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RI ARA

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"Fighting for the future of our members."
"NOW, more than ever!!!"

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November 22, 2020 E-Newsletter

Happy Thanksgiving To All Our Members & Their Families
Be Safe and Healthy

Older Voters Key to Biden Victory

The major U.S. news organizations officially declared Democratic nominees **Joe Biden** and **Kamala Harris** the winners in the race for President and Vice President on Saturday, clinching a clear, hard fought, and historic victory. Biden defeated President **Donald Trump** in several key swing states including Pennsylvania, whose 20 electoral college votes put him well over the 270 minimum needed to be elected.

In the days following the announcement, Biden was also declared the winner in Nevada, Arizona and Georgia.

The latest **exit poll data** show that two percent more voters over the age of 65 voted Democratic than in 2016. In Michigan Biden won the 65+ vote by 8% and in Arizona he won by 2%, a significant shift from four years ago. Organized labor also played a critical role in helping the Biden-Harris ticket win: the **AFL-CIO conducted a poll of 1,000 members** on Nov. 2 and 3 and found that they preferred Biden to Trump 58% to 37%, with retired members voting at a 69% to 30% margin.

"The Alliance would like to extend a hearty congratulations to President-Elect Biden and Vice President-Elect Harris," said **Robert Roach, Jr.**, President of the Alliance. "We would also like to thank our 4.4 million members for both voting despite major impediments and volunteering in record numbers."

Robert Roach, Jr
President, ARA

An estimated 160 million voters participated in this election, with more than 100 million voting before Election Day. The turnout rate was the highest **since 1900**.

Pfizer's "Free" Vaccine is a Marketing Ploy

This week Pfizer, along with its German partner company BioNTech, announced that its Covid-19 vaccine is more than 90% effective at preventing infection. The announcement generated excitement throughout the world, sent the stock market soaring and also raised questions about how the vaccine would be priced and distributed if it is approved by the Food and Drug Administration.

Pfizer has stated that their vaccine will be made available at no cost, and the corporation has agreed to supply 100 million doses to the United States at a price of $39 for a two-shot course, or $19.50 per dose. Pfizer's touting a "free" vaccine rings hollow, since the pharmaceutical corporation has benefitted from millions in tax breaks over the last two years and will receive significant support from the federal government to distribute the vaccine across the country.

"Progress toward an effective vaccine gives us some hope for containing the virus and preventing unneeded death. However, we must continue to fight to ensure any coronavirus vaccine or treatment is free and available to all who need it, no matter where they live," said **Joseph Peters, Jr.**, Secretary-Treasurer of the Alliance.

The Make ***Medications Affordable by Preventing Pandemic Price-gouging (MMAPPP) Act***, introduced by Representatives **Jan Schakowsky** (IL), **Francis Rooney** (FL), **Lloyd Doggett** (TX), **Rosa DeLauro** (CT), and **Peter DeFazio** (OR), would ensure that any taxpayer-funded vaccines or treatments for COVID-19 proven to be safe and effective will be accessible, affordable, and available to all who need them.

Joseph Peters, Jr.
ARA Security-
Treasurer

Holiday Celebrations and Small Gatherings

The COVID-19 pandemic has been **stressful** and isolating for many people. Gatherings during the upcoming holidays can be an opportunity to reconnect with family and friends. This holiday season, consider how your holiday plans can be modified to reduce the spread of COVID-19 to keep your friends, families, and communities healthy and safe.

Unfortunately, the COVID-19 epidemic is worsening, and small household gatherings are an important contributor to the rise in COVID-19 cases. CDC offers the following considerations to slow the spread of COVID-19 during small gatherings. These considerations are meant to supplement—**not replace**—any **state, local, territorial**, or tribal health and safety laws, rules, and regulations with which all gatherings must comply.

Considerations for Small Gatherings of Family and Friends Celebrating virtually or with members of your own household (who are consistently taking **measures** to reduce the spread of COVID-19) poses the lowest risk for spread. Your household is anyone who currently lives and shares common spaces in your housing unit (such as your house or apartment). This can include family members, as well as roommates or people who are unrelated to you. People who do not currently live in your housing unit, such as college students who are returning home from school for the holidays, should be considered part of different households. In-person gatherings that bring together family members or friends from different households, including college students returning home, pose varying levels of risk….**Read More**

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Health Care for Millions in Supreme Court's Hands

On November 10, the U.S. Supreme Court **heard oral arguments i**n a case that could up-end the country's entire health care system. The case, California v. Texas, was brought by 18 states and the Trump administration. If successful, it would strip health care coverage from millions of Americans, including people approaching Medicare eligibility due to age or disability, reopen the Medicare Part D donut hole, end Medicaid expansion, and allow insurers to deny coverage and institute lifetime maximums on an estimated 133 million Americans with pre-existing conditions.

Two years ago, in a decision that received bipartisan condemnation, a federal judge in Texas found that the entire Affordable Care Act (ACA) is unconstitutional because Congress reduced the individual mandate tax penalty to zero. The Trump administration applauded this decision,and, on appeal, another court agreed with that initial decision. Now the case is in the hands of the Supreme Court and a ruling is likely in 2021.

Observers noted that the justices appeared dubious about the arguments put forward by the plaintiffs, so there is some hope that they will preserve all or most of the ACA. But given the COVID-19 public health emergency, the stakes have grown even higher.

Elimination of the ACA would immediately end Medicaid expansion and would allow individual and employer-based plans to discriminate against people with pre-existing conditions—including those suffering the after-effects of COVID-19.

In addition, there would be significant cuts to Medicare. The ACA extended coverage for preventive care services and eliminated the Part D prescription drug donut hole. This has saved people with Medicare millions of dollars. In addition, the ACA prohibits Medicare Advantage plans from imposing higher cost-sharing on chemotherapy, renal dialysis, skilled nursing care, as well as other services, to prevent them from discouraging higher cost patients from enrolling in their plans. Undoing these improvements would adversely affect the health and economic security of Medicare beneficiaries.

There is reason to be hopeful about the outcome of the case, but justices are not bound by observers' impressions. Because the health, well-being, and economic security of millions is at risk, we must be aware of the danger that may be looming.

At Medicare Rights, we urge states and the federal government to work to ensure high-quality health care and coverage for everyone. If successful, this frivolous lawsuit would have the opposite effect, with devastating consequences.

- **Read more about California v. Texas.**
- **Read more about the implications of eliminating the Affordable Care Act.**

2020: Comparing your Medicare private options

As you're thinking about your Medicare options this Fall, don't be seduced by the bells and whistles available from some **Medicare Advantage** plans, the Medicare private options through which corporate health insurers contract with the federal government to deliver Medicare benefits. These corporate health plans profit from denying their members needed health care, and **many of them deny care** all too often. The big problem is that it is impossible to know which ones do and which ones do not.

Congress allows Medicare Advantage plans to spend money on health-related services that otherwise would be spent on medical services. Those might be valuable. But, the question is to what extent these health plans are stinting on the delivery of medical care, which could be more critical to your health and well-being if you have or develop a complex condition. And, that is hard to know.

The corporate Medicare plans do not explain how they allocate funds for the additional non-medical services they offer. They are not receiving extra money to do so. For the last several years, federal audits suggest that they have **overcharged the government tens of billions** a year for their services. Those overpayments may be one way they fund the non-medical services they sometimes offer, though the government is trying to get that money back.

They also may be funding these extra services by denying coverage for critical medical care inappropriately and/or by charging high copays for people who need care. There is no data on plan denial rates or copay amounts these plans charge their members for different services, so neither denial rates nor copay amounts can be a basis for choosing a plan.

Medicare private health insurance options also are **not reporting accurately or completely the Medicare-covered services they are delivering their members**, as they are required to do by law. That should give people who consider joining these plans pause. It's reasonable to believe that they are stinting on the delivery of the medically necessary services they are supposed to be covering and charging high copays for costly services.

Given the data, you should be concerned that if you join a Medicare private plan, you might be denied the care or coverage your treating physicians believe you need. Unfortunately, the **star-ratings are of no help** in choosing a plan.

All this said, Medicare Advantage plans have lower upfront costs than traditional Medicare. Because traditional Medicare does not have an out-of-pocket cap, it can be expensive to buy supplemental coverage that fills gaps, if you don't have wrap around coverage from a former employer or Medicaid. And, if you end up not needing a lot of care, it can be more expensive than Medicare private health insurance.

The problem is that if you have a complex condition, you are taking a gamble with Medicare private options. You're gambling that the doctors you want to use are in the network and remain in the network. You are gambling that it will cover the care you and your doctors believe you need. You're gambling that the copays will not be prohibitive and create a barrier to care. Your out-of-pocket costs for in-network medical care alone can be as high as $7,550 a year.

Do a lot of homework before choosing a Medicare private plan. Talk to your doctors. Find out which Medicare Advantage plan networks they are in, which Medicare Advantage plan they like most, and which, if any, they have issues with. You can get free guidance from your State Health Insurance Assistance Program or SHIP.

One thing to keep in mind. If you are switching from fee-for-service traditional Medicare, (the Medicare public option,) to a Medicare Advantage plan, you might not be able to switch back. You could be locked out of traditional Medicare if you develop a health condition and live in a state that does not require **Medicare supplemental insurers** to sell you coverage that fills gaps in Medicare. Only four states require insurers to sell coverage, New York, Connecticut, Massachusetts and Maine.

With strong data on two Covid-19 vaccines, we have more answers

The success of a second vaccine against Covid-19 means the world is a big step closer to curbing the coronavirus pandemic.

Moderna, joined by U.S. government scientists, announced Monday that their mRNA vaccine candidate was **94.5% effective in preventing Covid-19**, the disease caused by the novel coronavirus, according to an interim analysis of a 30,000-patient clinical trial. The news comes exactly one week after Pfizer and BioNTech said their respective Covid-19 vaccine candidate, also created using mRNA technology, was **more than 90% effective** in its own 60,000-patient clinical trial.

Here's what we know — and still need to learn — about the two most advanced Covid-19 vaccines and how they might reshape the pandemic that has killed 1.3 million people worldwide and infected at least 54.5 million.

Are the two vaccines equally effective?

It's too early to tell for certain, but the overall efficacy of the vaccines appears to be similar, based on the data disclosed to date. This isn't altogether surprising, since the Moderna and the Pfizer/BioNTech vaccine candidates are both based on the **same kind of technology**.

Based on data disclosed Monday, the Moderna vaccine appears to have been protective in important subsets of participants — the elderly and people from communities of color, the latter of which make up 37% of the volunteers in Moderna's trial.

Moderna also released data about the number of participants who developed severe Covid-19. There were 11 cases of severe disease, all of them in the placebo group. The elderly often respond less robustly to vaccines and are more vulnerable to having severe cases of Covid-19, if infected.

The clinical trial conducted by Pfizer and BioNTech included the same subpopulations of participants, but specific results have not been disclosed.

We don't know how effective these vaccines are in the long-term.

Some immunizations provide protection against a pathogen for decades (think the measles vaccine). It's thought that the benefits of a Covid-19 vaccine — no matter the manufacturer — won't last nearly as long. But researchers won't know how long until the immunity offered by these vaccines begins to wear off. This will be something scientists keep an eye on in the months to come.

"We do not know at this point what the durability of protection will be," Anthony Fauci, the director of the National Institute of Allergy and Infectious Diseases, said on a call with reporters Monday….**Read More**

Confused by all the Medicare "Open Season" Ads?

If you've watched TV at all in the last few weeks you've seen almost as many Medicare "open season" ads by retired football stars, actors (both famous and not so famous), and insurance companies as you saw political ads before the election. They seem to be promising you that if you will call their 800 number you could keep as much as an extra $144 in your Social Security check each month while at the same time getting a new Medicare Advantage/supplement plan that will give you free eyecare, free dental care, free meals, free rides, and more – all without paying anything additional.

If you're confused or wonder what is going on, we offer here our thoughts on what this is all about and how you should be careful about any changes you make in your current Medicare supplement. And remember, those ads are sponsored by insurance companies and the 800 numbers they urge you to call are staffed by people who want to sell you their particular Medicare advantage plan.

(TSCL does not sell any insurance products and we have no financial stake in the information we are providing here.)

The Trump Administration has been heavily promoting these Medicare Advantage plans because it believes they save the government money. In addition, insurers received additional incentives to cover COVID-19 costs under the stimulus legislation that was passed earlier this year.

Medicare Advantage is a private alternative to Medicare. People who enroll in one of these plans generally give up the ability to go to any provider that accepts Medicare, or to get care anywhere in the U.S. Instead, enrollees are limited to a network of doctors, hospitals and providers that contract with the plan. Going outside this network can leave patients liable for 100% of the bill.

While the plans may offer low or no premiums and put money back into your Social Security check TSCL strongly advises that you investigate the details of these plans, ESPECIALLY when you are considering dropping a Medigap plan. Once you drop a Medigap plan you may not be able to purchase that type of coverage again in the future in most states.

In addition, a close look at the details of any new Medicare Advantage plan is essential because it may reveal that some of the extra benefits such as dental care may be pretty meager. Plans can change and even drop these extras from year to year.

You also should be aware that there are a lot of scams out there and you may receive a mailer or a phone call from one of them. We think it's a good idea to just throw away all the mailers, even those from major insurance companies, and also ignore the phone calls.

The best way to compare is to set up a free counseling appointment with a State Health Insurance Program (SHIP) counselor. Choices need to be made based on the drugs you take and the doctors and hospitals you use, whether you plan to travel a lot, etc.

One of the additional dangers is that you might find a good Medicare Advantage plan you like but it may not even be offered again next year or the year after.

If you want to go online for help in selecting your plan you can go to **Medicare.gov** and select "find health and drug plans". You will be taken to the plan finder and you will be asked to put in information concerning your personal health situation.

But you still have to be careful. The list of drugs may look the same as last year but it may require you to use a mail order pharmacy. Or the fine print might show that the co-pays for non-preferred generics in the low-cost plan were more than double what you now pay, and coinsurance for brand and specialty drugs are higher. Or if you need a new prescription you might have to pay more under the low-cost plan. In addition, there could be a disclaimer about the low mail order costs that says drug costs may be higher depending on the mail order pharmacy you use, which means the estimated costs aren't accurate.

The bottom line is that there are a ton of money traps it is possible to fall into.

Finally, there is no doubt that Medicare Advantage plans do play an essential role for some beneficiaries. There are some areas of the country where Medicare Advantage is a good choice. You just have to be cautious and find knowledgeable help when comparing plans.

Coronavirus: Covid fee, a new addition to your health care bill

The novel coronavirus pandemic has taken a financial toll on many people and corporations, including many health care providers. But, Sarah Kliff and Jessica Silver-Greenberg report for the **New York Times** that some of these providers are making up for lost income by charging a COVID-19 fee to their patients. Assisted living facilities, ambulances, dentists and other health care providers are adding a COVID fee to their bills, to cover the costs of personal protective equipment and other novel coronavirus-related services during this pandemic.

For patients, these COVID-19 fees can be steep, and insurance generally does not pay for them.

One assisted facility tacked on a $900 charge to its bill. An ambulance company charged an additional $60. A dentist's office charged $45 on top of the cost of a dental cleaning.

Dentists have been particularly hard hit by the novel coronavirus. They have at once lost a lot of business and incurred additional expenses. They typically charge COVID fees of $12 to $45 to make up for some of their lost revenue. Some dental insurers are picking up a piece of that fee.

It's bad enough that patients are forced to bear these additional costs. What's worse is that they often do not know about them until they are billed for the health care services they receive. Many Americans are so accustomed to being upcharged that they pay the fee without question.

But, these fees might not be legal. According to several state attorneys general, these COVID fees, which can be as high as $1,000, takes advantage of patients. New York State now outlaws these fees, claiming that they violate consumer protection laws. Some fees are illegal under federal law.

If you have traditional Medicare, the public Medicare option, providers are prohibited from charging you an additional fee for Medicare-covered services. Under New York, Connecticut and Maryland laws, health care providers that are in-network are not permitted to charge a fee under state or federal law.

Medicare is now considering whether to pay an additional amount to some health care providers, given their increased costs for personal protective equipment. And, perhaps, private health insurers will follow suit. But, if insurers pay these additional fees, you can be sure that they will pass along the cost to you in higher premiums. People without insurance will be stuck with higher bills to pay out of pocket.

Red States' Case Against ACA Hinges on Whether They Were Actually Harmed by the Law

Attorneys for GOP-controlled states seeking to kill the Affordable Care Act told the Supreme Court last week that at least some of the 12 million people who newly enrolled in Medicaid signed up only because of the law's requirement that people have insurance coverage — although a tax penalty no longer exists.

The statement drew a rebuke from Justice Sonia Sotomayor, who said it belies reason. Several health experts also questioned the argument that poor people apply for Medicaid not because they need help getting health care but to meet the ACA's individual mandate for coverage.

The point is vital to the Republicans' case to overturn the ACA, an effort supported by the Trump administration. The states are trying to prove they were harmed by the 2010 health law — and thus have "legal standing" to challenge its constitutionality. They argue their Medicaid spending increased because of the mandate, even though Congress eliminated the tax penalty for not having health coverage in 2019. Even when the penalty existed, most poor people were exempt because of their low income.

Under the ACA, states can opt to expand Medicaid eligibility to all adults earning less than 138% of the federal poverty level, or about $17,600 for an individual. States and the federal government share the cost of their care.

If the states cannot prove they have standing, the justices can toss their case without ruling on its merits. The case also involves two individuals who purchased private insurance from Texas and are suing to have the law overturned.

The Medicaid costs issue was one of several ways Texas and other GOP-controlled states participating in the lawsuit say they were harmed by the ACA even after the individual mandate penalty was reduced to zero. Several justices, including conservatives Clarence Thomas and Amy Coney Barrett, posed questions about whether the states had standing.

The case heard last Tuesday, ***California v. Texas***, was the third time the high court has taken up a major suit on the ACA. Republican attorneys general in 18 states and the Trump administration want the entire law struck down, a move that would threaten coverage for more than 20 million people, as well as millions of others with preexisting conditions, including COVID-19.

Even if the court rules the states have legal standing, the ACA opponents must prove the elimination of a penalty makes the entire law unconstitutional.

The Republican states assert that since the law was upheld under Congress' taxing powers by the Supreme Court in 2012, once the tax penalty is gone, the entire law must fall, too.

A group of Democratic-controlled states led by California and the Democratic House of Representatives are urging the court to keep the law in place.

Sotomayor raised serious doubts about the plaintiffs' Medicaid argument and whether the states had suffered injury.

"At some point, common sense seems to me would say: Huh?" Sotomayor told Kyle Hawkins, Texas' solicitor general, who is leading the GOP states' legal fight. She questioned whether it seemed reasonable that once Medicaid enrollees are told there is no tax penalty for people who don't have coverage they would "enroll now, when they didn't enroll when they thought there was a tax? Does that make any sense to you?"

Hawkins defended his case, saying states need to show that only one person signed up for Medicaid because of the individual mandate. "There's a substantial likelihood of at least one person signing up for a state Medicaid program, which, of course, would cause at least one dollar in injury and satisfy the standing requirement," he said.

He cited a **Congressional Budget Office report** issued in 2017, when lawmakers were considering the change in the penalty. It said some people would continue to buy insurance or seek coverage "solely because of a willingness to comply with the law," even if the individual mandate penalty were eliminated.

Few surveys have asked Medicaid enrollees why they signed up for the program….**Read More**

Alito's politically charged address draws heat

The Supreme Court justice warned that not only is freedom of belief under threat, but freedom of expression is as well.

Supreme Court Justice Samuel Alito delivered an unusually inflammatory public speech Thursday night, starkly warning about the threats he contends religious believers face from advocates for gay and abortion rights, as well as public officials responding to the coronavirus pandemic.

Speaking to a virtual conference of conservative lawyers, the George W. Bush appointee made no direct comment on the recent election, the political crisis relating to President Donald Trump's refusal to acknowledge his defeat or litigation on the issue pending at the Supreme Court.

However, Alito didn't hold back on other controversial subjects, even suggesting that the pressure Christians face surrounding their religious beliefs is akin to the strictures the U.S. placed on Germany and Japan after World War II.

Justice Alito

"Is our country going to follow that course?" Alito asked. "For many today, religious liberty is not a cherished freedom. It's often just an excuse for bigotry and can't be tolerated, even when there is no evidence that anybody has been harmed. ... The question we face is whether our society will be inclusive enough to tolerate people with unpopular religious beliefs."

Alito argued that some recent Supreme Court decisions, including the landmark ruling upholding a constitutional right to same-sex marriage, fueled intolerance to those who believe marriage should be limited to unions between one man and one woman.

"Until very recently, that's what the vast majority of Americans thought. Now, it's considered bigotry," he said.

Alito also seemed to minimize the significance of a refusal of a Colorado baker to produce a wedding cake for a same-sex couple. The justice noted that the couple involved "was given a free cake by another bakery" and that the high-profile standoff prompted "celebrity chefs" to come to their defense.

Justices often include pointed, even barbed, language in their opinions. Indeed, Alito regularly does so, and many of his remarks Thursday night echoed similar comments he's made in caustic dissents. Still, it is uncommon for a justice to weigh in on hot-button topics like abortion or gay rights in speaking appearances open to the press or public.

During his half-hour-long speech, Alito warned that not only is freedom of belief increasingly under threat, but freedom of expression is as well.

"One of the great challenges for the Supreme Court going forward will be to protect freedom of speech. Although that freedom is falling out of favor in some circles, we need to do whatever we can to prevent it from becoming a second-tier constitutional right," he said.

While the conservative justice insisted he was not opining on the legal questions related to coronavirus lockdown orders and similar restrictions, he painted those moves as oppressive.

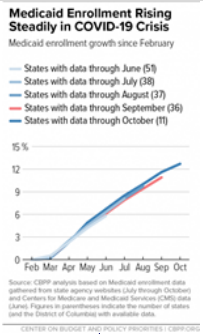
"The pandemic has resulted in previously unimaginable restrictions on individual liberty," Alito said, insisting that such an observation was transparently true. "The Covid crisis has served as a sort of constitutional stress test and in doing so it has highlighted disturbing trends that were already in evidence before the pandemic struck."...**Read More**

Medicaid Enrollment Still Rising

Medicaid enrollment rose 10.9 percent from February to September in the 36 states for which we have data, as millions lost their jobs or suffered sharp income losses due to the COVID -19 recession. If we extrapolate these increases nationwide, it would mean about 7 million more people enrolled in Medicaid — and likely more, given continued increases in October in states with available data. The growing need for Medicaid coincides with a large state budget crisis, which has already prompted **some states** to cut Medicaid (as described below) and will likely prompt more to do so unless the federal government provides more aid to states.

Before COVID-19 and the recession, Medicaid enrollment was flat or falling in most states. It has risen steadily since then, as the figure below shows.

These data include groups for whom enrollment is generally not shaped by economic conditions, such as elderly people and people with disabilities who are enrolled in both Medicare and Medicaid. Enrollment increases among adults covered through the Affordable Care Act's Medicaid expansion have been much larger, with Medicaid providing a safety net as millions of adults have lost jobs or income. Through September, expansion enrollment rose 18 percent in the 22 states that track such data; if extrapolated nationwide, that would amount to more than 2 million people.



These Medicaid enrollment figures are based on preliminary estimates from state websites, as of November 4. Complete enrollment figures for all states from the Centers for Medicare & Medicaid Services (CMS) are available only through June, but the state-reported data to which we have access largely match the trends in the CMS data for the months for which both are available, as shown in the figure.

We included further details and sources in an earlier analysis, which this blog post updates. These are the states for which we now have data, and through which month:

- **October:** Alaska, Arizona, Arkansas, Iowa, Kentucky, Maine, Minnesota, Mississippi, Nebraska, New Jersey, and Virginia;
- **September:** Colorado, Connecticut, Washington D.C., Florida, Illinois, Indiana, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Missouri, Nevada, New Hampshire, New Mexico, New York, North Carolina, Ohio, Oregon, South Dakota, Tennessee, Utah, Washington, West Virginia, and Wisconsin;
- **August:** Oklahoma and Texas;
- **July:** Montana.

These increases are almost certainly mitigating the large spikes in uninsurance rates that would otherwise occur as millions lose job-based coverage or can't afford private plan premiums due to the recession. But enrollment growth is also adding to state budget pressures. Already, some states have made or are considering Medicaid cuts, including reductions in provider payments, reversals of planned and needed coverage improvements, and furloughs and hiring freezes affecting workers who determine eligibility. And other states are considering cutting provider payments in the months ahead, a **Kaiser Family Foundation survey** of state Medicaid officials found. As states exhaust their options to defer budget cuts, they will likely proceed with these and other cuts to Medicaid and other health programs unless federal policymakers provide more funds and maintain **strong protections** for Medicaid enrollees.

Fox News: 72% voters want "government-run healthcare"

Vice-President Biden's victory in the presidential election is cause for huge relief and celebration, though the number of people who voted for Trump should give us pause. What it means and how best to move our nation forward will be a subject of research and conversation for some time. What's no surprise is that many people who voted for Trump support government-run health care, just as they overwhelmingly support Medicare and Social Security.

A new **Fox News poll** finds that 72 percent of voters favor "changing to a government-run health care plan." Of course, they do. They need health care, and they increasingly cannot afford it, even with private insurance.

Unfortunately, many Democrats in Congress who ran for the first time for Senate and House seats, refused to take a bold stand on health care affordability, let alone Medicare for all. They lost. What's noteworthy is that Democratic candidates in swing states who supported Medicare for all won.

And, **all 109 Democratic House candidates who co-sponsored Medicare for all** were elected or re-elected.

Even still, centrist Democrats refuse to admit that their failure to support Medicare for All is what cost them seats in the House and Senate. **Majority Whip James Clyburn** wrongly conflated Medicare for all– private health care paid for directly through the government –with socialized medicine– public health care provided by the government. And, he advised candidates to stay away from supporting Medicare for all.

Clyburn receives a lot of support from the health care industry. Like his fellow Democrats in Congress who depend on the health care industry for support, he won't concede that the cost of care with private health insurance is forcing **tens of millions of Americans to forego needed care**.

Centrist Democrats appear to believe that the Affordable Care Act is a solution to the crisis in our health care system. But, only 20 million Americans benefit from coverage through state health care exchanges. And, though they get coverage, the deductibles and copays too often force them to go without care.

Fox News reports that nearly two in three voters in Georgia want the choice of public health insurance. Both Raphael Warnock and Jon Ossoff, two Democratic Senate candidates who face runoff elections in Georgia in January, support the public health insurance option for anyone who wants it. And, that's what Americans support.

But, if the centrist Democrats have their way, they will try to limit access to the public option to people with low-incomes only. That might please their corporate backers from the health care industry, but it would not address the need to decouple health care from employment and give every American access to public health insurance.

Almost every working American risks losing a job and, with it, health insurance. Every working American deserves the protection of reliable government-administered public health insurance if they want it. If modeled on traditional Medicare, as the Biden-Sanders Unity Task Force proposes, with an out-of-pocket cap, the public option would ensure people have good health insurance. If public health insurance covered care from virtually every doctor and hospital in the country, as traditional Medicare does, and benefited from Medicare's negotiated provider rates, Americans would have access to lower-cost health insurance and health care from the doctors and hospitals they want to use.

Democrats in Congress should recognize that progressive activists organized voters in key communities and helped Biden win the presidential election. And, no one should disregard the fact that House candidates who backed Medicare for all, won reelection, even in swing states.

Provide Adequate SNAP Funding for Fiscal Year 2021

The **Agriculture appropriations bill** for fiscal year 2021 that the Senate Appropriations Committee released Tuesday includes substantially less funding for SNAP (food stamps) than the program is likely to need, because the bill's funding level is based on outdated, pre-COVID-19 funding estimates. Traditionally, appropriators wait until the House-Senate conference committee meets to set the final number for SNAP. This year, at a minimum, significant adjustments will be needed to update the number to reflect current need.

There are two basic issues. First, it's unclear just how much funding SNAP will need for fiscal year 2021, which started October 1, given the high degree of uncertainty concerning the depth and duration of the pandemic and the economic downturn (as well as the uncertainty surrounding various expansions in unemployment insurance and other programs and policies that were enacted in response to COVID but are slated to expire at the end of December). Second, although SNAP is an entitlement program — meaning that anyone who qualifies under program rules can receive benefits if they apply — Congress has historically appropriated a specific dollar amount for SNAP each year, and program costs cannot exceed the appropriated amount.

Congress could solve this problem by treating SNAP in the same manner as it treats most other entitlement programs: that is, by providing in the appropriations bill an amount reflecting an estimate of what will be needed, but accompanying that with flexibility for the federal agency operating the program to spend whatever is needed in the last quarter of the fiscal year so benefits are available throughout the year for all eligible applicants. This structure ensures that a program cannot run out of funding because of unexpected enrollment increases or other unanticipated costs.

Let's take the two issues in turn.

Uncertainty about need. When the Trump Administration developed **its estimates** nearly a year ago for the number of people who will participate in SNAP in fiscal year 2021 — and the funding required to meet that need — unemployment was below 4 percent and food inflation had been below 1 percent a year for five consecutive years. With a relatively strong economy, SNAP caseloads had fallen every year since peaking in fiscal year 2013. As a result, the Administration's estimates — upon which Senate appropriators based the SNAP funding level in their new bill — assumed that SNAP participation would continue to fall in 2021, to 37 million people a month, on average, and that food costs would rise only modestly.

But, due to COVID-19 and the resulting economic downturn, SNAP participation has risen to **more than 43 million people**, and food costs increased by more than 5 percent between June 2019 and June 2020, the month upon which SNAP benefit levels for fiscal year 2021 are based….**Read More**

Does Your Loved One Need Care Urgently?

What to do after a hospital or rehab discharge or a steep decline in function forces you to act quickly.

OFTEN THE NEED TO help your aging mom or dad develops slowly over time. You notice signs that they are slipping in their ability to perform daily activities. At first these are occasional and mostly benign, but eventually become more acute and demand attention.

However, sometimes these needs appear quickly. A medical emergency, an accident or a rapid decline in function necessitates urgent action. How do you know if this is the case? And what should you do if it is?

Plan Ahead

If this scenario scares you, then good. Elder care experts all recommend strongly that families put plans in place well before such a need arises. **Do your research** to find options in your community that you and your loved one will be happy with, if and when the times comes. Waiting until a health crisis occurs "can be dangerous," says Anthony Cirillo, a health, aging and caregiving expert and president of The Aging Experience. If you haven't done your homework and now have to act immediately, you might be limited in your choices. "That is why preparing for these situations sooner is important," he says.

If that ship has already sailed, you need first to evaluate just how much help your loved one needs. Will **at-home care** be enough? Will they require the support of an assisted living facility? Are their medical needs so great that they require a skilled nursing facility – otherwise known as a **nursing home?**

Don't expect your mom or dad to make it easy on you. According to AgingCare.com, older people often find it hard to accept the fact that they need any type of assistance. Giving up independence is difficult, and it usually takes a traumatic event to force them to realize they need assistance. "The added emotional stress of a sudden hospitalization or fall further complicates this process," it says.

Talk to an Expert

If an older loved one is being released from a **hospital** or rehab center and you don't know where he or she should go next, talk to an appropriate person at the facility they are leaving. "If you are their caregiver, meet with a case manager or discharge planner and talk about transitional care planning, including where your loved one will go when discharged," says John Mastronardi, executive director at The Nathaniel Witherell, a short-term rehab and skilled nursing facility in Greenwich, Connecticut. Do this well before discharge to learn what date they will be released, what level of care they will need moving forward and what the staff recommends for next steps.

Those recommendations will depend most on the care needed. Care after hospitalization "is not always cut and dried, not black and white," Mastronardi says. Will the elder require wound management, medication management, special medical equipment or skilled nursing care? Or are their needs less serious, such that they could be provided at an **assisted living facility** or at home through a certified home health care agency that provides part-time services? Depending on the answer, you will know if your loved one would be better served by assisted living or a skilled nursing facility. "You shouldn't be shy about (asking)," Mastronardi says. "Ask if the loved one needs more than going back home, and where should they go. There are many options."

You can also solicit the help of your loved one's **doctors** or a hospital counselor or social worker. "They can help and give decision support to wade through the myriad choices that can be confusing, overwhelming and tough to figure out," he says.

Finally, contact the facilities you are considering and speak with their advisors. "Don't be afraid to call for advice," says Maria Hood, director of admissions for United Hebrew, a campus of elder-care facilities in New Rochelle, New York. "When a family member calls me and says, 'I don't know anything,' I say, 'Of course you don't. It's OK. That's what I'm here for.' Even if it's early in the game, and maybe they just need help at home for now, we can talk about that."

Signs of Need

Urgent need isn't only caused by an illness or accident. Sometimes, those small signs of trouble suddenly become much bigger. But it's not always obvious. "Families sense that things are wrong, but can't put finger on it," Hood says. "At the end of the day you have to go with your gut. You know your loved one better than anybody."

Hood offers her own father as a perfect example: A man who always took pride in his appearance would stop shaving and go out in rumpled clothing. Gentle probing revealed he wasn't showering for fear of falling. One day, he drove her to the airport, and she noticed he would not drive faster than 45 mph on the highway. "He had white knuckles around the wheel," she says. These and other signs alerted Hood's family to the need for action.

Even so, you need to move delicately. "They are embarrassed. They don't want to be a burden," Hood says. "You have to say, 'We are a family, we are in this together, we are here to help each other.'"

Census Bureau releases new report on commuting patterns of older workers

The U.S. Census Bureau has released a report that examined the ways older adults get to work. **The Commuting Patterns of Older Workers: 2013–2017,** supported in part by NIA, provides statistics and characterizations of the commuting patterns of older adults.

The population in the United States is aging rapidly. From 2008 to 2017, the U.S. population age 65 and older grew by 31%, from 38.8 million to 50.8 million, largely due to the baby boomer generation. As baby boomers continue to age into this group, the older workers in the workforce at large will continue to grow.

Between 2013 and 2017, driving alone was the most common mode of commuting, used by over 75% of all workers. Workers age 55 to 64 drove to work alone at higher rates than workers age 25 to 54, but the proportion driving alone declined among workers age 75 and older, with nearly 12% of workers in that age group working from home. Researchers found that workers age 65 and older reported shorter average travel times to work than workers aged 25 to 54 or 55 to 64.

As functional limitations rise with age, older workers face additional challenges in commuting compared to younger workers. Working from home and not having to commute may enable older adults to continue working later in life.

Demographics and travel patterns will continue to change, meaning further research will be needed to investigate how population aging influences U.S. workers' commuting patterns, transportation planning, and policymaking.

RI ARA HealthLink Wellness News

HealthLink Wellness "Taking Control"

Clots, Strokes and Rashes: Is COVID a Disease of the Blood Vessels?

Whether it's strange rashes on the toes or blood clots in the brain, the widespread ravages of COVID-19 have increasingly led researchers to focus on how the novel coronavirus sabotages blood vessels.

As scientists have come to know the disease better, they have homed in on the vascular system — the body's network of arteries, veins and capillaries, stretching more than 60,000 miles — to understand this wide-ranging disease and to find treatments that can stymie its most pernicious effects.

Some of the earliest insights into how COVID-19 can act like a vascular disease came from **studying** the aftermath of the most serious infections. Those reveal that the virus warps a critical piece of our vascular infrastructure: the single layer of cells lining the inside of every blood vessel, known as the endothelial cells or simply the **endothelium**.

Dr. **William Li**, a vascular biologist, compares this lining to a freshly resurfaced ice rink before a hockey game on which the players and pucks glide smoothly along.

"When the virus damages the inside of the blood vessel and shreds the lining, that's like the ice *after* a hockey game," said Li, a researcher and founder of the **Angiogenesis Foundation.** "You wind up with a situation that is really untenable for blood flow."

In a study published this summer, Li and an international team of researchers compared the lung tissues of people who died of COVID-19 with those of people who died of influenza. They found stark differences: The lung tissues of the COVID victims had nine times as many tiny blood clots ("microthrombi") as those of the influenza victims, and the coronavirus-infected lungs also exhibited "severe endothelial injury."

"The surprise was that this respiratory virus makes a beeline for the cells lining blood vessels, filling them up like a gumball machine and shredding the cell from the inside out," Li said. "We found blood vessels are blocked and blood clots are forming because of that lining damage."

It's already known that the coronavirus breaks into cells by way of a **specific receptor**, called **ACE2**, which is found all over the body. But scientists are still trying to understand how the virus sets off a cascade of events that cause so much destruction to blood vessels. Li said one theory is that the virus directly attacks endothelial cells. Lab experiments **have shown** that the coronavirus can infect engineered human endothelial cells.

It's also possible the problems begin elsewhere, and the endothelial cells sustain collateral damage along the way as the immune system reacts — and sometimes overreacts — to the invading virus….**Read More**

'Breakthrough Finding' Reveals Why Certain COVID Patients Die

Dr. Megan Ranney has learned a lot about COVID-19 since she began treating patients with the disease in the emergency department in February.

But there's one question she still can't answer: What makes some patients so much sicker than others?

Advancing age and underlying medical problems explain only part of the phenomenon, said Ranney, who has seen patients of similar age, background and health status follow wildly different trajectories.

"Why does one 40-year-old get really sick and another one not even need to be admitted?" asked Ranney, an associate professor of emergency medicine at Brown University.

In some cases, provocative new research shows, some people — men in particular — succumb because their immune systems are hit by friendly fire. Researchers hope the finding will help them develop targeted therapies for these patients.

In **an international study** in Science, 10% of nearly 1,000 COVID patients who developed life-threatening pneumonia had antibodies that disable key immune system proteins called interferons. These antibodies — known as autoantibodies because they attack the body itself — were not found at all in 663 people with mild or asymptomatic COVID infections. Only four of 1,227 healthy individuals had the autoantibodies. The study, published on Oct. 23, was led by the COVID Human Genetic Effort, which includes 200 research centers in 40 countries.

"This is one of the most important things we've learned about the immune system since the start of the pandemic," said Dr. Eric Topol, executive vice president for research at Scripps Research in San Diego, who was not involved in the new study. "This is a breakthrough finding."

In **a second Science study** by the same team, authors found that an additional 3.5% of critically ill patients had mutations in genes that control the interferons involved in fighting viruses. Given that the body has 500 to 600 of these genes, it's possible researchers will find more mutations, said Qian Zhang, lead author of the second study.

Interferons serve as the body's first line of defense against infection, sounding the alarm and activating an army of virus-fighting genes, said virologist Angela Rasmussen, an associate research scientist at the Center of Infection and Immunity at Columbia University's Mailman School of Public Health.

"Interferons are like a fire alarm and a sprinkler system all in one," said Rasmussen, who wasn't involved in the new studies.

Lab studies show interferons are suppressed in some people with COVID-19, perhaps by the virus itself.

Interferons are particularly important for protecting the body against new viruses, such as the coronavirus, which the body has never encountered, said Zhang, a researcher at Rockefeller University's St. Giles Laboratory of Human Genetics of Infectious Diseases.

When infected with the novel coronavirus, "your body should have alarms ringing everywhere," said Zhang. "If you don't get the alarm out, you could have viruses everywhere in large numbers."

Significantly, patients didn't make autoantibodies in response to the virus. Instead, they appeared to have had them before the pandemic even began, said Paul Bastard, the antibody study's lead author, also a researcher at Rockefeller University.

For reasons that researchers don't understand, the autoantibodies never caused a problem until patients were infected with COVID-19, Bastard said. Somehow, the novel coronavirus, or the immune response it triggered, appears to have set them in motion.

"Before COVID, their condition was silent," Bastard said. "Most of them hadn't gotten sick before."

Bastard said he now wonders whether autoantibodies against interferon also increase the risk from other viruses, such as influenza….**Read More**

New report on indicators of well-being among older Americans

In October, the Federal Interagency Forum on Aging-Related Statistics released **Older Americans 2020: Key Indicators of Well-being**. Using official statistics from federal agencies, including NIA, the report identifies and updates 40 indicators that depict the well-being of older Americans in the areas of population, economics, health status, health risks and behaviors, health care, and environment.

The 2020 report is the eighth in a series of reports published by the Forum. These reports provide a comprehensive picture of the older adult population in the United States, information and opportunities to improve their lives, and a touchpoint for monitoring changes over time. In addition to the report, **the Forum provides several resources** including data and infographics to better understand the U.S. older adult population. **Read the full report** (PDF, 8.4M).

Fish Oil, Vitamin D Supplements Won't Prevent A-Fib: Study

Millions of people take a fish oil or vitamin D supplement in hopes of warding off a host of ills. But a new study finds the nutrients won't shield against the common and potential heart rhythm disorder known as atrial fibrillation.

"A-fib" affects about 2.7 million Americans and can lead to complications such as blood clots, stroke and even heart failure. The risk of a-fib increases with age, high blood pressure and heavy drinking, and may be more common in some families.

The study results "do not support using marine omega-3 fatty acids or vitamin D to prevent atrial fibrillation," said lead author Dr. Christine Albert. She's founding chair in the Department of Cardiology at Cedars-Sinai Medical Center's Smidt Heart Institute in Los Angeles.

On the other hand, "the results do provide reassurance that these supplements do not increase the overall risk of atrial fibrillation and appear to be generally safe for patients who are taking these supplements for other reasons," Albert said in a news release from the American Heart Association.

Her team presented the findings today at this year's virtual annual AHA meeting.

According to the investigators, prior research hasn't provided clear answers on either the benefits or harms of vitamin D and omega-3 fatty acids when it came to a-fib.

This five-year study included more than 25,000 adults, 50 and older, with no prior history of a-fib. It sought to determine whether vitamin D3 supplements of 2000 IU/day or 840 mg/day of omega-3 fatty acids reduced the risk of developing the heart arrhythmia.

During the study, 3.6% of participants overall did go on to develop a-fib. But there was no statistically significant difference in risk for a-fib between people who took the omega-3 fatty acid supplements and/or vitamin D3 supplements versus those who took a placebo.

Dr. Mitchell Weinberg is chair of cardiology at Staten Island University Hospital in New York City. He wasn't involved in the new research, but said the findings came as "little surprise."

Weinberg believes many people place too much hope in the power of supplements to improve their health.

"The idea that taking more of a given vitamin will extend your life or confer significant added health benefits is very attractive to the health-conscious patient," he said.

But, "while a variety of benefits have been attributed to these two supplements, the scientific evidence is not strong enough to support routine high-dose supplementation," Weinberg added.

"While vitamin D is important for bone health, the claim that vitamin D supplementation decreases the risk for heart disease, cancer and diabetes is not very convincing," he said. "Similarly, the beliefs that omega-3 fatty acids decrease triglycerides, reduce inflammation and decrease mood-related disorders, are without sufficient evidence."

Weinberg's advice: "For now, patients should focus on eating healthy, exercising regularly and consistently following up with a health care professional."

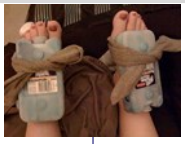
Because the new findings were presented at a medical meeting, they should be considered preliminary until published in a peer-reviewed journal.

Five things to know about gout

Gout can be a **painful health condition,** often a type of arthritis, which generally involves swelling in the joints and can be extremely painful. About 9.2 million Americans live with gout. With gout, your body produces more uric acid than your kidneys are able to filter out. Fortunately, gout can usually be treated, and you can live a productive life. Here are five things you should know about gout:

Who is likely to get gout?

About nine million adults experience gout at some point in their lives. Adults are prone to get gout, particularly men between 40 and 50. Current thinking is that gout runs in families, so whether you get it may spend on your genes. People who are overweight, who drink a lot of alcohol, or eat a lot of purines, such as high-fructose corn syrup, beer and scallops, are also more prone to gout.



Older people are also more likely to get gout because their kidneys are not working effectively to remove uric acid in their systems. And some medications, such as diuretics, also can lead to gout.

What causes gout?

When you have an excess of uric acid in your system, needle-like crystals of uric acid can build up and end up in your joints or soft tissues. There, they cause gout, an inflammation and swelling, redness, heat, and stiffness in the joints that can be very painful.

What are the symptoms of gout?

Often, people get gout first in the big toe, but not always. Sometimes, people get gout in their feet or ankles, knees or wrists, fingers and elbows. And sometimes the uric acid crystals end up in the kidneys and cause kidney stones. You can have an excess of uric acid without experiencing any symptoms, and then there's generally no cause for concern or treatment. Treatment is needed when there is intense swelling or pain in the joints.

What are the triggers for painful symptoms of gout?

Alcohol, drugs and stress are often triggers for a painful attack of gout, which usually begins at night and can last for three to ten days. The pain will typically end on its own, without treatment, but the swelling and pain can return at any time. There is an advanced and disabling stage of gout, in which the joints are permanently affected. With proper treatment, however, most people with gout never experience this stage.

How is gout treated?

Gout is commonly treated with Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), which are taken by mouth, or corticosteroids, which are taken by mouth or by injection. With proper treatment, most people with gout can live pain-free or close to it.

Black Patients Get Worse Care After Cardiac Arrest

Minority patients who suffer life-threatening cardiac arrest may get fewer treatments in the hospital -- and face a grimmer outlook -- than white patients, a new, preliminary study suggests.

The findings add to a large body of research finding racial disparities in U.S. health care, including heart disease treatment.

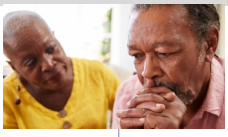
What's different is that the study looked at a "particularly dramatic presentation" of heart disease, said senior researcher Dr. Saraschandra Vallabhajosyula.

The study focused on over 180,000 Americans who were hospitalized for a heart attack and suffered cardiac arrest as a complication. During cardiac arrest, the heart stops beating normally and can no longer pump blood and oxygen to the body. It's fatal within minutes without emergency measures.

There are "very clear-cut" guidelines on how to manage cardiac arrest, as well as guidelines on heart attack care, said Vallabhajosyula, an interventional cardiology fellow at Emory University, in Atlanta.

Yet, his team found, there were racial disparities in certain aspects of hospital care.

Compared with white patients, minority patients were less likely to undergo an angiogram, an imaging technique that looks for blockages in the heart arteries. Just under 62% of Black patients had an angiogram, versus 70% of Asian, Hispanic and Native American patients, and 73% of white patients.



Similarly, while 58% of white patients had angioplasty to clear any heart blockages, that was true for only 45% of Black patients and 53% of other minority patients.

Disparities were seen in survival, as well. As a group, Asian, Hispanic and Native American patients were 11% more likely to die in the hospital than white patients were. The exception was Black patients, whose death risk was not elevated once factors like overall health were taken into account.

The reasons for the findings are unclear, according to Vallabhajosyula. One potential factor is the hospitals -- if, for instance, minority patients tended to land in hospitals with fewer resources.

But Vallabhajosyula said his team accounted for broad hospital characteristics -- whether they were rural or urban, for example -- and that did not fully explain the racial inequities.

The findings were scheduled for presentation this week at the American Heart Association's virtual annual meeting.

Studies presented at meetings are generally considered preliminary. But a body of research has documented long-standing racial disparities in heart attack care, with Black patients less likely than white people to get angiograms and more aggressive treatments like angioplasty and bypass surgery.

And the gap has not narrowed much over the years.

"This study is yet another example of persistent racial disparities in care throughout the U.S. health care system," said Dr. Khadijah Breathett, an assistant professor of cardiology at the University of Arizona College of Medicine, in Tucson.

In her own research, Breathett has found racial gaps in care for heart failure -- a serious chronic condition that disproportionately strikes Black Americans. In one study, Black patients hospitalized for worsening heart failure were less likely to be treated by a cardiologist, versus white patients. And care from a cardiologist was linked to better survival.

Breathett called the new findings "worrisome," partly because hospital care for these acute cardiac complications should be "fairly regimented and standardized."

Government figures show that Black Americans have the highest death rates from heart disease of all racial groups. That's due to a mix of factors, from socioeconomics and lack of health insurance to institutional racism.

When it comes to disparities in care, Breathett said "the elephant in the room" is health care providers' own implicit biases.

In one study, Breathett and her colleagues asked a group of providers to consider whether a heart transplant should be recommended to various hypothetical patients -- all Black or white men. Overall, providers tended to perceive Black men as less healthy than white men, and less likely to stick to post-transplant care.

On the positive side, Breathett said there is evidence that training can help health care providers recognize their own biases.

She said that medical centers should "do the hard work" of finding out where disparities exist within their own walls, and then address them.

Vallabhajosyula agreed that medical professionals need to evaluate themselves. "Are we carrying implicit biases that affect our care decisions?" he said.

And when it comes to cardiac arrest, Vallabhajosyula noted, even lay people's biases might matter.

Quick action from bystanders -- including CPR chest compressions -- can make the difference between life and death for cardiac arrest victims. Yet studies have found that people are more hesitant to perform CPR on women than men -- partly out of fear over hurting them, or being accused of sexual assault.

"It's crucial," Vallabhajosyula said, "that we keep promoting bystander CPR and educating people on when and how to do it."

Be Careful of Fake Coronavirus "Cures" and other Scams

According to Bloomberg News, "The Food and Drug Administration found more than 1,100 'fraudulent and unproven medical products related to Covid-19' as of September, Anand Shah, the FDA's deputy commissioner for medical and scientific affairs said last week. The agency has sent 120 warning letters to sellers, 230 reports to online marketplaces, and more than 270 complaints to domain registrars over the course of the pandemic.

"Fraudulent products highlight the anxiety the public feels about Covid-19 as well as the steady stream of fake facts fed to Americans daily. The prevalence of unchecked social media posts and unproven statements by some political officials have made it easier to mislead people about what works against the virus."

An example given by the report was about a church in Florida called the Genesis II Church of Health and Healing, which sold a chlorine dioxide product it claimed could cure the coronavirus.

After receiving a warning letter, the group continued to sell its "Miracle Mineral Solution" whose chlorine dioxide content was equivalent to industrial bleach, according to the Food and Drug Administration. Adverse reactions to those types of products include "respiratory failure, life-threatening low blood pressure, and acute liver failure," the FDA said.

Please remember, there is currently no cure for the coronavirus and there is no vaccine. Doctors have become better at treating patients who have the virus and there are promising vaccines on the way, but any company, person, or group that tells you they have a cure or a way to prevent it is lying to you and just trying to get your money;.