Rhode Island Alliance for Retired Americans ©

RI ARA

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

May 10, 2020 E-Newsletter

Publication 2020 Issue 19
Published in house by the
RI ARA

Older Americans Month 2020
A Proclamation

Whereas, ARA/RI ARA *includes a growing number of older Americans who make countless contributions to our community every day; and*
Whereas, ARA/RI ARA *is stronger when people of all ages, abilities, and backgrounds are included and encouraged to make their mark; and*
Whereas, *ARA/**RI RIA** recognizes the importance of the physical, mental, social, and emotional well-being of its citizens; and*
Whereas, ARA*/RI ARA can support our community members by:*

- *promoting independence, inclusion, and participation;*
- *engaging older adults through education, recreation, and service; and*
- *connecting people with opportunities to share their time, experience, and talents.*

Now, therefore, *we of the **Alliance for Reared Americans/Rhode Island Alliance for Retired Americans** do hereby proclaim May 2020 to be Older Americans Month. We urge every resident to recognize older adults and the people who support them as essential members of our community.*
Dated this 10th day of May, 2020
John A. Pernorio, President
Rhode Island Alliance for Retired Americans

Rhode Island Alliance *for* Retired Americans, Inc. • 94 Cleveland Street • North Providence, RI • 02904-3525 • 401-480-8381
riarajap@hotmail.com • http://www.facebook.com/groups/354516807278/

Inside the DLT: Helping Rhode Island's workforce during a pandemic.

By: Scott Jensen, Dept. of Labor and Training

Since March 9, 2020, more than 220,000 working Rhode Islanders have filed for income support benefits with the Department of Labor and Training (DLT), the vast majority of them for Unemployment Insurance (UI). This has been the busiest our programs have ever been, by far. To put it into context, prior to the pandemic, the most claim filings in a single week in Rhode Island's UI program happened in early 1992 during the RI banking crisis. In that week about 5,300 claims were filed. Since the beginning of March, we have seen that number eclipsed a dozen times, each in a single day. Here's another good comparison – during one of our busiest weeks in a typical year, we certify about 12,000 weekly benefit payments. This week, we'll process more than 140,000 payments. The scale of what we're dealing with was previously unimaginable. It's been an incredible slog, but due to hard work, ingenuity and some good luck we've managed to respond in a timely manner and connect Rhode Islanders with the benefits they need in these trying times.

How have we been able to keep afloat?

In March, we started to see a serious influx of claims being filed each day. We knew this would require new thinking and new methods to be able to keep up, so, we attacked the problem on three fronts: human resources, process improvements and technological enhancements. The reality was that each of these changes was necessary but could not work alone; they had to be implemented together to give us a fighting chance against the massive claim load.

Human Resources

Getting more boots on the ground was always a priority; doing so in an impactful way, however, had to be thought out. We landed on adding seventeen new front-line staff (RIESA Local 401 members); bringing back fifteen DLT retirees that had the skills and expertise necessary to make an immediate impact and contracting with a third-party provider to help ease the workload by performing less-complicated, routine functions. Adding people to the mix will prove to be helpful now and in the long-term. Doing so on three different fronts allowed us to tackle immediate issues and grow our team for the future.

Process Improvements

The Unemployment Insurance program is a bear. It's a big, hairy, federal program that is run by states. There are a lot of rules, both federal and state, that present challenges along the way. There are processes built on top of processes, making it complicated for those that work on it every day, let alone claimants attempting to get benefits. Processing claims through the system without reconsidering the common traps that hold claims up just wouldn't have worked. So, the team spoke with workers and managers alike to get a sense of what should be reimagined and then went to work making the recommended changes. These moves eased the process for claimants and smoothed out some edges for the men and women that work to process these claims.

Technology Upgrades

While a number of enhancements have been introduced in the last sixty days, the most significant changes have been the launch of the new Pandemic Unemployment Assistance (PUA) online application and the replacement of the TeleServe phone and internet certification tools. Congress established the PUA program to provide UI benefits to groups of people that have not traditionally qualified for the program: self-employed people, gig-economy workers, independent contractors and those that do not otherwise qualify for Unemployment. While the goal was laudable, the traditional UI systems were just not designed to process claims for these folks. We partnered with RIPL (Brown University) and Amazon Web Services (AWS) to set up a new, modern program application hosted in DLT's secure cloud environment. Being in the cloud enabled the application to take over 10,000 claims on day one without compromising the system. Since then we've received more than 40,000 PUA claims. The other significant change was the weekly certification tool upgrade. We knew that the analog TeleServe system would not be able to handle the incredible volume being thrown at it. Working with AWS, we deployed a new cloud-based system (UI Online) that has been able to handle more than 100,000 certifications per week without a hiccup. These tools, while necessary now, will also provide great relief to working Rhode Islanders in the years to come.

What about the results?

With these changes in place we've been able to process claims efficiently and effectively. Just over seventy percent (70%) of the claims we've received to date have processed cleanly, without the need for a DLT team member to physically touch that claim. The remaining claims have been assigned to work streams and are being processed daily. These claims typically have wages from multiple states or the federal government involved, which requires DLT to request and receive information from those entities before we can finalize them. As of last week, the average amount of time from date of filing to payment was just over twelve days. That is better than it was prior to the pandemic – evidence that the changes have delivered results. For some time, the focus has been on our UI program, for good reason. We don't want to forget about our brothers and sisters working in the TDI program though. The UI system, with its quirks, still holds an advantage over TDI, because all TDI claims have to be manually processed. With just over 20,000 TDI claims, our folks have been under a tremendous amount of pressure to keep the work moving so claimants can access their benefits in a timely manner. It's been tough, but they've met the challenge head on and have succeeded. In their spare time (hah hah), they've been kind enough to lend a hand with UI claims too. It's all about teamwork here at DLT.

The men and women of DLT have been hard at work, seven days per week, to serve our fellow Rhode Islanders. They've worked across programs and served in roles unfamiliar to them in order to get the job done. We could not have accomplished what we have without their dedication to duty and commitment to the State of Rhode Island. We're forever grateful.

Thank you Rhode Island Employment Security Alliance, Local 401 SEIU, AFL-CIO !!!!

Report says R.I. top-flight in handling jobless claims

By Patrick Anderson
Journal Staff Writer

Rhode Island was hit faster and harder by coronavirus-related unemployment claims than any other state, but a report says that could be a sign of success in the state's unemployment insurance system.

Although the state Department of Labor and Training acknowledges it has been swamped by the unprecedented surge in claims, it has accepted, processed and paid claims faster than other states, according to a report from Kevin Rinz, a labor economist in the Census Bureau's Center for Economic Studies.

"Only Rhode Island stands out as having both [received] a large number of claims relative to its labor force and [issued] a large number of first payments relative to its volume of claims," Rinz wrote.

….Read More

Top Republican fundraiser and Trump ally named postmaster general

A top donor to President Trump and the Republican National Committee will be named the new head of the Postal Service, putting a top ally of the president in charge of an agency where Trump has long pressed for major changes in how it handles its business.

he Postal Service's board of governors confirmed late Wednesday that Louis DeJoy, a North Carolina businessman who is currently in charge of fundraising for the Republican National Convention in Charlotte, will serve as the new postmaster general.

The action will install a stalwart Trump ally to lead the Postal Service, which he has railed against for years, and probably move him closer than ever before to forcing the service to renegotiate its terms with companies and its own union workforce. Trump's Treasury Department and the Postal Service are in the midst of a negotiation over a $10 billion line of credit approved as part of coronavirus legislation in March.

The confirmation came after The Washington Post asked for comment on the decision.

Trump has indicated he wants the Postal Service to dramatically raise fees for delivering packages for customers such as Amazon in exchange for tapping the line of credit. Trump has long argued that Amazon doesn't pay the Postal Service enough, a charge the agency has fiercely contested. (Amazon's chief executive, Jeff Bezos, owns The Post.)

"Louis DeJoy understands the critical public service role of the United States Postal Service, and the urgent need to strengthen it for future generations," Robert M. Duncan, chairman of the board of governors, said in a statement.

The White House declined to comment.

Rep. Gerald E. Connolly (D-Va.), chairman of the House subcommittee that oversees the Postal Service, denounced the move as a reward by Trump to a "partisan donor." "The Postal Service is in crisis and needs real leadership and someone with knowledge of the issues," Connolly said. "This crony doesn't cut it."

After criticizing the agency for years, Trump has been consolidating his influence lately. Three Republicans and one Democrat sit on the board of governors after the vice chairman, David Williams, a Democrat, resigned last week.

The departure came after Williams told confidants he was upset that the Treasury Department was meddling in what has long been an apolitical agency and felt that his fellow board members had capitulated to Treasury Secretary Steven Mnuchin's conditions for the $10 billion line of credit, according to four people familiar with Williams's thinking.

"Postal workers are the heart and soul of this institution, and I will be honored to work alongside them and their unions," DeJoy, who will start June 15, said in a statement.

Williams did not respond to a request for comment.

Democrats have urged the Postal Service to hold firm with Treasury over the terms of the loan, betting they could win more money for the agency in another round of legislation and threatening the Trump administration with taking the risk of disrupting mail service.

But in recent days, the Postal Service's board has appeared open to some of the Trump administration's terms, according to the four people, who spoke on the condition of anonymity to disclose private conversations. The precise terms could not be learned.

"[Williams's] main frustration is that he felt the Treasury Department was interfering in an apolitical board and an apolitical agency," said one person who spoke with him….**Read More**

2020 Social Security and Medicare Trustees report

This year's **Social Security and Medicare Trustees reports** were released without considering the effects of the coronavirus pandemic and so are not likely to reflect the current state of these trust funds. With so many people out of work, however, less money has been going into these funds. But, Medicare and Social Security are destined to continue because of their enormous popular support and their value to Americans.

Just recently, in response to the coronavirus pandemic, Vice President Joe Biden, **endorsed a plan** from Senators Elizabeth Warren (D-MA) and Ron Wyden (D-OR) to provide everyone receiving Social Security benefit s with $200 more a month during this pandemic. This additional income would be of enormous value to older adults and people with disabilities who are most at risk.

Nancy Altman, president of Social Security Works, writes:

"Social Security is built to be a solution in times of national emergencies and disasters. **After the terrorist attacks** of September 11, virtually every child who lost a parent that day received Social Security benefits , as did the surviving spouses and those disabled as a result of the attacks, and their families. Indeed, Social Security was among the first insurers working with families after the attacks. The first benefits were paid on Oct. 3, 2001, less than a month after that horrific day.

The same story unfolded in the **aftermath of Hurricane Katrina.** Emergency, on-the-spot payments were provided to tens of thousands of Americans who were driven from their homes and could no longer access their banks. To withstand the current public health crisis and the associated shock to the economy, Social Security has a substantial reserve, which, according to the just-released report, equals $2.9 trillion. Its purpose is to ensure that benefits will continue to be paid on time and in full, without interruption, in times like this.

Social Security's reserve is large enough to ensure sufficient revenue to continue to pay benefits in full and on time into the 2030s, no matter how long the current crisis lasts. When looking at the long-term, the next three-quarters of a century and beyond, the pandemic will be absorbed, as the Great Recession was."

The Trustees project that Social Security has another 15 years of funding and Medicare has another six, just like last year. The coronavirus pandemic will likely mean that these funds will be depleted sooner. Because so many people have lost their jobs and we are moving into a recession, payroll contributions to Social Security and Medicare will decrease over the next several years. Most likely, as well, more people will apply for Social Security benefits.

That said, Congress is already strengthening the Social Security and Medicare Trust Funds through its investments in the economy. The more people working and contributing to these programs through payroll contributions, the stronger they will be. To strengthen these funds further, Congress should rein in health care spending in Medicare and throughout the health care marketplace. And, it should **lift the cap on payroll contributions** so that wealthy Americans contribute their fair share towards Social Security.

How high will it go? As Covid-19 death toll in U.S. blows past 60,000, there are no easy answers

When STAT first **compared** projected U.S. deaths from Covid-19, in early April, there seemed to be a glimmer of good news: A prominent model had just lowered its estimate for total deaths through Aug. 4 from about 100,000 to 60,000, reflecting the apparent success of three weeks of social distancing across much of the country.

On Wednesday, April 29, the country blew past 60,000, more than three months before the Institute for Health Metrics and Evaluation projected. (The 60,000 almost certainly **undercounts** Covid-19 deaths, by about 9,000.) IHME, whose model has been **criticized** by many epidemiologists, now says the most likely death toll on Aug. 4 will be 72,433, though it could be as low as about 60,000 (obviously impossible) and as high as 115,000.

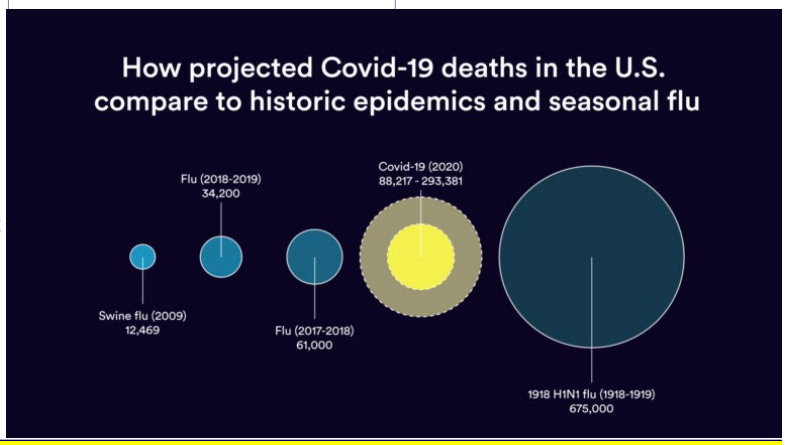
As some models stumble, and many no longer even try to project more than a few weeks, the Centers for Disease Control and Prevention has added models to those it **highlights** on its website. One stands out for the fact that it is not associated with a big-name institution. Produced by independent data scientist Youyang Gu, it has been tracking actual U.S. cases and deaths better than many.

Gu's model projects that U.S. Covid-19 deaths by early August could be as low as 88,217 and as high as 293,381, with a most likely toll of 150,760.

As with all the numbers swirling around the pandemic — more than 3.2 million cases and 230,000 deaths worldwide — these are challenging to grasp. Gu's lower number is roughly the capacity of the Florida Gators' stadium in Gainesville; imagine a homecoming game crowd all dying. It is the number of passengers in 360 full long-haul 767s. It is nearly double the number of U.S. combat deaths in the Vietnam War. And 293,381, of course, is nearly triple any of the above.

With U.S. deaths from Covid-19 passing 61,000 this week, the question is as difficult as ever: Are these large numbers or small numbers?...**Read More**

As of this date, 5/10/2020, 80,000 have died from COVID 19



Why one breakthrough drug won't end the pandemic

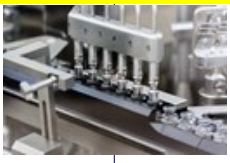
The nation's top health officials say they're rushing to make sure Americans can get widespread access to the experimental drug remdesivir after a study showed that it shortens the recovery time for some coronavirus patients.

The push to give the drug the regulatory approval it needs for broader distribution comes a day after the government's top infectious disease expert, Anthony Fauci, called the drug "an important proof of concept" and compared it to the discovery of the earliest HIV treatments in the 1980s. Investors sent U.S. stocks surging after the news was announced

But there are still major questions about how well remdesivir works, when the government might make it available to the public, and whether drugmaker Gilead can keep pace with rising global demand for the drug. Here's what to watch as more data is uncovered.

This isn't a cure

The results that made headlines Wednesday came from a trial sponsored by the National Institute of Allergy and Infectious Diseases, which Fauci runs.



The study of 1,063 patients revealed that those who received remdesivir had a 31 percent faster time to recovery than those who received a placebo — 11 days versus 15 days, on average. The findings also suggested that patients given remdesivir were slightly less likely to die. But that effect was so small that you would need to treat 28 patients with remdesivir to save one life, said Vincent Rajkumar, a physician at the Mayo Clinic.

A leak this month of early data from the NIAID trial had suggested more significant benefits for those taking remdesivir. But the findings released Wednesday tempered expectations.

Public health experts have also warned for months that finding a slam-dunk coronavirus drug will not be what ends the pandemic. Rather, widespread testing and the development of an effective vaccine — which could still be more than a year away — will rein in the virus and curb hospitalizations. "This is not a magic cure," said Jeffrey Gold, a doctor and chancellor of the University of Nebraska Medical Center, the lead researcher in the NIAID remdesivir study. But "if you marry that to more testing, contact tracing and the ability to identify earlier patients … all that adds into a ray of light and seeing our way through this."

We still haven't seen the actual data

One of the biggest head-scratchers is the way in which the results of the NIAID trial were announced.

Gilead, which makes the drug, put out a press release Wednesday morning saying the NIAID trial met its primary endpoint (even though the company was not involved in running the trial). Several hours later, Fauci disclosed some of the data to reporters during an Oval Office appearance. Later in the day, NIAID issued a press release echoing what Fauci said and adding a few extra details.

But no one outside of NIAID, Gilead and the hospitals where the trial was conducted have seen the actual data. Some scientists and health experts are wondering why there wasn't a simultaneous data release alongside the announcements.

"I understand the pressure, but if there is enough certainty to announce it to the nation, then they should be able to post a pre-print that details the methods and results," said Harlan Krumholz, professor of medicine at Yale School of Medicine. "Now we have heard results without any ability to evaluate them. I am hopeful that more complete information and actual data will be available soon."

Administering it is complicated

Remdesivir isn't a pill. Instead, it's an intravenous infusion that patients have to take anywhere from five to 10 days. Gilead says data it released Wednesday from its own trial, which did not include a control arm, suggests five days could be just as effective as longer dosing….**Read More**

Trump's Claim That U.S. Tested More Than All Countries Combined Is 'Pants On Fire'

"We've tested more than every country combined."

— President Donald Trump at White House press briefing on April 27, 2020

Responding to weeks of **criticism** over **his administration's** COVID-19 **response**, President Donald Trump claimed at a White House briefing that the United States has well surpassed other countries in testing people for the virus.

"We've tested more than every country combined," **Trump said** April 27.

It was a variation on claims he had made **April 24**, as well as on Twitter the day after — when he said the United States had tested "more than any other country in the World, and even more than all major countries combined."

The president **has** made **a habit** of **exaggerating** the United States' **capacity** for COVID-19 diagnostic testing. But the health system has ramped up its testing since its slow start during the first weeks of the American outbreak. So we wanted to check back. How many people here have been tested? And has the U.S. tested more people than "every country combined"?

We emailed the White House for comment but never heard back, so we turned to the data. Trump's claim didn't stand up to scrutiny.

In raw numbers, the United States has tested more people than any other individual country — but nowhere near more than "every country combined" or, as he said in his tweet, more than "all major countries combined."

Regardless, raw test numbers aren't a meaningful metric in gauging the nation's coronavirus response. When you factor in population size — which experts say is essential in understanding how well we are doing — the U.S. still falls short.

The Numbers

We consulted a few independent estimates, all of which were recommended to us by global health experts: the **COVID Tracking Project**, **Worldometer** and **Our World in Data**.

All of them place the U.S. total above 5 million tests — the figures range between 5.59 and 5.7 million. And it is correct that no other country has run so many diagnostic tests. But that's where any semblance of accuracy ends.

A **White House report** on global testing — which sources its numbers from Our World in Data — notes that the United States has done more testing than the combined totals of Australia, Austria, Canada, France, India, Italy, Japan, Singapore, South Korea, Sweden and the United Kingdom. (That addition checks out.)

But those are hardly all the world's "major countries" — let alone "every country." And to argue the list is exhaustive — especially when Germany and Spain are among Europe's biggest economies, Russia is obviously a major player on the world stage and when Germany's robust testing strategy has been credited with its low coronavirus death rate — is absurd, experts said.

And when you look at European countries alone — which again, is far short of what he claimed — Trump's comparison quickly falls apart.

The Worldometer data shows that, when you add up the number of tests run in Russia, Germany and Italy, the total lands around 6.72 million**.** You could also tally the number of tests run in Spain, Italy, France, Germany and the U.K. Both Worldometer and Our World in Data place that total above 6 million. Either way, it's more than what the U.S. has done.

Big picture, a truly exhaustive sum of testing by "every country" or even "all major countries" would generate higher numbers.

A Meaningful Metric?

Trump is also fixating on the wrong figures, global health experts said.

"The highest number of raw tests in and of itself is not meaningful for any particular country or location within a country," said Jennifer Kates, a vice president at the Kaiser Family Foundation. (Kaiser Health News is an editorially independent program of the foundation.)

The United States has a far bigger population than many of the "major countries" Trump often mentions. So it could have run far more tests but still have a much larger burden ahead than do nations like Germany, France or Canada...**Read More**

Tenuous Financial Situation for Older Adults in 2019 Does Not Bode Well for Their Post-Coronavirus Security

The Kaiser Family Foundation recently released a **report** detailing how financially secure or insecure Medicare beneficiaries were in 2019. Consistent with previous years, the report shows that any stereotype of baby boomers as uniformly affluent is deeply misguided. Instead, half of people with Medicare have incomes below $29,650 and one in four live on less than $17,000. Savings rates are similarly dire. Half of Medicare beneficiaries have below $73,000 in resources, one in four has less than $8,300, and about 1 in 9 has no savings or is in debt. They also face significant out-of-pocket health care expenses in absolute terms and as a **percentage of their income**.

Given these challenging starting circumstances, it is likely the effects of coronavirus on individual health and economic security will be particularly devastating to older adults and people with disabilities. Much attention has been given to the consequences of coronavirus financial turmoil on younger working families, but older adults, who face increased risk of serious illness if they get COVID-19, are also particularly financially vulnerable to drops in income and retirement savings and increases in out-of-pocket medical expenses.

Older adults who lose their jobs in the wake of the pandemic may find it harder to find new jobs than younger workers. They have less time for retirement investments in the stock market and elsewhere to recover, and if they decide to collect Social Security early to compensate for lost earnings, they will get lower monthly payments than they otherwise would have for the rest of their lives.

These increased financial risks for older adults are even more significant for Black and Hispanic seniors as well as for women. Each of these groups have median savings amounts that were substantially lower than their peers, even before the public health emergency.

Recent legislation aims to mitigate the immediate impact of economic turmoil by making direct payments and increasing unemployment benefits temporarily. These actions, while important, are short-term solutions to what is likely to be a long-term problem. Policymakers should consider the significant economic impact of the public health emergency on older adults and people with disabilities when making future decisions about essential programs like Medicare, Medicaid, and Social Security.

Read the KFF report.

Read Medicare Rights' recommendations for future action around COVID-19.

Coronavirus Public Health Emergency Highlights the Need for Medicare Enrollment Protections

A new Associated Press (AP) story, **"Medicare applications raise anxiety for seniors in pandemic**," highlights the challenges Medicare-eligible individuals may face when trying to enroll in the program during the coronavirus emergency. Their experiences, and those of callers to Medicare Rights' national helpline, indicate the pandemic is exacerbating an already cumbersome process.

Knowing how and when to sign up for Medicare can be a daunting task even in the best of times. Enrollment has become increasingly complex in recent years, in part because the rules haven't kept pace with changes in how people experience their initial Medicare eligibility.

Today, as in 1965 when the Medicare program was created, most people are automatically enrolled in Part A (hospital coverage) and Part B (outpatient coverage) when they turn 65 because they are receiving Social Security benefits. However, an increasing number of Americans are working longer and delaying Social Security benefits. **In 2016**, only 60% of Medicare-eligible 65-year-olds were taking Social Security, compared to 92% who were in 2002.

Unlike those who are automatically enrolled, this growing cohort must do so themselves. Most can sign up for Part A at any time without penalty but enrolling in Part B is more involved. It requires an understanding of complicated enrollment rules and confusing timelines, as well as the effects of delaying Part B, even by mistake.

People who have other coverage when they become eligible for Medicare have even more to wade through, like whether Medicare will pay primary or secondary, and whether they have access to any other enrollment windows. The answers are different for each type of insurance and situation.

The considerations are dizzying, and the stakes are high. As the article notes, not enrolling on time can have significant consequences. Beneficiaries may face lifetime Part B late enrollment penalties, harmful gaps in coverage, and exposure to high out-of-pocket costs.

Unfortunately, many people do make mistakes. Among the most frequent calls to our helpline are those from or on behalf of people eligible for Medicare who inadvertently, and through no fault of their own, failed to enroll in Part B on time and are living with severe repercussions.

We are concerned that due to the coronavirus national emergency, Medicare-eligible individuals who made enrollment mistakes in the past as well as those who are un- or under-insured may now need their Medicare, and that even more people may experience Part B enrollment pitfalls in the coming months. Accordingly, we strongly urge policymakers to take immediate action to address and anticipate pandemic-related coverage problems.

First, to help those who need coverage now but can't enroll, we support creating an enrollment pathway and leaving it in place for the duration of the emergency. This could be done by establishing a new Special Enrollment Period (SEP) or by re-opening and extending the General Enrollment Period (GEP). Under either approach, we urge policymakers to simultaneously address related enrollment barriers by reducing waits for coverage, financial penalties, and administrative requirements.

We also encourage policymakers to consider solutions for those who have access to an enrollment period during the pandemic, but who make a mistake or fall through the cracks. Individuals who experience such errors will need to sign up for Medicare as soon as the misstep is discovered—which may be well after the end of the emergency, and after the expiration of the coronavirus-specific SEP or GEP. To facilitate their access to coverage, we recommend expanding Equitable Relief, the federal government's authority to fix enrollment mistakes, to allow for its application for "good faith" reasons. Doing so would help those who experience Part B enrollment challenges because of the outbreak, but for whom discovery of the problem would be too late to use other forms of relief.

At Medicare Rights, we are deeply concerned about the risks the coronavirus poses to Medicare beneficiary health and well-being. We will continue to advocate for common-sense solutions to ensure older adults, people with disabilities, and their families can access the care, coverage, and services they need, now and in the future.

Coronavirus: Health insurance industry profiting

Unlike almost every other sector of the economy, the health insurance industry appears to be **profiting** from the coronavirus pandemic. While some people need costly COVID-19 care, elective surgeries have all but disappeared and people are going to the doctor and ER less. The cost of elective and emergency non-COVID care tend to be a lot greater than the cost of treating COVID-19 patients.

No question that fewer people have health insurance since the coronavirus outbreak. Thirty million people have lost their jobs, and millions have lost their employer coverage. But, so far, that has not affected health insurer profitability.

Moody's investor services reported at the end of April that most insurers would remain solidly profitable this year under the most likely scenarios for infection rates and patient health care needs in the US. It noted that most insurers have high levels of excess capital. It also stated that national insurers would make out best.

UnitedHealth Group showed **strong profits** in the first quarter of this year. Of note, it makes a lot of its money off of Medicare Advantage plans, private health plans that provide Medicare benefits. And, it has been gaining business in that market.

Notwithstanding their financial situations, **insurers are threatening to raise premiums** significantly next year if they don't get stimulus money. They are arguing that they are losing between $30 and 250 billion in revenues this year. They want the federal government to subsidize people's health insurance today. Many Democrats in Congress support legislation that would subsidize people's health insurance, paying for COBRA. But, COBRA does not guarantee people access to care, it simply extends people's coverage. Their health care coverage comes with high deductibles and copays. Moreover, the proposed legislation only helps people who have just lost their health insurance. And, it is not cost-effective.

Senator Bernie Sanders and Congresswoman Pramila Jayapal are proposing **legislation that would have Medicare cover people's health care**, which is cost-effective and ensures people access to care. And, it has the added advantage of enabling the government to collect data on who's receiving care and where resources need to be allocated.

Whatever happens in Congress, many states limit the amount that insurers can raise premiums from one year to the next. And, generally, **premiums for next year need to reflect expected costs**, not losses in 2020. Still, one California analysis suggested that health insurance premiums could rise as much as 40 percent in 2021.

Who knows how things will work out for corporate health insurers. Right now, many states are requiring insurers to cover people's COVID-19 related copays as well as to waive copays for telehealth. And, in some states, such as New York, governors have told insurers that they cannot cancel some health plans because of nonpayment of premiums.

Fact-checking Trump's knocks at Obama in his Fox town hall

President Trump's **virtual town hall on Fox News** on May 3 sounded like an oral reading of our **Trump database of false or misleading claims** (or our upcoming book, **"Donald Trump and His Assault on Truth,"** being published June 2 by Scribner). There were so many old chestnuts, from his false claims about NATO spending to his tale that the **United States has spent $8 trillion on Middle East** wars to his ahistorical bragging that he had built **the greatest economy in the history of the world**.

But the president's favorite foil is his predecessor, Barack Obama. Anything Obama did is inherently suspect, in Trump's telling, and anything Trump has done is surely superior.

We've also covered many of these in the past, such as his attacks on **Obama's successful handling of the swine flu pandemic**. But here are two repeated claims that we have not had the opportunity to unravel previously. We will deal with them quickly in this roundup, so we won't be awarding Pinocchios.

"Medically, we had empty cupboards. The cupboards — I say, the cupboards were empty."

This talking point emerged in April, with Trump often saying "the cupboard was bare," referring to the Strategic National Stockpile, a repository of emergency medicines and supplies created in 1999 in case of enemy attacks. In 2003, the stockpile's mission was expanded to prepare for a possible pandemic.

On its face, calling the cupboard empty might seem like a strange assertion because Trump has been president for three years, so he bears some responsibility for what was in the stockpile and whether it was appropriate for a pandemic. "The stockpile has grown and evolved to a greater than $8 billion enterprise," **wrote Greg Burel, the director at the time, in November 2019**.

Indeed, The Washington Post reported that a key administration official overseeing the stockpile sought to "bolster the nation's stockpile of defenses against biological and chemical weapons, a focus he made a priority over preparing for a natural pandemic."

A senior administration official suggested that Trump was specifically talking about the stockpile's inventory of N95 masks — fitted face masks that block most airborne particles. "The national stockpile was depleted of three-quarters of its N95 inventory during the H1N1 outbreak [in 2009], but the Obama administration failed to build it back," he said. The Washington Post reported that more than 85 million of those masks were distributed back in 2009, during the swine flu outbreak, but they were not replaced, despite warnings from industry officials in 2009 and 2010.

But the now-retired Burel, **in an interview with Vice News**, said officials faced "horrible" choices given the limited money ($650 million a year) received from Congress: "We had to trade off those funds that we had, and we chose to invest in those lifesaving drugs that would not be available from any other source, in the quantity needed, and in time. I definitely want to see my healthcare workers protected; that's very important. But if I'm thinking, 'Do I buy this many masks to protect this many workers, or do I buy this many medicines to keep people safe that we can't get elsewhere?' there's no easy answer here."

In any case, the shelf life of N95 masks is generally five years, so in theory, any masks purchased in 2009 would have needed to be replaced. (Some 5 million masks in the stockpile **were expired**; 12 million were not.) The Centers for Disease Control and Prevention said some masks in the stockpile dated to 2003, but in a study of 11 models, it found that most still appeared to work effectively.

In sum, Trump might have a point about Obama not replacing the masks, but his language is still misleading. He bears responsibility for choices made in the direction of the stockpile under his watch, including not prioritizing preparation for a pandemic. He cannot so sweepingly declare that an $8 billion stockpile was "empty."

Obama "did nothing" to fight AIDS? We know Trump likes to think that nothing happened before he became president, but a check of the appropriations numbers would show that Obama targeted a lot of money at fighting AIDS.

In fact, Obama spent about $3.5 billion a year on research and prevention, **according to an accounting by the Kaiser Family Foundation**, which is about the same as Trump's numbers in his first years as president. (Of course, the money that was spent had to be approved by Congress.) Obama also had a plan, **first issued in 2010** and then again in 2015, called the National HIV/AIDS Strategy for the United States. The **2015 version** called for reducing the number of new diagnoses by 25 percent by 2020.

Trump, **in 2019**, called for an even bolder goal, backed by increased funding — reducing new HIV infections in the United States by 75 percent within five years and by at least 90 percent within 10 years. The administration official said Trump's plan was "far more aggressive" than the previous administration's 25 percent goal. "The president has been clear that this sort of bold, aggressive undertaking should have been launched long ago," he said.

Okay. But that's not the same thing as doing nothing. (Sometimes, Trump has even claimed that Obama "spent no money" on AIDS or that Obama "chose not to" end the AIDS epidemic.) It's not clear whether Trump's goal is even attainable, and in any case his strategy clearly builds on Obama's earlier efforts. So, it's false to say Obama did nothing.

Medicaid Spend Down: Protecting your Assets

Whether it is you or your spouse preparing to enter a **nursing home**, or both of you are planning to enter long-term care together, a top concern is usually how to pay for care and what will happen to all of the things you've worked your entire life to acquire – your cars, your house, your savings, etc. If you know you have too many assets now to qualify for any financial assistance, then you will have to do what is known as the Medicaid spend down. Spending down is essentially paying out of pocket for long-term care until the money you have left is low enough to qualify you for Medicaid. As you're going through this process, you want to protect your assets in the meantime, so what do you do? Although situations vary and states have different rules and regulations for this situation, there are a few key steps to take in preparing for Medicaid spend down.

How to Protect Assets from Medicaid Spend Down and Nursing Home Care

Click on the links below for more information

- **Seek Legal Council**
- **Protect your Spouse**
- **Gift Early**

2020: What you might not know about Medicare Advantage plans

The Kaiser Family Foundation has a **new report** on **Medicare Advantage** plans–private health plans that offer Medicare benefits–in 2020. Here's what you might not know, including the latest data:

1. Enrollment in Medicare Advantage plans is now just over 24 million or about 40 percent of the Medicare population. In some counties, only 1 percent of people are enrolled in Medicare Advantage; in others, it's as many as 60 percent.
2. Average annual out-of-pocket costs for in-network care in HMOs and PPOs is $4,925; the average out-of-pocket cap for the combination of in-network and out-of-network care in PPOs is $8,828. Drug costs are not included in these caps.

3. Virtually everyone enrolled in a Medicare Advantage plan must get prior approval before receiving most costly medical services; preventive care services generally do not require prior authorization.
4. If you are hospitalized for more than five days and enrolled in a Medicare Advantage plan, your out-of-pocket costs are likely to be higher than in traditional Medicare (without supplemental coverage).
5. Six in ten people in Medicare Advantage plans pay no additional premium, and they generally get prescription drug coverage. Nine in ten Medicare Advantage plans offer prescription drug coverage. The average premium for the 40 percent of enrollees who pay a premium is $63 a month.
6. Of people enrolled in Medicare Advantage, about 20 percent have retirees benefits from employers or unions who require them to join in order to get their retiree wrap-around benefits. In some states, more than three in ten Medicare Advantage enrollees get retiree wrap-around coverage. And, in New Jersey, West Virginia and Michigan, four in ten Medicare Advantage enrollees or more get retiree wrap-around coverage.
7. United Healthcare, Humana and BlueCross BlueShield have the greatest number of Medicare Advantage enrollees. More than one in four (26 percent) are enrolled in United Healthcare, nearly one in five (18 percent) are enrolled in Humana and more than one in seven (15 percent) are enrolled in BlueCross BlueShield.

White House Blocks C.D.C. Guidance Over Economic and Religious Concerns

As President Trump rushes to reopen the economy, a battle has erupted between the White House and the Centers for Disease Control and Prevention over the agency's detailed guidelines to help schools, restaurants, churches and other establishments safely reopen.

A copy of the C.D.C. guidance obtained by The New York Times includes sections for child care programs, schools and day camps, churches and other "communities of faith," employers with vulnerable workers, restaurants and bars, and mass transit administrators. The recommendations include using disposable dishes and utensils at restaurants, closing every other row of seats in buses and subways while restricting transit routes between areas experiencing different coronavirus infection levels, and separating children at school and camps into groups that should not mix throughout the day.

But White House and other administration officials rejected the recommendations over concerns that they were overly prescriptive, infringed on religious rights and risked further damaging an economy that Mr. Trump was banking on to recover quickly.

A spokesman for the C.D.C. said the guidance was still under discussion with the White House and a revised version could be published soon….**Read More**

Trump says next coronavirus relief bill has to include payroll tax cut

The following is a statement fr om **Nancy Altman**, President of **Social Security Works**, in response to Donald Trump **stating** at yesterday's Fox News townhall that he will block all coronavirus response measures unless they include cuts to the payroll tax, whose revenue is dedicated to Social Security:

"More than **30 million Americans** are newly unemployed due to the coronavirus pandemic. Their paychecks are gone, but their rent, utility, grocery bills and other expenses still must be paid. **Seniors in nursing homes** are dying at alarming rates. **Hospitals** are desperate, as are **state and local governments**.

Americans everywhere need immediate assistance, but Donald Trump has now vowed that they won't get any — unless Congress bows to his demand to cut Social Security's payroll tax.

Payroll tax cuts waste money, delivering the wealthy and powerful the largest cuts while providing nothing to those who need it most, as **this linked chart** reveals. They are slow and inefficient. But they do reduce Social Security's dedicated funding, a longstanding right-wing ideological goal. That presumably is why Trump is insisting on them.

Trump **made it clear** weeks ago that his obsession with cutting payroll contributions has nothing to do with the coronavirus or the resulting economic fallout. He said he'd like a "permanent" reduction in payroll contributions, and that he'd support it "regardless" of the current situation. He has also said he wants **to cut Social Security once he is re-elected**.

There are dozens of far superior proposals for relief from the economic turmoil caused by coronavirus. These include making the one-time CARES Act emergency payments **ongoing and increasing their amount, expanding Social Security benefits, and having Medicare cover everyone's health care during the pandemic**.

Yet Trump now says he'd hold everything hostage — these proposals, as well as immediate assistance targeted to front-line workers, hospitals, and local governments. He insists he won't sign anything unless he gets his payroll tax cut. That's how desperately Trump and the right-wing ideologues surrounding him want to defund Social Security, so they have an excuse down the road to demand cuts to our earned benefits.

Trump's actions are a war on seniors. He wants to open up the economy, even though COVID-19 is disproportionately costing seniors their lives. Now he is insisting on threatening Social Security on which **most seniors rely** for their food, medicine, and other basic necessities.

Members of Congress, particularly House Democrats, need to stand strong and call Trump's bluff. Send the wildly popular measures mentioned above to Trump's desk, without including a toxic payroll tax cut. Political realities will force him to back down."

RI ARA HealthLink Wellness News

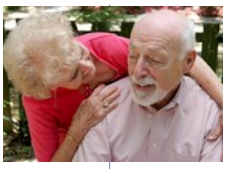
Pandemic Delaying Medical Care of Older Americans

The coronavirus pandemic has led many older adults to postpone medical care, a new survey finds.

The University of Chicago survey found that 55% of U.S. adults aged 70 and older experienced a disruption in their medical care during the first month of social distancing.

Thirty-nine percent put off non-essential care and 32% delayed primary or preventive care since social distancing began. And 15% said they delayed or canceled essential medical treatment, the survey found.

"The first month of social distancing in America certainly saved lives, and yet it also created a situation where many older adults are not getting the care they need to manage serious health conditions," said Dr. Bruce Chernof. He is president and CEO of the SCAN Foundation, an independent charity focused on care of older adults, that co-sponsored the survey.



"As our nation grapples with when and how to reopen, the health care system will reckon with unaddressed medical needs and learn how to maximize new protocols to care for older adults with complex needs in flexible, person-centered ways," Chernof added in a foundation news release.

The researchers found that older adults are worried about delays in getting support to manage their medical conditions. Many doctors, however, are using telehealth to keep tabs on their patients.

Nearly 25% said that their doctors had reached out to them since the start of the outbreak to check on how they were doing.

More than 20% had a telehealth appointment since the start of the pandemic. And nearly 50% said it was like having a personal visit. Only 4% said it was worse.

Terry Fulmer is president of the John A. Hartford Foundation, a survey co-sponsor. "Health care organizations have stepped up quickly to help older adults get their care needs met with this important technology," she said.

"Comfort levels with telehealth vary, but we are seeing rapid uptake in both urgent and primary care delivery. The survey results offer a promising glimpse into the future," Fulmer added.

In all, 83% of older adults said they were ready to self-isolate for several months, if necessary.

A month into social distancing, however, 33% said they felt lonely. To combat it, many were spending more time on hobbies, watching TV, chatting with family and being physically active.

Older Americans also said that health care professionals and non-elected public health officials were the most trustworthy, not elected officials.

The survey of 1,039 adults was conducted April 10 to 15. It has a margin of error of plus or minus 4.28 percentage points.

Cleaning Products You Should Never Mix, According To a Poison Control Expert

We're all in the cleaning mood nowadays, whether we like it or not. It's a good habit, of course, now that **COVID-19** is a regular part of our lives; but sometimes cleaning products can cause just as much harm as the protection they provide—and more doesn't always equal better.

One of the main concerns when it comes to using **household cleaning products** is mixing them improperly. Even when two products are safe to use on their own, mixing them can be harmful to your health. "These [cleaners] can be pretty strong. They do have health effects," Diane Calello, MD, executive and medical director of New Jersey Poison Center and an associate professor of emergency medicine at Rutgers New Jersey Medical School, tells *Health*. And some combinations—while still harmful to most—can be especially dangerous to those with certain health conditions, like **asthma**, **COPD**, and lung disease. Additionally, people who have recently had a lung transplant and older people are more likely to suffer from these combinations, according to Dr. Calello, due to decreased respiratory function.

Overall, a good rule of thumb is never to mix *any* cleaning products—but according to Dr. Calello, these five combinations should be avoided at all costs.

Bleach + vinegar

"Bleach and **vinegar** is a common mishap," Dr. Calello tells *Health*. When mixed, bleach and vinegar produce chlorine gas. "When you breathe in, [chlorine gas] generates acid in the lungs," says Dr. Calello (you don't need a chemistry degree to guess that isn't healthy). Symptoms you would notice if you made this mistake include: burning eyes, a burning sensation in your throat, deep breaths that feel painful, coughing, and an increasingly difficult time breathing easily.

Bleach + ammonia

It's also important to **avoid mixing bleach with ammonia**, which is found in many household cleaning products like window cleaners and floor waxes. (Tip: Always look at the ingredients label before mixing or using multiple household products). Mixing bleach with ammonia could result in the release of toxic chloramine gas—which also generates acid in your lungs when inhaled, says Dr. Calello—and can be fatal, **according to the US National Library of Medicine**. Mixing bleach with ammonia can cause chest pain and shortness of breath, and it requires immediate medical attention.

Drain cleaner + drain cleaner

We've all been there: You have a tiny bit of a product left, and you don't want that to go to waste, so you mix that with product from a new bottle. This is a harmless way to behave if you're working with ketchup, but if you do this with drain cleaner, it could produce a fairly strong chemical reaction, SAYS Dr. Calello. It can generate heat and leave you with burns on your skin. (Because it's a dangerous substance, Dr. Calello says you should never handle drain cleaner without gloves on, and the **U.S. National Library of Medicine has the same advice**.) If you can't seem to get your kitchen sink drain clean, think about calling a plumber for help with that chore—it's not worth mixing chemicals that could end up poisoning you.

Vinegar + hydrogen peroxide

Both of these products can be used to clean dishwashers. (Vinegar can take a foul smell out of your dishwasher, and hydrogen peroxide can kill mold in it.) But you should always make sure you don't mix the two products in your dishwasher—or anywhere else. "It does generate a weak acid [and] can create skin, eye, and respiratory irritation," says Dr. Calello.

Bleach + rubbing alcohol

In case this wasn't made clear above: **Bleach can be *very* dangerous**. You can't just be mixing it with whatever disinfectant you pull from the back of your laundry room shelf, and rubbing alcohol is yet another substance that doesn't play well with bleach. The pair, when mixed, can generate "a chloroform-like compound," Dr. Calello says. "It's not likely to be strong enough, for example, to cause anybody to pass out," says Dr. Calello, but, she continues, it can cause irritation of the eyes and skin.

Common Treatment May Not Help Seniors With Underactive Thyroid

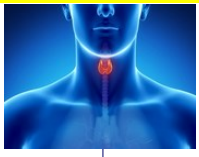
The medication Synthroid (levothyroxine) is often used to treat a condition called subclinical hypothyroidism, but a new study suggests the treatment might be a waste of time.

For the study, researchers followed 638 people aged 65 and older with subclinical hypothyroidism, also known as mild thyroid failure. About half of the patients were given the medication, and half were given an inactive placebo.

After one year, there was no difference in symptoms between the participants who received levothyroxine and those who received the placebo, the investigators found.

"Levothyroxine is one of the most commonly prescribed drugs in the U.S.," said lead study author Dr. Maria de Montmollin, from the University of Bern in Switzerland. But she believes doctors "should reconsider" offering the medication to older adults with the condition.

Subclinical hypothyroidism is a common condition that impacts 3% to 8% of the general population. It's more common in women, and prevalence increases with age.



For those who have the condition, a hormone called thyroid-stimulating hormone, or TSH, is mildly elevated. Hormones made directly from the thyroid, called T4 and T3, are normal.

If severe enough, the elevation of the TSH hormone seen in this condition can cause tiredness, weak muscles, memory loss, depression, dry skin and hair, and more.

Participants in the study were diagnosed with subclinical hypothyroidism by having their TSH hormone levels measured two times at least three months apart. They were included in the study if their TSH levels were elevated both times.

Next, over the course of one year, some participants received the medication levothyroxine and others received the placebo. The researchers paid close attention to a group of participants they called the high-symptom burden group, a group determined by two self-reported quality of life surveys and a test of participant hand strength.

At the end of the study, the researchers determined that participants in the high-symptom burden group improved similarly, regardless of if they had taken levothyroxine or the placebo pills. It is unknown why this occurred, but the authors said it may represent the natural course of the disease.

Do these results mean patients taking levothyroxine for subclinical hypothyroidism should stop their medication?

Not quite, said Dr. James Hennessey, an endocrinologist at Beth Israel Deaconess Medical Center in Boston, who reviewed the study.

Hennessey believes that levothyroxine can still be useful in the right patients. For example, levothyroxine can be used to avoid the negative impact on the heart sometimes caused by elevated TSH.

Study author de Montmollin agreed. "It is possible that some patients with very severe symptoms would still benefit from levothyroxine," she said. "It is advisable that all patients contact their treating physician and discuss the treatment with them."

Hennessey said the key to treatment is proper diagnosis. Symptoms like tiredness and weak muscles may occur naturally in older patients and are not always related to a thyroid problem. Additionally, to get an accurate diagnosis, he believes that more than the two elevated TSH blood tests used in the study may be needed.

Finally, he said it is important to use an age-adjusted TSH range for normal. This takes into account that TSH increases naturally with age. Because the TSH values from the study are not age-adjusted, it is possible that these values may be considered close to normal for people in this age group.

The study authors said that their research does not support routine treatment of subclinical hypothyroidism with levothyroxine. However, experts like Hennessey noted that more research may be required to determine the appropriate use of levothyroxine in specific populations.

The report was published May 5 in the *Annals of Internal Medicine*.

Coronavirus: The importance of health care proxies and the value of palliative care

Sadly, the novel coronavirus is wreaking havoc on the lives of older adults. Many more older adults are dying from COVID-19 than younger people. People with COVID-19 will have very different end-of-life experiences depending upon whether they have health care proxies and have thought through the end-of-life care they want.

No matter how old you are, it is always helpful to have designated someone to speak for you if there comes a time when you cannot speak for yourself. This person is your **health care proxy.** It is equally important for your peace of mind and theirs to share your health care wishes with that person.

Right now, many people are infected with or at risk of being infected with COVID-19 and dying, but anyone can get hit by a car or come down with a life-threatening illness at any time. Through a health care proxy, you can help ensure that you get the care you want. Palliative care–care that is comforting, that eases pain and improves quality of life for patients, involves no aggressive interventions. Curative care is intended to extend patients' lives through aggressive interventions.

The decision between palliative and curative care can take time, so it's good to plan in advance and talk the decision through with the people you love. Medicare covers the cost of conversation with your doctor about your end-of-life wishes as part of your **Annual Wellness visit**.

Having a health care proxy is all the more important during a pandemic. Patients with COVID-19 tend to be socially isolated from their families. They generally cannot meet in person with their doctors. They need to have difficult conversations and understand their chance of living. Without a health care proxy, they need to make decisions about the care they want in the most stressful of situations.

Hospitals often will help a person make end-of-life decisions on intake. But, in the midst of this health care pandemic, they might not be able to. In some cases, the hospital will simply ask if the patient wants life support. Without understanding the benefits and risks or the time to consider them, people cannot make good decisions. They are likely not to understand that a decision to elect life support sometimes can mean two weeks alone on a ventilator, apart from your kids and grandkids, and then death.

The choice of palliative care generally means that the palliative care provider is in touch with the patient's kids and grandkids, keeping them apprised of the patient's health. The patient is comfortable and will not go to the ICU or get put on a ventilator. Instead, the children might be allowed to visit a few times. And, the patient might be able to speak with them.

Health care proxy: An advance medical directive in the form of a legal document that designates another person (a proxy) to make health care decisions in case a person is rendered incapable of making his or her wishes known. The health care proxy has, in essence, the same rights to request or refuse treatment.