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It's Time to Get Back to Normal? Not According to Science

The science says "open the schools, stop wearing masks outside, and everyone at low risk should start living normal lives."

A popular Facebook and **blog post** by conservative radio host Buck Sexton claims scientific research indicates life should return to normal now despite the persistence of the covid-19 pandemic.

"Here's what the science tells anyone who is being honest about it: open the schools, stop wearing masks outside, and everyone at low risk should start living normal lives. Not next fall, or next year — now," reads the blog post, posted to Facebook on Feb. 8.

The post was flagged as part of Facebook's efforts to combat false news and misinformation on its News Feed. (Read more about PolitiFact's **partnership** with Facebook.)

KHN-PolitiFact messaged Sexton via his Facebook page to ask if he could provide evidence to back up the statement but got no response.

So we reviewed the scientific evidence and talked to public health experts about Sexton's post. Overall, they disagreed, noting the ways in which it runs counter to current public health strategies.

Let's take it point by point.

'Opening the Schools'

In March, when government and public health leaders realized the novel coronavirus was spreading throughout the U.S., many public institutions — including schools — were ordered to shut down to prevent further spread. Many students finished the 2020 spring semester remotely. Some jurisdictions did choose to reopen schools in fall 2020 and spring 2021, though others have remained remote.

Throughout the pandemic, researchers have studied whether in-person learning at schools contributes significantly to the spread of covid. The findings have shown that if K-12 schools adhere to mitigation measures — masking, physical distancing and frequent hand-washing — are adhered to, then there is a relatively low risk of transmission.

And getting kids back into the classroom is a **high priority** for the Biden administration.

n a **Feb. 3 White House press briefing**, Dr. Rochelle Walensky, director of the Centers for Disease Control and Prevention, said data suggests "schools can safely reopen." The CDC on Feb. 12 released **guidance** on how schools should approach reopening. It recommends the standard risk-mitigation measures, as well as universal masking, contact tracing, creating student learning cohorts or pods, conducting testing and monitoring community transmission of the virus.

Susan Hassig, associate professor of epidemiology at Tulane University, said science shows that schools can open safely if "mitigation measures are implemented and maintained in the school space."

Here's some of the latest research that tracks with these positions:

Let's legalize drug importation and import drug prices

In an opinion piece on addressing high prescription drug prices for **The Hill,** Gabriel Levitt and Steven Salant argue that Congress should allow drug imports from legitimate pharmacies around the world and cap drug prices at the lowest price paid by other wealthy countries.

Today, all but 1.5 percent of Americans fill their prescriptions in the United States. Most people are worried about the safety of drugs imported. But, many of the same exact drugs sold in the US are available around the world; in the US, you pay 3.5 times more for them. Not surprisingly, **three in ten Americans** cannot afford to fill their prescriptions.

A large majority of Americans of all political stripes–more than 75 percent–favor drug importation and Medicare drug price negotiation. The authors propose combining policies proposed by Republicans and Democrats to achieve lower drug prices.

The authors explain why importing drugs from certified licensed pharmacies abroad is **as safe as buying the drugs in the US**. But, the pharmaceutical industry does a good job of scaring people from importing drugs. Consequently, only about 2.3 million Americans import drugs. And, while drug importation is not legal, the FDA has never prosecuted people who import drugs for personal use. In 2019, the **House of Representatives passed HR3**, which would have set Medicare prices for 350 drugs over 10 years at a price benchmarked to the average of what other wealthy countries pay, international reference pricing. The Senate did not entertain the bill, and it went nowhere. The bill was a good first step at regulating drug prices, but it covered fewer than five percent of drugs on the market, did not apply to people without insurance, and left it to insurers to decide whether they wanted to piggyback on Medicare rates.

Levitt and Salant propose that Medicare link its drug price to the lowest price paid by another high-income country. They also say that a Medicare reference pricing bill must specify that if the drug manufacturer does not agree to the reference price, its drug cannot be included on the Medicare Part D formulary or the manufacturer loses its patent protection and other companies can manufacture the drug at the reference price.

Savings from reference pricing could be used to fund more drug research. We should not be funding research from the exorbitant prices people who rely on drugs are now forced to pay.

ADD YOUR NAME

Get The Message Out:
SIGN THE GPO/WEP PETITION!!!!

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Pandemic Treatment Access and Affordability (PTAA) Act

Representatives Jan Schakowsky (D-IL), Lloyd Doggett (D-TX), Rosa DeLauro (D-CT) and Peter Defazio (D-OR) introduced the Pandemic Treatment Access and Affordability (PTAA) Act, H.R. 597, on January 28, 2021. Americans pay the highest prices in the world for prescription drugs. H.R. 597 establishes critical protections against drug price gouging amid the COVID-19 pandemic. The federal government has spent tens of billions of taxpayer dollars on research and development (R&D) of vaccines and treatments for COVID-19, including $23 billion for manufacturing and purchasing. Despite this public investment, there is no guarantee that these taxpayer-funded drugs will be affordable, accessible, or available to all those who need them.

Access to COVID-19 Drugs for All Who Need Them

By prohibiting exclusive licensing and ending monopoly control, H.R. 597 ensures universal access to all taxpayer-funded drugs used to treat or prevent COVID-19.

Ensures Affordability

H.R. 597 mandates reasonable and affordable pricing for new, taxpayer-funded drugs that are used to treat or prevent COVID-19. JANUARY 2021 FACT SHEET

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Greater Transparency

Drug corporations must publicly report specific breakdowns of their total expenditures, including the amount which came from taxpayer dollars, related to any drug used to treat or prevent COVID-19.

Prevents Price Gouging

H.R. 597 blocks excessive pricing of drugs used to treat any disease that causes a public health emergency, not just the COVID-19 pandemic. Drug price gouging is a threat:

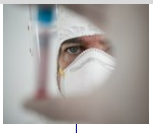
- Drug corporations used a $50 billion windfall from the 2017 tax bill for stock buybacks rather than lowering prices or investing in the development of new drugs;
- Drug prices continue to escalate. In 2020, drug corporations raised the prices of more than 400 drugs by more than five percent with no explanation;
- Remdesivir was developed with $70.5 million of taxpayer dollars, yet there is no requirement that the medication be affordable. In fact, on June 29, 2020, in the middle of the pandemic, Gilead increased the price of their drug Remdesivir -- one of the drugs approved to treat COVID 19 -- by 30% to $3,120 for a five-day treatment.

Feds OK'd Export of Millions of N95 Masks as U.S. Workers Cried for More

In the midst of a national shortage of N95 masks, the U.S. government quietly granted an exception to its export ban on protective gear, allowing as many as 5 million of the masks per month to be shipped overseas.

The Federal Emergency Management Agency issued the waiver in the final moments of Donald Trump's presidency last month, allowing a Texas company to export its products after it failed to secure U.S. customers, according to the FEMA letter obtained by KHN.

National Nurses United president Zenei Triunfo-Cortez called the export waiver "unconscionable" and said N95s remain under lock and key in many hospitals. She said she still has to "beg" for a new N95 if hers gets soiled during a shift caring for covid-19 patients.



Health care employers "and a federal agency that is supposed to be protecting the people of America are not doing their jobs," she said. "They have no regard for our safety."

The disconnect between front-line workers going without better protection and federal officials suddenly exporting masks boils down to one thing, workplace-safety experts say: The government has not pivoted quickly enough to lift supply chain crisis-mode guidelines and force employers to take costly and sometimes cumbersome steps to better protect workers with top-quality gear.

The FEMA letter references the challenge that Fort Worth-based Prestige Ameritech faced in finding customers for its government-approved, high-end respirators: Hospitals did not want to "fit test" employees to its N95s, a 15-minute process per employee to ensure that a new N95 model seals to the face, according to company president Mike Bowen.

Bowen said he ramped up N95 production during the pandemic from 75,000 to 9.6 million per month. Lately, he said, he can't sell them to major buyers, does not have the infrastructure to sell them to small buyers and has so many in storage that he may need to lay off workers and wind down production.

The FEMA letter references those challenges and says the waiver was granted in the "national defense interest" to ensure he keeps production running at pace. The letter was transmitted to Border Patrol officials who oversee exports 103 minutes before Joe Biden was sworn into office…..**Read More**

House Committee Will Focus on USPS Next Week

After months of continued Postal Service delays, the House Committee on Oversight and Reform will hold a hearing on the Postal Service on February 24. Among the witnesses are Postmaster General **Louis DeJoy**, American Postal Workers Union President **Mark Dimondstein** and Postal Service Inspector General **Tammy L. Whitcomb**.

Committee Chairwoman **Carolyn Maloney** says, "The hearing will examine legislative proposals to place the Postal Service on a more sustainable financial footing going forward while preserving the delivery performance standards on which the American people rely."

Older Americans rely on the Postal Service to deliver prescription drugs and other essential goods, and increasing numbers of Americans are reporting delays in delivery of their bills, resulting in substantial late fees and penalties.

The delays are a result of so-called "reforms" implemented by Mr. DeJoy, including elimination of overtime and suspension of requirements for timely delivery. Postal service employees have also been hit hard by the pandemic, with thousands of workers unable to work due to illness or quarantine requirements.

"Everyone relies on the post office," said **Joseph Peters, Jr.**, Secretary-Treasurer of the Alliance. "Americans have relied on it for 200 years and Congress needs to ensure that it can meet its critical mission."

Joseph Peters, Jr.

ACTION NEEDED: The Alliance has teamed up with other organizations that support the Postal Service to gather hundreds of thousands of signatures on a petition that will be delivered to Congress before next week's hearing. Please **click here and add your name.**

Medicare Cuts Payment to 774 Hospitals Over Patient Complications

The federal government has penalized 774 hospitals for having the highest rates of patient infections or other potentially avoidable medical complications. Those hospitals, which include some of the nation's marquee medical centers, will lose 1% of their Medicare payments over 12 months.

The penalties, based on patients who stayed in the hospitals anytime between mid-2017 and 2019, before the pandemic, are not related to covid-19. They were levied under a program created by the Affordable Care Act that uses the threat of losing Medicare money to motivate hospitals to protect patients from harm.

On any given day, **one in every 31 hospital patients** has an infection that was contracted during their stay, according to the Centers for Disease Control and Prevention. Infections and other complications can prolong hospital stays, complicate treatments and, in the worst instances, kill patients.

"Although significant progress has been made in preventing some healthcare-associated infection types, there is much more work to be done," the CDC says.

Now in its seventh year, the **Hospital-Acquired Condition Reduction Program** has been **greeted with disapproval and resignation** by hospitals, which argue that penalties are meted out arbitrarily. Under the law, Medicare each year must punish the quarter of general care hospitals with the highest rates of patient safety issues. The government **assesses the rates** of infections, blood clots, sepsis cases, bedsores, hip fractures and other complications that occur in hospitals and might have been prevented. The total penalty amount is based on how much Medicare pays each hospital during the federal fiscal year — from last October through September.

Hospitals can be punished even if they have improved over past years — and some have. At times, the difference in infection and complication rates between the hospitals that get punished and those that escape punishment is negligible, but the requirement to penalize one-quarter of hospitals is unbending under the law. Akin Demehin, director of policy at the American Hospital Association, said the penalties were "a game of chance" based on "badly flawed" measures….**Read More**

To Vaccinate Veterans, Health Care Workers Must Cross Mountains, Plains and Tundra

A Learjet 31 took off before daybreak from Helena Regional Airport in Montana, carrying six Veterans Affairs medical providers and 250 doses of historic cargo cradled in a plug-in cooler designed to minimize breakage.

Even in a state where 80-mph speed limits are normal, ground transportation across long distances is risky for the Moderna mRNA-1273 vaccine, **which must be used within 12 hours of thawing.**

The group's destination was Havre, Montana, 30 miles from the Canadian border. About 500 military veterans live in and around this small town of roughly 9,800, and millions more reside in similarly rural, hard-to-reach areas across the United States.

About 2.7 million veterans who use the VA health system are classified as "rural" or "highly rural" patients, residing in communities or on land with fewer services and less access to health care than those in densely populated towns and cities. An additional 2 million veterans live in remote areas who do not receive their health care from VA, according to the department. To ensure these rural vets have access to the covid vaccines, the VA is relying on a mix of tools, like charter and commercial aircraft and partnerships with civilian health organizations.

The challenges of vaccinating veterans in rural areas — which the VA considers anything outside an urban population center — and "highly rural" areas — defined as having fewer than 10% of the workforce commuting to an urban hub and with a population no greater than 2,500 — extend beyond geography, as more than 55% of them are 65 or older and at risk for serious cases of covid and **just 65% are reachable via the internet**.

For the Havre event, VA clinic workers called each patient served by the Merril Lundman VA Outpatient Clinic in a vast region made up of small farming and ranching communities and two Native American reservations. And for those hesitant to get the vaccine, a nurse called them back to answer questions.

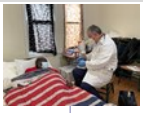
"At least 10 additional veterans elected to be vaccinated once we answered their questions," said Judy Hayman, executive director of the Montana VA Health Care System, serving all 147,000 square miles of the state…..**Read More**

Countless Homebound Patients Still Wait for Covid Vaccine Despite Seniors' Priority

Opening another front in the nation's response to the pandemic, medical centers and other health organizations have begun sending doctors and nurses to apartment buildings and private homes to vaccinate homebound seniors.

Boston Medical Center, which runs the oldest in-home medical service in the country, started doing this Feb. 1. Wake Forest Baptist Health, a North Carolina health system, followed a week later.

In Miami Beach, Florida, fire department paramedics are delivering vaccines to frail seniors in their own homes. In East St. Louis, Illinois, a visiting nurse service is offering at-home vaccines to low-income, sick older adults who receive food from Meals on Wheels.



In central and northern Pennsylvania, Geisinger Health, a large health system, has identified 500 older homebound adults and is bringing vaccines to them. Nationally, the Department of Veterans Affairs has provided more than 11,000 vaccines to veterans who receive primary medical care at home.

These efforts and others like them recognize a compelling need: Between 2 million and 4.4 million older adults are homebound. Most are in their 80s and have multiple medical conditions, such as heart failure, cancer, and chronic lung disease, and many are cognitively impaired. They cannot leave their homes or can do so only with considerable difficulty.

By virtue of their age and medical status, these seniors are at extremely high risk of becoming seriously ill and dying if they get covid-19. Yet, unlike similarly frail nursing home patients, they haven't been recognized as a priority group for vaccines, and the Centers for Disease Control and Prevention only recently offered **guidance on serving them**.

"This is a hidden group that's going to be overlooked if we don't step up efforts to reach them," said Dr. Steven Landers, president and CEO of Visiting Nurse Association Health Group, which provides home health and hospice care to over 10,000 people in New Jersey, northeastern Ohio and southeastern Florida. ...**Read More**

New Report Highlights Racial and Economic Disparities in Medicare

Historically, Medicare has done significant work in reducing racial and ethnic disparities in health status and access to health care, including driving the desegregation of America's hospital systems in the 1960s. However, **as a new report from the Kaiser Family Foundation demonstrates**, that work remains incomplete. Not only do racial and ethnic disparities persist, the COVID-19 pandemic has exacerbated them.

Several issues combine to create these disparities. Average income and savings for Black or Hispanic beneficiaries are lower than for white beneficiaries. In addition, Black or Hispanic beneficiaries are less likely to have access to private wraparound coverage—like Medigap plans or retiree plans—to supplement their Medicare coverage. They are more likely, however, to have Medicaid coverage and low-income subsidies for Part D, demonstrating the important role Medicaid and other programs play in eliminating disparities in access to care. Still, more Black or Hispanic beneficiaries report struggles in finding care, including delays in getting appointments and problems finding a specialist, and far too many find affording care impossible, resulting in delayed care and rising debt.

The report also shows that Medicare beneficiaries who are Black or Hispanic report higher prevalence of poor health and many chronic conditions such as high blood pressure and diabetes compared to white beneficiaries. Black beneficiaries are more likely to need emergency care, hospitalization, and readmission, and are more likely to be hospitalized at low-quality facilities.

During the pandemic, outcome disparities have been even worse. Rates of infection are higher, and the death rates from COVID-19 are nearly twice as high for Hispanic, Indigenous, and Black beneficiaries as for white beneficiaries. Nursing facilities with relatively high percentages of Black or Hispanic residents were more likely to see at least one death from the virus.

As all of these data show, disparities in care and outcomes continue. Medicare has made great strides in ending discrimination in health care, but more improvements are both necessary and possible. Such changes must come both within health care and the larger social and economic systems where inequities flourish.

People Born In 1960 Face Permanent Social Security Benefit Reductions

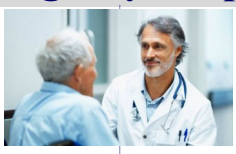
About 4 million people who turn 61 this year could be facing a deep hit to their Social Security benefits when they retire, warns **The Senior Citizens League (TSCL)**. "This is caused by a flaw in the Social Security benefit formula," states Mary Johnson a Social Security policy analyst for The Senior Citizens League. "To prevent benefit cuts, Congress would need to fix this flaw by the end of 2021 before this group turns 62 and are eligible to start benefits," she says.

The feature in the Social Security benefit formula that makes the critical calculation of an individual's initial Social Security retirement benefit (which is linked to the year that workers turn age 60) is sensitive to economic recessions. Known as the average wage index (AWI), it is susceptible to permanent benefit reductions when beneficiaries turn 60 in a year of extraordinarily high unemployment as was the case in 2020.

The initial retirement benefits of people who turned 60 last year, could be permanently reduced by almost 10 percent according to **an estimate** by Social Security's Chief Actuary, Stephen Goss. Without timely remedial action from Congress, people born in 1960 could wind up with Social Security benefits that are 9.1 percent lower than others with identical earnings and retirement histories born just one year prior to them (1959). If this estimate proves to be correct, an age 62 starting benefit of $1,565.00 per month would instead be $1,422.60, a difference of more than $142.00 per month. Over the course of a 25-year retirement, retirees with this benefit level would receive about $55,727 less in benefits.

Due to the COVID-19 caused recession, wages and earnings have plummeted to lower levels in 2020 than in 2019 and "that appears to be dragging down the AWI," says Johnson...**Read More**

Do Medicare Advantage plans give you appropriate access to doctors?



Most Medicare Advantage plans establish networks that restrict your access to doctors and hospitals. And, the data show that people in Medicare Advantage plans overall have a greater chance of getting care from lower quality providers than people in traditional Medicare. A new paper by David Meyers et al. in the **Journal of General Internal Medicine** finds that Medicare Advantage plans with five-star ratings tend to have narrow networks that restrict access to certain types of care considerably.

Here's what some of the independent research reveals: People enrolled in Medicare Advantage are less likely to receive care from the **highest quality hospitals** and **nursing homes** and are more likely to **disenroll if they develop a complex condition**. Black, Hispanic, and Asian Americans enrolled in Medicare Advantage plans have poorer health outcomes than white Americans. It's not clear, however, whether this racial disparity stems from the makeup of the Medicare Advantage plan networks.

In their new research, Meyers and his team find a correlation between plans with higher star-ratings and the breadth of their provider networks. They find that the big health insurers offering for-profit Medicare Advantage plans with higher premiums and a large number of enrollees have wider networks. And, they find that Medicare Advantage plans with the highest star ratings tend to have narrow networks.

Furthermore, the researchers find that if you're in a Medicare Advantage plan, odds are that you will have inadequate access to in-network mental and behavioral health providers, cardiologists, psychiatrists, and primary care providers.

Beyond **star-ratings, which do not tell you enough** about the quality of a plan to rely on, we don't know which Medicare Advantage plans give you access to high-quality providers. That's inexcusable.

The researchers argue specifically for more information to people choosing among Medicare Advantage plans about the breadth of their provider networks and reforms that ensure adequate numbers of mental health providers in Medicare Advantage plan networks.

All said, you can't possibly look at the available information and choose a Medicare Advantage plan that's right for you. You don't know enough about what the Medicare Advantage plan offers or what your future health care needs will be. Only traditional Medicare allows you the freedom to meet those needs when and where you choose.

Will Our New Congress Pass a Benefit Boost?

By Shannon Benton, Executive Director, Senior Citizens League

As our nation goes through the process of getting vaccinated for COVID-19 and getting our lives back on track, TSCL is working on a number of long-term issues that await Congressional attention. We expect policy makers in Congress will be turning their attention to the question of boosting benefits and restoring the long-term solvency of the Medicare and Social Security Trust Funds.

There is widespread support among older Americans for a benefit boost. TSCL surveys have found that 83% of survey participants think Congress should increase Social Security benefits by about 2% of the average benefit, roughly $30 per month ($360) in 2021. Sixty-two percent of survey participants also favor a more generous annual cost of living adjustment (COLA) by tying the annual inflation adjustment to the Consumer-Price Index for the Elderly (CPI-E), and 50% favor enacting a guarantee that COLAs would never be lower than 3%.

Congress has a number of options to pay for the higher benefits that drew strong support in our 2020 Senior Survey:

- 72% support applying the Social Security payroll tax to all earnings (instead of capping the amount of wages to be taxed at $142,800), a move that would reduce Social Security's long - term deficit by as much as 73%.
- 43% support very gradually increasing the Social Security payroll tax rate paid by employers and employees.

Shoring up the Medicare Part A Trust Fund will be more difficult. Simply cutting payments to hospitals would not be in the best interests of patients or hospitals, because many medical centers are already faltering financially.

During the pandemic, non-emergency elective hospital procedures were temporarily stopped to lower the risk of COVID-19 transmission, to preserve scarce personal protective equipment and to keep hospital beds available for COVID care. According to JAMA, the Journal of the American Medical Association, hospitals across the country have taken a major hit to their normal operating income. The American Hospital Association recently reported the average loss of revenues to U.S. hospitals of $50.7 billion per month from March 1, 2020 to June 30, 2020. We don't yet know how much more hospitals have lost through the end of 2020.

Policy experts question how patients will make up postponed care (some services can't be made up) and the degree to which delays in getting care will have adverse health consequences. Both of these concerns suggest that another type of surge for hospitals—the aftermath of postponed care — may be coming next. Cutting hospital reimbursements now could potentially limit access to care when Medicare beneficiaries need it the most.

TSCL will be working for legislation to ensure both hospitals and Medicare Part A weather COVID-19 and its aftermath to keep both strong and working for all who depend on Medicare!

Medicare Pays More for Drugs than Medicaid

Last week the Congressional Budget Office (CBO) released a report that revealed Medicare outpatient plans are three times more expensive for the same drugs as those covered by Medicaid.

According to *Bloomberg News*, "Budget officials analyzed prices of 176 popular brand name drugs and found the price for a 30-day supply of medication was $118 on average through Medicaid and $343 through Medicare Part D, which pays for prescription drugs in retail pharmacies. The government also paid twice as much on the same drugs through Medicare versus the Veterans Affairs program."

The report found similar price disparities in expensive specialty drugs that treat complicated conditions like cancer.

Why does that happen?

Again, according to *Bloomberg News*, "Manufacturers have to offer Medicaid plans their lowest possible price under federal regulations in order to participate in other federal drug programs, which is likely why the Medicaid prices are so low."

In addition, the Secretary of Health and Human Services (HHS) is prohibited from negotiating directly with pharmaceutical companies on behalf of the more than 40 million Americans who get their prescription drug coverage from Medicare Part D.

The Senior Citizens League strongly believes allowing the HHS Secretary to negotiate with the drug companies is one important way to reduce the costs of drugs for seniors. We will be continuing our efforts to get Congress to pass legislation that would make this possible.

Legislation to Control Drug Prices Possible This Year?

Given the above story about how Medicare users pay so much more for drugs than Medicaid users, could this be the year we finally win?

According to an article in *The Hill,* a Washington, D.C., newspaper that covers legislative matters in Congress, it just might happen.

Last year the House of Representatives, led by Speaker Nancy Pelosi (D- Calif.), passed major drug legislation that would have allowed the government to negotiate directly with the drug companies, thus bringing the prices of drugs down. ..**Read More**

Cash surrender value

Life insurance is a useful tool, but there may be times when you wish you could wave **those premiums** away and get some of your money back. Thankfully, some (although not all) insurance policies do give you that option. Whole life insurance, permanent life insurance, variable life insurance and universal life insurance all have cash value components, which means that if you cancel your policy, you will get some money back. Term life insurance does not offer a cash value option.

Before you surrender your life insurance policy to get access to its cash surrender value, it is important to understand what the cash surrender value of life insurance is and how the value is determined.

What is cash surrender value?

Cash surrender value is the amount of money your **life insurance provider** would give you if you surrendered, or cancelled, your policy. **Cash value** is a component of a whole life policy and other types of permanent life insurance. With these types of life insurance policies, your insurance provider takes a portion of your premiums and puts it into a cash value account, where the money can grow. Depending on which type of policy you have, that cash value component will move with market subaccounts, rely on internal company calculations or grow at the current standard interest rate.

If you decide to give up your life insurance policy, you get the cash value of the investments made within it after any surrender fees have been subtracted. As noted above, term life insurance policies do not have this component….**Read More**

Clover Health exposes risks of Medicare Advantage

A little known company, Clover Health, has done quite a job breaking into the Medicare Advantage business. It raised millions from Wall Street, went public, and upped its valuation into the billions of dollars. At the time of its IPO, it did not disclose it was under federal investigation. **Forbes** reports that Clover Health has strong ties to Walgreens and SeekMedicare, a for-profit Medicare counseling business, which appears to be steering folks to enroll in Clover Health.

The Justice Department has been investigating Clover Health because of its relationship with SeekMedicare. SeekMedicare is accused of misleading its customers, providing them with biased information about their Medicare choices. SeekMedicare claims it is "independent" and "unbiased" even though it is a subsidiary of Clover Health, and Walgreens is one of its investors.

SeekMedicare operates in-person Medicare advisor programs in nearly 100 Walgreens stores. It tells older adults that it offers unbiased information about their Medicare choices. It's not clear the extent to which it is steering people to Clover Health, but odds are it is. Clover Health, for its part, advertises the additional benefits it offers people with Medicare.

The bigger problem: There's nothing stopping any entity from claiming it can help people choose a Medicare plan. And, there's nothing stopping these entities from steering people to the Medicare Advantage plans that maximize their profits, even when those plans are not the best choice. On top of that, insurers can pay insurance agents and brokers in ways that can lead the agents and brokers to steer people to Medicare Advantage plans that increase their earnings without considering the needs of the people they advise.

Congress needs to own the fact that the Medicare Advantage program is fully rigged to maximize profits at the expense of people's health care needs. Congress needs to end Medicare Advantage as it currently operates and revisit whether there is a way to offer people private insurance coverage that works without endangering the lives of vulnerable older and disabled Americans.

US life expectancy dropped a full year in first half of 2020, according to CDC

Life expectancy in the US dropped a full year in the first half of 2020, according to a report published Thursday by the US Centers for Disease Control and Prevention's National Center for Health Statistics. Experts say that Covid-19 was a significant factor contributing to the decline.

The life expectancy for the entire US population fell to 77.8 years, similar to what it was in 2006, **CDC** data shows.

Changes to life expectancy also widened racial and ethnic inequities. Compared to 2019, life expectancy for non-Hispanic Black people in the US fell about three times what it did for non-Hispanic White people, by 2.7 years. It fell by twice as much for Hispanic people, by 1.9 years.

Life-expectancy disparities between Black people and White people had been shrinking in recent years, but these latest figures reverse some of that progress.

Over the past 40 years, life expectancy has increased slowly but rarely declined. Between 2014 and 2017 -- a peak period of the opioid epidemic -- life expectancy declined a third of a year, which itself was significant.

Life-expectancy estimates before 1980 have been measured less consistently, but experts told CNN that estimates for drops in life expectancy after World War II range from less than a year to three years.

The **pandemic** has taken a massive toll on the US population. About 490,000 people have lost their lives to the disease, and the CDC estimates excess deaths in 2020 to be even higher..

"A year of life expectancy lost doesn't really give you a true sense of how serious this has been. Millions of life years were actually lost," Eileen Crimmins, a professor at the University of Southern California who has researched changes in mortality, told CNN. "Covid is on track to cause more deaths than cancer or heart disease, and that's important."

Most deaths due to Covid-19 have been among older adults, which would have a small effect on overall life expectancy.

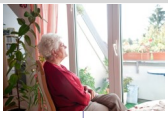
But Theresa Andrasfay, a researcher at the University of Southern California who has published work on the potential impact of Covid-19 on life expectancy, notes that while deaths among younger adults may be less common, the numbers are still substantial.

"Those deaths have a significant effect on life expectancy because they contribute to more foregone years of life," she told CNN….**Read More**

Housing Programs for Senior Citizens

Housing is never cheap, and when you're a senior on a fixed income who may have medical bills and more to cover, it can get downright expensive. It's not uncommon for seniors to find themselves spending the majority of their retirement savings on rent.

One option for seniors looking for a home to call their own is to turn to a housing program for assistance. These programs can vary greatly, but they generally provide subsidies or other forms of financial aid to ensure that seniors have a place to live without bankrupting themselves for those who otherwise might not be able to do that. Different housing programs have different requirements, but if you're struggling to put a roof over your head, odds are good that you're eligible for at least some kind of housing program.



Public Housing and the Section 202 Program

If you have a low income and can spend 30 percent of your income on rent and utilities, you could qualify for public housing. Run by the U.S. Department of Housing and Urban Development (HUD), public housing tends to be situated in places where residents can access better jobs and education, while seniors can use it to remain independent and in their own communities for as long as possible. Although most public housing is in cities, one in five public housing developments is in a rural area.

A similar program, the Section 202 program, also exists specifically for seniors. Section 202 housing is designed to offer a place to live for seniors who can safely live on their own but may need help with some parts of daily life, such as showering. Residents pay 30 percent of their income for housing with the rest of their rent and utilities covered by subsidies. Additional services, such as some meals, transportation and more, are often included.

The Housing Choice Voucher Program

The HUD also operates the Housing Choice Voucher Program (HCVP), formerly known as Section Eight Housing. This program is operated through 3,300 public housing agencies at the state, county and municipal level to provide rental vouchers to low-income people. Once approved, the applicant finds their own apartment in their area….**Read More**

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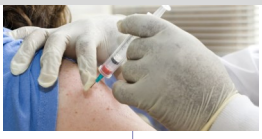
Pfizer, Moderna Vaccines Less Effective Against South African COVID Variant

Two of the world's leading coronavirus vaccines don't work as well against a more contagious South African variant, though both did manage to neutralize the virus, two new studies show.

But experts pointed out that what level of neutralization is needed to actually protect against the variant is still unclear and these latest studies on the Pfizer and Moderna vaccines were done in a lab setting, and not the real world, the *Washington Post* reported. Both reports were published Wednesday in the *New England Journal of Medicine.*

"These are in vitro studies and we don't know if there is a threshold for neutralization that defines protection. In fact, we don't even know that there is a quantitative correlation between antibodies levels and protection," *NEJM* Editor-in-Chief Eric Rubin said in a podcast on the findings. "It is very concerning that we don't know the clinical significance of these findings."

The two studies used genetically engineered versions of the South African variant against blood samples from vaccinated volunteers, the *Post* reported. The strain has been identified in many countries, including the United States, along with a variant first identified in Britain that scientists say is also highly contagious.



Moderna's research letter in the *NEJM* on its COVID-19 vaccine showed a sixfold drop in antibody levels against the South Africa strain, the newspaper said. The shot's efficacy against the variant has not yet been determined.

Pfizer, in testing its vaccine against the variant in a lab, found the shot generated about a third of the antibodies that are normally mobilized with the original strain. The activity, however, appeared to be enough to neutralize the virus.

Still, Pfizer said in a statement that it was "taking the necessary steps… to develop and seek authorization" for an updated vaccine or booster shot that could better combat the variant.

In Johannesburg, South African scientists planned to meet Thursday to discuss the Pfizer study, a Health Ministry spokesman told *Reuters*.

"I do know that our scientists will be meeting to discuss [the study] and they will advise the minister," Popo Maja told the news service. "We are not going to be releasing a statement until advised by our scientists. We will also be guided by the regulator."

Vaccines for all Americans by August: Biden

Every American who wants a coronavirus vaccine should be able to get one by the end of July, President Joe Biden said this week.

His message, delivered during a town hall meeting hosted by *CNN*, was more optimistic than one he delivered last week when he warned that logistical hurdles would most likely mean that many people would still not have been vaccinated by the end of the summer, *The New York Times* reported.

Meanwhile, Dr. Anthony Fauci, the nation's top infectious disease expert, on Tuesday revised his own optimistic estimate from last week, when he predicted the beginning of an "open season" for vaccines by April, the *Times* reported.

"That timeline will probably be prolonged, maybe into mid-to-late May and early June," he said in an interview with *CNN.*

At a time when Americans are keen for life to return to normal, Biden tried on Tuesday night to reassure the public.

While the president said he did not want to "overpromise," he said at one point that "by next Christmas I think we'll be in a very different circumstance, God willing, than we are today." At another point he predicted that by the time the next school year starts in September, the nation would be "significantly better off than we are today," the *Times* reported.

The White House also said Tuesday that states would begin receiving 13.5 million doses each week — a jump of more than 2 million doses.

The increases were welcomed by state officials desperate to inoculate more vulnerable Americans before more contagious variants of virus become dominant, the *Times* reported.

The Biden administration has been working with Pfizer to get the company more manufacturing supplies through the Defense Production Act, the *Times* reported. The administration announced last week that Pfizer and Moderna, the other maker of a coronavirus vaccine authorized in the United States, would be able to deliver a total of 400 million doses by the end of May, well ahead of schedule….**Read More**

Legal Action Center Calls for Better Medicare Coverage for Substance Use Disorder Treatments

This week, the Legal Action Center released a **report** identifying gaps in Medicare's coverage of common and recommended treatments for substance use disorders compared to private insurance and Medicaid.

While Medicare covers treatments for substance use disorder, and has in fact expanded such coverage in recent years, the report highlights significant barriers to accessing needed care. These barriers particularly affect services that are provided by freestanding substance use disorder treatment facilities—residential or outpatient—that are not otherwise Medicare providers. Coverage for outpatient services obtained from a primary care doctor or during an inpatient hospitalization is on par with other insurers.

As the report notes, the need for behavioral health and substance use disorder treatment among Medicare beneficiaries is high and growing. In 2019, over one million individuals over age 65 were diagnosed with **alcohol dependence**, approximately 300,000 people with Medicare are diagnosed with an opioid use **disorder annually**, and from 2018 to 2019 the number of individuals over age 65 with a substance use disorder diagnosis **increased 26%**.

The Legal Action Center recommends amending the 2008 Mental Health Parity and Addiction Equality Act to apply to Medicare coverage. This would, they argue, expand Medicare coverage of the types of services and service providers currently unable to bill Medicare. Another option would be to directly expand Medicare coverage. No matter the mechanism, Medicare Rights Center agrees with the need for improved coverage in this area and continues to urge both the Centers for Medicare & Medicaid Services and Congress to act to ensure adequate treatment is available in appropriate and accessible settings for every beneficiary who needs such services.

Pfizer Says COVID Shot 85% Effective After 1 Dose; May Not Require Deep Freeze

There was a double dose of good news Friday from COVID vaccine maker Pfizer: The company said just one dose may provide 85% protection against SARS-CoV-2, and vials of the vaccine might not require ultra-cold storage after all.

The latter finding could be a game-changer for vaccine distribution, because the need for refrigerators capable of storing vaccines at temperatures down to -112 degrees Fahrenheit has been a major roadblock at centers across the United States. The U.S. government is set to distribute hundreds of millions of doses of the two-dose Pfizer vaccine to Americans over the coming months.

Now, based on results from ongoing vaccine "stability studies," Pfizer now believes that its vaccine could be safely stored for up to two weeks at standard freezer temperatures of just -13°F to 5°F.

As reported by *CBS News,* Pfizer CEO Albert Bourla said the company will now request that the U.S. Food and Drug Administration change its guidance on the storage of the vaccine, which was developed along with its German partner, BioNTech.

"We appreciate our ongoing collaboration with the FDA and CDC as we work to ensure our vaccine can be shipped and stored under increasingly flexible conditions," Bourla said. "If approved, this new storage option would offer pharmacies and vaccination centers greater flexibility in how they manage their vaccine supply."

Not only is storage and distribution of the Pfizer vaccine perhaps made easier, but there's also new data suggesting that strong protection against the new coronavirus sets in after just one dose. According to research published in *The Lancet* medical journal, the first dose of the shot gave health care workers at Israel's largest hospital 85% protection.

The Sheba hospital near Tel Aviv began vaccinating its workers as far back as Dec.19, *CBS News* reported. Over 9,000 people are employed at the hospital; about 7,000 received the first dose of the Pfizer vaccine and the others weren't inoculated.

Tracking down hospital staff who'd either gone on to develop COVID-19 symptoms or had been in contact with people known to be infected, the Israeli researchers found 170 cases of COVID-19.

Comparing rates of infection between those who'd gotten the first dose of the the vaccine versus those who hadn't been inoculated, they calculate that protection reached 47% between day 1 and day 14 post-vaccination, and 85% between day 15 to day 28.

"What we see is a really high effectiveness already right after two weeks, between two weeks to four weeks after vaccine," study co-author Gili Regev-Yochay told a small group of journalists, *CBS News* reported.

The findings build on prior Israeli findings, which found the Pfizer vaccine to be 95% effective one week after a second dose.

Does all this mean that vaccinated people can't transmit SARS-CoV-2 to other people?

"That is the big, big, question. We are working on it. This is not on this paper and I hope we will have some good news soon," Regev-Yochay said.

Urinary Incontinence a Common Issue for Older Women, But Treatments Can Help

Nearly 1 in 2 women over the age of 50 deal with the indignities of urinary incontinence, but experts say no one has to suffer in silence.

Frequently considered an inevitable problem of aging, most women never even try to get treatment for the urinary leakage that they experience, said Dr. Christopher Hartman, chief of urology at Long Island Jewish Forest Hills in New York City.

Why?

"Many women often cite embarrassment as the reason for their delay in seeking care," he explained.

Before they decide to get help, women need to determine what kind of incontinence they have. Stress urinary incontinence is most frequently caused by laughing, coughing, sneezing or exercising. Conversely, urge incontinence occurs when a person experiences a strong desire to urinate and cannot stop this sensation, Hartman explained. This is typically the result of a problem with the bladder itself or certain triggers such as caffeine and spicy foods, which cause the bladder to contract.

A third type, mixed incontinence, is the combination of stress and urge incontinence. Less common is overflow incontinence, in which a woman does not empty her bladder completely, Hartman said.

Beyond what type of incontinence is happening, the severity of the condition can vary widely, said Dr. Elizabeth Kavaler, a urology specialist at Lenox Hill Hospital in New York City.

"Urinary incontinence is the involuntary loss of urine. It can involve a few drops of leakage to a full accident," she said.

"Over 25 million Americans admit to regularly having issues controlling their bladders, which drives the over-$33 billion-a-year industry in protective products, medications and surgery."

So, what can trigger incontinence?

Stress incontinence is caused by pelvic floor weakness, Kavaler said. In women, stress incontinence is associated with vaginal births, chronic constipation, obesity and chronic lung disease. In men, stress incontinence can be seen after prostate cancer surgery. ….**Read More**

Guys, Exercise Will Boost Your Aging Hearts, Testosterone Won't: Study

Testosterone levels tend to fall in older men, but a new study shows that exercise -- and not supplemental testosterone -- is the way to rejuvenate the aging male heart.

Australian researchers found that without exercise, testosterone replacement therapy offered patients no improvement at all in cardiovascular health. But exercise alone -- absent any testosterone supplementation -- *did* boost arterial function.

As a bonus, exercise also boosted the men's natural testosterone levels, the study found.

According to study author Dr. Bu Yeap, the bottom line is clear: "To improve the health of arteries, exercise is better than testosterone."

Yeap, who is president of the Endocrine Society of Australia, acknowledged that "there is a gradual decline in testosterone levels as men grow older, extending into middle and older age." And that decline is often accompanied by expanding waistlines and a wide array of health conditions.

As a result, testosterone therapy has gained traction, largely in a bid for increased energy and muscle mass. In fact, global sales of the hormone have skyrocketed 12-fold in just the first decade of the 21st century….**Read More**

A Third of COVID Survivors Have Long-Haul Symptoms, Even After Mild Cases

Many patients with mild to moderate COVID-19 could become "long haulers," suffering symptoms months after they clear their non-life-threatening infection, new research shows.

About 33% of COVID-19 patients who were never sick enough to require hospitalization continue to complain months later of symptoms like fatigue, loss of smell or taste and "brain fog," University of Washington (UW) researchers found.

"We were surprised to have one-third of people with mild illness still experiencing symptoms," said lead researcher Jennifer Logue. She's a research scientist with the UW department of medicine's division of allergy and infectious diseases, in Seattle. "If you contract coronavirus, there's a good chance you could experience a lingering effect."

These results show why everyone should protect themselves against coronavirus infection, given that the 177 Seattle-area patients tracked in the study were relatively young and healthy, said Dr. Kristin Englund, an infectious disease specialist who leads the Cleveland Clinic's COVID long-hauler recovery clinic.

More than 90% of the patients (average age: 48) suffered only mild to moderate COVID-19 and didn't need hospitalization, the study authors said. Few had health problems that would put them at risk for serious COVID-19 infection (for example, only 13% had high blood pressure, 5% had diabetes and 4.5% were active smokers).

"It's not just our hospitalized patients we have to focus in on," Englund said. "There are a lot of patients out there who can still continue to have these persisting and really life-altering symptoms."

Nearly 28 million COVID-19 infections have been reported in the United States, which could mean millions of Americans suffering from symptoms that last months and possibly years, she said….**Read More**

Many Psych Meds Trigger Weight Gain, But New Research Points to Better Options

Scientists may have uncovered the reason critical medications for schizophrenia and bipolar disorder cause weight gain and diabetes — findings they hope will lead to better drugs.

The medications, known as antipsychotics, help control the hallucinations, delusions and confused thoughts that plague people with schizophrenia. They can also help stabilize extreme mood swings in those with bipolar disorder.

The drugs, which include clozapine, olanzapine, ziprasidone and many others, "serve an important purpose," said Dr. Zachary Freyberg, the senior researcher on the new study.

"In many cases," he added, "they can be life-saving."

The problem is their "metabolic" side effects, said Freyberg, an assistant professor of psychiatry and cell biology at the University of Pittsburgh School of Medicine.

Antipsychotics often trigger weight gain, cholesterol spikes and elevations in blood sugar that can lead to type 2 diabetes.

In fact, those side effects commonly drive patients to stop taking the drugs, said Dr. Ken Duckworth, chief medical officer of the nonprofit National Alliance on Mental Illness.

Duckworth, who was not involved in the new research, said it's important to understand why those adverse effects occur.

These findings, he said, "begin to unravel" the issue.

Specifically, the Pitt researchers zeroed in on dopamine, a chemical that transmits messages between cells by interacting with receptors on their surfaces. In the brain, dopamine plays a role in pleasure, motivation and learning.

While there are many antipsychotic drugs, they all work in a similar way: blocking certain dopamine receptors, known as D2-like receptors.

If those receptors only existed in the brain, that might be well and good.

In reality, Freyberg explained, the body actually has more dopamine receptors outside the brain than within it.

"It's naive to think [antipsychotics] only work from the neck up," he said….**Read More**

Chronic Heartburn Raises Odds for Cancers of Larynx, Esophagus

People with chronic heartburn may face increased risks of several rare types of cancer, a large U.S. government study shows.

Researchers found that among more than 490,000 Americans aged 50 and up, those with gastroesophageal reflux disease (GERD) had about twice the risk of developing cancers of the esophagus or larynx (also known as the voice box).

GERD, or acid reflux, occurs when stomach acids chronically escape into the esophagus, which is the muscular tube connecting the throat and the stomach. The most common symptom is heartburn.

The condition is exceedingly common, affecting an estimated 20% of Americans, according to the U.S. National Institutes of Health (NIH).

GERD has long been established as a risk factor for esophageal adenocarcinoma, which, in the United States, is the most common type of tumor arising in the esophagus.

The new study, published Feb. 22 in the journal *Cancer*, links GERD to a second type of esophageal cancer -- called squamous cell carcinoma -- as well as laryngeal cancer, which arises in the voice box.

Experts stressed that the absolute risk is low: The vast majority of people with GERD will never develop the cancers, all of which are fairly rare.

"Our findings should not alarm people diagnosed with GERD," said Christian Abnet, a researcher with the U.S. National Cancer Institute who led the study.

However, worldwide, squamous cell carcinoma is actually the much more common form of esophageal cancer, he noted, which is one reason why investigating any link to GERD is important.

Why would heartburn matter when it comes to cancer?

The esophagus is not used to the "caustic" substances dwelling in the stomach and small intestine, including acids and digestive enzymes, Abnet explained.

The longstanding theory around adenocarcinoma is that chronic exposure to those substances may damage the esophageal tissue in a way that occasionally leads to cancer.

In fact, the NIH says, about 10% to 15% of GERD patients have reflux severe enough to cause abnormalities in the esophageal lining, known as Barrett's esophagus. And of people with Barrett's, the risk of developing esophageal adenocarcinoma is about 0.5% per year.

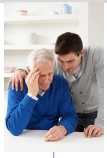
It's possible, Abnet said, that similar mechanisms could also contribute to squamous cell carcinoma in the esophagus and to laryngeal cancer….**Read More**

Why Some 'Super Ager' Folks Keep Their Minds Dementia-Free

Researchers may have uncovered a key reason some people remain sharp as a tack into their 80s and 90s: Their brains resist the buildup of certain proteins that mark Alzheimer's disease.

The study focused on what scientists have dubbed "super agers" -- a select group of older folks who have the memory performance of people decades younger.

Compared with older people who had average brain power, super agers showed far less evidence of "tau tangles" in their brains, the researchers found.



Tau is a protein that, in healthy brain cells, helps stabilize the internal structure. But abnormal versions of tau -- ones that cling to other tau proteins -- can develop as well.

In people with Alzheimer's, the brain is marked by a large accumulation of those tau tangles, as well as "plaques," which are clumps of another protein called amyloid.

For years, amyloid plaques have gotten most of the attention as a potential target for Alzheimer's treatment, said researcher Tamar Gefen, who led the new study.

But a body of evidence tells a different story: It's the buildup of tau -- not amyloid -- that correlates with a decline in memory and thinking skills, said Gefen, an assistant professor at Northwestern University Feinberg School of Medicine, in Chicago.

These latest findings on super agers, she said, are in line with that research.

It's not clear how many super agers are out there. One reason is that there's no single definition of the term, said Claire Sexton, director of scientific programs and initiatives at the Alzheimer's Association….**Read More**

Medical Alert Systems or Emergency Response Monitors

Medical Alert Systems were first created in the 1970s with the aim of helping seniors in the event of an emergency. They are sometimes referred to as personal emergency alert devices, or emergeny response systems. Emergency response systems help seniors receive immediate help and medical attention in the event of an emergency. They are much smaller and more inconspicuous than they originally were during the 70s, and can either be clipped on like a pager or worn around the neck. There are even medical alert systems that sync with smart phones for those tech savvy seniors. Currently, most emergency response systems have a sensor that detects falls, as well as a button one can push in order to communicate directly with a consultant to determine the level of help needed.

Reasons to Use an Emergency Response System

- One out of three seniors fall every year.
- About half of all seniors have a fear of falling.
- Emergency response systems allow seniors to live independently.
- They give reassurance to the family and friends their loved one is protected.
- Emergency response systems provide peace of mind to seniors that help is easily accessible, should they suffer from a heart attack or stroke.

When Is It Time to Consider a Medical Alert System?

If you are over 65, you may be considering investing in a medical alert system for your home. Age, however, isn't the only factor to keep in mind when making this decision. Both seniors and their care networks and families can benefit from the safety and independence a medical alert system affords. Additional considerations when deciding to get a medical alert system may include whether:

- You have fallen at least once in the past year
- You use a mobility aid like a walker, cane, or wheelchair
- Your medicine has side effects of dizziness, low blood pressure, or drowsiness
- You have gone to the E.R. or been hospitalized in the past year
- You have one or more chronic conditions (i.e. diabetes, arthritis, Parkinson's)
- You need assistance with your day to day activities

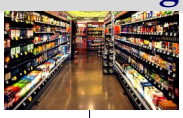
Ultimately, if you are looking to "age in place" as long as possible, a medical **alert emergency system** may be helpful even if you have no serious health concerns or history of injuries….**Read More**

No Evidence Coronavirus Spreads Through Food or Food Packaging: FDA

There's no evidence that the new coronavirus can spread through food or food packaging, U.S. health officials say.

Of the more than 100 million cases of COVID-19 worldwide, there hasn't been any epidemiological evidence of food or food packaging as the source of SARS-CoV-2 (the virus that causes COVID-19) transmission to humans, and national and international surveillance systems have found no signs of such transmission.

"After more than a year since the coronavirus disease 2019 [COVID-19] outbreak was declared a global health emergency, the U.S. Department of Agriculture, the U.S. Food and Drug Administration and the U.S. Centers for Disease Control and Prevention continue to underscore that there is no credible evidence of food or food packaging associated with or as a likely source of viral transmission of severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2], the virus causing COVID-19," Acting USDA Secretary Kevin Shea and Acting FDA Commissioner Dr. Janet Woodcock said in a statement.



"Our confidence in the safety of the U.S. food supply remains steadfast. Consumers should be reassured that we continue to believe, based on our understanding of currently available reliable scientific information, and supported by overwhelming international scientific consensus, that the foods they eat and food packaging they touch are highly unlikely to spread SARS-CoV-2."

They said it's "particularly important to note that COVID-19 is a respiratory illness that is spread from person to person, unlike foodborne or gastrointestinal viruses, such as norovirus and hepatitis A, that often make people ill through contaminated food."

A recent opinion from the International Commission on Microbiological Specifications for Foods stated: "Despite the billions of meals and food packages handled since the beginning of the COVID-19 pandemic, to date there has not been any evidence that food, food packaging or food handling is a source or important transmission route for SARS-CoV-2 resulting in COVID-19."

That's supported by additional literature reviews and analyses from other countries.

"Based on the scientific information that continues to be made available over the course of the pandemic, the USDA and FDA continue to be confident in the safety of the food available to American consumers and exported to international customers," Shea and Woodcock concluded.