differently, also. Due to these two differences, a public pension should not be used to offset the amount of Social Security earned.

Unintended/undesirable consequences

Loss in earned benefits is severe, often resulting in substantial lifestyle reductions and even poverty, for formerly productive working citizens of middle/low class.

- GPO: 74% percent of those affected by GPO lose their entire spousal benefits. According to the 2010 Congressional Research Service Report, the average yearly public pension for those affected by the GPO is $23,244. For a person with this average pension, the GPO can result in an annual loss of more than $15,480 in earned Social Security benefits. Few people can sustain a loss of that much money in retirement. Older workers often have pensions that pay half that amount, and theystill lose the same percentage of their deserved Social Security retirement benefits. It is possible for one's spouse to pay Social Security taxes of as much as $90,000 and yet their survivor may receive nothing from what was a contribution of joint marital income.
- WEP: The WEP was not designed to affect the middle or low wage earners that it can deeply penalize. WEP cuts to earned benefits are substantial, commonly causing serious lifestyle reductions. Someone with a pension of only $900 a month from a "non-covered" government job can have his/ her earned monthly Social Security benefits cut from $600 to $300.

The GPO, particularly, represents discrimination against women

The GPO currently penalizes more than one half million retirees; 79% of them are women. Of those affected by the GPO, the average non-covered government pension for men was $961 more per month than the pension paid to women. The women affected often have lower pensions to start with, and then the Government Pension Offset reduces their Social Security benefits by even more, an average of $6,900 a year for women, as opposed to $4,000 a year for men. (Congressional Research Service 2/12/10, using SSA Table DE01)

Penalties not well publicized.

Until recently no law existed to inform employees about the GPO/WEP penalties. Large numbers of current public employees (including pre-retirees) have never been told that public service employment is jeopardizing their already-earned Social Security benefits. Neither the SSA nor government sufficiently publicized these penalties, resulting in financially devastating decisions for many. Careers were chosen and retirement contracts entered without knowledge of the WEP/ GPO penalties. The law to require notification of new employees about the WEP/GPO did not go into effect until 2005. Even with notification, the WEP/ GPO are so lacking in logic, that many employees still do not understand their long term financial effects.

Who is affected?

Teachers: One third of all America's educators teach in positions affected by the WEP/ GPO, negatively affecting teacher recruitment. With retirements and other attrition every year, our country always needs more high-quality new teachers. To provide a competitive educational system, we should be attracting those looking for a meaningful second career as well as bright young people. Discouraging them with penalties is bad public policy.

Federal workers before 1984, state and local workers: Americans working in 29% of state and local government positions and 18% of Federal positions can be affected by the offsets. These include first responders–fire and police personnel– who may have come from the military, as well as teachers, librarians, air traffic controllers, secretaries and others whose fully-earned Social Security from previous jobs will be cut back when they retire.

Solution

The $8-10 billion annual cost to repeal the GPO/WEP is minimal when compared to the total amount paid in Social Security retirement benefits annually. The annual estimated cost to repeal GPO/WEP amounts to less than 2% of the overall Social Security benefits paid to recipients each year. (Estimated Trust Fund Information at www.ssa.gov.)

The cost of not repealing these laws is to continue a gross governmental inequity!

For more information go to https://ssfairness.org/

Help us to help you by signing the Petition below.

ADD YOUR NAME

Get The Message Out: SIGN THE PETITION!!!!!

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riarajap@hotmail.com • http://www.facebook.com/groups/354516807278/

Half of Retirees Report Paying Tax on Social Security Benefits for 2019

Half of retirees participating in a new survey by The Senior Citizens League (TSCL) say they paid income taxes on a portion of their Social Security benefit income for the 2019 tax year. "There was no change from previous years in the 50 percent of retiree households who report that they pay tax on a portion of their benefits, despite the 2017 tax reform law, says Mary Johnson, a Social Security and Medicare policy analyst for The Senior Citizens League.

The revenues from taxation of benefits are earmarked for funding Social Security and Medicare benefits. "Those revenues take on new importance in 2020, as the coronavirus takes a significant toll on Social Security and Medicare payroll tax revenues with more than 40 million people out of work," Johnson says.

The number of older taxpayers who find that a portion of their Social Security benefits are taxable tends to grow over time. Unlike income brackets that are adjusted for inflation, the income thresholds that subject Social Security benefits to taxation have never been adjusted since Social Security benefits became taxable in 1984. When the law was first passed, less than 10 percent of all Social Security recipients **were estimated** to have incomes high enough to be affected by the tax on benefits. But today, even retirees with modest incomes can be affected by the tax.

Up to 85 percent of Social Security benefits can be subject to taxation if an individual has a combined income of $25,000 and married couples filing jointly have a combined income of $32,000. Had income thresholds been adjusted for inflation, they would be about $62,902 for individuals and $80,515 for joint filers in 2020. "Combined income" is determined by adding one's adjusted gross income, plus any tax - free interest income, and one - half of Social Security benefits.

According to the **2020 Social Security Trustees report**, which does not include estimates of the impact of the coronavirus, Social Security is expected to receive about $853.3 billion in payroll tax revenues this year. "That estimate is higher than it actually will be, since it was based on just a 5 percent unemployment rate," Johnson notes. "Currently the unemployment numbers are roughly four times higher than that," she points out. In addition, the Coronavirus Aid, Relief and Economic Security Act (CARES Act), allows employers to defer the employer portion of payroll taxes in 2020 for up to two years.

The Social Security Trustees further estimate that $38.9 billion in revenues in 2020 would come from the taxation of Social Security benefits. "Yet those revenues are also likely to be lower, impacted by both large numbers of older Americans who lost income from jobs, as well as from lower distributions from retirement accounts that have lost value from last year," Johnson notes. Under the CARES Act, retirees are allowed to completely waive required minimum distributions for 2020 from retirement accounts.

At the same time, new claims for Social Security benefits are growing, as many older workers who have lost jobs file for Social Security benefits earlier than planned. The combined impact increases pressure on Social Security to address solvency issues. A future solvency option supported by more than 72 percent of The Senior Citizens League's survey participants is to apply the Social Security payroll tax to all earnings, instead of just the first $137,700 in wages. The survey was conducted from mid - January through April of this year.

The Senior Citizens League is currently conducting its new 2020 Survey of Senior Costs.

To learn more and participate visit **www.SeniorsLeague.org.**

Coronavirus: Conservatives planning to slash Social Security

Just below the surface of the crises currently engulfing the nation is a debate over Social Security, with wide-ranging consequences. The Democratic Party is on board for expanding, not cutting, Social Security. The Republican Party is planning to **slash Social Security**. Support for **expanding it** makes sense, as Social Security provides a large measure of economic security to tens of millions of retirees, people with disabilities and others. And, the vast majority of the **public supports its expansion**.After supporting a number of bipartisan attempts to cut Social Security over the last several decades, Vice-President Biden now supports expanding it, if elected president. **President Trump** campaigned on the promise of never cutting Social Security, though his actions in office have shown that to be a lie. If he gains a second term, efforts to cut are likely.

What is most concerning, though, is that Senator Mitt Romney is leading a charge, with many Democrats in tow, to implement a fast-track process to cut Social Security and Medicare behind closed doors. He also wants to eliminate unemployment insurance expansion which has been critical to the lives of 43 million recently unemployed Americans as a result of the pandemic. Sixty House members now support Romney's dangerous idea.

In sharp contrast, the progressive wing of the Democratic Party, including Senators Bernie Sanders, Ed Markey and Kamala Harris, are **proposing** to give workers a **$2,000 monthly stipend** as part of the next coronavirus stimulus package. They want to make sure that working Americans have the money to pay for basic necessities throughout this pandemic, including expanded unemployment insurance, paycheck protection help for small businesses and larger Social Security payments to retirees.

Outright emergency payments at a time of serious economic hardship is a far cry from **a conservative proposal** that would exploit people's desperation by giving them some money now from the Social Security Trust Funds if they agree to take less Social Security later. As David Sirota writes in **Jacobin**, what's so especially inexcusable and unseemly about this proposal is that it would require tens of millions of people with literally no savings to protect themselves by using money that they will need for their economic wellbeing, at the same time as Congress literally gives tens of billions of dollars to companies with billions of dollars in reserves.

The proponents of this inequitable proposal are effectively suggesting that government handouts to profitable businesses without proof of need and no payback are acceptable. But, in their view, individuals should self-finance, increasing their current economic security by trading away their future economic security. If fiscal neutrality is the goal, why not impose corporate and individual wealth taxes, which would be far more equitable?

Biden is now on the side of Americans, tweeting "Give people coronavirus economic relief and don't hold their hard-earned benefits hostage." Working families' economic security depends on him prevailing in November. And, when he does, all of us holding him to his promise to expand, not cut Social Security.

Coronavirus: Older adults take full advantage of Medicare telehealth benefit

Medicare began covering a broad array of **telehealth services** during this coronavirus pandemic. And, older adults and people with disabilities are taking full advantage of this new benefit, reports Rebecca Pifer for **Healthcare Dive**.

It is truly extraordinary how quickly telehealth services have taken off for people with Medicare. In just one week in April, nearly 1.3 million people with Medicare received telehealth services. In one week in March, 11,000 people took advantage of telehealth services.

Part of the reason for this enormous growth in telehealth services is that Medicare now pays for phone calls between patients and doctors. And, its payment rates during the pandemic are quite high–around $46 for a five to ten-minute call, according to a researcher at the Urban Institute, up from $14.

Right now, Medicare coverage of an extensive array of telehealth services is only available during the pandemic. In addition to phone calls, Medicare's telehealth benefit includes coverage for care from doctors who are out of state. But, HHS is exploring the possibility of extending coverage beyond the pandemic and possibly permanently. CMS Administrator Seema Verma has indicated that at least some services will be made permanent.

For older adults, in particular, telehealth services are a godsend at this time. Older adults are **especially at risk** of experiencing severe complications from COVID-19. Being able to get care without having to leave their homes and expose themselves to others is extremely valuable.

Until the pandemic, Medicare only covered **telehealth services** in the most limited of instances. It covered some telehealth for people in rural communities and it did not cover telehealth services when people were in their homes. In 2016, a total of 90,000 people with traditional Medicare received telehealth services.

CVS charged with healthcare fraud

Just a couple of years ago, a whistleblower charged **CVS with $1 billion in Medicare drug fraud**. Now, CVS has been sued for overcharging Blue Cross Blue Shield for generic drugs. **Healthcare Dive** reports that Blue Cross Blue Shield is seeking millions of dollars in damages.

Blue Cross Blue Shield claims that, for more than ten years, CVS charged it a higher price for certain drugs than CVS was charging the general public for these drugs if they were paying cash for them. CVS denies the charges against it. It says they are without merit.

While Blue Cross Blue Shield had negotiated the price it paid for these generic drugs with CVS, Blue Cross claims it should have benefited from the lower price that CVS charged people who paid cash for them. Put differently, Blue Cross argues that the cash price should be the highest price it pays. And, it says that CVS used a discount program to keep Blue Cross from knowing the cash price.

The CVS membership program provides discounts on certain generic drugs to anyone who signs up. It also gives discounts to people who do not sign up, according to the Blue Cross lawsuit. The Blues argue that this membership program set the true cash price for the drugs, also referred to as the "usual and customary [U&C] price." By concealing these prices in the membership program, insurers, including the plaintiffs, were not alerted to, and did not pay the lower U&C, or cash price.

According to the lawsuit, CVS "tried to find a way to both broadly offer discounts to retain critical pharmacy customers, including cash paying customers, and also avoid the unprofitable result of reporting the discounted prices as the U&C price."

CVS argues the membership program prices were not the U&C prices. And, its membership program prices were neither concealed nor fraudulent.

Blue Cross Blue Shield is not the only company that has filed suit against CVS for fraudulent overcharges. The Sheet Metal Workers union and the state of Mississippi have also sued CVS for this behavior.

Will we see an end to surprise medical bills?

Doctors and other health care providers are billing unsuspecting patients ever increasing amounts for out-of-network care. A new report from the **Health Care Cost Institute** reveals which doctors and other health care providers are more likely to charge insured patients for out-of-network care, sending out "**surprise medical bills**." Congress agrees surprise medical billing is a problem, but it can't seem to agree on how to address it.

In many cases, surprise medical bills are for thousands of dollars, and patients have no control over them. Too often, patients end up in medical debt. Fortunately, it is less of a problem for people with Medicare because providers are limited in what they can charge people with Medicare.

Pathologists, specialists who study tissues and fluids to help diagnose medical conditions, are the health care providers who most frequently bill for out-of-network care. More than one in three pathologists billed hospitalized patients for out-of-network care more than 90 percent of the time. And about one in five pathologists billed patients for outpatient visits out-of-network more than 90 percent of the time.

Much like pathologists, a large share of emergency care providers bill patients for out-of-network inpatient care. About 44 percent of providers in both specialties. Emergency care doctors do not send out surprise medical bills as frequently as pathologists. But, when they do bill for out-of-network care, the charges can be sky-high.

Members of Congress on both sides of the aisle support legislation to address surprise medical bills. But, they have not been able to reach agreement on a solution. The simplest solution would be for the government to limit what health care providers can charge for their services out of network. But, hospitals and private-equity firms, which sometimes own pathology and emergency care medicine practices, are arguing for arbitration.

Recent Congressional legislation appropriating stimulus money for hospitals in response to the coronavirus pandemic specifically forbids hospitals from sending surprise bills to patients receiving COVID-19 care. Still, stories abound of patients receiving surprise bills for COVID-19 care, including one person in Denver who received a bill for $140,000.

HCCI researchers found that in addition to pathologists and emergency medicine providers, many other types of specialists bill patients for out-of-network care, though at different frequencies. The proportion of providers with at least one out-of-network claim for inpatient visits ran the gamut from 18% for cardiology to 44% for emergency medicine. For outpatient visits, the share of providers with at least one out-of-network claim ranged from 15% for behavioral health to 49% for emergency medicine.

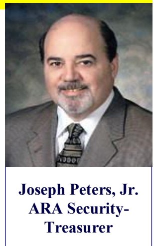
Nursing Homes and Assisted Living Facilities are Taking Residents' Stimulus

Recently the **Federal Trade Commission warned** that some long term care facilities are attempting to take the stimulus checks of residents on Medicaid. These nursing homes and assisted living facilities are forcing residents to sign their checks over to the facility by claiming that the facility gets to keep their stimulus check as "resources" for the federal health care program.

However, **tax law** states that tax credits don't, in fact, count as resources for federal benefit programs such as Medicaid. According to the CARES Act, the economic impact payments are a tax credit, and Congress defining the stimulus payments that way is supposed to ensure that the government cannot seize them.

If a facility has taken the stimulus check of you or a loved one, contact your state attorney general and ask them to help you get it back.

"It is disgraceful that any nursing facility would attempt to steal low-income residents' stimulus payments," said **Joseph Peters, Jr.**, Secretary-Treasurer of the Alliance. "Nursing homes and assisted living facilities cannot take money from residents just because they're on Medicaid."


Joseph Peters, Jr.
ARA Security-Treasurer

Move to Help Medicare Beneficiaries Afford Insulin Does Not Go Far Enough

This week, the Trump administration announced a new two-year demonstration program that will reduce insulin costs for some people with Medicare drug coverage. The lower costs will no doubt be welcomed by the 1.3 million enrollees who stand to benefit, and we applaud this help. However, we are disappointed that this initiative will not offer relief to all who need it or address larger issues around prescription drug access and affordability.

Under the new program, the **Part D Senior Savings Model**, beginning in 2021 people with Medicare will be able to purchase a Part D plan that caps monthly insulin cost-sharing at $35. The Centers for Medicare & Medicaid Services (CMS) estimates this will save affected enrollees $446 per year, on average, while also providing them with much-needed certainty regarding their monthly insulin costs. While participation is voluntary for insurers and drug makers, CMS expects plans to be available in every state.

Efforts to improve access to insulin are long overdue. When diabetics are unable to afford their needed medication, they suffer serious health complications, including blindness, amputations, and even death. Unfortunately, insulin costs have skyrocketed in recent years, and a lack of affordability is an **increasing problem.**

These facts make steps to reduce insulin costs at the pharmacy counter very welcome. However, the new program does not do enough to rein in costs. Not only will some Medicare beneficiaries be left out in the cold, the model does nothing to curtail costs for other drugs that are just as vital to consumer health, such as heart medications, cancer drugs, or treatments for neurological conditions or serious autoimmune disorders. It also fails to cap overall drug costs for people with Medicare to ensure they can afford all of their medications throughout the year.

At Medicare Rights, we continue to support strong action on multiple fronts to bring down drug costs. This includes authorizing Medicare to negotiate drug prices, capping out-of-pocket expenses for both drugs and other Medicare expenditures, and **reforming the Part D appeals process** to make it easier for people to obtain needed prescriptions. To that end, we continue to support comprehensive legislation like **the Elijah E. Cummings Lower Drug Costs Now Act (H.R. 3)** which would meaningfully address prescription drug affordability and strengthen the Medicare program.

Read more about the Part D Senior Savings Model.

Read more about issues with insulin affordability.

Read more about other efforts to reduce drug costs.

Coronavirus: Republicans in Congress side with Pharma, won't block price-gouging

You would like to think that everyone in Congress would stand behind **basic principles** laid out by House Representative Jan Schakowsky (D-IL) and her colleagues in Congress to ensure that all novel coronavirus treatments are priced fairly and available to everyone. But, a group of Republican lawmakers, in partnership with Pharma, are doing nothing to block price-gouging for COVID-19 drugs and vaccines, Sharon Lerner reports for **The Intercept**.

Rep. Schakowsky and fellow House Democrats want reasonable prices for COVID-19 vaccines and treatments. The costs of research and manufacturing for these treatments should be public. Pharmaceutical companies should not have control over how to scale up production of these drugs or who has access to them. And, during this pandemic, pharmaceutical companies should not be able to profit indiscriminately.

Conservative organizations are daring to suggest that ensuring these drugs are affordable and available is "dangerous, disruptive, and unacceptable." In fact, it's these arguments that are dangerous, disruptive and unacceptable. The groups suggest that pharmaceutical companies will harm people with COVID-19 if they are not able to profit handsomely from these drugs. In fact, **lowering drug prices will not affect innovation.**

Thirty-one conservative organizations reject the value of ensuring everyone access to COVID-19 drugs and keeping pharmaceutical companies from setting high prices for them. The Hudson Institute, the Council for Citizens Against Government Waste, and Consumer Action for a Strong Economy, many of whom are supported by Pharma, are among those conservative organizations opposing fair pricing for these drugs.

It should be said that taxpayers have supported the research that is responsible for the vaccines now in clinical trials. Notwithstanding, Pharma insists that it would not be producing these drugs if it didn't have intellectual property rights–patents–to them.

To be clear, pharmaceutical patents are the problem. They confer monopoly pricing power on pharmaceutical companies. They do not allow for fair prices. They undermine access to needed treatments. They hurt Americans. A November 2019 **Gallup poll** found that 34 million Americans knew someone who had died because he or she had not gotten a needed drug. It also found that 58 million people could not afford their prescription drugs. Drugs don't work if people cannot afford them.

Other wealthy countries are working together to combat COVID-19. The World Health Organization is moving to ensure that research and data related to COVID-19 is not proprietary. President Trump says that the US will withdraw from the World Health Organization.

To date, **Pharma lobbyists have succeeded** at keeping reasonable COVID-19 drug pricing legislation from being enacted as part of stimulus packages. How many lives will be lost if they continue to succeed?

What are the parts of Medicare?

Dear Marci,
I will turn 65 soon and need to enroll in Medicare. I've heard that there are different parts of Medicare. What are those parts?
-Aurelio (Cleveland, OH)

Dear Aurelio,
There are four parts of Medicare: Part A, Part B, Part C, and Part D.

- Part A provides coverage for inpatient hospitalization, skilled nursing facility stays, home health care, and hospice care.
- Part B provides outpatient coverage, including for physician services, diagnostic tests, durable medical equipment, and outpatient hospital services.
- Part C is an alternate way to receive your Medicare benefits; provides Part A inpatient/hospital and Part B outpatient/medical coverage and supplemental benefits not covered by Original Medicare (see below for more information).
- Part D provides prescription drug coverage.

Most beneficiaries choose to receive their Parts A and B benefits through Original Medicare, the traditional fee-for-service program offered directly through the federal government. It is sometimes called Traditional Medicare or Fee-for-Service (FFS) Medicare. Under Original Medicare, the government pays directly for the health care services you receive. You can see any doctor and hospital that takes Medicare (and most do) anywhere in the country.
In Original Medicare:

- You go directly to the doctor or hospital when you need care. You do not need to get prior permission/ authorization from Medicare or your primary care doctor.
- You are responsible for a monthly premium for Part B. Some also pay a premium for Part A.
- You typically owe a coinsurance for each service you receive.

There are limits on the amounts that doctors and hospitals can charge for your care.
If you want prescription drug coverage with Original Medicare, in most cases you will need to actively choose and join a stand-alone Medicare private drug plan (PDP).
Note: There are a **number of government programs** that help reduce your health care and prescription drug costs if you meet the eligibility requirements.
Unless you choose otherwise, you will have Original Medicare when you enroll in Medicare.
Instead of Original Medicare, in most areas you have the option of getting your Medicare benefits from a Medicare Advantage Plan, also called Part C or Medicare private health plan. This means that you must still pay your monthly Part B premium (and your Part A premium, if you have one). Medicare Advantage Plans must offer, at minimum, the same benefits as Original Medicare (those covered under Parts A and B) but can do so with different costs and coverage restrictions. You also typically get Part D as part of your Medicare Advantage benefits package (MAPD).
Many plans also cover supplemental benefits that are not covered by Original Medicare, like dental care, vision care, and gym memberships. Many different kinds of Medicare Advantage Plans are available. You may pay a monthly premium for this coverage, in addition to your Part B premium.
-Marci

Hundreds of nursing homes ran short on staff, protective gear as more than 30,000 residents died during pandemic

New federal data released Thursday reflect the rising death toll from covid-19 at the nation's nursing homes and the desperate need at thousands of facilities for critical personnel and basic supplies.

More than three months after the **coronavirus** began sweeping through U.S. nursing homes, thousands of homes are still underequipped for the continuing onslaught, the data show.

So far, the number of nursing home deaths attributed to covid-19 has reached nearly 32,000 residents and more than 600 employees, and both counts are sure to rise: About 12 percent of the nation's 15,000 homes have not yet reported figures. The new numbers, building on **data released Tuesday** that showed about 26,000 resident deaths, include the death toll from more homes.

The data offer a statistical portrait of an industry at the center of the pandemic's fury unable to properly care for its 1.4 million residents: Nearly 2,000 facilities reported a shortage of nursing staff and more than 2,200 said they lack enough aides, according to the data.

The figures on basic supplies are similarly dire: More than 250 nursing homes lack any surgical masks and another 800 are within a week of running out. More than 2,000 are a week away from running out of gowns and more than 800 are a week away from depleting hand sanitizer supplies. More than 500 lack any N95 masks used to prevent infection, according to the data.

"We have failed the residents and we have failed the staff as a society," said Michael Wasserman, president of the California Association of Long Term Care Medicine.

Nursing homes with stringent infection control and adequate staffing were better equipped to prevent the spread of the coronavirus once it struck, Wasserman said, but even the best nursing homes lacked personal protective equipment and access to testing.

"This is something the CDC should have been studying from the beginning," he said.

The federal government's decision to provide information about **outbreaks at nursing homes** comes after more than a dozen states refused to make public the same information, spurring lawsuits across the United States.

As of the end of May, 14 states were not disclosing information about the pandemic's impact on nursing homes, according to a survey by USA Today. In some states — including Arizona and Idaho — media organizations have filed lawsuits demanding the information, arguing that the public ought to know which nursing homes have outbreaks. In other states, legal pressure has led to public release of the information. In Florida, for example, state officials released more information following a lawsuit drafted by the Miami Herald and supported by other media organizations including The Washington Post.

The federal government eventually stepped into the dispute, requiring more public disclosure about the nursing home outbreaks. In April, the U.S. agency that oversees nursing homes — the Centers for Medicare and Medicaid Services — issued a rule calling for nursing homes to report information on coronavirus cases and deaths among residents and staff to the agency….**Read More**

When A Doctor No Longer Accepts Medicare, Patients Left Holding The Bag

Pneumonia. Heart problems. High cholesterol. Betsy Carrier, 71, and her husband, Don Resnikoff, 79, relied on their primary care doctor in Montgomery County, Maryland, for help managing their ailments.

But after seven years, the couple was surprised when the doctor informed them she was opting out of Medicare, the couple's insurer.

"It's a serious loss," Resnikoff said of their doctor.

Patients can lose doctors for a variety of reasons, including a physician's retirement or when either patient or doctor moves away. But economic forces are also at play. Many primary care doctors have long argued that Medicare, the federal health insurance program for seniors and people with disabilities, doesn't reimburse them adequately and requires too much paperwork to get paid.

These frustrations have prompted some physicians to experiment with converting their practices to more lucrative payment models, such as concierge medicine, in which patients pay a fee upfront to retain the doctor. Patients who cannot afford that arrangement may have to search for a new physician.

The exact number of physicians with concierge practices is unknown, health care experts said. One physician consulting company, Concierge Choice Physicians, estimates that roughly 10,000 doctors practice some form of membership medicine, although it may not strictly apply to Medicare patients.

Shawn Martin, senior vice president of the American Academy of Family Physicians, estimated that fewer than 3% of their 134,000 members use this model but the number is slowly growing.

The move to concierge medicine may be more prevalent in wealthier areas.

Travis Singleton, executive vice president for the medical staffing company Merritt Hawkins, said doctors switching to other payment systems or those charging Medicare patients a higher price for care are likely "in more affluent, well-to-do areas where, frankly, they can get fees."

It is far easier for physicians than hospitals to opt out of taking Medicare patients. Most hospitals have to accept them since they rely on Medicare payments to fund inpatient stays, doctor training and other functions.

The majority of physicians do still accept Medicare, and most people insured by the federal program for seniors and people with disabilities have no problem finding another health care provider. But that transition can be tough, particularly for older adults with multiple medical conditions.

"When transition of care happens, from one provider to another, that trust is often lost and it takes time to build that trust again," said Dr. Fatima Sheikh, a geriatrician and the chief medical officer of FutureCare, which operates 15 rehabilitation and skilled nursing centers in Maryland.

Shuffling doctors also heightens the risk of mishaps.

A **study** of at least 2,200 older adults published in 2016 found that nearly 4 in 10 were taking at least five medications at the same time. Fifteen percent of them were at risk of drug-to-drug interaction.

Primary care providers mitigate this risk by coordinating among doctors on behalf of the patient, said Dr. Kellie Flood, a geriatrician at the University of Alabama-Birmingham.

"You really need the primary care physicians to serve as the quarterback of the health care team," said Flood. "If that's suddenly lost, there's really not a written document that can sum all that up and just be sent" to the new doctor.

Finding a physician who accepts Medicare depends partly on workforce demographics. From 2010 to 2017, doctors providing primary care services to Medicare beneficiaries increased by 13%, according to the Medicare Payment Advisory Commission (MedPAC), a nonpartisan group that advises Congress.

However, the swell of seniors who qualify for Medicare has outpaced the number of doctors available to treat them. Every day, an estimated 10,000 Americans turn 65 and become eligible for the government program, the Census Bureau **reported.**

NEA Tiverton, Rhode Island takes vote of no confidence in Superintendent

Tiverton, R.I. – The faculty members of NEA Tiverton met last week and, with overwhelming support, took a vote of no confidence in Peter Sanchioni, the Superintendent of the Tiverton school system. While the vote was unanimous, a few members not in attendance did not agree with this step, and we remain troubled that even this protected action would lead to further bullying and intimidation from the Superintendent.

The members listed the following concerns:

1. **The termination of the union president for doing union work.** The Superintendent has continually demonstrated a refusal to acknowledge the fact that when the union and management come to the table, they sit as equals.
2. **The perpetuation of a distressing culture.** Instead of cultivating a culture of open dialogue and soliciting input, the Superintendent's top-down management style is one of bullying and intimidation with the expectation that union members will just fall in line. When individuals step forward to challenge the Superintendent, they are met with a domineering, belittling attitude and sarcastic responses.
3. **The demoralization of ineffective leadership.** The recent debacle of the Superintendent distributing layoff notices – faulty notices – that used inaccurate termination language during a global pandemic; a difficult time when educators and support professionals are already stretched thin and stress levels are heightened.
4. **The basic failure to understand the necessity of educating the whole child.** In these times of strife and uncertainty, the failure of the Superintendent to grasp the importance of educating our students in all aspects of the world they will someday enter as adults – including art, music, health and physical education, as well as providing for the social and emotional needs with guidance and social services and ensuring those with special needs are treated as equals – shocks our collective conscience.

Therefore, despite low morale in our ranks brought on by the onslaught of failure of the Superintendent's leadership at every turn, NEA Tiverton has come together to call upon the Tiverton School Committee to bring about an independent agent to investigate our concerns. We would expect this agent to report directly to the School Committee, as we believe an outsider would not be subjected to the tactics we have endured.

At a time when leadership from the top needed to show vision and the ability to collaborate with those on the front lines of our children's education, we were instead given the back of his hand and essentially told we were to be seen and not heard.

We have never lost faith in our students. We have lost confidence in our Superintendent.

Stephanie Mandeville
Communications Director
NEA Rhode Island
smandeville@neari.org

Sign the Petition below

Amy Schwartz Mullen

RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

In Hard-Hit Areas, COVID's Ripple Effects Strain Mental Health Care Systems

In late March, Marcell's girlfriend took him to the emergency room at Henry Ford Wyandotte Hospital, about 11 miles south of Detroit.

"I had [acute] paranoia and depression off the roof," said Marcell, 46, who asked to be identified only by his first name because he wanted to maintain confidentiality about some aspects of his illness.

Marcell's depression was so profound, he said, he didn't want to move and was considering suicide.

"Things were getting overwhelming and really rough. I wanted to end it," he said.

Marcell, diagnosed with schizoaffective disorder seven years ago, had been this route before but never during a pandemic. The Detroit area was a coronavirus hot spot, slamming hospitals, attracting concerns from federal public health officials and recording more than 1,000 deaths in Wayne County as of May 28. Michigan ranks fourth among states for deaths from COVID-19.

The crisis enveloping the hospitals had a ripple effect on mental health programs and facilities. The emergency room was trying to get non-COVID patients out as soon as possible because the risk of infection in the hospital was high, said Jaime White, director of clinical development and crisis services for Hegira Health, a nonprofit group offering mental health and substance abuse treatment programs. But the options were limited.

Still, the number of people waiting for beds at Detroit's crisis centers swelled. Twenty-three people in crisis had to instead be cared for in a hospital.

This situation was hardly unique. Although mental health services continued largely uninterrupted in areas with low levels of the coronavirus, behavioral health care workers in areas hit hard by COVID-19 were overburdened. Mobile crisis teams, residential programs and call centers, especially in pandemic hot spots, had to reduce or close services. Some programs were plagued by shortages of staff and protective supplies for workers.

At the same time, people battling mental health disorders became more stressed and anxious.

"For people with preexisting mental health conditions, their routines and ability to access support is super important. Whenever additional barriers are placed on them, it could be challenging and can contribute to an increase in symptoms," said White.

After eight hours in the emergency room, Marcell was transferred to COPE, a community outreach program for psychiatric emergencies for Wayne County Medicaid patients.

"We try to get patients like him into the lowest care possible with the least restrictive environment," White said. "The quicker we could get him out, the better."

Marcell was stabilized at COPE over the next three days, but his behavioral health care team couldn't get him a bed in one of two local residential crisis centers operated by Hegira. Social distancing orders had reduced the beds from 20 to 14, so Marcell was discharged home with a series of scheduled services and assigned a service provider to check on him…..**Read More**

This Time, Hardly Anyone Followed Trump's Lead on Virus Drugs

Prescriptions soared after the president began promoting two antimalarial drugs to treat coronavirus infections. Nothing of the sort happened when he later announced he was taking one of them.

Newly compiled prescription data shows that President Trump's decision to take an antimalarial drug to ward off the coronavirus did not inspire many Americans to do the same, reflecting the fast-changing landscape surrounding the virus and efforts to treat it.

First-time prescriptions ticked up by only several hundred the day after **Mr. Trump mentioned** at a White House event on May 18 that, as a preventive measure, he was taking one of two antimalarial drugs he had touted, according to nationwide data analyzed by The New York Times.

That increase paled in comparison to the tens of thousands of first-time prescriptions that poured into retail pharmacies after Mr. Trump first promoted the two medications during a White House telecast two months earlier.

The drugs, chloroquine and hydroxychloroquine, have not been proven to treat Covid-19 and have been fiercely debated as a potential cure or prophylactic measure, despite warnings from medical experts about their efficacy and possibly dangerous side effects.

First-time prescriptions of the drugs in retail pharmacies have remained higher than usual since the pandemic began, averaging about 2.25 times their previous weekday rate, according to the analysis.

By the evening of March 19, the day the president first praised the drugs on television, the rate of first-time prescriptions had surged to more than 46 times the weekday average, the highest level to date. By contrast, on May 19 — the day after Mr. Trump revealed in the late afternoon that he had begun taking one of the drugs — the rate changed comparatively little: rising to about 2.8 times the average, the equivalent of about 400 prescriptions. The level remained slightly elevated for most of the week.

The stark difference could be explained in part by the timing of the two announcements, said Dr. Walid Gellad, who leads the Center for Pharmaceutical Policy and Prescribing at the University of Pittsburgh.

By May, the initial wave of fear and uncertainty about the virus had lessened, he said, and more was known from scientific studies about the questionable benefits — even possible harm — of taking the two drugs.

Even the president taking one of the medications might not be enough to counter those developments.

In addition, Dr. Gellad said, the pool of people inclined to take the drugs may have been depleted by May. "People who were going to do this already did it," he said. "They already have it in their cabinet.

The prescription data analyzed by The Times was compiled by IPM.ai, a subsidiary of Swoop, a company in Cambridge, Mass., that specializes in health care data and analytics based on artificial intelligence. The data did not include the identities of the prescribers or the patients.

Last week, the White House press secretary Kayleigh McEnany said Mr. Trump reported "feeling perfect" after taking hydroxychloroquine and suggested he would take it again if exposed to the virus. The president has said he took a short course of the drug because two people in the White House had tested positive for the virus….**Read More**

Rapid Changes To Health System Spurred By COVID Might Be Here To Stay

The U.S. health care system is famously resistant to government-imposed change. It took decades to create Medicare and Medicaid, mostly due to opposition from the medical-industrial complex. Then it was nearly another half-century before the passage of the Affordable Care Act.

But the COVID-19 pandemic has done what no president or social movement or venture capitalist could have dreamed of: It forced sudden major changes to the nation's health care system that are unlikely to be reversed.

"Health care is never going back to the way it was before," said Gail Wilensky, a health economist who ran the Medicare and Medicaid programs for President George H.W. Bush in the early 1990s.

Wilensky is far from the only longtime observer of the American health care system to marvel at the speed of some long-sought changes. But experts warn that the breakthroughs may not all make the health system work better, or make it less expensive.

That said, here are three trends that seem likely to continue.

Telehealth For All

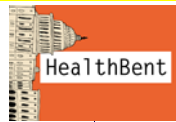
Telehealth is not new; medical professionals have used it to reach patients in rural or remote settings since **the late 1980s**.

But even while technology has made video visits easier, it has failed to reach critical mass, largely because of political fights. Licensing has been one main obstacle – determining how a doctor in one state can legally treat a patient in a state where the doctor is not licensed.

The other obstacle, not surprisingly, is payment. Should a video visit be reimbursed at the same rate as an in-person visit? Will making it easier for doctors and other medical professionals to use telehealth encourage unnecessary care, thus driving up the nation's $3.6 trillion health tab even more? Or could it replace care once provided free by phone?

Still, the pandemic has pushed aside those sticking points. Almost overnight, by necessity, every health care provider who can is delivering telemedicine. A new **survey from Gallup** found the number of patients reporting "virtual" medical visits more than doubled, from 12% to 27%, from late March to mid-May. That is due, at least in part, to **Medicare having made it easier** for doctors to bill for virtual visits.

It's easy to see why many patients like video visits — there's no parking to find and pay for, and it takes far less time out of a workday than going to an office.



Doctors and other practitioners seem more ambivalent. On one hand, it can be harder to examine a patient over video and some services just can't be done via a digital connection. On the other hand, they can see more patients in the same amount of time and may need less support staff and possibly smaller offices if more visits are conducted virtually.

Of course, telemedicine doesn't work for everyone. Many areas and patients don't have reliable or robust broadband connections that make video visits work. And some patients, particularly the oldest seniors, lack the technological skills needed to connect.

Primary Care Doctors In Peril

Another trend that has suddenly accelerated is worry over the nation's dwindling supply of primary care doctors. The exodus of practitioners performing primary care has been a concern over the past several years, as baby boomer doctors retire and others have grown weary of more and more bureaucracy from government and private payers. Having faced a difficult financial crisis during the pandemic, more family physicians may move into retirement or seek other professional options.

At the same time, **fewer current medical students** are choosing specialties in primary care.

"I've been trying to raise the alarm about the kind of perilous future of primary care," said Farzad Mostashari, a top Health and Human Services Department official in the Obama administration. Mostashari runs Aledade, a company that helps primary care doctors make the transition from fee-for-service medicine to new payment models.

The **American Academy of Family Physicians** reports that 70% of primary care physicians are reporting declines in patient volume of 50% or more since March, and 40% have laid off or furloughed staff. The AAFP has joined other primary care and insurance groups **in asking HHS for an infusion of cash**.

"This is absolutely essential to effectively treat patients today and to maintain their ongoing operations until we overcome this public health emergency," the groups wrote.

One easy way to help keep primary care doctors afloat would be to pay them not according to what they do, but in a lump sum to keep patients healthy. This move from fee-for-service to what's known as capitation or value-based care has unfolded gradually and was championed in the Affordable Care Act….**Read More**

Blood Pressure Meds Help the Frail Elderly Live Longer

Blood pressure drugs help even the most frail elderly live longer, and older people who are healthier get the biggest benefit, Italian researchers say.

"We knew that high blood pressure medication was protective in general among older people, however, we focused on whether it is also protective in frail patients with many other medical conditions who are usually excluded from randomized trials," said lead author Dr. Giuseppe Mancia, professor emeritus at the University of Milano-Bicocca in Milan.

For the study, his team collected data from more than one million people aged 65 and older in northern Italy who had received three or more blood pressure medication prescriptions.

The investigators also looked at the outcomes of older people with a variety of health conditions.

For those in good health at the outset of the study, the probability of death over seven years was 16%. That rose to 64% for patients who were in very poor health.

The researchers found that people who took their blood pressure medications regularly were 44% less likely to die during the study if they started in good health while those who were in poor health were 33% less likely to die compared to older people who did not adhere to their medication regimen.

The same pattern was seen for heart disease deaths.

"Our findings definitely suggest that even in very frail people, antihypertensive treatment reduces the risk of death; however, the benefits may be smaller in this group," Mancia said in an American Heart Association news release.

He urged doctors to do their best to encourage patients to take their medicine, because "medications do nothing if people don't take them."

The report was published June 8 in the journal *Hypertension*.

More information

For more about high blood pressure, visit the **American Heart Association.**

I Went to Stroke Camp. This Is What It's Like

*Stroke is a leading cause of serious long-term disability. Nearly one in four **stroke patients** is disabled, and their daily care often falls to family members who are their caregivers. Women often assume the role of a **primary caregiver**, thus shouldering a high burden of the stress, according to a February 2020 study published in the journal Stroke. Stroke camps can help caregivers unplug, recharge, and get a break from significant stress. MaryLee Nunley of Peoria, Illinois, a caregiver, shares what it's like to attend stroke camp with her husband John Nunley, who was 55 at the time of his stroke. Now married 24 years, Marylee is the founder of the non-profit organization **United Stroke Alliance** and is currently head of its **Stroke Camp** division.*

A bad case of pancreatitis and a stroke

Early in 2001, John had a very bad case of pancreatitis (an inflammation of the pancreas) where he was hospitalized for four months. It was the worst case they'd seen at the hospital at that time, and he had all of the complications that could have occurred. Collapsed lungs, pancreatic pseudocysts, VRE (vancomycin-resistant enterococcus) infection, MRSA (methicillin-resistant *Staphylococcus aureus*), and abdominal infections that were eating up his pancreas.

Because of the infection, he was put in an induced coma for four weeks and had seven surgeries in two weeks as they attempted to clean out the infection and his pancreas. In fact, he was still recovering from this after he went home, and had an ostomy bag draining pancreatic fluid when he had a stroke.

A history of heart disease

Prior to pancreatitis, John had a **history of heart disease**, but he had worked out and gotten himself in good shape. He [exercised] six days a week and was strong and doing well when a routine ERCP (endoscopic retrograde cholangiopancreatography—scope to look for gastric problems) caused pancreatitis. There were seven days when it was touch and go whether he would survive, then came the stroke. It was a Sunday afternoon in September of 2001, and luckily I was in the room with him. He was lifting a **television** onto a shelf in our bedroom when he collapsed. He tried to get up and then fell a second time. I could tell that was very unlike him, so I helped him up and onto the bed. He had the look of a frightened child and when he tried to speak, it was just gibberish.

Recognizing the signs of stroke

I recognized the **signs of a stroke** and called 911. (The American Stroke Association recommends the **acronym FAST,** which stands for face drooping , arm weakness, speech difficulties, and time to call 911.) An ambulance arrived and transported him to a local stroke center; I followed in my car.

The stroke was confirmed right away, and it was caused by a clot to his left carotid artery. He had **elevated cholesterol,** but not a dangerous level, and he was a former smoker, but hadn't smoked for over 15 years when the stroke occurred. I suspect this was partly caused by the elevated blood glucose levels from how sick he was with pancreatitis.

Stroke rehabilitation

Post-stroke, John had right-sided weakness and couldn't walk right away, but luckily, within the week, they taught him to walk again. He had to be cautious because his right side has diminished sensation; he had to learn to watch his foot when he put it down for balance. He was a very good patient in rehab and wanted to get better, so his progress was good but speech was another story. He didn't have any language at first, only gibberish and swear words (involuntary language). While he was in the hospital for four weeks, he had physical therapy, occupational therapy, and speech therapy.

Regaining speech

Speech was the most challenging and frustrating for him. It was such a learning experience for me, too. I learned how language works in the first place, and the work that goes into re-learning language. He couldn't say my name and cried thinking that it meant he didn't remember me. He did learn "my woman" which he called me for that first year until he could finally say my name. He had speech therapy for 2 two years, two to three times a week in an outpatient setting. When (health insurance) benefits ran out, I found a speech software and he continued to work very hard for two more years until he felt good conversationally. (Here's how **speech therapy helped a stroke survivor**.)...**Read More**

Disinfecting Food This Way Could Actually Poison You, CDC Warns

Last month, the **CDC had surveyed Americans** about cleaning behaviors and know-how related to coronavirus prevention, and the results may shock you. The agency released their findings from a survey taken by over 500 participants, a sample that represented the U.S. population by gender, age, region, race/ethnicity, and education. The study was done, in part, to asses the cause of an increase in calls to poison centers, and participants were asked questions about "general knowledge, attitudes, and practices related to use of household cleaners and disinfectants," the report states.

The biggest finding was that 39 percent of people reported using common household cleaners, like bleach, in non-recommended ways that are actually really harmful to their health.

Majority reported an increased frequency of cleaning at home, which is great, but some of the cleaning behaviors reported are ill-advised and downright dangerous. These include applying bleach and other household disinfectants to hands (reported by 18%) and body (10%), inhaling their vapors (6%), and downright gargling or drinking solutions with bleach (4%). Yikes!

Another shocking finding showed that 19% of those surveyed said that they have also applied bleach on their food, which CDC warns is extremely harmful to your health.

Bleach is extremely harmful if used incorrectly

Bleach is a chlorine-based corrosive substance. Chlorine is a chemical element that can be found as a liquid, gas, or solid, and is present in many household cleaning products. Cleaning your home surfaces with bleach while using the correct protective gear, like gloves and a mask, is a great way to get rid of pesky germs of all stripes. However, CDC warns that applying household cleaning products and disinfectants directly to skin, or ingesting them, poses a risk of severe tissue damage and corrosive injury, and should be strictly avoided.

Cleaning fruits and vegetables with bleach, even if you're going to peel them later, can have you ingesting chlorine, since it can seep into your food even if you rinse or peel it.

The survey showed that 25% of participant experienced at least one adverse health effect that they believed was a side effect of using cleaners and disinfectants: nose or sinus irritation (11%); skin irritation (8%); eye irritation (8%); dizziness, lightheadedness, or headache (8%); upset stomach or nausea (6%); or breathing problems (6%).

No evidence of coronavirus infections through food….**Read More**