National COVID data; Joe Golton's comments; Scott Galloway on getting vaccinated; Vaccination data (U.S. vs. world); The Mutated Virus Is a Ticking Time Bomb (or is it?); CA & AZ getting hit hard; Why Nursing Homes Failed; Suing patients for unpaid bills

If you wish to subscribe to my coronavirus email list, simply send a blank email to: cv-subscribe@mailer.kasecapital.com

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It's so strange being on the other side of the world on Lamu Island, Kenya while our democracy is under assault and a pandemic is raging…

In the fall, when we planned this three-week trip to visit my parents and sister, who live here, we didn't anticipate the added bonus of this being a great place to avoid COVID-19. There are no idiotic political battles about mask wearing here and, with the beautiful weather, we're spending nearly all of our time outdoors.

Sadly, we're flying home on Saturday night. I wish we could stay longer in a safe and stable country like this one… (I say with only slight tongue-in-cheek, sadly…)

I've posted pictures and videos from our trip on Facebook here, here, here, here, here, and here.

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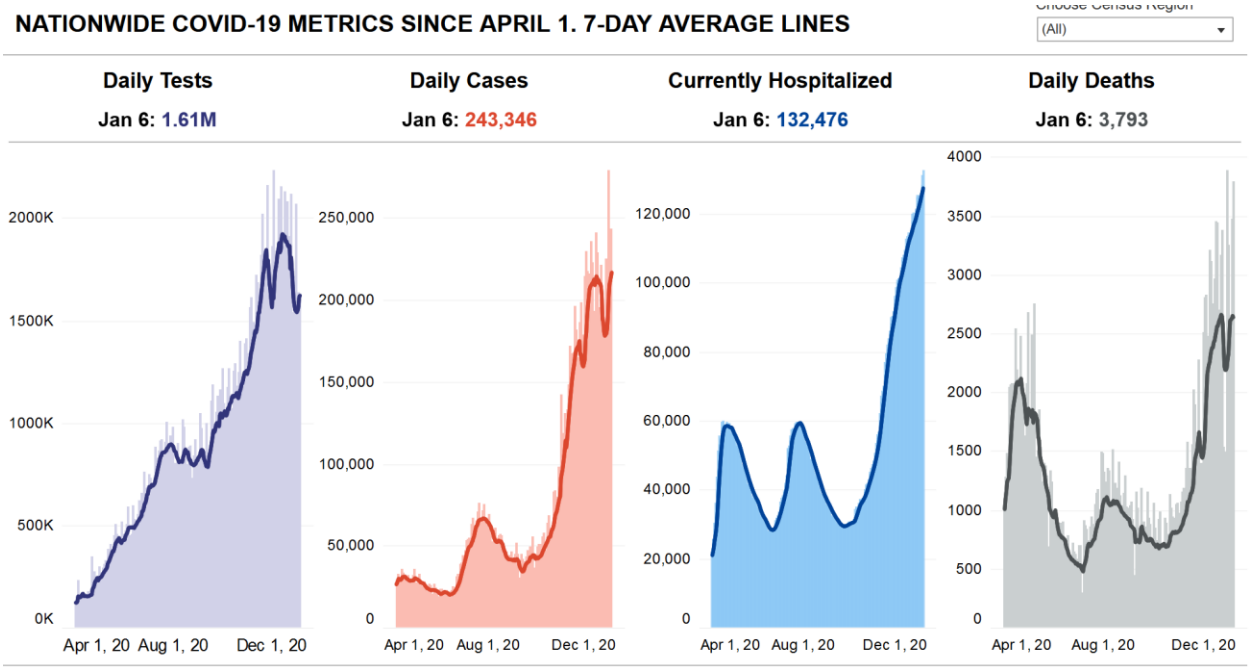
1) Here's the latest national data:



We can see that, after the expected dip in testing around the holidays (leading to a dip in cases), and the dip in deaths due to reporting delays, the COVID numbers are spiking back up. The currently hospitalized data is the best indicator I follow.

2) In my December 3 e-mail, I wrote:

My old friend Joe Golton believes that December is going to be the peak of U.S. COVID-19 deaths, much higher than the CDC's ensemble forecast. He writes:

> The ensemble mid-point forecast is for 50,270 deaths during the four weeks ending December 26 (if you adjust that forecast to encompass all of December, it is approximately 56,500 projected deaths).
>
> I have been running a simple spreadsheet model that has been reasonably accurate at short-term forecasting since March and it's telling me to expect closer to *95,000 deaths* in December.

He e-mailed this update earlier this week:

> Actual December deaths came out at about 80,000. This was significantly above the 97.5% percentile projection of the COVID-19 ensemble forecast (which was just shy of 74,000 when adjusted to 31 days), but below my 95,000 projection.
>
> I believe there are three reasons my projections proved too high:
>
> > 1) I modeled Thanksgiving leading to a huge increase in cases. Didn't happen - the number of new cases/day stayed about the same over the couple weeks I expected the surge to manifest.
> >
> > 2) My 10,000 fudge factor for overloaded hospitals was too high. I don't know how many people died due to hospital overload. Based on anecdotal evidence from skimming through many articles, I suspect on the order of 1,000, but I have no concrete evidence to back up this assertion.
> >
> > 3) I have used a 25-day lag between officially reported cases and deaths for the past four months. I'm increasingly suspecting that it has lengthened to more like 28-33 days. If there are at least a few days of over 4,000 deaths/day over the next couple weeks, and most days are above 3,500 (except for Sundays and Mondays, when less reporting happens), then I'll know that the lag has indeed lengthened. It will also mean that the number of people who die will increase from December to January, as a chunk of the death surge I projected for late December got pushed into early January.
>
> I think we're now in the early 8th inning. I believe that we'll see another 1-2 weeks of new cases exceeding 200,000/day (sometimes over 300,000), as the Christmas surge appears to be much higher than the Thanksgiving surge. But then I think that by the end of January, the number of new cases per day will clearly start to decline.
>
> Part of the reason I am predicting a decline soon is the more restrictive policies put in place in many states over the past few weeks. We're already seeing declining case

> numbers in SF Bay area, for example, where policies have been very restrictive in recent weeks.
>
> Deaths lagging by nearly a month means that, if daily cases are in decline by late January, then daily deaths will be in decline by late February.

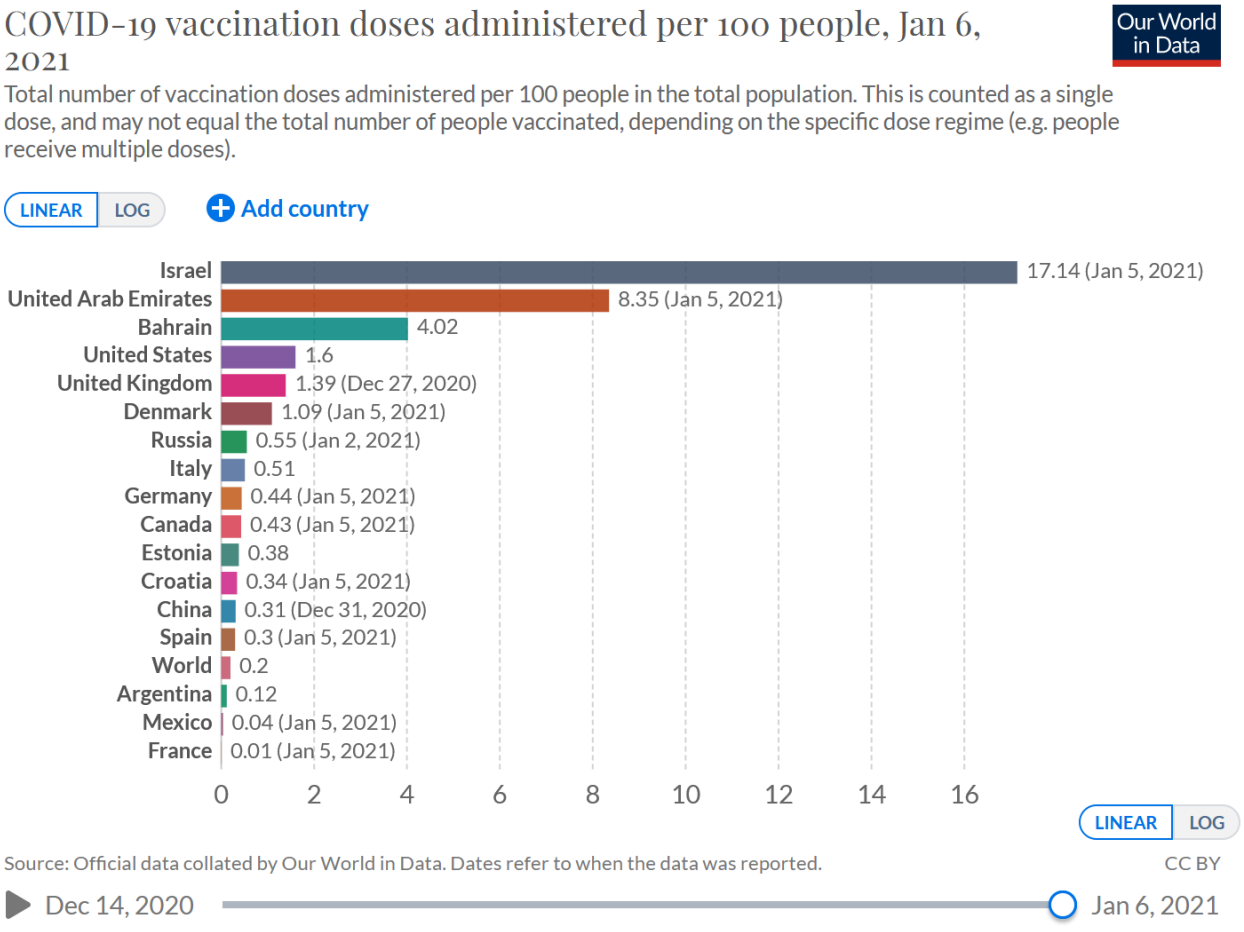
Joe just sent me this update:

> Yesterday we saw the first day of more than 4,000 deaths (4,100), so it looks like my over-forecasted deaths in December is in large part due to the 25-day lag lengthening to something longer, perhaps 28-33 days. I'm thinking closer to 33 days than 28 but the data is very messy with reporting being all over the place through the holidays. I'm just sure at this point that the average number of days it takes to die from a newly reported case is at least a few days more than the 25 I've been using for modeling.

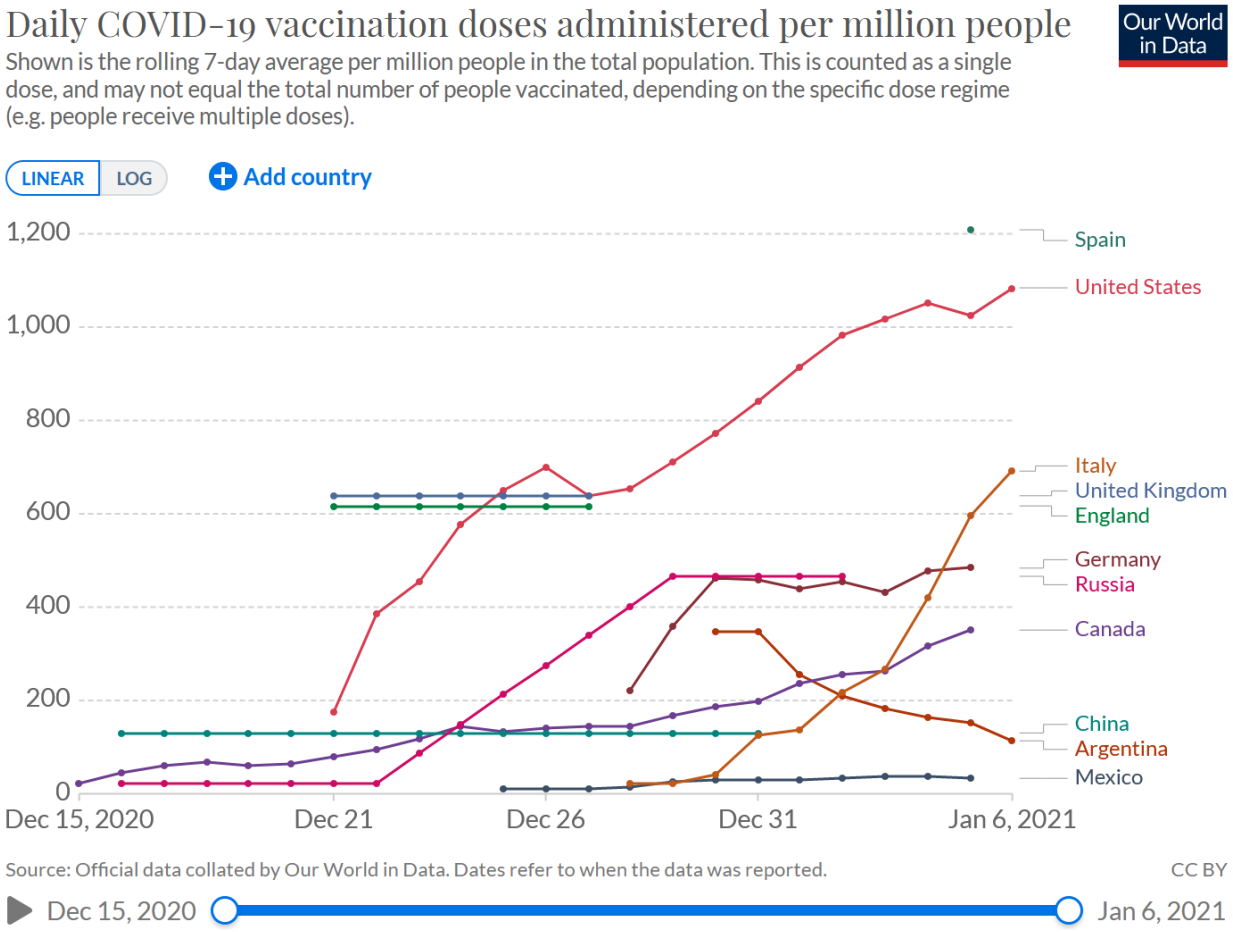
3) If you know anyone who is thinking about not getting vaccinated, please send them this video by NYU marketing professor, bestselling author, blogger, and entrepreneur Scott Galloway. Start watching at 1:07:57. Excerpt:

> All this bullsh*t narrative around the risks. You are much more likely to be killed by *your own dog* than have an adverse reaction that results in death from a vaccine. Vaccines are the best thing that's ever happened to us.
>
> And you know what really frightens me – what I'm hearing from my friends and cohort? The following: "I'm going to wait."
>
> This is the narcissist's playbook. "I'm going to see what the long-term effects are. I'm going to wait."
>
> Well, this isn't about you. Why? If we don't get to herd immunity, we're going to have another 200 million infections. At a 1% mortality rate, that means two million Americans are gonna die.
>
> And maybe they're browner than you. Maybe they're heavier than you. Maybe they're older than you. And you've decided that you really don't have that big a risk from COVID-19…
>
> Well, guess what, *this isn't fu*king about you*! This is about not being a threat in the *web of death* that is combing our nation and snaring vulnerable people because of the asymptomatic carriers who have no effects from this. "I'm going to wait?!"

4) There's been a lot of criticism (see below) about the vaccine rollout, but we're actually doing well relative to the rest of the world, with the notable exception of Israel (here's an article about it: How Israel Became a World Leader in Vaccinating Against Covid-19), as this chart shows (source):



And our trend line is very steep, which is great news (this chart excludes Israel so we can see the other countries):



5) The next few items are mostly from the *NY Times Coronavirus Briefing* over the last few days. I highly recommend it – here's the latest one and you can sign up for it here.

The vaccine blame game

In the week since our last newsletter, U.S. distribution of coronavirus vaccines has descended into turmoil. Now, millions of vaccines could expire before they reach people in need.
The Trump administration predicted 20 million people would receive at least one dose of a Covid-19 vaccine by the end of 2020. The final figure was about four million. And only 365,294 people in nursing homes and long-term-care centers have been vaccinated, despite more than 2.5 million doses distributed for those facilities, the Centers for Disease Control and Prevention reported.

Critics say the U.S. government has mismanaged the rollout from top to bottom. Federal, state, and local officials blamed each other for botched logistics and funding shortfalls.

State officials — struggling to handle outbreaks, mass testing campaigns, overflowing intensive care units and uncertain contact tracing — say they need more help from the federal government. And local governments are chafing at state restrictions.

In New York City, only 110,000 people have received a vaccine dose — about a quarter of the total number received by the city. Mayor Bill de Blasio called on the state government — which has limited vaccinations to health care workers and those living and working at nursing homes — to allow older people and essential workers to receive the vaccine.

Gov. Andrew Cuomo asserted that the problem was a local issue, and urging Mr. de Blasio and other local leaders to take "personal responsibility" for their performance. Mr. Cuomo also threatened to fine hospitals if they did not step up the vaccination rate.

The $900 billion federal pandemic relief package will provide an additional $9 billion toward vaccination costs. But funds will arrive long after local health departments have started vaccinating residents. Slowdowns touch almost every part of the country.

- In Puerto Rico, a shipment of vaccines did not arrive until the workers who would have administered them had left for the Christmas holiday.
- In Houston, the city health department's phone system crashed on the first day of a free vaccination clinic, after receiving more than 250,000 calls.
- In Tennessee, older people lined up on a sidewalk, leaning on walkers and wrapping themselves in blankets while they waited for a county health department to open its free clinic. The clinic exhausted its supply of vaccine before 10 a.m.
- In Florida, vaccine rollout sites continue to be overwhelmed in some places, with people waiting for hours. Gov. Ron DeSantis said hospitals may have future supplies of coronavirus vaccine reduced if they do not administer doses quickly enough.

The U.S. is not alone: The Netherlands and France are just two of several countries that have been slow to roll out vaccinations. But the level of disorder in the U.S., as with the virus's toll, seems unique.

6) More articles of interest related to the vaccine:

- As Rollout Falters, Scientists Debate New Vaccination Tactics
- Early Vaccine Doubters Now Show a Willingness to Roll Up Their Sleeves
- Does It Matter Which COVID-19 Vaccine You Get?
- How the Pfizer-BioNTech COVID-19 vaccine was developed (60 Minutes)

7) An interesting idea (from POLITICO Nightly):

"It's total chaos," said Peter Hotez, a vaccine expert at the Baylor College of Medicine in Houston. "It's increasingly looking like we had a plan that was well-suited to vaccinate Singapore."

The nation's top infectious disease specialist Anthony Fauci said the country will soon ramp up to 1 million vaccinations a day. Joe Biden has pledged to deliver 100 million vaccines in his first 100 days in office.

But Hotez believes there is no way to get to those numbers with the current plan. He told me today that the country should just throw out the tiered system rather than forcing

drugstore pharmacists to enforce the rules. He said in addition to getting shots into the hands of nursing homes, hospitals and other providers, states should just set up outdoor tents in sports stadiums or other places with lots of parking to vaccinate whoever shows up. This is in the works in some states.

We need to "get the vaccine in people's arms," he said. "The only other choice is to continue with 3,000 deaths a day."

8) My reader, Professor Kevin Maki, with spot-on comments:

We are in a race to vaccinate people before this strain spreads widely. So far we are not doing well. We should be vaccinating a million people per day and have been averaging about one-quarter that number, although we have hit 500K on some days I am hearing.

Generally, we vaccinate about 50% of the US population for influenza over a period of roughly four months from about Oct. 1 (or late Sept.) through the end of January (not too many influenza vaccinations are given in February and March, even though the flu season is Oct 15 through April 15). Even assuming that we vaccinate only 125 million people over that four-month period, that is roughly 1 million people per day. It is a scandal that we are only vaccinating one-fifth that number now for Covid-19.

Although there are some logistical problems, we had months to prepare for this. Part of the problem seems to be funding for state health departments and part seems to be a variety of other issues. The CARES 2 Act includes $8 billion for vaccine distribution efforts. Why that could not have been allocated sooner through a separate bill is a mystery to me. Part of the problem may be that the media kept telling everyone that we would not have a vaccine this year, so the sense of urgency around preparation for distribution was lacking. That will almost certainly cost lives, and is inexcusable.

To date, 40 million doses were made available by Pfizer and Moderna and so far only 4.3 million doses have been administered. Notably, ND and SD are leading the nation in terms of percentage of allocated doses that have been delivered. They have administered about two-thirds of what was received while most states have administered less than half that amount. This is a huge miss.

We are now seeing 60,000 new infections in nursing homes each week with a 20% IFR. With only 1.4 nursing home residents in the US, it is inexcusable that we have not vaccinated all of them who are willing to take it already.

If I was in charge I would have used age as a criterion for healthcare workers. I would have made vaccine available for everyone 65+ years of age and healthcare workers 50+ years of age. I would have used Walgreens, Walmart and CVS as well as Department of Health vaccination centers for distribution. I would have focused on getting a first dose out to as many people as possible and not held back second doses. After that first tier, I would have focused on younger healthcare works and people 40-64 years of age.

> The way things have been rolled out is suboptimal in my view and will cost lives. It is unacceptable that we have only used about 5 million (or less) of the 40 million available doses and are delivering a large fraction to people at very low risk for death. We should have vaccination centers that are open 24/7 in every state.

Another reader adds:

> Someone working on the vaccination rollout at a major drug store chain told me the CDC has been horrific to work with and the 500+ individual (and ever changing) requirements, many unrelated to safety, are causing significant delays to the rollout. The CDC's bureaucracy is hurting, not helping, vaccine availability.
>
> That said, whatever bugs there have been so far are rapidly being resolved. The urgency is high and people are working around the clock to get this done. We will be doing 1M+ vaccinations per day very soon.

9) For more on the federal government's failures:

- Washington Post: Website crashes and other tech problems plague early coronavirus vaccine rollout
- NY Times: 'Covid, Covid, Covid': In Trump's Final Chapter, a Failure to Rise to the Moment
- Washington Post: The CDC's failed race against covid-19: A threat underestimated and a test overcomplicated

10) Here's more on the new variant: The Mutated Virus Is a Ticking Time Bomb. Excerpt:

> *There is much we don't know about the new COVID-19 variant—but everything we know so far suggests a huge danger.*
>
> A new variant of the coronavirus is spreading across the globe. It was first identified in the United Kingdom, where it is rapidly spreading, and has been found in multiple countries. Viruses mutate all the time, often with no impact, but this one appears to be more transmissible than other variants—meaning it spreads more easily. Barely one day after officials announced that America's first case of the variant had been found in the United States, in a Colorado man with no history of travel, an additional case was found in California.
>
> There are still many unknowns, but much concern has focused on whether this new variant would throw off vaccine efficacy or cause more severe disease—with some degree of relief after an initial study indicated that it did not do either. And while we need more data to feel truly reassured, many scientists believe that this variant will not decrease vaccine efficacy much, if at all. Health officials have started emphasizing the lack of evidence for more severe disease.
>
> All good and no cause for alarm, right? Wrong.

A more transmissible variant of COVID-19 is a potential catastrophe in and of itself. If anything, given the stage in the pandemic we are at, a more transmissible variant is in some ways much more dangerous than a more severe variant. That's because higher transmissibility subjects us to a more contagious virus spreading with exponential growth, whereas the risk from increased severity would have increased in a linear manner, affecting only those infected.

Increased transmissibility can wreak havoc in a very, very short time—especially when we already have uncontrolled spread in much of the United States. The short-term implications of all this are significant, and worthy of attention, even as we await more clarity from data. In fact, we should act quickly *especially* as we await more clarity—lack of data and the threat of even faster exponential growth argue for more urgency of action. If and when more reassuring data come in, relaxing restrictions will be easier than undoing the damage done by not having reacted in time.

11) Here's the NYT Coronavirus Briefing with more on this:

Containing the new variant

Experts are worried that during the next few weeks the new and more contagious variant of the coronavirus known as B.1.1.7 could explode in the United States, becoming the dominant variant and quickly overwhelming hospitals — as has happened in Britain.

The new variant has been more resistant to lockdown measures in Britain, according to new research. Dozens of cases of the new variant have now been discovered in at least five U.S. states: California, Colorado, Florida, Georgia and New York. But public health experts say there is still time to contain it — if only they could see it.

Unfortunately, my colleague Carl Zimmer reports, the U.S. has no large-scale, nationwide system for checking coronavirus genomes for new mutations. Such a program could help deepen our understanding of the new variant, along with other, possibly more dangerous variants that may be on the horizon.

It's even more important in the U.S., Carl told me, because the virus is so out of control. "The more mutation you have, the more of the chance you have that it's going to turn into something dangerous," he said.

Currently, genetic sequencing of the coronavirus is done by a patchwork of academic, state and commercial labs, and at an abysmally low rate. Of the roughly 1.4 million people who test positive each week, fewer than 3,000 samples are sequenced. Experts say the U.S. should be sequencing at least five times as many samples if the country wants to better understand the variant and spot new mutations.

If a national surveillance program was put in place, as in Britain, scientists could determine how widespread the variant is, as well as pinpoint emerging hot spots. Public health officials could then warn the public and institute better ways to contain it, such as using better masks, closing

schools or instituting temporary lockdowns. (A spokesman for the incoming Biden administration told Carl that it may be open to the idea of a national program.)

But as we've learned throughout the pandemic, moving quickly is key.

"We've already had this mutant take us by surprise," Carl said. "It's been in this country for weeks and so it's all over the place now, and we didn't know it. If there's another dangerous variant, we need to know when it crops up. Otherwise, it's like waiting for half your house to be on fire before you call the fire department."

12) And an earlier one:

The new variant, in one chart

In today's issue of The Morning newsletter, my colleague David Leonhardt explained the new variant in one simple, frightening chart. He compared the spread of the virus in Britain and South Africa, the countries that first detected the new variant, with the spread in a group of nearby countries.

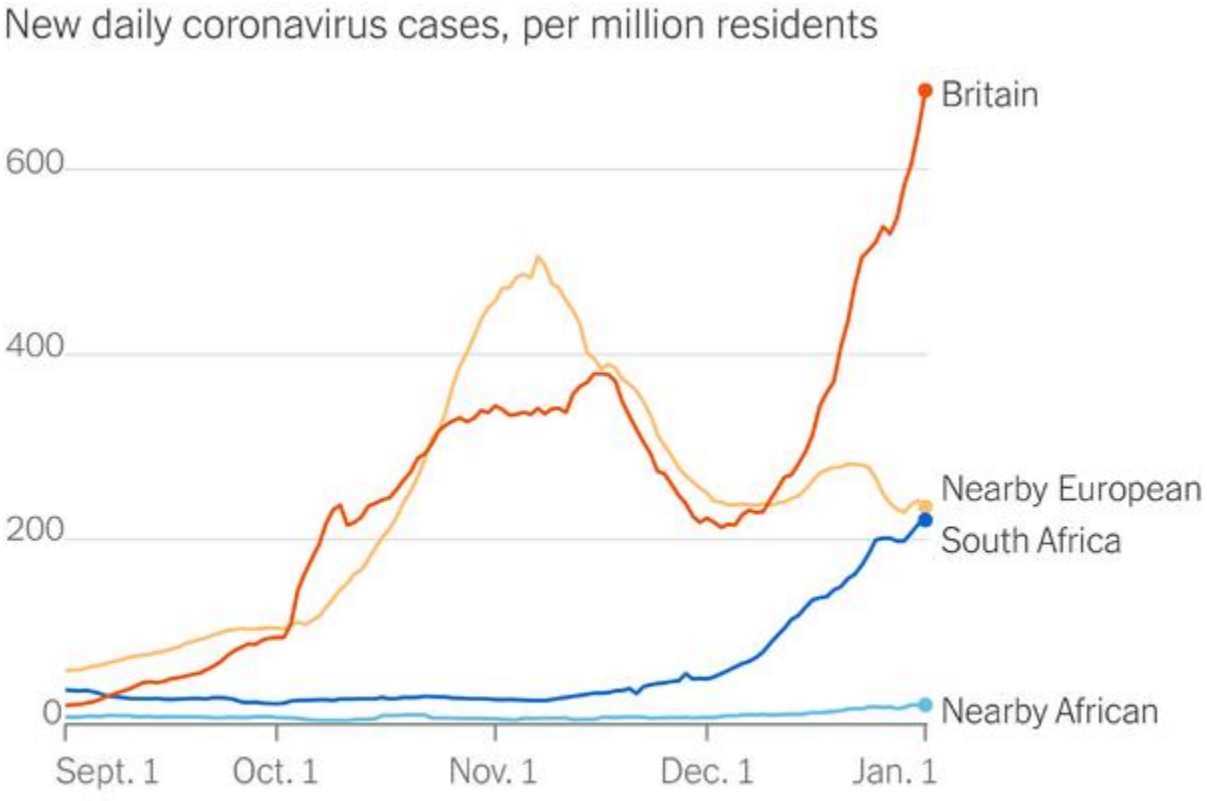


Chart shows rolling 7-day averages. "Nearby European" is Belgium, Germany, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain and Switzerland. "Nearby African" is Botswana, Eswatini, Lesotho, Namibia, Mozambique and Zimbabwe.

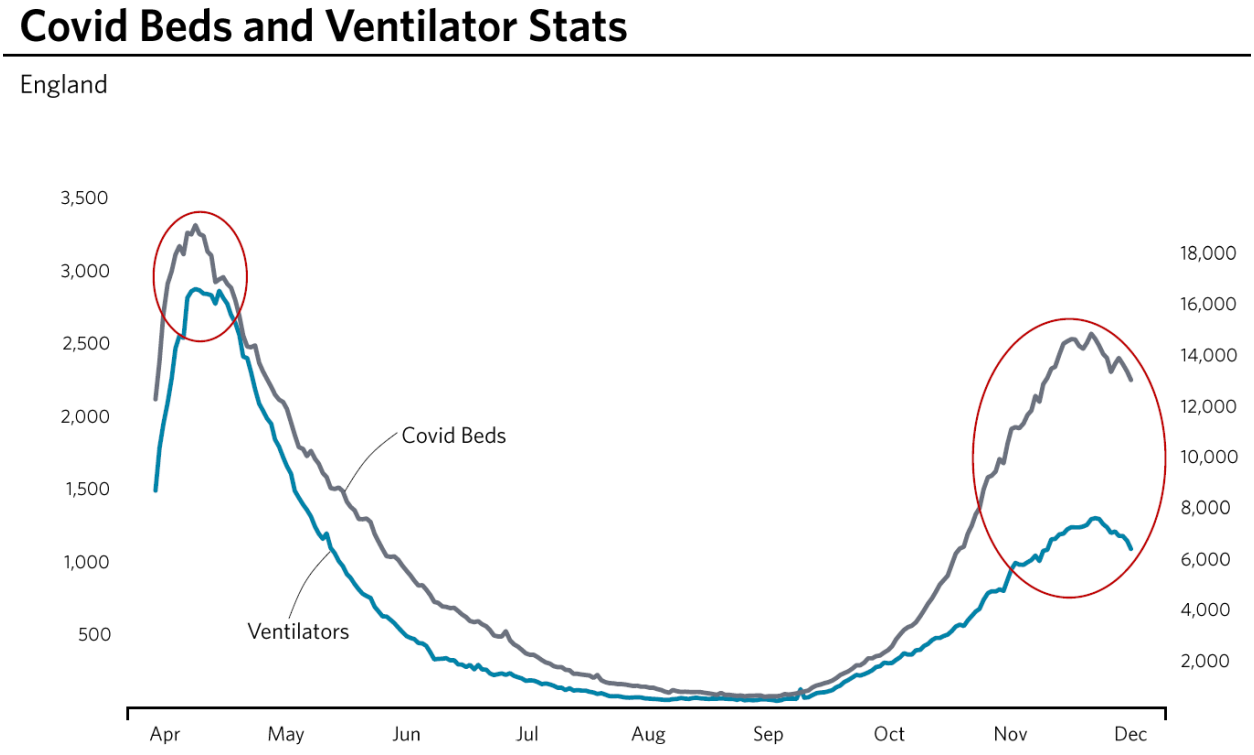
By The New York Times | Sources: Local and national governments and health organizations, World Bank

More than 30 other countries, including the U.S., have diagnosed cases with the variant, which appears to be between 10 percent and 60 percent more transmissible than the original version. It could soon become the dominant form of the virus.

The new variant may end up "exacerbating an unrelenting rise in deaths and overwhelming the already strained health care system," my colleague Apoorva Mandavilli wrote last week.

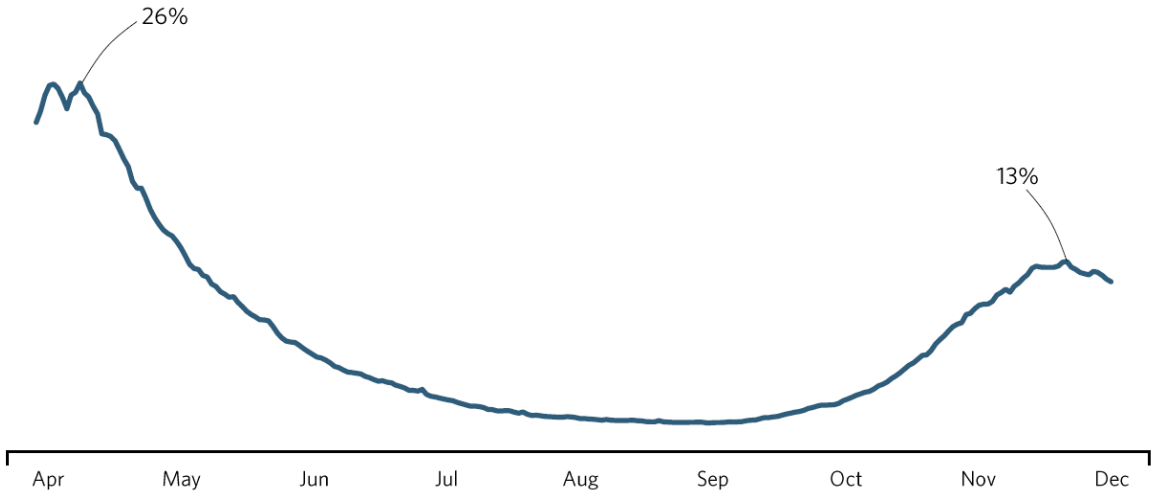
13) But another reader is more sanguine on the variant, with comments on what's happening in the UK:

> The analysis on the B117 strain appears to be badly flawed. Of note, the analysis was completed by the now-discredited Neil Ferguson, whose predictions have repeatedly missed by orders-of-magnitude…every time to the high side. The fearmongering around the B117 strain needs to be taken down not one, but many notches.
>
> Key stats in the UK appear to be rolling over already, the new strain notwithstanding, which is inconsistent with the idea that a new strain will have an order-of-magnitude more serious effect on infections:



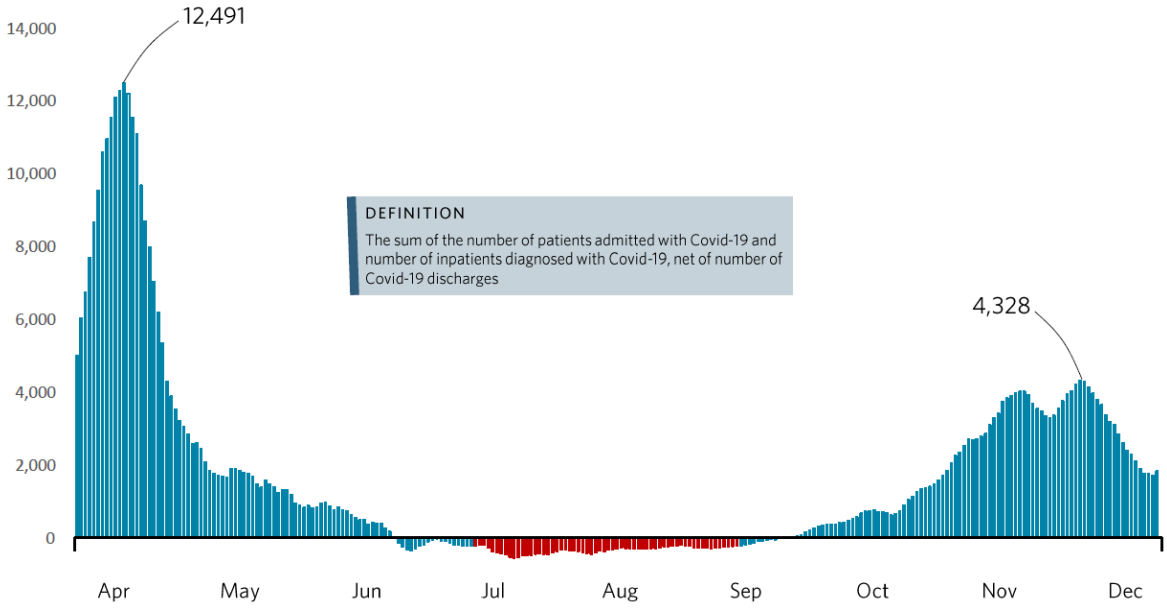
Occupied Covid Beds – As Percentage of All Occupied Beds

England



Net Hospitalisations

England



And here is an analysis (part of a much longer thread) from a virologist at the University of St. Andrews concluding that "Based on this preliminary matched-control study,

B.1.1.7 does not seem to be associated w/ more hospitalisations or increased 28-d mortality."

This feels a lot like the Kawasaki panic (or the long-Covid panic, or ten other panics along the way) that have little basis in the evidence but prompt very scary headlines.

14) The NYT with an update on the tough situation in California:

"A surge on top of a surge"

The holidays were not kind to California. New infections in the state have skyrocketed — driven by Thanksgiving gatherings and then Christmas festivities — despite weekslong lockdowns in December throughout much of the state. Now, Gov. Gavin Newsom is warning of "a surge on top of a surge" linked to the holidays that will only get worse in the coming weeks.

The situation is perhaps most dire in Los Angeles County, where it's estimated that one person becomes infected every six seconds, and one person dies every 10 minutes. The latest crisis has stretched the health care system there so thin that incoming patients at one hospital were told to wait in an outdoor tent. The region is running out of oxygen, and ambulance crews have been instructed to stop transporting people who have little chance of survival.

California has the second highest rate of new cases per 100,000 people after Arizona. Over the past month, the number of Covid-19 patients in California hospitals has doubled, and many intensive care units are overflowing. In Southern California and the San Joaquin Valley, intensive care units are at zero percent capacity.

More inoculations would help ease California's burden, but as with the rest of the country, the vaccine rollout in California has been sluggish, with only about a third of the state's 1.3 million doses reaching the arms of patients. Worryingly, at least six people in the state have been found to have been infected with the new, more transmissible variant of the virus.

There has been some progress. Infection rates appear to have stabilized in recent days, but reporting anomalies tied to the holidays mean that it may be another week before we have a solid understand of how much the virus has recently spread.

Even if infection rates slow, my colleague Shawn Hubler, who covers California, said officials were bracing for a harrowing month, and asking an already exhausted population to hunker down until this latest surge passed.

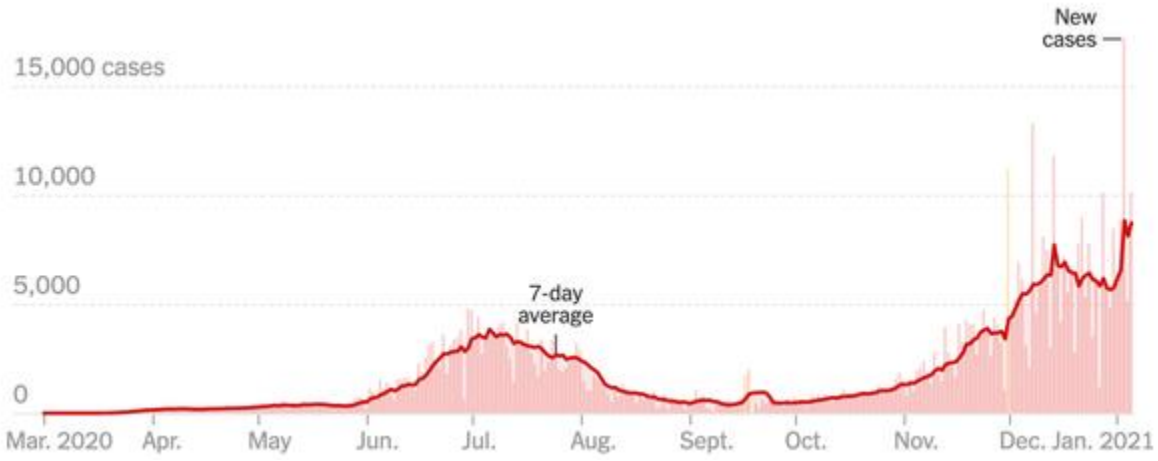
"There are many more people who are obeying the law, than not," Shawn said. "But it's still not enough."

15) And Arizona:

Arizona's second surge

For the second time this year Arizona is the state with the highest rate of new virus cases in the U.S. Over the past week, the state has averaged more than 8,000 cases per day, more than twice the rate during its summer surge.

The hospital system is stretched alarmingly thin, and hundreds of health care workers are being flown in from other states. Medical experts say drastic measures — like rationing care — may soon have to be considered. At the same time, Arizona is administering vaccines at one of the slowest rates in the country.



Daily reported new cases in Arizona.The New York Times

Public health experts in the state say the virus was able to come roaring back because of lax enforcement of some virus measures and a lack of public vigilance that could help stem the outbreak. Gov. Doug Ducey, a Republican, has consistently rejected appeals for tougher restrictions like a statewide mask mandate, the cancellation of big sporting events or the shutdown of in-person schooling. He drew criticism this week after videos surfaced on social media of his son dining and partying in crowded spaces without a mask.

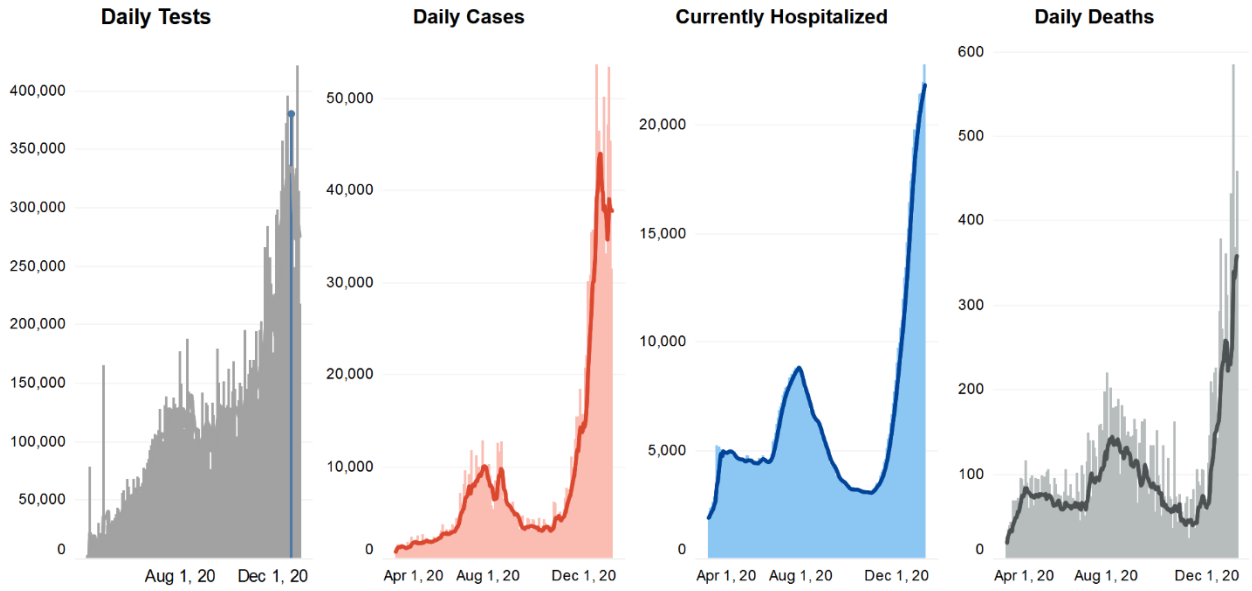
Some Arizonans do not believe that virus restrictions are the solution and also doubt that the recent spike is something to be concerned about. Francisco Sirvent, a lawyer who lives in Chandler, started a Facebook group in April called “Reopen Arizona” that now has almost 500 members.

“I think people are going about their life a little bit more, and that’s probably why the spike happened,” he said, adding, “I’m an absolute believer that we need to develop herd immunity.”

16) Here’s the latest data for both states:

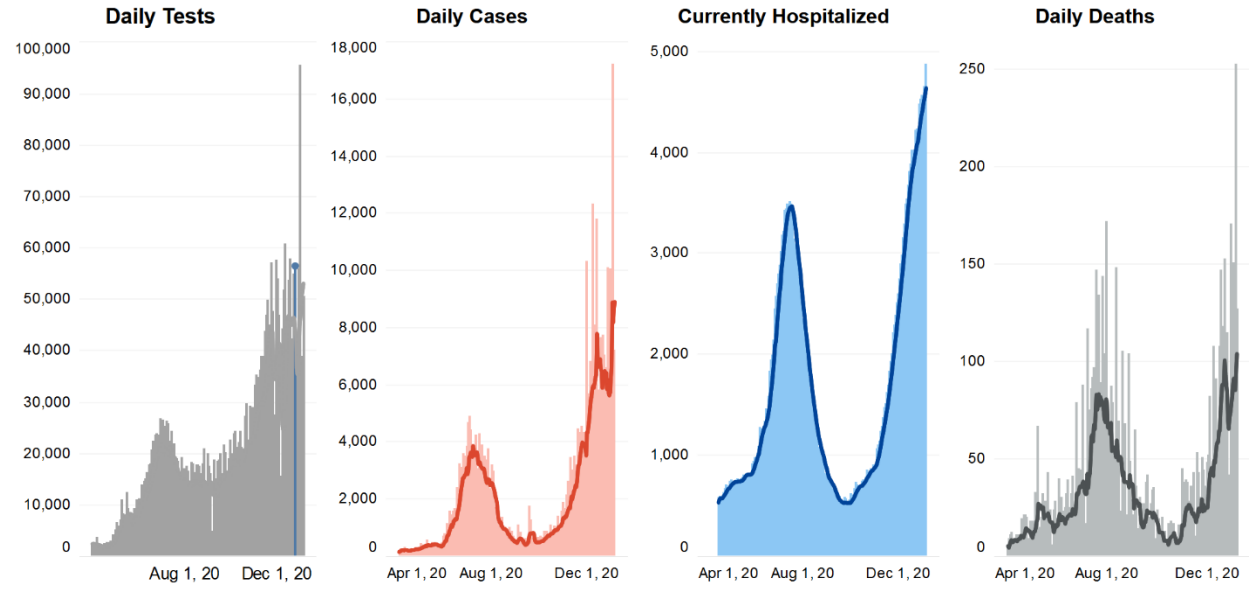
California COVID-19 METRICS SINCE APRIL 1. 7-DAY AVERAGE LINES

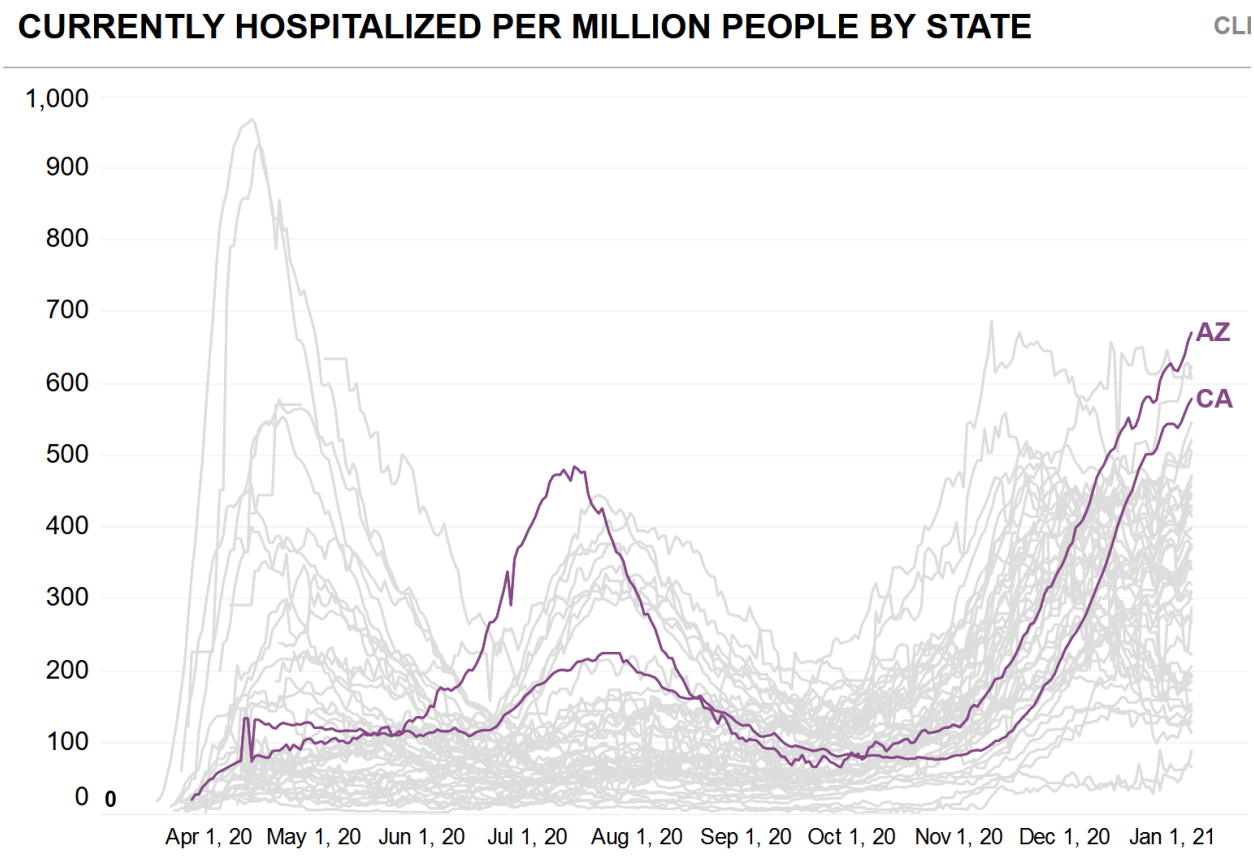
Choose State: California



Arizona COVID-19 METRICS SINCE APRIL 1. 7-DAY AVERAGE LINES

Choose State: Arizona

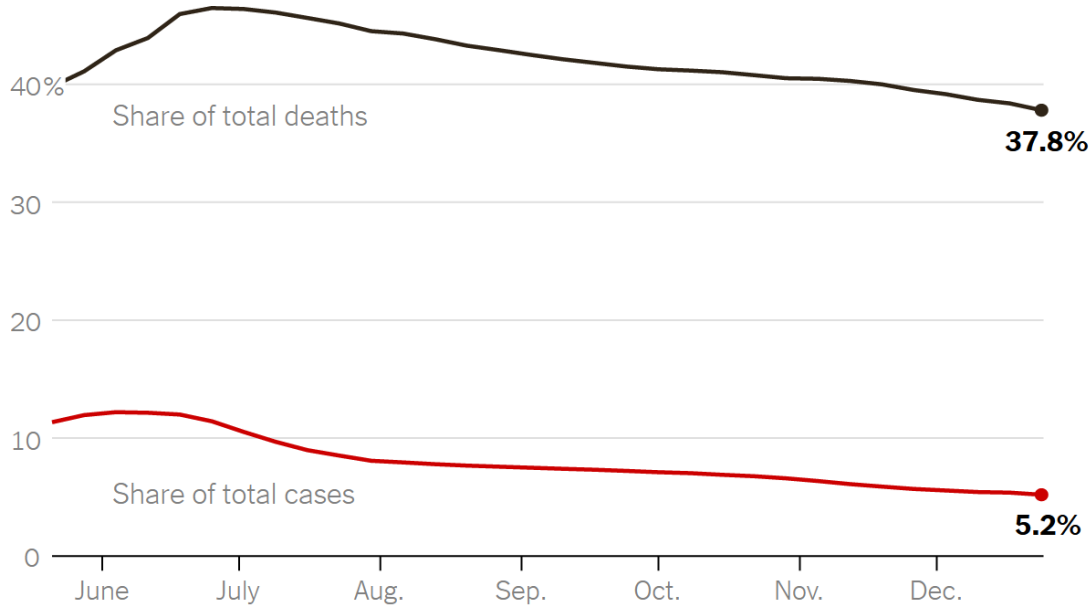




17) What a total disgrace! This Is Why Nursing Homes Failed So Badly. Excerpt:

> The first coronavirus outbreak in the United States occurred in a nursing home near Seattle, in late February. Since then, the country has endlessly revised its hot spot map. Yet the situation in nursing homes and assisted-living facilities has only gotten worse: More than 120,000 workers and residents have died, and residents are now dying at three times the rate they did in July.

In the U.S., long-term care facilities account for 5 percent of all coronavirus cases and almost 40 percent of total deaths.



Note: Weekly data as of Dec. 24. Includes long-term care facilities, nursing homes, skilled nursing facilities and assisted living facilities. ▪ Source: COVID Tracking Project

Long-term care continues to be understaffed, poorly regulated and vulnerable to predation by for-profit conglomerates and private-equity firms. The nursing aides who provide the bulk of bedside assistance still earn poverty wages, and lockdown policies have forced patients into dangerous solitude.

18) And another disgrace!

Suing patients for unpaid bills

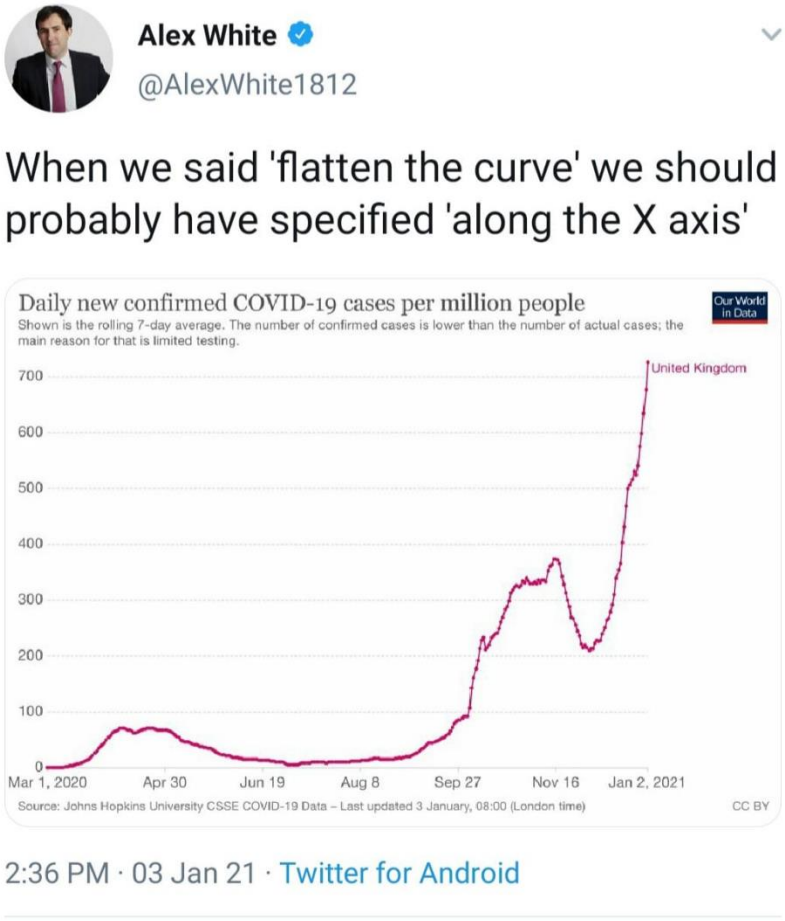
When the coronavirus arrived in New York, Gov. Andrew Cuomo ordered state-run hospitals to stop suing patients over unpaid medical bills. Almost every major private hospital in the state voluntarily followed suit, except Northwell Health, the state's largest health system.

My colleague Brian Rosenthal, an investigative reporter, found that the nonprofit health system, which operates 23 hospitals, sued more than 2,500 patients last year, for an average bill of $1,700, plus large interest payments. The flurry of lawsuits hit teachers, construction workers, grocery store employees and others at a time of widespread unemployment.

Across the state, Brian found that around 50 hospitals have sued about 5,000 patients since March, but Northwell stands out for its aggressive number of lawsuits and because of its connections to Mr. Cuomo. Northwell's chief executive officer, Michael Dowling, has been a close friend to Mr. Cuomo for more than three decades and has served as the governor's closest ally in the hospital industry during the pandemic.

Medical debt lawsuits are becoming more common across the country, as health care costs have risen and insurance companies push more of the financial burden onto patients. These cases are rarely contested in court, and they usually lead to default judgments that allow hospitals to garnish wages and freeze accounts to extract money, sometimes without the patient's knowledge.

19) Sad but true:



Best regards,

Whitney