IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT SAN ANTONIO DIVISION

MI FAMILIA VOTA, TEXAS STATE CONFERENCE OF THE NATIONAL ASSOCIATION FOR THE ADVANCEMENT OF COLORED PEOPLE, MICAELA RODRIGUEZ and GUADALUPE TORRES,

Plaintiffs,

v.

GREG ABBOTT, Governor of Texas; RUTH HUGHS, Texas Secretary of State,

Defendants.

Case No. 5:20-cv-00830

PLAINTIFFS' EMERGENCY MOTION FOR TEMPORARY RESTRAINING ORDER AND/OR PRELIMINARY INJUNCTION AND BRIEFING SCHEDULE

PLAINTIFFS' EMERGENCY MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION AND TO SET BRIEFING SCHEDULE

Plaintiffs respectfully move for a temporary restraining order and preliminary injunction

immediately excising the mask mandate exemption from Governor Abbott's Executive Order and

concomitant relief from Defendant Hughes pursuant to section 2 of the Voting Rights Act.

Defendants oppose the motion and the proposed briefing schedule.

Last Wednesday, the Fifth Circuit remanded to this Court to resolve a limited question:

Were the district court to conclude that the exemption from wearing a mask in public places contained in Executive Order GA-29 for poll workers, voters, and others in polling places violated section 2 of the Voting Rights Act, the district court might excise that provision if it concluded that this would redress the injuries the Plaintiffs have alleged. It is at least conceivable that such a remedy would not materially or substantially affect the ongoing election, but that would be a matter for the district court to determine.

Further indicating the urgency of this issue, last Friday the Circuit issued the mandate to permit

this Court to immediately resolve Plaintiffs' objection to the mask exemption just ninety minutes

after Defendants filed their opposition.

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This matter is urgent. Early voting is already underway with masks not required at polling places. Election day is but two weeks away. Plaintiffs now ask this Court to order the following relief immediately pending the determination of Plaintiffs' motion for a preliminary injunction and, after such determination, preliminary enjoining Defendants as follows:

- Defendant Abbott is hereby ordered to excise the following exemption from wearing a mask in public places contained in Executive Order GA-29: "8. any person who is voting, assisting a voter, serving as a poll watcher, or actively administering an election."
- Defendant Hughs is hereby ordered to make all revisions to Election Advisory No. 2020-19 necessary and appropriate to comply with the as-excised version of the Executive Order, including excising the following statement: "There is no authority under Texas law to require voters to wear face coverings when presenting to vote"; and excising any other provisions in Advisory No. 2020-19 that suggest face coverings are not mandatory at polling locations.

To succeed on a motion for a preliminary injunction, Plaintiffs must show "(1) a substantial likelihood of success on the merits, (2) a substantial threat that plaintiffs will suffer irreparable injury if the injunction is not granted, (3) that the threatened injury outweighs any damage that the injunction might cause the defendant, and (4) that the injunction will not disserve the public interest." *Planned Parenthood v. Sanchez*, 403 F.3d 324, 329 (5th Cir. 2005).

In support of this motion, Plaintiffs expect to show (1) they are likely to succeed in demonstrating that the exemption for voters, poll workers, and poll watchers in Executive Order GA 29's statewide mask mandate disproportionately burdens the rights of Black and Latino voters in violation of section 2 of the Voting Rights Act; (2) that the Voting Rights Act violation

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will cause irreparable harm to the Plaintiffs; and (3) that an injunction will serve the public interest and no harm will result from a preliminary injunction because the State has already determined that requiring masks protects Texans' health and safety and requiring masks at polling places presents no burden on the right to vote. Further, Plaintiffs will show that the requested relief would not materially affect the ongoing election.

In light of the fact that early voting is already underway and Election Day is just 2 weeks from now, time is of the essence. As such, Plaintiffs respectfully ask this court for the following briefing schedule on their motion for emergency relief:

- a. Defendants to submit, on ECF, their opposition to Plaintiffs' preliminary injunction motion no later than 48 hours after filing of Plaintiffs' motion;
- Plaintiffs to submit, on ECF, their reply, if any, in further support of Plaintiffs' preliminary injunction motion no later than 24 hours after filing of Defendants' opposition; and
- c. A hearing no later than Monday, October 26, 2020, subject to the Court's availability.
- d. Alternately, Plaintiffs would forego submission of a reply brief if the Court were available to hold a hearing promptly after Defendant's opposition is filed.

Dated: October 20, 2020

Respectfully submitted,

/s/ Sean Lyons

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Counsel for Plaintiffs

CERTIFICATE OF CONFERENCE

I certify that Plaintiffs' counsel conferred with Defendants' counsel by email on October 20, 2020, regarding Plaintiffs' emergency motion for temporary restraining order and preliminary injunction and to set a briefing schedule. Defendants oppose the motion, and the parties were not able to reach an agreement as to a briefing schedule.

> /s/ Sean Lyons Sean Lyons

<u>CERTIFICATE OF SERVICE</u>

I certify that a true and accurate copy of the foregoing document was filed electronically (via

CM/ECF) on October 20, 2020, and that all counsel of record were served by CM/ECF.

/s/ Sean Lyons_____

Sean Lyons

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No. 5:20-cv-00830

Plaintiffs,

V.

GREG ABBOTT, Governor of Texas; RUTH HUGHS, Texas Secretary of State,

Defendants.

DECLARATION OF ANGELICA RAZO, TEXAS STATE DIRECTOR OF PLAINTIFF MI FAMILIA VOTA

I, Angelica Razo, hereby state on my own knowledge and belief that:

1. I am of legal age and competent to provide this declaration. All the information herein is based on my own personal knowledge unless otherwise indicated.

2. I am the Texas State Director of Mi Familia Vota, a plaintiff in the above-captioned matter. I am authorized to provide this declaration on behalf of Mi Familia Vota.

3. Mi Familia Vota is a national civic engagement organization. Our mission is to "build Latino political power by expanding the electorate, strengthening local infrastructures, and through year-round voter engagement." Our mission consists of public education, voter registration, and voter engagement. We have operations in Texas, Arizona, California, Colorado, Florida, and Nevada—states with the highest Latino population counts but also serve communities where Latino participation in the electoral process is lacking.

4. Our election-related work usually involves facilitating voter registration and voter education.

5. We also provide services which are not related to voting, including running citizenship workshops; referring people to pro bono legal services; providing education services in climate justice and immigration justice, including know-your-rights workshops; running youth development services; and administering a COVID-19 relief fund for those in need. We advocate on issues including immigration, voting rights, the environment, workers' rights, education, and health care.

The Latino Community in Texas has Been Disproportionately Affected by COVID-19

6. The Latino community in Texas, along with the Black community, has been deeply affected by COVID-19. Many of the community members we work with have either themselves been infected with the virus or have had friends or loved ones infected. Too many have died. I understand from press and public health reporting that Latinos who contract the virus have worse outcomes. Few members of our community have been completely unaffected by the virus.

7. For example, I understand that the hardest hit zip codes in Dallas County are predominantly Black and Latino areas.

8. My understanding is that Latinos in Texas have suffered from COVID-19 at rates higher than the general population because many are essential workers and work in crowded workplaces where social distancing is not possible.

Additionally, many live in large, multi-generational households so if one person gets infected the infection spreads to family members.

9. I also understand that Latino who contracted COVID-19 have worse health outcomes and higher fatality rates. **The Mask Exemption Carve-Out for Polling Places will Disproportionately Burden Latinos and Other Minority Groups**

10. Governor Abbott ordered that masks are mandatory in most public places, which I believed was a prudent and important public health measure. Unfortunately, the order carved out voters and poll workers—masks are not required at polling places.

11. Many Latino community members we work with have expressed concern about this carve-out affecting them at the polls. They are planning to vote in person because, under Texas law, many Texans are not eligible to vote absentee.

12. With no requirement that masks be worn at the polls,

we understand that Latino Texans are concerned they will have increased risk of exposure COVID-19 in order to vote in-person.

13. We have also heard from poll workers who were concerned that the voters they are serving and other poll workers they are working alongside are allowed to be unmasked. The risk to poll workers was particularly raised by those who were signing up to be poll workers for the first time—they want to help our electoral system but do not want to risk exposure to a deadly disease in the process.

14. The risk of contracting COVID-19 is not just a risk to the voter or poll worker. Voters have raised concerns to my staff about putting their families at risk if they go to polling places to vote. As I said above, many Latinos in Texas live in multigenerational families and many care for older family members. Because masks are not required, when a younger person enters a polling place, she risks not only contracting COVID-19 herself from unmasked fellow voters and poll workers, but also risks spreading the virus to older family members such as grandparents who live with her. It has been widely reported that elderly people are particularly vulnerable to COVID-19, so younger Latinos fear that by voting they could be putting their own grandparents at risk of a potentially fatal disease.

15. Many Latino voters are concerned about the impacts of COVID-19 based on personal experience and knowledge of the widespread reporting about the risks. That concern is, unfortunately, well-placed as it reflects that the Latino community has higher rates of infection and more severe outcomes for those infected.

16. As a result, Latino voters—more than other Texans fear the risk of exposure to COVID-19 from voting without a mask mandate. Latinos have to choose between not voting or risking their lives, or the lives of their loved, ones to vote. This difficult choice will dissuade some Latinos from voting.

17. In the March primary, many Latino communities face long lines. We have also heard about long lines in Latino communities during early voting for the general election, which recently started. If there are long lines again during the remainder of early voting and on election day, voters will have to be exposed to unmasked fellow voters for a long period of time while waiting to vote. It is generally understood in our community, based on messaging from public health experts, that the longer someone is exposed to a mask-less person who has COVID-19, the higher the risk of contracting the disease. So long lines will make people more scared of contracting COVID-19.

18. Striking the carve-out—in other words, requiring masks to be worn at polling places, just like other public places—will make those voting in-person safer and minimize the risk that Latinos and other people of color will avoid voting to keep themselves safe from the virus.

Mi Familia Vota Has Advocated to Make Polling Places Safer

19. Mi Familia Vota has expended our time and resources to try to make polling places safer, time that we would have otherwise spent educating voters on issues that are central to our organization mission.

20. We lobbied Secretary of State Hughs by letter in March 2020, urging her to take immediate action to make voting safer, including by making in-person voting safer. We asked Secretary of State Hughs to issue sufficient uniform guidance to help counties find safe polling places, boost curbside voting, ensure that all polling locations have appropriate protective supplies, and assist counties with recruiting and training poll workers to administer polling sites safely.

21. We have also worked with county election officials, county by county, in order to learn what their varying pandemic election policies are in order to accurately inform voters.

22. In Dallas, we are part of the Dallas V.O.T.E.S. (Voting Openly Trouble-Free Equitably Safely) Coalition which has been working with the Dallas County Elections Department and the Dallas County Commissioners Court to ask them to provide and require voters and poll workers with PPE, including but not limited to masks, at polling locations.

23. We are also fielding many more calls from voters in the communities that we serve, who are extremely concerned about how to vote during the pandemic.

I declare under penalty of perjury under the laws of the United States that the foregoing is hue and correct. Executed on October ____, 2020.

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No. 5:20-cv-00830

Plaintiffs,

v.

GREG ABBOTT, Governor of Texas; RUTH HUGHS, Texas Secretary of State,

Defendants.

DECLARATION OF GARY L. BLEDSOE PRESIDENT OF PLAINTIFF TEXAS STATE CONFERENCE OF THE NATIONAL ASSOCIATION FOR THE ADVANCEMENT OF COLORED PEOPLE

1. My name is Gary L. Bledsoe. I am of legal age and competent to provide this

declaration. The facts stated herein are true, correct, and within my personal knowledge.

2. I am the President of the Texas State Conference of the National Association for

the Advancement of Colored People ("Texas NAACP"), a plaintiff in the above-captioned

matter. I am authorized to provide this declaration on behalf of the NAACP. I have held the

position of President since first being elected to the position in 1991.

3. The Texas NAACP coordinates the Texas branches of the NAACP, a nonpartisan,

nonprofit organization that is to my knowledge the nation's largest civil rights organization. The

Texas State Conference includes approximately 100 units statewide, and more than 10,000

individual dues-paying members who reside in Texas—many of whom are registered to vote in

Texas. The NAACP's membership consists largely of African-Americans, and it aims to support

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all people of color and members of underrepresented and vulnerable populations, such as those with disabilities.

4. The NAACP's mission is "to secure the political educational, social, and economic equality of rights in order to eliminate race-based discrimination and ensure the health and well-being of all persons." One of our key objectives in support of this mission is fostering voter education and participation. To achieve those goals, the Texas NAACP engages in voter protection, education, and registration activities across the state.

Black Texans Are Disproportionately Impacted by the Mask Exemption at the Polls

5. Texas's Governor has recognized that making masks voluntary does not work. And he has scaled back the reopening of our State. This amounts to an admission that the virus is not contained. The virus is spreading and many more people could be infected and die.

6. In this context, the Governor signed Executive Order GA, which requires mandatory face coverings throughout the state. The Order acknowledges that there is a public health benefit from face coverings in reducing the transmission of COVID-19. But the Order has an exemption for voters, poll workers, and poll watchers. This exception deprives Texans at the polls of a crucial protection from exposure to the virus.

7. The Order's exemption disproportionately burdens Black Texan's ability to participate in the political process. Many Black Texans vote in person. Because of worse outcomes, and greater community spread—both because of their jobs and denser communities— Black Texans are justifiably more wary of contracting the virus. Consequently, the Order's exemption for its face covering mandate at polling stations—compounded by the threat of long lines at polling stations—will disproportionately threaten and chill Black Texans from participating in the election.

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Many Black Texans Vote in Person

8. For many of our members, voting in person is very important, particularly because of how this opportunity was denied to African Americans for so many years.

9. Moreover, under Texas law, many of our members are not eligible to vote absentee.

10. Even those who are eligible may choose to vote in person because of the issues with the Postal Service and the limitations Texas law places on how absentee ballots can be delivered to voting officials.

11. As a result, voting in person is only that much more important to ensure our members' votes count. And it is critical that our many members whose only option is to vote in person as well as those who want to vote in person can do so safely during the pandemic.

Black Texans Have Reasonable Fears of Disproportionate Impacts from COVID-19

12. The virus has spread greatly in Texas since May, and Black Texans and other minority populations in our State have been the hardest hit.

13. Many of our members and constituents have told us that they fear contracting coronavirus if they vote in person under the State's current COVID-safety procedures where other voters and poll workers will not be required to wear masks. And many Black Texans are concerned about the impacts of COVID-19 to a greater degree than the general population—and with good reason. Because of higher rates of infection of the disease amongst communities of color, worse outcomes once infected, and widespread reporting on these dangers, people in the Black community experience the dangers and devastation of the virus differently.

14. Many of our constituents and members suffer from underlying health conditions such as diabetes, heart disease, and high blood pressure, which put them at higher-than-average risk for becoming seriously ill from COVID-19.

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15. More Black Texans, by population, have contracted the virus than non-Black Texans. Attached as Exhibit A is a true and correct copy of an article published by Vox on September 29, 2020, that substantiates the then-statistic that 1 in 1,000 Black Americans have died in the pandemic (which I understand has since gotten worse). And of those who have not contracted it, many of them know more people in their community that have. As a result of their lived experience of the pandemic, Black Texans' fears of contracting, spreading, and dying from the virus are generally more immediate. And the threat of contracting the virus while voting with other Texans who are not wearing masks is a greater chill than for the general population.

16. The lack of a mandate for face covering in polling stations is compounded by long voting lines serving communities of color. Based on the state's experience of excessively long lines in primary voting in March of this year, there is every reason to believe that polling lines, combined with no requirement that voters and poll workers wear masks, could produce crowds that could become a "super spreader" event. The higher early voting turnout so far strongly suggests this. Voters could be in these crowded lines for extended periods of time, both inside and outside. These lines compound the dangers from polling stations where face coverings are not required.

17. Finally, Black Texans understand that if they cannot vote safely, that will create broader risks to Texas communities, because of the many African-Americans who serve as frontline workers in grocery stores, hospitals, public transit, and the hospitality industry where they come in contact with a higher number of people. As a result, they recognize the consequences of contracting the virus for others—as well as themselves—is greater than the average population.

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Failing to Require Face Coverings at the Polls Will Impact Black Texans Disproportionately

18. Without basic protections like mandatory face coverings at the polls, Black Texans must choose between not voting or risking their lives or the lives of their loved ones to vote. This burden will dissuade some Black Texans, including some of our members, from voting.

19. The chill from the Order's exemption is born disproportionately by Black Texans because of the mutually exacerbating combination of worse outcomes for Black Texans once infected, greater risk of infection from longer lines, and greater societal repercussions to their work and home communities once infected.

20. The public interest and all voters will be greatly served by a sensible and reasonable order that protects the lives of people. Excising the exception for face coverings in polling places is an important step.

I declare under penalty of perjury that the foregoing is true and correct.

Executed in Travis County, State of Texas, on the <u>20th</u> day of October 2020.

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Gary L. Bledsoe President Texas State Conference of the NAACP

Exhibit A

It's true: 1 in 1,000 Black Americans have died in the Covid-19 pandemic

Biden cited a horrific statistic to make his case against Trump. The worst part is it's true.

By Dylan Scott@dylanlscottdylan.scott@vox.com Sep 29, 2020, 11:30pm EDT



Joe Biden speaks during the first of three planned presidential debates. Scott Olson/Getty Images

During a discussion on race in America in **the first presidential debate**, former Vice President Joe Biden cited a horrific statistic to punctuate his case that President Donald Trump has not been good for Black Americans: 1 in 1,000 Black Americans have died in the **Covid-19 pandemic**.

"You talk about helping African Americans — 1 in 1,000 African Americans has been killed because of the coronavirus," the Democratic nominee said Tuesday. "And if he doesn't do something quickly, by the end of the year, 1 in 500 will have been killed. 1 in 500 African Americans."

"This man is the savior of African Americans? This man cares at all? This man's done virtually nothing," Biden continued. "Look, the fact is, you have to look at what he talks about. You have to look at what he did, and what he did has been disastrous for the African American community."

The most remarkable thing about Biden's statement? It was true.

According to **the APM Research Lab**, as of mid-September, "1 in 1,020 Black Americans has died (or 97.9 deaths per 100,000)." More than 200,000 Americans are confirmed dead from Covid-19, and a disproportionate number of them are Black. It's that simple. (Biden's

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statement that 1 in 500 could die by the end of the year without swift action would appear to reflect the estimates that the US death toll could grow to 400,000 by January 1.)

There are several reasons why. Black Americans have disproportionately higher rates of preexisting conditions, including heart disease and cancer, which are associated with more deaths and hospitalizations from Covid-19. Black Americans are also more likely to work in jobs that are considered "essential," which **requires them to go into work and risk exposure to the coronavirus**.

Housing segregation has also led to Black Americans having less access to clean water and created many longstanding health disparities. Race, place, income, and health, as should be obvious by now, are inextricably linked. And the health consequences of these inequities have been especially evident during the pandemic, as David Williams, a professor of public health and sociology at Harvard, wrote in **a May 2020 editorial for JAMA**:

Economic status matters profoundly for reducing the risk of exposure to SARS-CoV-2. Lower-income and minority workers are overrepresented among essential service workers who must work outside the home when shelter-in-place directives are given. Many must travel to work on buses and subways.

But the bottom line is, due to both systemic racism and factors particular to Covid-19 and the accompanying economic crisis, Black Americans have died at disproportionately high rates during the pandemic. The Trump campaign has feinted during the 2020 campaign toward appealing to Black Americans, or at least assuaging their white supporters that the Republican Party is not racist. Trump's support has grown slightly among predominantly Black men, but Biden is still expected to overwhelmingly carry Black voters.

But Biden, as he did throughout the debate, brought the issue back to Covid-19. America's failures, in the past six months but also throughout its history, have led to that tragic outcome.

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Plaintiffs

v.

GREG ABBOTT, Governor of Texas; RUTH HUGHS, Texas Secretary of State,

Defendants.

DECLARATION OF CATHERINE L. TROISI IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

1. My name is Catherine L. Troisi. I am over the age of eighteen (18), of sound mind, and in all respects competent to testify. The facts stated herein are true, correct, and within my personal knowledge.

2. I have been asked by counsel for plaintiffs to opine on the novel coronavirus and its implications on in person voting in Texas. Based on my 40 years of experience as an epidemiologist and work in public health in the area of infectious disease epidemiology specializing in viruses, I have reached the following high-level conclusions, which are supported in more detail throughout my declaration:

- There is a high probability that SARS-CoV-2, the novel coronavirus and causative agent of COVID-19, will continue to spread throughout the fall and winter.
- The virus is spread from person to person through the air and on environmental surfaces. Therefore, gatherings such as at polling places contribute to virus spread.

- Racial and ethnic minority groups have an increased risk of severe outcomes should they become infected with SARS-CoV-2.
- There are ways to mitigate the risk of virus transmission at polling places, including requiring wearing of masks by both voters and poll workers.

QUALIFICATIONS

3. I am an infectious disease epidemiologist and public health expert as well as an Associate Professor in the Department of Management, Policy, and Community Health and Department of Epidemiology, Human Genetics, and Environmental Sciences and Center for Infectious Diseases at the University of Texas Health Science Center at Houston, School of Public Health and an Adjunct Associate Professor at Baylor College of Medicine.

4. I have a B.A. in Chemistry from The University of Rochester (NY) in 1974, an M.S. in Biochemistry from Michigan State University in 1975, and a PhD in Epidemiologic Sciences from The University of Michigan in 1980, specializing in influenza studies. I completed a postdoctoral position at Baylor College of Medicine in the Department of Virology and Epidemiology. I am a graduate of the National Public Health Leadership Institute at the University of North Carolina and have received post-doctoral training in epidemiologic techniques and public health preparedness.

5. My forty-year career in public health has been in the area of infectious disease epidemiology specializing in viruses. I was on the faculty in the Department of Virology and Epidemiology at Baylor College (the name was changed to Department of Molecular Virology during my tenure there) from 1983-1996, and I joined the faculty at University of Texas Health Science Center at Houston School of Public Health in Disease Control and Biological Sciences in 1997. I left academia in 2003 for seven years to practice public health at the Houston Health Department, beginning as Bureau Chief for HIV/STD and Viral Hepatitis Prevention, was

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promoted to Assistant Director of the Health Department, overseeing the Division of Prevention and Communicable Diseases, and finally creating and filling a new position as Director of Public Health Practice. I rejoined the UTSPH faculty in 2010, in the Departments of Management, Policy, and Community Health and Epidemiology, Human Genetics, and Environmental Sciences and the Center for Infectious Diseases.

6. I was Incident Commander in the National Incident Management System structure (i.e., in charge of the Houston Health Department's response) in 2009 for the H1N1 influenza pandemic, a respiratory virus.

7. I am also currently an elected Executive Board Member of the American Public Health Association, a Board Member of International Network of Epidemiology in Policy, an Elected Fellow, Texas Public Health Association, a member of the National Association of County and City Health Officials epidemiology workgroup, and a member of the American College of Epidemiology. I have received several awards and honors including the Excellence in Community Service Award, UTSPH, 2013 and 2019, and the Association of Schools and Programs in Public Health Service Award, 2018. I was elected to Sigma Xi (Scientific Honor Society) in 1979, received a fellowship from the University of Michigan 1977-1980, and was a Eugene B. Casey Fellow at Baylor College of Medicine. I have testified before the US House of Representatives Committee on Homeland Security, Ebola Preparedness (October 2014, Dallas, TX), Governor Perry's Task Force on Public Health Prevention, Ebola Preparedness (October 2014, Austin, TX), the Texas House County Affairs Committee, Syringe Exchange Programs (April 2019, Austin, TX).

8. In the last four years, I have testified and/or been deposed in:

- 3 -

- *Tex. Democratic Party v. Debeauvoir et. al.*, No. D-1-GN-20-1610 (201st Jud. Dist. Travis County, Tex. 2020)
- Lewis v. Hughs, No. 20 Civ.00577 (OLG) (W.D. Tex. 2020)
- *DCCC v. Ziriax*, No. 20 Civ.21 (JED/JFJ) (N.D. Okla. 2020)
- American Women v. Missouri, No. 20AC-CC00333 (Cole Cnty. Ct. 2020)

9. Attached as Appendix A and incorporated by reference to this declaration is a copy of my curriculum vitae. I am being compensated for my work in this matter at a rate of \$150 an hour. My compensation is not dependent on my opinions or conclusions.

BACKGROUND ON COVID-19

10. The first reports of this novel coronavirus, now named SARS-CoV-2, occurred on December 31, 2019. The first confirmed case in the United States was noted one month later on January 20, 2020. In the nearly nine months since that first confirmed U.S. case, there have been over 8.1 million cases in all 50 states plus District of Columbia, with over 218,000 deaths reported as of October 19, 2020.¹ The United States as a whole is averaging over 50,000 confirmed cases per day and has experienced a 27% increase in cases over the past two weeks.² The United States has approximately 4.4% of the world's population but 20% of the COVID-19 cases and deaths.³

¹ CDC, United States CPVOD-19 Cases and Deaths by State, CDC,

https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html (accessed Oct. 19, 2020).

² Tracking Our COVID-19 Response, COVID Exit Strategy,

https://www.covidexitstrategy.org/?utm_campaign=wp_the_health_202&

utm_medium=email&utm_source=newsletter&wpisrc=nl_health202 (accessed Oct. 19, 2020).

³ See https://gisanddata.maps.arcgis.com/apps/opsdashboard/index.html#/

bda7594740fd40299423467b48e9ecf6. (accessed Oct. 19, 2020).

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11. The COVID-19 infection is caused by the SARS-CoV-2 virus and is spread in two ways: (1) by the respiratory route (through the air and through mucous membranes), and (2) by fomites, that is, environmental surfaces that are contaminated with the virus.⁴ SARSCoV-2 can also be found in feces, although the importance of this in transmission is not yet known.⁵ The main route of virus transmission is through the respiratory track.

12. Factors that increase probability of transmission include indoor space, close contact, crowding, and duration of contact (longer than 15 minutes).⁶

13. There is increasing evidence that aerosolized droplets (which means the virus is found in fine particles suspended in the air) can spread the virus.⁷ One study found that aerosols of COVID-19 can remain viable in indoor environments for minutes while another found that aerosols remained infectious for at least 16 hours.⁸ Other studies show that COVID-19 aerosols were carried on air currents in a restaurant, infecting people across the room⁹ and that a bus rider became infected even though the rider was seated about 4.5 meters (~15 feet) away from the

⁴ CDC, Frequently Asked Questions, CDC, (accessed Oct. 19, 2020), https://www.cdc.gov/coronavirus/2019-ncov/fag.html.

⁵ CDC, Infectious SARS-CoV-2 in Fees of Patient with Severe COVID-19, CDC Emerging Infectious Diseases, Research Letter Vol. 26, No. 8, (Aug. 2020),

https://wwwnc.cdc.gov/eid/article/26/8/20-0681 article (accessed Oct. 19, 2020).

⁶ Health Departments, *Community-Related Exposures*, CDC, (Updated July 31, 2020),

https://www.cdc.gov/coronavirus/2019-ncov/php/public-health-recommendations.html (accessed Oct. 19, 2020).

⁷ Dyani Lewis, Mounting evidence suggests coronavirus is airborne—but health advice has not caught up, Nature, (July 23, 2020), https://www.nature.com/articles/d41586-020-02058-1. ⁸ EIU Healthcare, Does the coronavirus stay longer in the air than previously thought?, COVID-19 Facts, (July 15, 2020), https://www.covid-19facts.com/?p=84800.

⁹ Jianyun Lu, et al., COVID-19 Outbreak Associated with Air Conditioning in Restaurant, Guangzhou, China, 2020, Emerg. Infet. Dis., (July 2020), accessed at https://pubmed.ncbi.nlm.nih.gov/32240078/.

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infected subject.¹⁰ Choral practice and fitness classes have also been linked to aerosol transmission.¹¹ The World Health Organization (WHO) has recently changed its position and acknowledged that aerosol transmission may occur outside of medical facilities¹² based on information provided by over 200 scientists from 32 countries.¹³ A recently published article clearly articulates the evidence that aerosols play an important role in transmission of the virus, perhaps more than droplets, outlining how aerosol transmission explains many of the epidemiologic characteristics we are observing.¹⁴ Another recent publication questions the centuries-old guidance of protection from droplet spread at six-feet distancing.¹⁵The virus is infectious and each person can infect, on average, between 2 and 5 to 6 other persons, in the

https://wwwnc.cdc.gov/eid/article/26/8/20-0633_article; CDC, *High SARS-CoV-2 Attack Rate Following Exposure at a Choir Practice—Skagit County, Washington, March 2020*, CDC MMWR 69(19), 606-610, (May 12, 2020),

¹⁰ Ye Shen, et al., *Community Outbreak Investigation of SARS-CoV-2 Transmission Among Bus Riders in Eastern China*, 2020, JAMA Intern Med., (Sept. 1, 2020), *accessed at* https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2770172.

¹¹ CDC, *Cluster of Coronavirus Disease Associated with Fitness Dance Classes, South Korea,* CDC Emerging Infectious Diseases, Research Letter Vol. 26 No.8, (Aug. 2020),

https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e6.htm.

¹² WHO, *Transmission of SARS-CoV-2: implications for infection prevention precautions*, WHO Newsroom, (July 9, 2020), https://www.who.int/news-room/commentaries/detail/transmission-of-sars-cov-2-implications-for-infection-prevention-precautions.

¹³ 239 Scientists From 32 Countries Call For WHO To Address Airborne Spread Of Novel Coronavirus, KFF, (July 6, 2020), https://www.kff.org/news-summary/239-scientists-from-32-countries-call-for-who-to-address-airborne-spread-of-novel-coronavirus/.

¹⁴ Jose-Luis Jimenez, *COVID-19 Is Transmitted Through Aersols. We Have Enough Evidence, Now It Is Time to Act,* Time, (Aug. 25, 2020), https://time.com/5883081/covid-19-transmitted-aerosols/.

¹⁵ Jones Nicholas, et al., *Two metres or one: what is the evidence for physical distancing in covid-19?*, BMJ 2020, (Aug. 2020), *accessed at* https://www.bmj.com/content/370/bmj.m3223.

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absence of protective measures, leading to exponential spread.¹⁶ SARS CoV-2 is more infectious than influenza¹⁷ and current estimates are that it is ten times as deadly.¹⁸

14. Reported illnesses from SARS-CoV-2 have ranged from no to mild symptoms to severe illness and death. Symptoms can include fever, dry cough, and shortness of breath. In addition to lung damage, the virus can cause damage and failure of other organs including heart, kidney, and intestines.¹⁹ When severe, COVID-19 is a systemic illness characterized by hyperinflammation, cytokine storm, and elevations of cardiac injury biomarkers.²⁰ Forty percent of deaths from COVID-19 are due to cardiac damage, and these serious consequences can occur even after respiratory symptoms are resolved.²¹ Three months after clearing the virus, 50 to 80% of patients continue to have bothersome symptoms.²² Children generally do not have severe

¹⁶ <u>Vanessa B. Ramirez, *What is R0? Gauging Contagious Infections*, Healthline, (Apr. 20, 2020), https://www.healthline.com/health/r-nought-reproduction-number; CDC, *Pandemic Planning* <u>Scenarios</u>, CDC Healthcare Workers, (Updated Sept. 10, 2020),</u>

https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html (accessed Oct. 19, 2020).

¹⁷ <u>Rachael Rettner</u>, *How does the new coronavirus compare with the flu?*, Live Science, (May 14, 2020), https://www.livescience.com/new-coronavirus-compare-with-flu.html.

¹⁸ Lisa L. Maragakis, *Coronavirus Disease 2019 vs. the Flu*, Hopkins Medicine, (accessed Oct. 19, 2020), https://www.hopkinsmedicine.org/health/conditions-and-

diseases/coronavirus/coronavirus-disease-2019-vs-the-flu.

¹⁹ Zsuzsanna Varga, et al., *Endothelican cell Infection and endotheliitis in COVID-19*, The Lancet 395(10,234), 1417-1418, (Apr. 20, 2020), *accessed at*

https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30937-5/fulltext (accessed Oct. 19, 2020).

²⁰ Id.

²¹ <u>Riccardo M. Inciardi, et al., Cardiac Involvement in a Patient with Coronavirus Disease 2019</u> (COVID-19), JAMA Cardiol. 2020 5(7), 819-824, (Mar. 27, 2020),

https://jamanetwork.com/journals/jamacardiology/fullarticle/2763843.

²²Angelo Carfi, et al., Persistent Symptoms in Patients After Acute COVID-19, JAMA. 2020

<u>324(6), 603-605, (Aug. 2020), accessed at https://pubmed.ncbi.nlm.nih.gov/32644129/; Mark W.</u> Tenforde, *Symptom Duration and Risk Factors for Delayed Return to Usual Health Among Outpatients with COVID-19 in a Multistate Health Care Systems Network—United States, March-June 2020,* MMWR. 69(30), 993-998, (Jul. 31, 2020), accessed at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7392393/.

disease from COVID-19, but there has been recognition of multi-system inflammatory syndrome in SARS-CoV-2 infected children.²³ A recent systemic review and metanalysis found that the overall estimate of infected persons who remain asymptomatic throughout infection was 20% (95% confidence interval [CI] 17–25) with a prediction interval of 3%–67% in 79 studies analyzed.²⁴ CDC uses an estimate of 40% of infected persons will either never show symptoms or have very mild symptoms, but they can transmit the virus to others up to 14 days following infection.²⁵

15. According to the CDC, certain groups such as those over 65 years of age and those with certain underlying medical conditions (including chronic lung disease such as moderate to severe asthma, chronic heart disease, diabetes, obesity, chronic kidney disease, liver disease, immunosuppression) are at higher risk of serious illness and death from COVID-19.²⁶ Pregnant women are at increased risk of a severe outcome.²⁷ However, anyone can be infected

https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1003346 ²⁵ <u>CDC</u>, *Pandemic Planning Scenarios*, CDC Healthcare Workers, (Updated Sept. 10, 2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html (accessed Oct. 19, 2020).

²³ <u>CDC</u>, *HAN00432*, CDC Emergency Preparedness and Response, (May 14, 2020), https://emergency.cdc.gov/han/2020/han00432.asp (accessed Oct. 19, 2020).

²⁴ Carl Heneghan, COVID-19: What proportion are asymptomatic?, CEBM, (Apr. 6, 2020), https://www.cebm.net/covid-19/covid-19-what-proportion-are-asymptomatic/; Stefanie Hossmann, et al., Occurrence and transmission potential of asymptomatic and presymptomatic SARS-CoV-2 infections: A living systematic review and meta-analysis, PLOS Medicine, (Sept. 22, 2020), accessed at

²⁶ <u>CDC</u>, *People at Increased Risk*, CDC Your Health, (Updated Sept 11, 2020),

https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html (accessed Oct. 19, 2020).

²⁷ <u>CDC</u>, <u>Characteristics of Women of Reproductive Age with Laboratory-Confirmed SARS-CoV-</u> <u>2 Infection by Pregnancy Status—United States, January 22-June 7, 2020, MMWR 69(25), 769-</u> <u>775, (June 26, 2020),</u>

https://www.cdc.gov/mmwr/volumes/69/wr/mm6925a1.htm?s_cid=mm6925a1_w

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with COVID-19 and suffer serious outcomes.²⁸ Rates of hospitalization increase with age.²⁹ A recent CDC study shows that 56% of Americans have a co-morbid condition that would put them at increased risk of serious sequelae should they become infected.³⁰

16. Racial minorities have been particularly affected by this pandemic for several reasons. They are more likely to get infected due to increased possibility of exposure (crowding, essential jobs that interact with the public, multi-generational housing,) and, once infected, experience worse outcomes (lack of health care access, higher rates of co-morbid conditions).³¹ A CDC graphic (below) clearly demonstrates these disparities.²⁷ In the United States overall, Black, non-Hispanic persons are 2.6 times more likely to be infected, 4.7 times more likely to be hospitalized, and 2.1 times more likely to die than Caucasians. Hispanics are 2.8 times more likely to die. compared to Caucasians. These numbers are 2.8, 5.3, and 1.4, respectively, for American Indian, Native Hawaiians.

https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm?s_cid=mm6915e3_w. ³⁰ CDC, Updates Estimates of Chronic Conditions Affecting Risk for Complication from Coronavirus Disease, United States, CDC Emerging Infectious Diseases 26(9), (Sept. 2020), https://wwwnc.cdc.gov/eid/article/26/9/20-2117_article?deliveryName=USCDC_331-DM35835. ³¹ CDC, Health Equity Considerations & Racial Ethnic Minority Groups, CDC Community,

Wrk & School, (Updated July 24, 2020), https://www.cdc.gov/coronavirus/2019ncov/community/health-equity/race-

²⁸ <u>CDC</u>, *Symptoms*, CDC Your Health, (Updated May 13, 2020),

https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html (accessed Oct. 19, 2020).

²⁹ Shikha Garg, et al., *Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Disease 2019—COVID-Net, 14 States, March 1-30, 2020,* MMWR 69(15), 458-464, (Apr. 17, 2020),

ethnicity.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fneed-extra-precautions%2Fracial-ethnic-minorities.html (accessed Oct. 19, 2020).

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Rate ratios compared to	American Indian or Alaska	Asian, Non-	Black or African	Hispanic or
White, Non-Hispanic	Native, Non-Hispanic	Hispanic	American, Non-Hispanic	Latino
Persons	persons	persons	persons	persons
Cases ¹	2.8x	1.1x	2.6x	2.8x
	higher	higher	higher	higher
Hospitalization ²	5.3x	1.3x	4.7x	4.6x
	higher	higher	higher	higher
Death ³	1.4x	No	2.1x	1.1x
	higher	Increase	higher	higher

17. The disparities seen in severe outcomes from COVID-19 are true for Texas alone as well as for the whole United States. We can't make valid comparisons based on who is getting infected because only 6% of reported cases in Texas indicate racial/ethnic background of the patient. However, 98% of reported COVID-19 deaths do indicate race/ethnicity. Hispanics comprise 39% of the Texas population but 56% of the COVID-19 deaths, a 44% increase in deaths over the representation in the population, indicating a disparity in outcomes.³²

18. Based on available data, in Texas, Black and Latino people are most likely to contract COVID-19; amongst Black Texans there are 284 cases per 100,000 and amongst Hispanic/Latino Texans there are 204 cases per 100,000, as compared with only 143 cases emerging per 100,000 amongst white Texans. In terms of COVID-19 fatalities in Texas, Hispanic/Latino people are by far the most likely to die from COVID-19, with 87 deaths occurring amongst Hispanic/Latino people per 100,000; Black people also experience disproportionate fatalities, with 57 deaths per 100,000 people, as compared to 44 deaths per 100,000 people for white people.³³

³² Race and Ethnicity data by state, Covid Tracking Project,

https://covidtracking.com/race/dashboard#state-tx (accessed Oct. 19, 2020).

³³ *Infection and Mortality by Race and Ethnicity*, Covid Tracking Project, https://covidtracking.com/race/infection-and-mortality-data#TX (accessed Oct. 19, 2020).

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19. In Texas, the U.S. age-adjusted COVID-19 mortality rate for Black people and for Indigenous people is more than twice as high and the mortality rate for Latino people is more than four times as high as the mortality rate for white people.³⁴

20. Within my area of expertise, social distancing, masks, frequent hand-washing, and environmental disinfection are the only ways to limit the spread of the virus,³⁵ as there is no FDA-licensed vaccine that could be administered to elicit immunity to the virus and there will not be one by November 3, 2020.³⁶ The availability of COVID-19 tests and timely results is also a critical tool for combatting community spread of COVID-19.

21. Social (also called physical) distancing refers to maintaining a distance of at least 6 feet between persons. Social distancing is a proven method to stop the spread of viruses such as the novel coronavirus through the respiratory route.³⁷ As noted, the novel coronavirus is spread through both droplet and aerosol transmission. These are produced through coughing, sneezing, talking, and singing. Droplets are fairly heavy, and most studies have shown that they cannot

³⁴ APM Research Lab, *The Color of Coronavirus: COVID-19 Deaths by Race and Ethnicity in the U.S.* (updated Oct. 15 2020), https://www.apmresearchlab.org/covid/deaths-by-race#rates. ³⁵ CDC, *Protect Yourself*, CDC Your Health, (Updated Sept. 11, 2020),

https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html (accessed Oct. 19, 2020).

³⁶ Richard Harris, *Pfizer COVID-19 Vaccine Won't Be Ready By Election Day*, NPR, (Oct. 16, 2020), https://www.npr.org/sections/coronavirus-live-updates/2020/10/16/924502362/pfizer-covid-19-vaccine-wont-be-ready-by-election-day.

³⁷ Kelvin Droegemeier, *Rapid Expert Consultation on Social Distancing for the COVID-19 Pandemic,* The Nat'l Academies of Sciences, (Mar. 19, 2020),

https://www.nap.edu/catalog/25753/rapid-expert-consultation-on-social-distancing-for-the-COVID-19-pandemic-march-19-2020.

travel more than approximately 6 feet,³⁸ although under certain circumstances, they can travel a longer distance.³⁹ Aerosols can travel farther and remain lingering in the air.⁴⁰

22. Non-PPE masks (also known as cloth masks) offer a certain degree of protection

against the virus in observational studies.⁴¹ While masks vary in effectiveness due to variations

in type of fabric used, number of layers, presence or absence of an internal filter, as well as how

closely they fit and other factors, many studies have shown they offer protection against SARS-

CoV-2 infection, protecting both others and the wearer.⁴² Masks must be worn correctly to offer

³⁸ <u>CDC</u>, *supra* n. 22.

³⁹ Lydia Bourouiba, *Potential Implications for Reducing Transmission of COVID-19*, JAMA 323(18), 1,837-1,838, (Mar. 26, 2020),

https://jamanetwork.com/journals/jama/fullarticle/2763852.

⁴⁰ CDC, SARS-CoV-2 & Potential Airborne Transmission, CDC More Resoures, (Updated Oct.

^{5, 2020),} https://www.cdc.gov/coronavirus/2019-ncov/more/scientific-brief-sars-cov-2.html (accessed Oct. 19, 2020).

⁴¹ Lynne Peeples, Face masks: what the data say, Nature, (Oct. 6, 2020),

https://www.nature.com/articles/d41586-020-02801-

^{8?}utm_campaign=KHN%3A%20Daily%20Health%20Policy%20Report&utm_medium=email&_hsmi=97059706&_hsenc=p2ANqtz-9iFt-

³p_qhcM7ABPp5V2koFfAvsRdNex51yXpHdonEYUb2KSaelq_C4pK66eoYkae-DwswTkKSI8pZqbYnCqkD-

hYcu2aHJHLvXo9SHdsmMllEPso&utm_content=97059706&utm_source=hs_email.

⁴² Derek. K. Chu, et al., *Physical distancing, face masks, and eye protection to prevent personto-person transmission of SARS-CoV-2 and COVID-19: a systematic review and meta-analysis,* The Lancet 395(10,242), 1973-1987, (June 27, 2020), *accessed at*

https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31142-9/fulltext; Mayo Clinic Staff, *COVID-19: How much protection do face masks offer?*, Mayo Clinic, (Aug. 20, 2020), https://www.mayoclinic.org/diseases-conditions/coronavirus/in-depth/coronavirus-mask/art-20485449; Jeremy Howard, et al., *Face Masks Against COVID-19: An Evidence*

Review, Preprints 2020, (July 10, 2020), accessed at

https://www.preprints.org/manuscript/202004.0203/v.; <u>G. Kamps, et al., Persistence of</u> coronaviruses on inanimate surfaces and their inactivation with biocidal agents, Hospital Infection Journal 104(3), 246-251, (Mar. 1, 2020), accessed at

https://www.journalofhospitalinfection.com/article/S0195-6701(20)30046-3/fulltext.

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protection (e.g., both nose and mouth must be covered).⁴³ Therefore masks are recommended to prevent spread of infection as well as physical distancing.

23. The main purpose of non-PPE masks is source control; in other words, when worn by an infected person, the non-PPE masks act as a barrier to prevent infected persons from transmitting large respiratory droplets into the air.⁴⁴

24. Research shows that "public mask wearing is most effective at stopping spread of the virus when compliance is high."⁴⁵

25. Any place where people gather and do not maintain physical distancing, such as a polling place, represents a heightened danger for transmission of COVID-19 disease. Due to the possibility of close proximity (less than 6 feet) between voters, between poll workers and voters, and between poll workers and poll workers, as well as the transmission of the virus on polling machine screens and other environmental surfaces, there is risk of spread of the virus at polling places through droplets, airborne, or environmental surfaces. This is particularly important because some people who are infected with the novel coronavirus do not have any symptoms but can transmit the virus and/or are infectious before they develop symptoms.⁴⁶ This means that

⁴³CDC, *How to Wear Masks*, CDC Your Health, (Updated Aug. 7, 2020), https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-to-wear-cloth-facecoverings.html (accessed Oct. 19, 2020).

⁴⁴ Jaclyn K. Cichowicz, et al., *Respiratory Protection vs. Source Control—What's the Difference?*, NIOSH Science Blog, (Sept. 8, 2020), https://blogs.cdc.gov/niosh-scienceblog/2020/09/08/source-control/; Jeremy Howard, *supra* n. 40.

⁴⁵ Jeremy Howard, *supra* n. 40; In a previous study of the effectiveness of respiratory protective devices in reducing influenza transmission, high compliance is defined as 80% or better compliance. J Yan, et al., *Modeling the Effectiveness of Respiratory Protective Devices in Reducing Influenza Outbreak*, Risk Analysis 39, 647–661 (2019).

⁴⁶ Li R, Pei S, Chen B, et al. Substantial undocumented infection facilitates the rapid dissemination of novel coronavirus (SAROVIS-CoV2). Science (New York, NY). 2020.

isolating only symptomatic persons will not stop the spread of infection. Instead, we have to

assume anyone could be infected and transmit that infection to another person.

26. As a result of the many ways the coronavirus can spread, with respect to elections,

the Centers for Disease Prevention and Control states that:

The more an individual interacts with others, and the longer that interaction, the higher the risk of COVID-19 spread. Elections with only in-person voting on a single day are higher risk for COVID-19 spread because there will be larger crowds and longer wait times. Lower risk election polling settings include those with:

- a wide variety of *voting* options
- longer voting periods (more days and/or more hours)
- any other feasible options for reducing the number of voters who congregate indoors in polling locations at the same time

The CDC also recommends that voters consider alternatives that minimize contact with or the amount of time you are in contact with others to help reduce the spread of COVID-19.⁴⁷ Furthermore, the CDC recommends that poll workers and voters wear masks, noting that "[m]asks are meant to protect other people in case the wearer is unknowingly infected but does not have symptoms."⁴⁸

LONGEVITY OF COVID-19

27. In my expert opinion, it is highly likely that the novel coronavirus will continue to

be transmitted through this fall and winter and, as discussed below, people will continue to have

to wear masks, social distance, hand-wash, and take proper precautions into November.

Currently we are seeing increases in COVID-19 cases in 43 states plus the District of

Columbia.49

⁴⁷ <u>CDC</u>, *Considerations for Election Polling Locations*, CDC Community, Work & School, (Updated June 22, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/election-polling-locations.html (accessed Oct. 19, 2020).

⁴⁸ *Id*.

⁴⁹ *Supra* n. 2.

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28. Herd immunity occurs when a high percentage of people in a community become immune to an infectious disease (one that is spread person to person) that its transmission slows down or stops altogether. This can occur naturally through widespread infection or through vaccination. In most cases, 70-80% of the population must be immune for herd immunity to occur. Herd immunity protects those in the community who cannot be vaccinated and for whom infection may be very serious, e.g., babies, seniors, immunocompromised, cancer patients.⁵⁰ We are nowhere near reaching the 70-80% of people who need to be immune for herd immunity to occur; a recent serological prevalence study show antibody prevalence levels in the United States range from 1% to 6.9%⁵¹ while another study showed antibody prevalence of less than 10%.⁵²

COVID-19 AND TEXAS

29. Texas is currently seeing an increase in new COVID-19 cases and hospitalization rates. As of October 16, 2020, over 820,000 cases have been reported with 17,000 deaths. Over the past week, Texas has averaged over 4,100 confirmed daily cases, with a 24% increase in rolling average of cases. ⁵³ The 14-day trend of COVID-19 testing positivity rates is at 8.6%⁵⁴

⁵⁰ Noreen Iftikhar, *What is Herd Immunity and Could It Help Prevent COVID-19?*, Health Line, (Apr. 2, 2020), https://www.healthline.com/health/herd-immunity#how-it-works (accessed Oct. 19, 2020).

⁵¹ Fiona P. Havers, et al., *Seroprevalence of Antibodies to SARS-CoV-2 in 10 Sites in the United States, March 23-May 12, 2020, JAMA Intern. Med., (July 21, 2020), accessed at https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2768834.*

⁵² Shuchi Anand, et al., *Prevalence of SARS-CoV-2 antibodies in a large nationwide sample of patients on dialysis in the USA: a cross-sectional study*, The Lancet, (Sept. 25, 2020), *accessed at* https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)32009-2/fulltext. ⁵³See

https://txdshs.maps.arcgis.com/apps/opsdashboard/index.html#/ed483ecd702b4298ab01e8b9cafc 8b83 (accessed Oct. 19, 2020).

⁵⁴See

https://txdshs.maps.arcgis.com/apps/opsdashboard/index.html#/0d8bdf9be927459d9cb11b9eaef6 101f (accessed Oct. 19, 2020).

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and is increasing, indicating widespread community spread of the virus (the goal is 3-5%).⁵⁵ Both hospital and ICU beds have a low availability. The case fatality rate in Texas since the beginning of the pandemic is at 2.1%.⁵⁶

30. Texas currently has no stay at home order.⁵⁷ Although Governor Abbott issued a mask order effective on July 3, 2020, it is not uniformly enforced and is not required at polling places.⁵⁸ We will surely see this increase in the number of infected persons continue, in my expert opinion, as this very infectious virus is still prevalent, there is no vaccine, and no herd immunity. Pushback against non-pharmaceutical interventions such as physical distancing⁵⁹ and mask-wearing⁶⁰ will only exacerbate transmission of the SARS-CoV-2 virus, along with general pandemic fatigue.⁶¹ Even if Texas was able to "flatten the curve" and decrease the rising rate of infections, travel in and out of state by Texans or visitors to Texas via states with a higher level of infection could import infection and lead to community spread in Texas. As with the rest of the United States, it is likely that coronavirus will be present in Texas in November and that

https://www.texastribune.org/2020/06/29/texas-coronavirus-stay-at-home-harris-dallas/. ⁵⁸ Valeria Olivares, *Nearly 80 Texas counties have opted out of Gov. Greg Abbott's mark order.*

Other refuse to enforce it, The TX Tribune, (July 9, 2020),

https://www.texastribune.org/2020/05/22/texas-coronavirus-masks/.

⁵⁵ <u>Which U.S. States meet WHO recommended testing criteria?</u>, Johns Hopkins Coronavirus <u>Resource Center, https://coronavirus.jhu.edu/testing/testing-positivity</u>.

⁵⁶*Supra* n. 2.

⁵⁷ Cassandra Pollock & Juan G. Garnham, *Texas city and county leaders ask Gov. Greg. Abbott* for authority to implement local stay-at-home orders, The TX Tribune, (June 29, 2020),

https://www.texastribune.org/2020/07/09/texas-mask-order-enforcement/.

⁵⁹ <u>See https://www.unacast.com/COVID19/social-distancing-scoreboard?view=state&fips=48</u> (accessed Oct. 19, 2020).

⁶⁰ <u>Alex Samuels, For some, forgoing masks in public during the coronavirus pandemic has</u> become a political statement, The TX Tribune, (May 22, 2020),

⁶¹ Julie Bosman, et al., *As the Coronavirus Surges, a New Culprit Emerges: Pandemic Fatigue,* N.Y. Times, (Oct. 17, 2020), https://www.nytimes.com/2020/10/17/us/coronavirus-pandemic-fatigue.html?campaign_id=2&emc=edit_th_20201018&instance_id=23251&nl=todaysheadlines ®i_id=20801062&segment_id=41412&user_id=a1d37690a71a3c57114034e48f1643bc.

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associated needs for social distancing, frequent hand-washing, sanitizing high-touch surfaces, and protective wear will be needed.

RECOMMENDATIONS

31. In my expert opinion (and consistent with CDC guidelines), for the upcoming November election in Texas, precautions will need to be in place for public health and safety, given that it is highly likely that the virus will be circulating during voting season. Masks are a critical precaution to prevent the spread of the virus.

32. Notably, voters are not the only ones who face increased risk of infection. Poll workers are at a heightened risk of acquiring SARS-CoV-2 infection as they come in contact with a large number of people on voting days and must share space with other poll workers. Poll workers also are often older.

33. Transmission is a significant risk at polling places because infected people who are asymptomatic or presymptomatic—and therefore have not been tested or do not know that they have the disease—are contributing to spread of the virus.⁶² Therefore, a voter going to the polls or a poll worker could infect others without knowing they themselves are infected. Moreover, given their central role in facilitating the voting process, poll workers will experience significantly more contacts (and opportunities for infection) with other individuals during Election Day than will the average voter. In any event, voters and poll workers who do become infected with the SARS-CoV-2 virus can further spread it to others in their household.

34. The main route of virus transmission is through the respiratory track. Factors that increase probability of transmission include indoor space, close contact, crowding, and duration

⁶² <u>Ruiyun Li, et al., Substantial undocumented infection facilitates the rapid dissemination of</u> <u>novel coronavirus (SARS-CoV-2), Science 368(6,490), 48-493, (May 1, 2020), accessed at</u> https://science.sciencemag.org/content/early/2020/03/24/science.abb3221.

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of contact (longer than 15 minutes).⁶³ Public health measures to stop transmission, therefore, include mandating mask wearing for voters, protecting both the wearer and those around him/her.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed in Harris County, State of Texas, on the 20th day of October 2020.

Catherine Troisi Date: 2020.10.20 08:17:06-05'00' Catherine L Troisi

⁶³ <u>CDC</u>, <u>Community-Related Exposures</u>, <u>CDC</u> Health Departments, (Updated July 31, 2020), https://www.cdc.gov/coronavirus/2019-ncov/php/public-health-recommendations.html (accessed Oct. 19, 2020)
IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF TEXAS SAN ANTONIO DIVISION

MI FAMILIA VOTA, TEXAS STATE CONFERENCE OF THE NATIONAL ASSOCIATION FOR THE ADVANCEMENT OF COLORED PEOPLE, MICAELA RODRIGUEZ and GUADALUPE TORRES,

NO. 5:20-cv-00830

Plaintiffs

v.

GREG ABBOTT, Governor of Texas; RUTH HUGHS, Texas Secretary of State,

Defendants.

DECLARATION OF PLAINTIFF GUADALUPE TORRES

I, Guadalupe Torres hereby state on my own knowledge and belief that:

- 1. I am of legal age and competent to provide this declaration.
- 2. I am a plaintiff in the above-entitled action.
- 3. I am a registered voter in Denton County, Texas.
- 4. I am Latina.
- 5. I live in Lewisville, and the part of Lewisville where I live is predominantly Latino.
- 6. I have always voted in person.
- 7. I do not qualify to vote by mail in Texas.
- 8. I live with my mother and my father, who both have health problems.
- 9. My mother, father, and I got COVID-19 in the early summer, though we were very careful, wore masks, and social distanced.
- 10. I was asymptomatic for over a week after I tested positive for COVID-19. After a week or so, I began to experience symptoms.

- 11. My mother and father both lost a lot of weight and became weak because of COVID-19. My mother still has trouble breathing, and my father's chronic cough has gotten worse. I am worried they both sustained lung damage.
- 12. Even though I contracted COVID-19, I know that not all people who get the virus are immune. I am worried about being exposed and getting sick from the virus again.
- 13. Because their health is fragile, I am very worried about what happens if we get the disease again.
- 14. Getting sick was financially difficult for my family.
- 15. During the time we were sick, my father, my mother, and I all were out of work for three weeks. My dad didn't get paid, which meant we couldn't afford our rent. Luckily, our landlord was understanding, but if he gets sick again, we would again fall behind on our rent.
- 16. Because I didn't get paid, I couldn't afford tuition and my college almost put a hold on my account. I would not have been able to register for classes or get my transcript. Although the financial aid office eventually helped with some additional aid, I am now on a payment plan, had to get help from my parents, and am working extra shifts to try to make up the difference. If I get sick again, I might not be able to catch up.
- 17. I have seen many cases of COVID-19 this summer. At this point, it is affecting everyone I know. Almost all of my friends have had a death in their family because of COVID-19.
- 18. I have seen many people refuse to wear masks in public. It is my understanding that masks are not required at polling places, and I am very concerned that many people will choose not to wear masks, and this will put me and other voters at risk.
- 19. I am worried about having to stand in long lines at my polling place. Even if they try to put up markers for social distancing, as lines of people get longer, it becomes harder or impossible to socially distance because they run out of room, and people start crowding.
- 20. Because I was asymptomatic for part of my illness, I know other people could be going to vote without knowing they are sick, and maybe without wearing masks or being careful about what they touch.
- 21. I don't feel safe voting in person during the pandemic. I am concerned that I will get sick again, or get my parents sick. But I don't want to give up my right to vote, either.
- 22. I wanted to vote early, but there have been record numbers of people voting. I am glad so many people are voting, but it means that early voting polling places near me have been busy with long lines.

- 23. I have not voted yet because I am worried about standing in line with people who aren't wearing masks.
- 24. If I knew everyone was going to be wearing a mask, I would definitely go out to vote. I would still be worried about the lines, but I know masks make the chances of transmission drastically lower.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct. Executed on October 19, 2020.

Jundaluge Joures Guadalupe Torres

IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT SAN ANTONIO DIVISION

MI FAMILIA VOTA, TEXAS STATE CONFERENCE OF THE NATIONAL ASSOCIATION FOR THE ADVANCEMENT OF COLORED PEOPLE, MICAELA RODRIGUEZ and GUADALUPE TORRES,

Case No. 5:20-cv-00830

Plaintiffs,

v.

GREG ABBOTT, Governor of Texas; RUTH HUGHS, Texas Secretary of State,

Defendants.

DECLARATION OF SEAN LYONS

I, SEAN LYONS, an attorney duly admitted to practice in the Western District of Texas, declare under penalty of perjury:

1. I am a partner at Lyons and Lyons, counsel to Plaintiffs in this action. I have personal knowledge of the facts set forth herein and could testify to them if called as a witness. This declaration is submitted in support of Plaintiffs' Emergency Motion for a Temporary Restraining Order and a Preliminary Injunction asking the Court for a temporary restraining order immediately excising the polling place exemption (exemption no. 8) from the statewide mask mandate issued in Executive Order GA-29, with concomitant changes to Election Advisory No. 2020-19 to comply with the as-excised version of Executive Order GA-29,¹ as well as a preliminary injunction to the same end.

¹ Specifically, to make all revisions to Election Advisory No. 2020-19 necessary and appropriate to comply with the as-excised version of the Executive Order, including excising the following statement: "There is no authority under Texas law to require voters to wear face coverings when presenting to vote"; and excising any other provisions in Advisory No. 2020-19 that suggest face coverings are not mandatory at polling locations.

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2. Plaintiffs make this request as an emergency motion and seek an immediate temporary restraining order because of the urgency of their request. This relief will immediately protect the voting rights of Black and Latino Texans who are currently being prejudiced, absent relief. Last Wednesday, the Fifth Circuit remanded to this Court to resolve a limited question:

Were the district court to conclude that the exemption from wearing a mask in public places contained in Executive Order GA-29 for poll workers, voters, and others in polling places violated section 2 of the Voting Rights Act, the district court might excise that provision if it concluded that this would redress the injuries the Plaintiffs have alleged. It is at least conceivable that such a remedy would not materially or substantially affect the ongoing election, but that would be a matter for the district court to determine.

A true and complete copy of the Fifth Circuit's opinion from October 14, 2020 is attached as Exhibit 1.

3. Further indicating the urgency of this issue, on Friday October 14, the Circuit issued the mandate to permit this Court to immediately resolve Plaintiffs' objection to the mask exemption just ninety minutes after Defendants filed their opposition.

4. As the Court is aware, early voting in Texas is currently underway and election day is in just two weeks. The harm to Black and Latino voters caused by permitting mask-less persons at polling centers is occurring right now, and Plaintiffs need immediate relief.

5. Given the urgency of this situation, Plaintiffs respectfully request an immediate temporary restraining order and the following schedule on Plaintiffs' preliminary injunction motion:

a. Defendants to submit, on ECF, their opposition (if any) to Plaintiffs' preliminary injunction motion no later than 48 hours after filing of Plaintiffs' motion;

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- b. Plaintiffs to submit, on ECF, their reply, if any, in further support of Plaintiffs' preliminary injunction motion no later than 24 hours after filing of Defendants' opposition; and
- c. A hearing no later than Monday, October 26, 2020, subject to the Court's unavailability.

6. Alternately, Plaintiffs would forego submission of a reply brief if the Court were available to hold a hearing promptly after Defendant's opposition is filed.

Plaintiffs' counsel conferred with defense counsel by email dated October 20,
2020 and Defendants informed plaintiffs that they oppose Plaintiffs' motion and will not agree to
Plaintiffs' proposed briefing schedule.

8. A true and correct copy of Governor Abbott's Executive Order GA-29 is attached as Exhibit 2.

9. A true and correct copy of Election Advisory No. 2020-19 which was issued by the Director of Elections under the authority of the Secretary of State is attached as Exhibit 3.

A true and correct copy of the Declaration of Robert M. Stein, dated August 26,
2020, and exhibits, is attached as Exhibit 4.

11. A true and correct copy of the Center for Disease Control and Prevention's Morbidity and Mortality Weekly Report titled "Race, Ethnicity, and Age Trends in Persons Who Died from COVID-19—United States, May-August 2020," by Jeremy A.W. Gold, Vol. 69, dated October 16, 2020, *available at* <u>https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6942e1-</u> <u>H.pdf</u>, is attached as Exhibit 5.

12. A true and correct copy of the Center for Disease Control and Prevention's Morbidity and Mortality Weekly Report titled "Hospitalization Rates and Characteristics of

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Children Aged < 18 Years Hospitalized with Laboratory-Confirmed COVID-19," by Lindsay Kim et al., dated August 14, 2020, *available at* https://bit.ly/3dDfpBO, is attached as Exhibit 6.

13. A true and correct copy of the APM Research Lab, *The Color of Coronavirus: COVID-19 Deaths by Race and Ethnicity in the U.S.* (updated Oct. 15, 2020), *available at* www.apmresearchlab.org/covid/deaths-by-race#rates, is attached as Exhibit 7.

14. A true and correct copy of the Center for Disease Control and Prevention article titled "Health Equity Considerations and Racial and Ethnic Minority Groups," dated July 24, 2020, *available at* <u>https://bit.ly/2EjWE94</u>, is attached as Exhibit 8.

15. A true and correct copy of the Texas Tribune article titled "Across Texas and the Nation, the Novel Coronavirus is Deadlier for People of Color," by Emma Platoff and Carla Astudillo dated July 30, 2020, *available at* <u>https://bit.ly/32foWtB</u>, is attached as Exhibit 9.

16. A true and correct copy of The Guardian article titled "Texas Closes Hundreds of Polling Sites, Making it Harder for Minorities to Vote," by Richard Salame dated March 2, 2020, *available at* <u>https://bit.ly/37iiHJs</u>, is attached as Exhibit 10.

17. A true and correct copy of the Tex Med. article titled "An Unfortunate Legacy: COVID-19 Reveals Long-Standing Health Inequities," by Sean Price dated September 2020, is attached as Exhibit 11.

Dated: October 20, 2020 San Antonio, Texas

> <u>/s/ Sean Lyons</u> SEAN LYONS

Exhibit 1

United States Court of Appeals for the Fifth Circuit

United States Court of Appeals Fifth Circuit

FILED October 14, 2020

No. 20-50793

Lyle W. Cayce Clerk

MI FAMILIA VOTA; TEXAS STATE CONFERENCE OF THE NAACP; GUADALUPE TORRES,

Plaintiffs—Appellants,

versus

GREG ABBOTT, GOVERNOR OF THE STATE OF TEXAS; RUTH HUGHS, TEXAS SECRETARY OF STATE,

Defendants—Appellees.

Appeal from the United States District Court for the Western District of Texas USDC No. 5:20-CV-830

Before OWEN, *Chief Judge*, and DAVIS and SOUTHWICK, *Circuit Judges*. PRISCILLA R. OWEN, *Chief Judge*:

Mi Familia Vota, the Texas State Conference of the NAACP (NAACP), and Guadalupe Torres (collectively the Plaintiffs) appeal the dismissal of their claims challenging certain Texas voting procedures during the COVID-19 pandemic. We affirm the judgment of the district court in part, reverse the judgment with respect to the Voting Rights Act claim, and remand that claim.

Ι

Texas officials have taken steps to mitigate the risks associated with the COVID-19 pandemic that voters may encounter. Among these are advisories from the Secretary of State¹ and an Executive Order issued by Texas Governor Greg Abbott.²

The Secretary of State's office issued an advisory urging poll workers to wear face masks; recommending the use of signs to urge voters to wear face masks while at the polls; advising how to use markings or tape to facilitate social distancing; advising how to disinfect electronic voting equipment; suggesting that polling locations provide styluses or swabs or pencils with erasers or coffee stirrers for voters to use instead of touching electronic voting devices; and explaining that if a poll worker could not identify a masked voter, the worker could ask the voter to lower the mask briefly to facilitate identification. Other advice was offered concerning efforts that could and should be taken to mitigate exposure to and spread of COVID-19.

In July 2020, Governor Abbott issued Executive Order GA-29. That order expressed his views that

- "as Texas reopens in the midst of COVID-19, increased spread is to be expected, and the key to controlling the spread and keeping Texans safe is for all people to consistently follow good hygiene and social-distancing practices,"
- "due to recent substantial increases in COVID-19 positive cases, and increases in the COVID-19 positivity rate and

¹ See, e.g., Tex. Sec'y of State, Election Advisory No. 2020-19 (June 18, 2020); Tex. Sec'y of State, Election Advisory No. 2020-14 (Apr. 6, 2020).

² Executive Order GA-29 (July 2, 2020).

hospitalizations resulting from COVID-19, further measures are needed to achieve the least restrictive means for reducing the growing spread of COVID-19, and to avoid a need for more extreme measures,"

- "given the current status of COVD-19 in Texas, requiring the use of face coverings is a targeted response that can combat the threat to public health using the least restrictive means, and if people follow this requirement, more extreme measures may be avoided," and
- "wearing a face covering is important not only to protect oneself, but also to avoid unknowingly harming fellow Texans, especially given that many people who go into public may have COVID-19 without knowing it because they have no symptoms."³

That Executive Order, which went into effect July 3, 2020, provided:

Every person in Texas shall wear a face covering over the nose and mouth when inside a commercial entity or other building or space open to the public, or when in an outdoor public space, wherever it is not feasible to maintain six feet of social distancing from another person not in the same household.⁴

Failure to wear a mask under these conditions is punishable by a fine, but there are eleven enumerated exceptions or exemptions, including children younger than ten, those with medical conditions or disabilities, while eating or drinking or while seated at a restaurant to eat or drink, while engaging in exercise outdoors and maintaining social distancing, while voting

⁴ Id.

³ Id.

or assisting in the voting process, and while engaging in religious worship, "though a face covering is strongly recommended."⁵

The Plaintiffs filed suit in July, after this Executive Order issued. They allege that Black and Latino communities have been disproportionately impacted by COVID-19 because these communities have experienced higher infection, hospitalization, and death rates. They assert that Texas's policies and laws, "individually and cumulatively, operate to deny voters the right to vote in a safe, free, fair, and accessible election." Plaintiffs posit that long lines, the use of electronic voting devices rather than paper ballots, limited curbside voting, and the permissiveness of mask-wearing at polling locations present substantial health risks that create fear of voting and therefore infringe upon the right to vote. The Plaintiffs asserted causes of action under the Fourteenth Amendment's Due Process and Equal Protection Clauses, the First Amendment, the Fifteenth Amendment, and section Two of the Voting Rights Act.

Plaintiffs seek robust judicial involvement in Texas's elections, requesting an injunction ordering that Governor Abbott and Secretary of State Hughs take specific, affirmative actions, identified in the prayer for relief in their Complaint, which we quote in its entirety:

a. Order Defendants to modify in-person voting procedures during the early voting period and on Election Day to ensure that polling sites are safe and of low risk to the health of all registered voters, and specifically order that Defendants:

i. Extend the period of early voting to begin on October 5, 2020.

ii. Require voters, poll-workers, persons assisting voters, and any other person at a polling site to wear a mask,

⁵ Id.

including providing masks to persons who do not already have one, with exceptions only for individuals who cannot wear masks due to a disability;

iii. Allow counties to offer extended, temporary, and/or mobile early voting locations with flexible hours and days.

iv. Suspend the requirement that curbside voters must qualify as having a disability or, alternatively, order that any voter may identify as "disabled" due to the threat that the coronavirus poses to his or her health and life, for the purpose of being found eligible to vote curbside.

v. Open additional polling places and provide enough voting booths and poll workers at each polling place to ensure that voters are not required to wait more than twenty minutes to vote, to minimize coronavirus transmission.

vi. Staff all polling places with sufficient number of poll workers to keep voter lines to less than 20 minutes, including by actively recruiting new poll workers who are not at high risk for serious illness due to COVID-19.

vii. Prohibit the closure of polling places currently scheduled to be available on Election Day. Should a polling place need to be closed or moved in order to meet health and safety requirements, require that a new polling place be made available within the same voting precinct.

viii. In counties that use electronic voting machines, including counties that participate in the Countywide Polling place Program, make available sufficient numbers of both paper ballots and electronic voting machines so that voters have the option of voting by hand-marking a paper ballot or by voting on the electronic voting machine, to minimize the risk of coronavirus transmission.

ix. Revise voter identification requirements to allow voters to show identification without requiring poll workers to physically handle identification or documentation,

apply the natural disaster exception to the pandemic, and allow voters to sign affidavits regarding the natural disaster exception at the polling place.

x. Ensure that poll workers are given protective gear, including masks and gloves, in sufficient quantity to allow poll workers to change protective gear frequently. Provide poll workers with ample opportunity to wash their hands.

b. Order Defendants to enable counties that need to revise election policies in order to protect voters' health to do so, provided that the proposed revisions do not violate any relief ordered by this Court.

c. Order Defendants to rescind or modify any voting practice or procedure deemed by this Court to unlawfully discriminate against Black, Latino, or other underserved voters on the basis of a protected characteristic, to eliminate such discrimination.

d. Order that all such relief be extended until there are no existing cases of coronavirus in the state of Texas; or until there is a vaccine freely and readily available to all Texans, whichever comes sooner.

In their motion for a preliminary injunction, the Plaintiffs made clear that the bases for the request for injunctive relief were only the First Amendment and the Due Process Clause of the Fourteenth Amendment. They explained that "[a]lthough Plaintiffs' complaint also alleges violations of the Equal Protection Clause, Fifteenth Amendment, and Section 2 of the Voting Rights Act based on race or ethnicity, Compl. ¶¶ 202-07, those claims do not form the basis of this motion."

In their brief before this court, the Plaintiffs have abandoned their request that early voting be ordered to begin on October 5, 2020, and have narrowed their challenge to Executive Order GA-29 and four sections of the Texas Election Code:

- Executive Order GA-29, requiring masks to be worn in public places but exempting voters and poll workers.
- Texas Election Code section 64.009, permitting voters who are "physically unable to enter" polling locations to vote curbside.
- Texas Election Code section 43.007, permitting certain counties to participate in Texas's Countywide Polling Place Program if those counties meet particular criteria, including the use of electronic voting machines, which means that those counties do not provide paper ballots.
- Texas Election Code sections 85.062-85.063, concerning the number and location of polling places during early voting.

The district court granted the State's motion to dismiss, holding that the case presented non-justiciable political questions. Governor Abbott and Secretary Hughs maintain that the dismissal was appropriate on other grounds as well, including sovereign immunity and lack of standing. We review all of these issues de novo.

II

The Supreme Court's most recent decision addressing whether an issue constituted a political question is *Rucho v. Common Cause*, in which the Court held that claims of excessive partisanship in districting are not justiciable.⁶ In *Rucho*, legislatures in two states had enacted congressional redistricting plans that were "highly partisan, by any measure."⁷ The Supreme Court framed the issue before it as "whether there is an

⁶ 139 S. Ct. 2484, 2491 (2019).

⁷ *Id*. at 2491.

'appropriate role for the Federal Judiciary' in remedying the problem of partisan gerrymandering-whether such claims are claims of *legal* right, resolvable according to *legal* principles, or political questions that must find The Court concluded that partisan their resolution elsewhere."8 gerrymandering claims constitute political questions because they "lack 'judicially discoverable and manageable standards for resolving [them]."'9 The Court explained that "[f]ederal judges have no license to reallocate political power between the two major political parties, with no plausible grant of authority in the Constitution, and no legal standards to limit and direct their decisions."¹⁰ The Court emphasized that "'[j]udicial action must be governed by standard, by rule,' and must be 'principled, rational, and based upon reasoned distinctions' found in the Constitution or laws."¹¹ The Rucho decision strongly indicates that, by contrast, race discrimination and Voting Rights Act claims, like those asserted by the Plaintiffs, do not present political questions.

In *Rucho*, the Supreme Court recognized that "[i]n two areas—oneperson, one-vote and racial gerrymandering—our cases have held that there is a role for the courts with respect to at least some issues that could arise from a State's drawing of congressional districts."¹² The *Rucho* decision recognized that "[l]aws that explicitly discriminate on the basis of race, as well as those that are race neutral on their face but are unexplainable on

⁹ Id.

¹² *Id.* at 2495-96.

⁸ *Id*. at 2494.

¹⁰ *Id*. at 2507.

¹¹ *Id.* (quoting *Vieth v. Jubelirer*, 541 U.S. 267, 296-97 (2004) (plurality opinion)).

grounds other than race, are of course presumptively invalid."¹³ The Court recounted that it had applied those principles in "concluding that a challenge to an 'uncouth twenty-eight sided' municipal boundary line that excluded black voters from city elections stated a constitutional claim."¹⁴ Well-established standards exist and have been applied in cases of race discrimination but not to partisan gerrymandering, *Rucho* noted. "[O]ur country's long and persistent history of racial discrimination in voting—as well as our Fourteenth Amendment jurisprudence … has reserved the strictest scrutiny for discrimination on the basis of race."¹⁵

Our court has set forth the standards that govern a discriminatory effect claim under section 2 of the Voting Rights Act:

[1] [T]he challenged standard, practice, or procedure must impose a discriminatory burden on members of a protected class, meaning that members of the protected class have less opportunity than other members of the electorate to participate in the political process and to elect representatives of their choice, [and]

[2] [T]hat burden must in part be caused by or linked to social and historical conditions that have or currently produce discrimination against members of the protected class.¹⁶

We conclude that the Plaintiffs' racial discrimination and Voting Rights Act claims do not present political questions. We do not consider whether the Plaintiffs' remaining claims constitute political questions

¹³ *Id*. at 2496.

¹⁴ Id.

¹⁵ *Id.* at 2502.

¹⁶ Veasey v. Abbott, 830 F.3d 216, 244 (5th Cir. 2016).

because all of their claims were properly dismissed on other grounds.

III

Governor Abbott and Secretary Hughs assert sovereign immunity based on the Eleventh Amendment because a suit against a state official in her official capacity is essentially a suit against the State. However, the Supreme Court's decision in *Ex parte Young*¹⁷ allows injunctive or declaratory relief against a state official in her official capacity, provided the official has a sufficient "connection" with the enforcement of an allegedly unconstitutional law.¹⁸

We first consider the claims other than those based on the Voting Rights Act and conclude that the Governor does not have authority to enforce, or a role to play in enforcing, the Election Code provisions or the executive order at issue. The Governor of Texas has no connection, statutory or otherwise, to the enforcement of sections 64.009, 43.007, 85.062, or 85.063 of the Texas Election Code.

Governor Abbott promulgated Executive Order GA-29. But the statutory authority under Texas Government Code § 418.012 to issue, amend or rescind an Executive Order¹⁹ "is not the power to enforce it," as

¹⁷ 209 U.S. 123, 157 (1908) ("In making an officer of the state a party defendant in a suit to enjoin the enforcement of an act alleged to be unconstitutional, it is plain that such officer must have some connection with the enforcement of the act, or else it is merely making him a party as a representative of the state, and thereby attempting to make the state a party.").

¹⁸ In re Abbott, 956 F.3d 696, 708 (5th Cir. 2020).

¹⁹ TEX. GOV. CODE § 418.012 ("Under this chapter, the governor may issue executive orders, proclamations, and regulations and amend or rescind them. Executive orders, proclamations, and regulations have the force and effect of law.").

this court explained in *In re Abbott*.²⁰ For example, were a court to conclude that the exclusion from the mask requirement in Executive Order GA-29 for voters and poll workers was unconstitutional, the Governor would have no authority to fine those who refused to wear a mask while in polling places. Enforcement actions would be undertaken by local authorities. There is no suggestion in any statutes or regulations that Governor Abbott has authority to enforce or would play a role in enforcing the executive order at issue.²¹ The Secretary of State of Texas similarly has no connection to the enforcement of Executive Order GA-29, or Texas Election Code §§ 85.062-85.063.

The Secretary of State's connection to Texas Election Code § 43.007, however, requires more detailed analysis. Section 43.007 requires counties to use electronic voting devices rather than paper ballots in order to be eligible to participate in Texas's Countywide Polling Place Program.²² The Secretary of State is required by Texas Election Code § 31.014 to provide standards for certifying electronic devices and may exclude counties whose electronic voting devices do not meet certain standards from the Program. Section 31.014 references section 43.007 multiple times. One relevant subsection provides, in part, that the Secretary

shall adopt rules that require a device described by this section used during the early voting period or under the countywide

²⁰ 956 F.3d at 709.

²¹ See Morris v. Livingston, 739 F.3d 749, 746 (5th Cir. 2014) ("Section 501.063 does not specially task Governor Perry with its enforcement, or suggest that he will play any role at all in its enforcement.").

²² TEX. ELECTION CODE § 43.007(d)(4) ("The secretary of state shall select to participate in the program each county that: ... uses direct recording electronic voting machines").

polling place program under Section 43.007 to update data in real time. If a county uses a device that does not comply with the rule in two consecutive general elections for state and county officers, the secretary of state shall assess a noncompliance fee. The noncompliance fee shall be set at an amount determined by secretary of state rule.²³

But the Plaintiffs' claim regarding section 43.007 is based on its prohibition of the use of paper ballots for those counties participating in the Countywide Polling Place Program. If a court were to conclude that electronic voting as the exclusive means of voting was unconstitutional as applied to the Plaintiffs, the court could order the Secretary not to enforce that requirement. But that still would not *require* counties who currently are participating in the Countywide Polling Place Program to print and use paper ballots. The Secretary is not responsible for printing or distributing ballots.²⁴ That responsibility falls on local officials. It would remain their choice as to whether to incur the expense of printing, distributing and counting paper ballots instead of utilizing the electronic devices they already have in place.

Directing the Secretary not to enforce the electronic-voting-devicesonly provision in section 43.007 would not afford the Plaintiffs the relief that they seek, and therefore, the Secretary of State "is not a proper defendant."²⁵ Although a court can enjoin state officials from enforcing statutes, such an injunction must be directed to those who have the authority to enforce those statutes. In the present case, that would be county or other local officials. No

²³ Tex. Election Code § 31.014(c).

²⁴ See TEX. ELECTION CODE §§ 52.002, 31.043; see also In re Cercone, 323 S.W.3d 293, 294 (Tex. App. 2010) (pet. denied) (recognizing, in a suit regarding an election in Dallas County, that the "Elections Administrator for Dallas County ... is responsible for printing and mailing the general election ballots").

²⁵ In re Abbott, 956 F.3d 696, 709 (5th Cir. 2020) (quoting Morris, 739 F.3d at 746).

county or local official is a party to the current suit and cannot be enjoined in this suit to print and use paper ballots.

Accordingly, with the exception of the Voting Rights Act claim, the Eleventh Amendment bars all the claims against Governor Abbott and Secretary Hughs. There is no sovereign immunity with respect to the Voting Rights Act claims. Our court has held that the Voting Rights Act, "which Congress passed pursuant to its Fifteenth Amendment enforcement power, validly abrogated state sovereign immunity."²⁶

IV

Much of the relief sought by the Plaintiffs to remedy the alleged Voting Rights Act injuries and the injuries from alleged constitutional violations (were they not barred by sovereign immunity) is beyond the power of a court to grant. It is one thing for a court to strike down a law that violates the Voting Rights Act or the Constitution and to enjoin a state official from enforcing it. It is entirely another matter for a court to order an executive performing executive functions, or an executive performing essentially legislative functions, to promulgate directives mandated by the court. Of course, federal courts may draw redistricting maps in certain limited circumstances,²⁷ but that narrow exception does not provide authority for courts to order state officials to promulgate legislation, regulations or executive orders. Even in redistricting cases, the "primary locus of responsibility" for promulgating legislation "does not shift" to federal

²⁶ OCA-Greater Hous. v. Texas, 867 F.3d 604, 614 (5th Cir. 2017); see also Fusilier v. Landry, 963 F.3d 447, 455 (5th Cir. 2020).

²⁷ See, e.g., League of United Latin Am. Citizens v. Perry, 548 U.S. 399, 415 (2006); Wise v. Lipscomb, 437 U.S. 535, 540 (1978).

courts.28

The Texas Legislature has given Governor Abbott the authority to issue executive orders in times of emergencies,²⁹ and those orders have the force of a law.³⁰ But a court cannot compel the Governor to issue orders as a means of redressing claims under the Voting Rights Act or the Constitution. Neither the Fifteenth Amendment nor any other provision in the Constitution permits a court to dictate to legislative bodies or executives what laws and regulations they must promulgate.

As the Sixth Circuit has explained:

Federal Courts do have jurisdiction and power to pass upon the constitutionality of Acts of Congress, but we are not aware of any decision extending this power in Federal Courts to order Congress to enact legislation. To do so would constitute encroachment upon the functions of a legislative body and would violate the time-honored principle of separation of powers of the three great departments of our Government. This principle is equally applicable to the power of a Federal Judge to order a state legislative body to enact legislation. The enactment of legislation is not a ministerial function subject to control by mandamus, prohibition or the injunctive powers of a court.³¹

²⁹ Tex. Gov. Code § 418.014.

³⁰ TEX. GOV. CODE § 418.012 ("Under this chapter, the governor may issue executive orders, proclamations, and regulations and amend or rescind them. Executive orders, proclamations, and regulations have the force and effect of law.").

³¹ Smith & Lee Assoc., Inc. v. City of Taylor, 102 F.3d 781, 797 (6th Cir. 1996) (quoting Joseph Skillken & Co. v. City of Toledo, 528 F.2d 867, 878 (6th Cir.1975), vacated and remanded sub. nom. Joseph Skilken & Co. v. City of Toledo, Ohio, 429 U.S. 1068 (1977), decision adhered to on remand, 558 F.2d 350 (6th Cir.1977)).

²⁸ LULAC, 548 U.S. at 415.

In *City of Taylor*, the district court had ordered the City to amend its zoning ordinance to adopt the court's definition of "family."³² The Sixth Circuit held that "the District Court exceeded its proper scope of authority when it" did so, "remind[ing] district courts that Article III powers are finite."³³

The Ninth Circuit has held that principles of federalism do not permit federal courts to order relief that would require the Governor of a State to essentially enact legislation.³⁴ In *M.S. v. Brown*, the Oregon legislature had passed a statute permitting the issuance of driver's cards to individuals who could not prove they were United States citizens,³⁵ but the voters of that state had exercised their referendum power to reject that legislation, and accordingly, the law had never gone into effect.³⁶ The plaintiff argued that the referendum was motivated by racial animus and sought relief ordering the Governor of Oregon to issue driver's cards in accordance with the legislation that had been rejected by the voters.³⁷ The Ninth Circuit affirmed the district court's dismissal of the claims, reasoning "[i]n particular, we have explained that '[p]rinciples of federalism counsel against' awarding 'affirmative injunctive and declaratory relief' that would require state officials to repeal an existing law and enact a new law proposed by plaintiffs."³⁸

³² Id.

³³ Id.

³⁶ *Id.* at 1084.

³⁷ *Id.* at 1081-82.

³⁴ *M.S. v. Brown*, 902 F.3d 1076, 1089 (9th Cir. 2018).

³⁵ *Id.* at 1086.

³⁸ Id. at 1089 (quoting Jacobson v. Tahoe Reg'l Plan. Agency, 566 F.2d 1353, 366 (9th Cir. 1977), aff'd in part, rev'd in part on other grounds sub nom. Lake Country Estates, Inc. v. Tahoe Reg'l Plan. Agency, 440 U.S. 391 (1979)).

An examination of the relief that the Plaintiffs seek in the case before us reveals that in many instances, court-ordered-relief would require the Governor or the Secretary of State to issue an executive order or directive or to take other sweeping affirmative action. If implemented by the district court, many of the directives requested by the Plaintiffs would violate principles of federalism.

In *M.S. v. Brown*, the Ninth Circuit stated in dicta that "federal courts have jurisdiction to order a remedy requiring the enactment of legislation in certain narrow circumstances, such as where fundamental rights are at stake."³⁹ We do not consider today whether there might be such narrow circumstances and if so, what they might be.

V

The Plaintiffs' Voting Rights Act claim does not present a political question and is not barred by sovereign immunity. The remaining question is whether relief could be granted by the district court at this time that would redress their alleged injury, were the district court to conclude that there has been a Voting Rights Act violation.

As discussed above, the district court would not have authority to order the Governor or Secretary of State to promulgate regulations or legislation. To the extent that the requests for relief specified in the Complaint would not fall within that category of relief, we are mindful of the Supreme Court's repeated admonishment that "lower federal courts should ordinarily not alter the election rules on the eve of an election."⁴⁰

The Plaintiffs seek to overhaul Texas's voting scheme. Early voting

³⁹ *Id.* at 1087.

⁴⁰ Republican Nat'l Comm. v. Democratic Nat'l Comm., 140 S. Ct. 1205, 1207 (2020).

in Texas commenced October 13, 2020. The changes sought by the Plaintiffs by and large would up-end the process. In large measure, it would be a futile act to remand the Voting Rights Act claim for plenary consideration with regard to the November 2020 election because it would be inappropriate for the district court to grant much of the requested relief with the election ongoing.

We see a possible exception, however, with regard to the November 2020 election. Were the district court to conclude that the exemption from wearing a mask in public places contained in Executive Order GA-29 for poll workers, voters, and others in polling places violated section 2 of the Voting Rights Act, the district court might excise that provision if it concluded that this would redress the injuries the Plaintiffs have alleged. It is at least conceivable that such a remedy would not materially or substantially affect the ongoing election, but that would be a matter for the district court to determine.

We accordingly reverse the district court's judgment in part and remand the Voting Rights Act claim for further proceedings in the district court, consistent with this opinion.

* * *

We AFFIRM the judgment of the district court in part. We REVERSE the district court's judgment with regard to the Voting Rights Act claim and REMAND that claim to the district court.

Exhibit 2



GOVERNOR GREG ABBOTT

July 2, 2020

The Honorable Ruth R. Hughs Secretary of State State Capitol Room 1E.8 Austin, Texas 78701



Dear Secretary Hughs:

Pursuant to his powers as Governor of the State of Texas, Greg Abbott has issued the following:

Executive Order No. GA-29 relating to the use of face coverings during the COVID-19 disaster.

The original executive order is attached to this letter of transmittal.

Respectfully submitted,

Gregory S. Davidson Executive Clerk to the Governor

Attachment

GSD/gsd

POST OFFICE BOX 12428 AUSTIN, TEXAS 78711 512-463-2000 (VOICE) DIAL 7-1-1 FOR RELAY SERVICES



BY THE GOVERNOR OF THE STATE OF TEXAS

> Executive Department Austin, Texas July 2, 2020

EXECUTIVE ORDER GA 29

Relating to the use of face coverings during the COVID-19 disaster.

WHEREAS, I, Greg Abbott, Governor of Texas, issued a disaster proclamation on March 13, 2020, certifying under Section 418.014 of the Texas Government Code that the novel coronavirus (COVID-19) poses an imminent threat of disaster for all counties in the State of Texas; and

WHEREAS, in each subsequent month effective through today, I have renewed the disaster declaration for all Texas counties; and

WHEREAS, the Commissioner of the Texas Department of State Health Services (DSHS), Dr. John Hellerstedt, has determined that COVID-19 continues to represent a public health disaster within the meaning of Chapter 81 of the Texas Health and Safety Code; and

WHEREAS, I have issued executive orders and suspensions of Texas laws in response to COVID-19, aimed at using the least restrictive means available to protect the health and safety of Texans and ensure an effective response to this disaster; and

WHEREAS, as Texas reopens in the midst of COVID-19, increased spread is to be expected, and the key to controlling the spread and keeping Texans safe is for all people to consistently follow good hygiene and social-distancing practices; and

WHEREAS, due to recent substantial increases in COVID-19 positive cases, and increases in the COVID-19 positivity rate and hospitalizations resulting from COVID-19, further measures are needed to achieve the least restrictive means for reducing the growing spread of COVID-19, and to avoid a need for more extreme measures; and

WHEREAS, I have joined the medical experts in consistently encouraging people to use face coverings, and health authorities have repeatedly emphasized that wearing face coverings is one of the most important and effective tools for reducing the spread of COVID-19; and

WHEREAS, given the current status of COVID-19 in Texas, requiring the use of face coverings is a targeted response that can combat the threat to public health using the least restrictive means, and if people follow this requirement, more extreme measures may be avoided; and

WHEREAS, wearing a face covering is important not only to protect oneself, but also to avoid unknowingly harming fellow Texans, especially given that many people who go into public may have COVID-19 without knowing it because they have no symptoms; and

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Governor Greg Abbott July 2, 2020 *Executive Order GA-29* Page 2

WHEREAS, the "governor is responsible for meeting ... the dangers to the state and people presented by disasters" under Section 418.011 of the Texas Government Code, and the legislature has given the governor broad authority to fulfill that responsibility; and

WHEREAS, failure to comply with any executive order issued during the COVID-19 disaster is an offense punishable under Section 418.173 by fine;

NOW, THEREFORE, I, Greg Abbott, Governor of Texas, by virtue of the power and authority vested in me by the Constitution and laws of the State of Texas, do hereby order the following on a statewide basis effective at 12:01 p.m. on July 3, 2020:

Every person in Texas shall wear a face covering over the nose and mouth when inside a commercial entity or other building or space open to the public, or when in an outdoor public space, wherever it is not feasible to maintain six feet of social distancing from another person not in the same household; *provided, however, that this face-covering requirement does not apply to the following*:

- 1. any person younger than 10 years of age;
- 2. any person with a medical condition or disability that prevents wearing a face covering;
- 3. any person while the person is consuming food or drink, or is seated at a restaurant to eat or drink;
- any person while the person is (a) exercising outdoors or engaging in physical activity outdoors, and (b) maintaining a safe distance from other people not in the same household;
- 5. any person while the person is driving alone or with passengers who are part of the same household as the driver;
- any person obtaining a service that requires temporary removal of the face covering for security surveillance, screening, or a need for specific access to the face, such as while visiting a bank or while obtaining a personalcare service involving the face, but only to the extent necessary for the temporary removal;
- 7. any person while the person is in a swimming pool, lake, or similar body of water;
- any person who is voting, assisting a voter, serving as a poll watcher, or actively administering an election, but wearing a face covering is strongly encouraged;
- 9. any person who is actively providing or obtaining access to religious worship, but wearing a face covering is strongly encouraged;
- 10. any person while the person is giving a speech for a broadcast or to an audience; or

11. any person in a county (a) that meets the requisite criteria promulgated by FILED IN THE OFFICE OF THE SECRETARY OF STATE 2:30 (m) 0'CLOCK

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Governor Greg Abbott July 2, 2020 Executive Order GA-29 Page 3

the Texas Division of Emergency Management (TDEM) regarding minimal cases of COVID-19, and (b) whose county judge has affirmatively opted-out of this face-covering requirement by filing with TDEM the required face-covering attestation form—provided, however, that wearing a face covering is highly recommended, and every county is strongly encouraged to follow these face-covering standards.

Not excepted from this face-covering requirement is any person attending a protest or demonstration involving more than 10 people and who is not practicing safe social distancing of six feet from other people not in the same household.

TDEM shall maintain on its website a list of counties that are not subject to this face-covering requirement pursuant to paragraph number 11. The list can be found at: <u>www.tdem.texas.gov/ga29</u>.

Following a verbal or written warning for a first-time violator of this facecovering requirement, a person's second violation shall be punishable by a fine not to exceed \$250. Each subsequent violation shall be punishable by a fine not to exceed \$250 per violation.

Local law enforcement and other local officials, as appropriate, can and should enforce this executive order, Executive Order GA-28, and other effective executive orders, as well as local restrictions that are consistent with this executive order and other effective executive orders. But no law enforcement or other official may detain, arrest, or confine in jail any person for a violation of this executive order or for related non-violent, non-felony offenses that are predicated on a violation of this executive order; provided, however, that any official with authority to enforce this executive order may act to enforce trespassing laws and remove violators at the request of a business establishment or other property owner.

This executive order hereby prohibits confinement in jail as a penalty for the violation of any face-covering order by any jurisdiction.

Executive Order GA-28 is hereby amended to delete from paragraph number 15 the phrase: ", but no jurisdiction can impose a civil or criminal penalty for failure to wear a face covering."

The governor may by proclamation amend this executive order or add to the list of people to whom this face-covering requirement does not apply.

This executive order does not supersede Executive Orders GA-10, GA-13, GA-17, GA-19, GA-24, GA-25, GA-27, or GA-28 as amended. This executive order shall remain in effect and in full force until modified, amended, rescinded, or superseded by the governor.

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Governor Greg Abbott July 2, 2020 *Executive Order GA-29* Page 4



Given under my hand this the 2nd day of July, 2020.

appart

GREG ABBOTT Governor

ATTESTED BY: RUTH R. HUGHS

RUTH R. HUGHS Secretary of State

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> > JUL 0 2 2020

Exhibit 3

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The State of Texas

Elections Division P.O. Box 12060 Austin, Texas 78711-2060 www.sos.texas.gov www.votetexas.gov



Phone: 512-463-5650 Fax: 512-475-2811 Dial 7-1-1 For Relay Services (800) 252-VOTE (8683)

Ruth R. Hughs Secretary of State

ELECTION ADVISORY

<u>NO. 2020-19</u>

TO: County Clerks/Elections Administrators and County Chairs

FROM: Keith Ingram, Director of Elections

DATE: June 18, 2020

RE: Voting In Person During COVID-19

Background

The purpose of this advisory is to assist election officials to prepare for and facilitate in-person voting during the current public health crisis caused by the novel coronavirus (COVID-19). This advisory is intended to supplement our office's guidance in <u>Election Advisory No. 2020-14</u> (issued on April 6, 2020) and the <u>recommended health protocols</u> for Texas election officials and voters in response to COVID-19 (issued on May 26, 2020). We will address curbside voting and ballot-by-mail procedures in separate advisories.

Given the rapidly changing nature of the ongoing public health disaster, this guidance may be updated or supplemented as additional information becomes available.

Precinct Requirements

July 14, 2020 Elections

For a primary runoff election, county election precincts may be consolidated pursuant to Section 42.009 of the Texas Election Code ("the Code"). The consolidation of precincts is subject to Section 42.005 (officer-line rule), which means that each consolidated precinct must only have one ballot style. With a consolidated precinct, the county election precincts become a single larger precinct; the results are reported by the consolidated precinct rather than for each individual precinct. If you are participating in the countywide polling place program, and you have opted to use countywide voting for the primary runoff election, you may only consolidate to a minimum of four locations. In addition, Section 43.007(m)(1) requires that each county in the countywide polling place program have at least one countywide polling location in each commissioners precinct.

Case 5:20-cv-00830-JKP Document 53-5 Filed 10/20/20 Page 31 of 136 November 3, 2020 Elections

In a general election for state and county officers, counties are required to use county election precincts as their election-day precincts. The Code does not authorize the consolidation of precincts in a general election. However, a county may combine certain precincts for a general election in accordance with Section 42.0051 if it has county election precincts with less than 500 registered voters. (In a county with a population of 250,000 or more, combination may occur if there are less than 750 registered voters in a precinct.) Counties can combine these precincts with other precincts to avoid unreasonable expenditures for election equipment, supplies, and personnel. When combining county election precincts, the individual precincts, ballots, and records stay separated by precinct, but you have one single polling place, with one team of judges and clerks that serves both precincts.

As a reminder, any combination of precincts must comply with applicable state and federal law, including the Voting Rights Act. (Section 42.0051(d)). The county does not need to obtain approval from our office to combine precincts.

Polling Places

Public Buildings as Polling Places

Pursuant to Section 43.031 of the Code, each polling place shall be located inside a building and that building shall be a public building, if practicable. A public building is defined as any "building owned or controlled by the state or a political subdivision," including cities and schools. (Section 43.031(a)). Section 43.031(c) requires an entity that owns or controls a public building to make the building available for use as a polling place in any election that covers territory in which the building is located. If an entity that owns or operates a public building is closed due to concerns or orders relating to COVID-19, the entity still may need to make its building available for use as a polling place.

When choosing public buildings that can accommodate social distancing, as recommended by the Centers for Disease Control and Prevention (CDC), consider using large spaces, such as publicly owned community centers, school cafeterias, and gymnasiums. It may be possible to continue using existing polling locations for upcoming elections. However, where possible, election officials should consider relocating polling places to larger venues if doing so will facilitate social distancing.

An entity that owns or controls a public building may not charge for any expenses associated with the use of the facility as a polling place if election day is a day on which the building is normally open for business. If the building is not normally open for business on election day, a charge may be made only for reimbursement for the actual expenses resulting from the use of the building in the election. (Section 43.033). If building owners express concerns over utilizing their buildings as polling places, our office recommends that election officials discuss these concerns with the owners to determine their specific concerns and how they may best be addressed.

Private Buildings as Polling Places

If a suitable public building is unavailable for use, the polling place may be located in another building, including churches, clubhouses, private community centers, and grocery stores. (Section 43.031(d)). Consistent with Governor Greg Abbott's <u>Executive Order No. GA-26</u>, our office strongly recommends that nursing homes, senior centers, and residential care facilities not be used

Case 5:20-cv-00830-JKP Document 53-5 Filed 10/20/20 Page 32 of 136 as polling places if they are currently occupied with residents. If election officials customarily use these facilities as polling places but move to a different location, you should work with facility representatives to provide information to voters about voting in person at the new location and, if eligible, voting by mail.

Notice of Polling Location Changes

Given the ongoing public health crisis, different polling locations may have to be utilized to accommodate voter turnout, as well as to ensure the health and safety of voters and election workers. If a polling place changes for the November general election after notice of the election is given under Section 4.003 of the Code, the county election official must provide notice of a polling location change. (Section 43.061). The amended notice must be posted or given no later than the earlier of 24 hours after the location is changed or 72 hours before the polls open on election day. The county election official must provide notice of the location change by posting this information on the county election website or by notifying each candidate on the ballot (or, for a position representing multiple counties: the county chair; for an independent candidate: the county judge).

For the November uniform election and the primary runoff elections, if a different polling place is being used from the previous election held by the same authority, a <u>Notice of Previous Precinct</u> (<u>PDF</u>) must be posted at the entrance of the previous polling place informing voters of the current polling place location, if possible. (Section 43.062).

Additionally, any websites that contain polling location information should be updated as needed. If your county uses social media to provide polling place information, your posts should direct voters back to your official website to ensure only official, accurate, and authorized information is being disseminated to the public. We recommend posting on your website an alert to voters that the information is subject to change, and that they should check back before going to vote. We suggest you develop a plan for working with local media to keep the public informed of polling location changes. Finally, if any changes are made to polling locations, make sure to notify the Secretary of State's office and submit the changes to TEAM so that all polling locations are properly updated in the online public listings.

Inside the Polling Place

Social Distancing

In accordance with the CDC's <u>recommendations for social distancing</u>, our office recommends that polling locations be set up in a way that allows voters to practice social distancing by spacing themselves at least 6 feet apart. This may be accomplished by using tape or chalk to mark adequate spacing on polling place floors or providing directional markings so voters know where to go as they move through the line. Before making any markings to the facility, we recommend that election officials discuss the markings with the building owner. When setting up a polling place, election workers may place tape or draw lines (with chalk) every 6 feet to encourage voters to practice social distancing. Please provide instructions and supplies, if applicable, to election workers to assist with removing the chalk or tape when closing the location at the end of the voting period. Election officials also may need to evaluate the location of power outlets in the voting area and utilize extension cords or power strips to allow for more spacing between equipment.

If a polling place is being used for business other than voting, such as a grocery store, and there are lines to enter the location, consider forming two separate lines; one for patrons waiting to enter

Case 5:20-cv-00830-JKP Document 53-5 Filed 10/20/20 Page 33 of 136 the building and one for individuals waiting to vote. Additionally, in order to ensure a voter's health, safety, and privacy, a polling place may limit the number of people inside a building to a certain number, so long as the line is able to continue safely outside. When forming lines for voters outside of a polling place, please remember to take weather factors into consideration.

Cleaning and Sanitizing Polling Places

The CDC has issued <u>recommendations</u> for preventing the spread of coronavirus specifically in election polling locations. Here are a few of their specific suggestions:

- Encourage workers to wash their hands frequently with soap and water for at least 20 seconds. If soap and water are not readily available, use an alcohol-based hand sanitizer that contains at least 60% alcohol.
- Practice routine cleaning of frequently touched surfaces with household cleaning spray or wipes, including tables, doorknobs, light switches, handles, desks, toilets, faucets, and sinks.
- Disinfect surfaces that may be contaminated with germs after cleaning: A list of products with EPA-approved emerging viral pathogens claims is available on the EPA's <u>website</u>. Products with EPA-approved emerging viral pathogens claims are expected to be effective against the virus that causes COVID-19 based on data for harder to kill viruses. Follow the manufacturer's instructions for all cleaning and disinfection products (e.g., concentration, application method and contact time, use of personal protective equipment).

The guidelines reproduced here are examples. Please read the CDC's guidance in full as you work to ensure a safe environment for all voters and election workers.

Voter Check-in and Qualification Process

During the ongoing public health crisis, our primary concern is the health and safety of voters, election workers, and local election officials and their staff. Below are ways our office believes election officials can ensure safety for election workers and voters.

This list is not exhaustive and may be expanded to include other options that are specific to a county's individual processes. In addition, you should review our office's guidance on recommended health protocols for Texas election officials and voters, issued on May 26, 2020.

Election Worker Health and Safety

Election officials may consider screening all employees or polling place workers prior to entering an elections office or polling place. This may be accomplished by taking the temperature of employees and polling place workers prior to entering the polling place or office and/or by asking such individuals to self-screen on a daily basis. The checklist provided in our <u>health protocols</u> can be provided to election workers for self-screening purposes.

Our health protocols identified the following signs or symptoms of possible COVID-19:

- Cough
- Shortness of breath or difficulty breathing
- Chills
- Repeated shaking with chills
- Muscle pain
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- Headache
- Sore throat
- Loss of taste or smell
- Diarrhea
- Feeling feverish or a measured temperature greater than or equal to 100.0 degrees Fahrenheit
- Known close contact with a person who is lab-confirmed to have COVID-19

Please continue to monitor guidance from the CDC and the Texas Department of State Health Services regarding COVID-19 symptoms, as public health recommendations may be updated or supplemented in the future.

Employees and polling place workers should wash or sanitize their hands upon entering the election office or polling place, and between interactions with voters or other personnel. While working, employees and polling place workers should maintain at least six feet separation from other individuals not within the same household, to the extent feasible. In addition to encouraging the practice of such social distancing when feasible, other measures such as hand hygiene, cough etiquette, cleanliness, and sanitation should be rigorously practiced.

If any employee or polling place worker develops signs or symptoms of COVID-19 while at work, send the worker home immediately and clean and sanitize the areas in which the person was working. Do not allow employees or polling place workers with new or worsening signs or symptoms of COVID-19 to return to a polling place or election office until:

- In the case of an employee or polling place worker who was diagnosed with COVID-19, the individual may return to work when all three of the following criteria are met:
 - at least 3 days (72 hours) have passed since recovery (resolution of fever without the use of fever-reducing medications); and
 - the individual has improvement in symptoms (e.g., cough, shortness of breath); and
 - at least 10 days have passed since symptoms first appeared; or
- In the case of an employee or polling place worker who has symptoms that could be COVID-19 and does not get evaluated by a medical professional or tested for COVID-19, the individual is assumed to have COVID-19, and the individual may not return to work until the individual has completed the same three-step criteria listed above; or
- If an employee or polling place worker has symptoms that could be COVID-19 and wants to return to work before completing the above self-isolation period, the individual must obtain a medical professional's note clearing the individual for return based on an alternative diagnosis.

To ensure that polling places have adequate workers, we strongly recommend that you work with your party officials to ensure that there are backup election workers available to replace any workers who are sick or unable to work. If both the presiding judge and alternate judge are unavailable to serve and this is discovered after the 20th day before election day, the presiding officer of the appointing authority, or if the presiding officer is unavailable, the authority responsible for distributing supplies for the election, shall appoint a replacement judge. (Section 32.007). Additionally, if the authority is unable to find an election judge who is a qualified voter of the specific precinct needing a judge, the authority may appoint individuals that meet the eligibility requirements of an election clerk, which encompasses a broader territory. (Section 32.051(b)). Please see Advisory <u>2020-14</u> for more details.

Case 5:20-cv-00830-JKP Document 53-5 Filed 10/20/20 Page 35 of 136 Personal Protective Equipment for Workers

Many jurisdictions have issued personal protective equipment (PPE) to their election workers. Based on recommendations from the Texas Department of Emergency Management (TDEM), we believe that face coverings, hand sanitizer, and disinfectant wipes are likely to be the most beneficial PPE for election workers and voters.

- Face Coverings: We strongly encourage all election workers to wear face masks or face shields throughout the election period when serving as an election worker. The authority appointing election judges may want to consider establishing guidelines for the use of face coverings by employees and election workers. For primary runoff elections, this authority is the county chair. (Section 32.006). For the general election for state and county officers, this authority is the commissioners court. (Section 32.051(a)(2)). For early voting workers, the authority is the early voting clerk. (Section 83.032). Election officials may want to consider providing plastic face shields as an alternative for election workers who are unable or hesitant to wear cloth or paper face masks. We also recommend allowing workers to periodically take breaks outside of the voting area to allow them time to remove their protective face coverings. For guidance on how workers can disinfect and reuse face coverings, please consult the following CDC resources:
 - <u>Use of Cloth Face Coverings to Help Slow the Spread of COVID-19</u>
 - Decontamination and Reuse of Filtering Facepiece Respirators
- Plastic Guards for Check-in Stations: Election officials may consider installing plastic guards at check-in tables so long as they do not interfere with the check-in process. Protective plastic guards can allow a voter to show their identification to the election worker and complete the check-in process with minimal physical contact, if any. Additionally, plastic guards can provide an alternative form of protection for election workers who are unable to wear a face mask. Election officials may also want to consider alternating workers at the check-in station if they have workers who are unable or hesitant to wear a face mask.
- **Poll Worker Training:** We recommend that counties incorporate health and safety considerations in their training of poll workers for upcoming elections. This training should provide instructions on cleaning and sanitizing the polling location, including the sanitizing of voting systems and electronic pollbook equipment. We recommend that you also provide training on health protocols, including proper social distancing, wearing and removing masks and other applicable personal protective equipment, and hand washing or the use of hand sanitizer.

Voter Health and Safety

The Texas Election Code does not authorize an election judge to ask a voter about their health history. This means that election workers cannot require a voter's temperature to be checked prior to entering the polling place; nor can an election worker ask a voter whether they have experienced symptoms of an illness in the past 14 days.

• Face Coverings: There is no authority under Texas law to require voters to wear face coverings when presenting to vote. However, election officials should make efforts to communicate to voters that wearing face coverings is strongly encouraged, including through posted signs. The Secretary of State is designing signs that can be used for this purpose. Additionally, election officials may design their own signs for posting. These

Case 5:20-cv-00830-JKP Document 53-5 Filed 10/20/20 Page 36 of 136 signs must be approved by the Secretary of State prior to use. (Section 62.013). Election officials can also consider reasonable social distancing measures for voters who are not wearing face coverings in the polling place.

- Voter Identification Implications: An election judge has discretion to ask the voter to temporarily lower or remove their face covering if the judge is not able to determine the voter's identity while wearing a face covering. (Sections 32.071 and 63.001(d)). The voter should be permitted to wear their face covering through the rest of the voting process after their identity has been confirmed. If a voter refuses to temporarily lower or remove their face mask, and the election judge cannot identify the voter with the mask in place and the ID presented, the voter should be offered a provisional ballot and may cure the deficiency later by appearing at the voter registrar's office during the cure period. (1 T.A.C. 81.71).
- Electioneering: Section 61.003 prohibits electioneering for or against any candidate, measure, or political party during the voting period and within 100 feet of an entrance to the building where the polling place is located. This prohibition applies to clothing and accessories worn by the voter, including face coverings. If a voter is wearing a face mask that qualifies as electioneering for or against any candidate, measure, or political party, the election judge may ask the voter to place a cover over the mask or provide the voter with a disposable face mask to be worn over the electioneering mask while within the 100-foot zone described in Sections 61.003 and 85.036.
- Voter Presenting with Symptoms of COVID-19: If a voter presents to vote in person with any of the above-identified signs or symptoms of COVID-19, an election judge may utilize their authority to preserve order and prevent breaches of the peace by offering the voter several options for voting, as described below. (Section 32.075). An election judge does not have the authority to refuse a voter who is presenting symptoms. Additionally, please instruct your workers to protect their own health by wearing face coverings, gloves, and/or washing and sanitizing their hands after interacting with any voters presenting signs or symptoms of COVID-19.

Below are guidelines to provide your election workers regarding interactions with voters who may be ill when they appear at the polling place:

- **Face Coverings:** If the symptomatic voter is not wearing a face covering, the election judge should offer a disposable face covering and/or gloves, if available, for the voter to use in the polling place. Although voters cannot be required to wear a face mask, the judge may ask the voter to wear a face mask temporarily in consideration of the health and safety of the election workers and other voters.
- **Curbside Voting:** The election judge may remind the symptomatic voter that they have the option to vote curbside and ask the voter if they would like to utilize that option. (Section 64.009). Election officials may want to place a sign outside of the polling location informing voters who feel ill that they may be eligible to vote curbside. This sign must be approved by the Secretary of State's office.
- Voting Order Priority Discretion: Alternatively, the election judge may accept the symptomatic voter before accepting others offering to vote at the polling place who arrived before the symptomatic voter. (Section 63.0015). We strongly suggest that election officials work with their election judges to develop protocols for when

Case 5:20-cv-00830-JKP Document 53-5 Filed 10/20/20 Page 37 of 136 this procedure will be used to ensure that the process is conducted fairly, uniformly, and not to the detriment of other individuals waiting to vote. These protocols should account for the possible need to communicate with other voters about the reason for invoking the procedure without revealing information the confidentiality of which is protected by state or federal law. Please review Section 63.0015 of the Code for additional information regarding the procedures for giving voting order priority to voters with certain disabilities.

In addition, election officials can consider reasonable social distancing measures for voters who exhibit signs or symptoms of COVID-19 when presenting to vote in person.

As discussed below, you are encouraged to sanitize voting system equipment after each use. As common sense would suggest, this recommendation should be followed with particular care as to voters who present to vote in person with visible signs or symptoms of COVID-19.

Electronic Voting Systems, Check-in Equipment and Voting Stations

Sanitizing Voting Machines

As addressed in our <u>Advisory 2020-14</u>, please check with your vendor about the specific procedures you should follow to clean and sanitize any equipment that is handled by voters or polling place workers. We received specific information from the following vendors about proper techniques for cleaning equipment:

- Hart Intercivic Voting System Equipment: Users may sanitize Hart equipment with 50% or higher clear, fragrance-free, isopropyl alcohol solution and a lint-free wipe. Do not use ammonia or detergent-based solutions as these may be harmful to the screen or the plastics surrounding the display. To avoid spotting, make certain that equipment screens are wiped dry (do not leave puddles).
- ES&S Voting System Equipment: You can use a soft, lint-free cloth and isopropyl alcohol to clean the touchscreen of the voting machine. Do not spray directly on the touch screen. Only lightly dampen the cloth; do not soak it. Do not use any harsh cleaning products on the screen as this may damage the touch screen. Do not allow any liquid cleaner to come in contact with ballot stock.

Sanitizing Electronic Pollbooks and Paper Check-in Records

Please check with your ePollbook vendor about the specific procedures you should follow to clean and sanitize any equipment that is handled by voters or polling place workers. Although election workers cannot sanitize a piece of paper, we believe you may take the following measures to protect worker and voter health and safety:

- Provide every voter with a pen, pencil, or separate marking device to use at the check-in station. Allow voters to keep the device or rotate sanitized pens after every voter.
- Encourage voters to bring their own writing utensils or styluses. This cannot be a requirement, as you cannot impose additional requirements to access the voting process.
- Encourage voters to use hand sanitizer before and after signing the pollbooks.

Voting Tools

Many ePollbooks and voting devices utilize touchscreens that allow a voter to interact directly with the device. Traditionally, voters have used their hands to touch or interact with the equipment. In light of concerns about cleaning and sanitizing these devices, election officials may want to consider providing the voter with a stylus or stylus substitute. Please check with your vendors (ePollbook and voting systems) to ensure styluses are compatible with their machines and discuss alternative stylus tools. Examples of marking devices that election officials have reported success in using include: pencil erasers, cotton swabs, coffee stirrers, tablet styluses, and food-service gloves (not medical grade). Be sure to check with your vendors well in advance of the voting period to ensure the stylus tools you intend to use are compatible with your devices.

The benefit of allowing voters to utilize a stylus-type tool is that it prevents the voter from having to physically touch the ePollbooks or voting machines. Depending on the device, election officials may be able to provide a different marking tool for each voter that can be discarded or retained by the voter upon leaving the polling place. Alternatively, election officials may consider developing a procedure by which reusable devices are used and subsequently sterilized after use by a voter. One thing to keep in mind when choosing a tool, especially depending on your ePollbooks, is the tool's ability to produce a legible signature capture on the ePollbook. The decision to invest in styluses should be made as soon as possible so the county has the ability to order supplies.

Even if the county is providing a voting tool to assist the voter, voters may want to bring their own devices to the polling place. We recommend providing information on your website regarding the acceptable types of voting tools for the equipment that will be used in your polling locations.

Note also that a stylus or stylus substitute purchased by election officials are subject to the prohibition on electioneering for or against any candidate, measure, or political party under Sections 61.003 and 85.036. If a company wants to provide supplies, election officials should ensure that the presence or use of such supplies within the 100-foot zone does not constitute electioneering for or against a candidate, measure, or political party. If a voter provides their own voting tool that is used to electioneer for or against a candidate, measure, or political party, the election judge may provide the voter with another voting tool to use while within the 100-foot zone described in Sections 61.003 and 85.036.

Voting Booths

Sections 51.032 and 62.004 of the Code require voting booths that provide privacy for voters while marking their ballots. In addition to voter privacy, we encourage voting booths to be spaced at least 6 feet apart in accordance with the CDC's social distancing guidelines. This spacing helps to ensure voter privacy as well as health and safety. Election officials may want to consider mapping out their individual polling places to provide direction to election workers on how to set up the location to facilitate social distancing.

Ballot Boxes

Similar to the social distancing markers placed before the voter check-in table, election workers should place tape or another marker every 6 feet to encourage social distancing while voters wait to deposit their ballots.

Case 5:20-cv-00830-JKP Document 53-5 Filed 10/20/20 Page 39 of 136 Precinct Ballot Scanners (if applicable)

Please check with your voting system vendor about the specific procedures you should follow to clean and sanitize any equipment that is handled by voters or polling place workers. Ballot scanners may have difficulty reading damp paper, so encourage voters to use care with hand sanitizer to avoid dampening paper ballots.

Poll Watchers

A poll watcher's role in an election is established in Chapter 33 of the Texas Election Code. Poll watchers are permitted in polling places (before and after the polls close), early voting ballot board meetings, and the central counting station. In light of COVID-19 concerns, poll watchers may be asked to adhere to certain health and safety measures to protect the health and well-being of other poll watchers, election workers, and voters. For more information regarding poll watcher qualifications, duties, and privileges, please see our <u>Poll Watcher's Guide</u>. Below are additional suggestions for poll watcher interactions:

- Face Coverings: While poll watchers cannot be required to wear a face covering, the Secretary of State's office strongly recommends that poll watchers wear some type of face covering, such as a mask or face shield, while in service. Election officials may consider having extra masks and/or face shields available for poll watchers if they arrive at a polling place without one. Even if poll watchers refuse face coverings while generally observing activities at their location, election officials should ask poll watchers to temporarily use a face covering if their poll watching activities require that they sit or stand within 6 feet of election officials or voters.
- **Social Distancing**: To the extent feasible, poll watchers should maintain at least 6 feet of separation from other individuals not within the same household. In addition to practicing such distancing when feasible, other measures such as hand hygiene, cough etiquette, cleanliness, and sanitation should be rigorously practiced. A person commits an offense if the person serves in an official capacity at a location at which the presence of watchers is authorized and knowingly prevents a watcher from observing an activity the watcher is entitled to observe. (Section 33.061).
- **Poll Watcher Health**: Election officials can ask that poll watchers review the health protocols and self-screen before entering the polling place to determine if they have any visible signs or symptoms related to COVID-19. If a poll watcher arrives at the polling location with any signs or symptoms of possible COVID-19, an election official may request that the appointing party, candidate, or political action committee appoint a replacement poll watcher. The appointing authority is not required to appoint an alternative. The presiding judge should document the request for an alternative poll watcher and any subsequent actions by the appointing authority. This should be documented on the poll watcher appointment form and in a standard affidavit form that can be found in an election kit.

Case 5:20-cv-00830-JKP Document 53-5 Filed 10/20/20 Page 40 of 136 Voter Assistants and Interpreters

Assistant of the Voter's Choice

A voter entitled to assistance may choose any person as his or her assistant except the voter's employer, an agent of that employer, or an officer or agent of the voter's labor union. (Section 64.032). A voter who needs assistance may want to consider bringing a family member or a member of their own household to assist them. However, there is no requirement that the assistant be a member of the voter's household. If a voter chooses their own assistant, it is up to the voter and the assistant to decide whether the assistant will wear a face mask.

The assistant must take the Oath of Assistance prior to assisting the voter. No other person except for the person rendering assistance is permitted to be present while the voter prepares his or her ballot.

Assistance by Election Workers

A voter who is eligible for assistance but does not choose an assistant may receive assistance from two election officers. (Section 64.032(a)). If a voter is assisted by election officers in the general election for state and county officers, each officer must be aligned with a different political party unless there are not two or more election officers serving the polling place who are aligned with different parties. (Section 64.032(b)). Each assistant must take the Oath of Assistance prior to assisting the voter. No other person except for the person(s) rendering assistance is permitted to be present while the voter prepares his or her ballot.

If a voter is assisted by two election officers, those officers should wear face coverings while providing assistance. Additionally, to the extent possible, the election worker should practice social distancing while maintaining the voter's right to a secret ballot (i.e., don't make the voter call out their vote from 6 feet away).

Poll Watchers and Assistants/Interpreters

Poll watchers may observe assistance given to voters by election officials and inspect the ballot before it is deposited in the ballot box to determine if it was prepared in accordance with the voter's wishes. (Section 33.057(a)). If a poll watcher is not wearing a face covering, election officials may provide face shields or some other divider to poll watchers observing assistance.

NOTE: A watcher may not be present at the voting station when a voter is preparing the voter's ballot or is being assisted by a person of the voter's choice, including by a person also serving as an interpreter at the voting station. (Section 33.057(b)).

Communication about Voting Procedures and Changes

With information and processes regarding COVID-19 constantly being updated, it is imperative that election offices communicate any changes in voting procedures to the public and interested parties. This includes, but is not limited to, posting information on the county's website, updating social media pages, and coordinating with the media.

Case 5:20-cv-00830-JKP Document 53-5 Filed 10/20/20 Page 41 of 136 Polling Place Signage

As a reminder, pursuant to state and federal law, all election materials prepared for voters in English must also be provided in Spanish and any other required languages for a specific jurisdiction. (Election Code, Chapter 272). Our office will be providing preapproved signs for posting inside and outside the polling locations. However, should an entity wish to design their own signs, those signs must be approved by the Secretary of State prior to use.

Frequently Asked Questions

Q1: Due to COVID-19, can an election official require that voters have their temperature

A: No, an election official cannot require a voter's temperature to be checked prior to entering the polling place to vote. If the building you are using is open for business, and has a temperature check for its employees on entering the building, you should coordinate with the person in charge of the building as to how you can separate these two groups at the entrance(s).

Q2: Can election officials require voters to wear a mask prior to entering the polling

A: No, you cannot require voters to wear face coverings prior to entering the polling location to vote. However, you may make masks available to all voters, as well as post signs encouraging the wearing of masks. If a voter has visible signs or symptoms of COVID-19, you may remind the voter that they have the option to vote curbside. In addition, you may post SOS-approved signs at the entrance to the polling location informing voters of this option. Election officials can also consider reasonable social distancing measures for voters who are not wearing face coverings in the polling place.

Q3: May election officials require an assistant/interpreter use a mask?

A: No, just as you cannot require a voter to use a mask in order to vote, you cannot require an assistant/interpreter to use a mask if they do not want to use one.

Q4: If an election worker cannot identify a voter under a mask, may the election worker

A: The election judge has discretion to ask the voter to temporarily lower or remove their face mask if the judge is not able to determine the voter's identity while wearing the mask. (Sections 32.071 and 63.001(d)). The voter should be permitted to wear their face covering through the rest of the voting process after their identity has been confirmed. If a voter refuses to temporarily lower or remove their face mask, and the election judge is unable to identify the voter with the mask in place and the ID presented, the voter should be offered a provisional ballot and may cure the deficiency by appearing at the voter registrar's office during the cure period. (1 T.A.C. 81.71).

Q5: How should election officials sanitize equipment after use?

A: The SOS recommends that election officials sanitize equipment after each use, particularly if a voter is showing any signs or symptoms of COVID-19. Please contact your vendor about the specific procedures you should follow to clean and sanitize the equipment being used.

Case 5:20-cv-00830-JKP Document 53-5 Filed 10/20/20 Page 42 of 136 Q6: May election officials require the use of a pencil with an eraser to mark on the electronic

A: Yes. However, you should contact your vendor to make sure that it will work on the type of electronic voting machine being used. In addition, if you impose such a requirement, you must provide the pencils (or other stylus alternatives) for voters to utilize when voting.

Q7: May election workers give voters pencils as they come in to vote so that they may use the

A: Pencils are allowable for signatures on a combination form. The SOS recommends that you train your workers not to "erase" mistakes or errors on the combination form so as to preserve the document in its original form. If there is an error on a combination form, the election worker should mark through it or make a notation like they would if a voter or election worker were using a pen. (Section 62.015).

Q8: May election officials place social distancing requirements on a poll watcher?

A: No, you cannot place social distancing requirements on a poll watcher. A person commits an offense if the person serves in an official capacity at a location at which the presence of watchers is authorized and knowingly prevents a watcher from observing an activity the watcher is entitled to observe. (Section 33.061).

Q9: May a poll watcher observe a voter being assisted in preparing their ballot?

A: A watcher may not be present at the voting station when a voter is preparing the voter's ballot or is being assisted by a person of the voter's choice, including by a person also serving as an interpreter at the voting station. (Section 33.057(b)).

Q10: If a county is using an electronic voting system for voting that requires the voter to use a DRE or Ballot Marking Device, can a voter request a paper ballot instead of voting on the electronic voting system equipment?

A: No. Counties are not required to offer voters the option of voting on a paper ballot if the county uses an electronic voting system. However, if a county is using paper ballots, they are required to offer some kind of accessible voting system equipment in the polling place for voters who need to use that equipment to mark their ballot privately and with limited assistance.

KI:LP

Exhibit 4

IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF TEXAS SAN ANTONIO DIVISION

MI FAMILIA VOTA, TEXAS STATE)	
CONFERENCE OF THE NATIONAL)	
ASSOCIATION FOR THE)	
ADVANCEMENT OF COLORED)	
PEOPLE, MICAELA RODRIGUEZ and)	No. 5:20-cv-00830
GUADALUPE TORRES)	
)	DECLARATION OF ROBERT
Plaintiffs)	M. STEIN
)	
VS.)	
)	
GREG ABBOTT, Governor of Texas;)	

RUTH HUGHS, Texas Secretary of State,

Defendants.

DECLARATION OF ROBERT M. STEIN

I. Summary of Opinions

The plaintiffs' attorneys have asked me several questions about Harris County, Texas voters' preferences, opinions and knowledge about in-person and mail-in voting in this November's Presidential Election. These questions include:

- 1. Are voters concerned about the health/safety of voting during the COVID pandemic?
- 2. Are there racial differences in the level of concerns expressed by voters?
- 3. Are these concerns about COVID affecting the likelihood that people will vote in Harris County?
- 4. Is COVID-mitigation at polling places important to voters?
- 5. Is social distancing at polls important to voters, or is there data suggesting that lack of social distancing would deter people from voting?

In August 2020 I collaborated with colleagues to conduct a survey of registered voters (N=5,862) in Harris County, Texas about voting in the November Presidential election during the COVID-19 pandemic.¹ Respondents were asked a series of questions about where and when they would prefer to vote under different threats from COVID-19, the importance of steps election officials have taken to protect voters from contracting and spreading the virus while voting in-person and why some voters did not vote in the July Democratic and Republican and primary run-off elections. The responses of registered voters to this survey serve as the basis of my answers to the plaintiffs' queries.

It is my considered opinion that Harris County voters, specifically those who have and will vote in-person are concerned about contracting and spreading the COVID-19 virus while voting. Harris County is the largest county in Texas and mirrors the demographic makeup of the state's electorate. I believe the findings reported below can to be generalized to the population of registered voters in Texas.

- More than a quarter of eligible voters in Harris County did not vote in the July 2020 Democratic and Republican primary runoff election because of concern with contracting COVID-19.
- A substantial portion of Harris County voters report that the actions election officials propose to take to protect voters and poll workers from COVID-19 while voting inperson will substantially affect their decision to vote in-person, on or before Election Day.
- For voters, the most impactful action elections officials propose to take to protect their safety during in person voting is assuring there is adequate social distancing at polling locations.
- There are substantial and significant racial differences in the level of concerns expressed by voters:

¹ This on-going research is funded in part by a grant from Rice University's COVID-19 Research Fund.

- Non-White voters are significantly more likely *not* to have voted in the July election because of COVID-19;
- Non-White voters are significantly more likely than White voters to identify the actions election officials propose to make voting safe as substantially affecting their decision to vote in-person.
- II. Background and Qualifications

I am a fellow in urban politics at the Baker Institute and the Lena Gohlman Fox Professor of Political Science at Rice University. I am also the faculty director of Rice's Center for Civic Leadership. A copy of my curriculum vitae is attached. I am being compensated at \$250 per hour for my effort.

My current research focuses on alternative modes of elections and voting procedures in the United States; emergency preparedness, behavioral response to severe weather events, and risk assessment; and home weatherization programs in low- and moderate-income households. My work has been supported by the National Science Foundation, the City of Houston's Office of Public Safety and Homeland Security, The Arnold Foundation and Pew Charitable Trusts, among others.

Since 2010, I have been an expert witness in several cases involving election administration and voting. I have consulted for several jurisdictions in the design, implementation and evaluation of alternative voting systems including early voting, Election Day vote centers, mail-assisted voting and in-person polling locations. In these jurisdictions, I have worked closely with election administrators and elected officials to fulfill their obligation to conduct elections. These jurisdictions include: Collin, Harris and Lubbock, counties, Texas, 64 Colorado counties that make up the Colorado County Clerks Association and Albuquerque, New Mexico.

III. Survey of registered voters in Harris County, Texas

Online interviews were conducted with 5,962 registered Harris County voters between July 30 and August 23, 2020 using the *Qualtrics* survey software. Interviews were solicited via email addresses for 165,000 randomly selected registered voters in Harris, County, Texas. The margin of error for the survey is +/- 1.1%. The table below reports the proportion of survey sample and all registered voters in Harris County for selected voter traits.

			All
		Survey	registered
		Sample	voters
		Column %	Column %
Party	Democrat	49%	50.1%
	Republican	44%	34.3%
	Unaffiliated	7%	15.6%
Race	White	66%	47.0%
	African-Amer.	10.1%	24.0%
	Hispanic	13.2%	23.0%
	Asian	3.6%	5.0%
	Other	7.0%	1.0%
Gender	Male	46%	45.7%
	Female	54%	53.3%
Over65	Under 65	63%	75.6%
	Over65	37%	24.3%

The sample is skewed toward older (i.e., 65 and older) White Republicans, with a significant under sample of African-American voters. Weighting of the sample, however, does not significantly change the findings reported below. There are sufficient a number of under sampled African-American and younger (i.e., below 65) voters to make reliable generalizations about these subpopulations.

July, 2020 Party Primary Runoff Election

The July Democratic and Republican primary runoff election was the first election conducted in Texas during the COVID-19 pandemic. Were voters deterred from voting because of the pandemic? Were there differences in the degree to which voters were deterred from voting in the July election by race and ethnicity? Survey respondents were asked if they voted in the July, 2020 Democratic or Republican runoff primary election. Those who did not vote in the either primary runoff election were asked why they did not vote.

		Count	Column %
Reason for not	COVID-19	940	27.6%
voting in the July Democratic or Republican primary runoff election.	I did not know there was an election	482	14.2%
	I felt my vote would not make a difference	178	5.2%
	I was not interested in the candidates or campaign issues	734	21.6%
	Inconvenient polling place or hours	121	3.6%
	Long lines	28	0.8%
	Other	876	25.7%
	Registration problems	46	1.4%

Reasons for not voting in the July, 2020 Primary Runoff Election

The modal reason (27.6%) given for not voting in either primary runoff election was COVID-19 and the possibility of contracting the virus while voting in-person. Only 'other' reasons for not voting approached the share of eligible voters not voting because of COVID-19.

Contracting and/or spreading the COVID-19 virus was cited by only 23% of White voters as the reason for not voting in the July 2020 primary runoff election. Among non-Whites, the proportion of registered voters who cited COVID-19 as the reason for not voting in the July election ranged from 45% for Hispanics, 44% for Asian-American voters and 37% for African-Americans. On average, nearly 50% more non-Whites than White voters cited COVID-19 as the reason for not voting in the primary runoff election.

Among White voters, disinterest in the candidates and campaign issues was the modal reason cited (25%) for not voting in the primary runoff election.

Reasons for not voting in the July, 2020 Primary Runoff Election By race/ethnicity (% column)

			African-			
		White	American	Hispanic	Asian	Other
Reason for not	COVID-19	23.0%	44.9%	37.4%	43.6%	21.3%
voting in the July	I did not know there was an	13.1%	12.5%	16.7%	18.6%	17.6%
Democratic or	election					
Republican	I felt my vote would not	6.1%	2.0%	3.8%	3.8%	4.1%
primary runoff	make a difference					
election.	I was not interested in the	24.8%	9.0%	16.1%	16.0%	19.3%
	candidates or campaign					
	issues					
	Inconvenient polling place or	2.6%	7.8%	5.2%	2.6%	5.3%
	hours					
	Long lines	0.6%	2.7%	1.0%	0.0%	1.2%
	Other	28.9%	17.6%	17.7%	12.2%	30.3%
	Registration problems	0.9%	3.5%	2.0%	3.2%	0.8%

A disproportionate share of non-White voters chose not to vote in the July 2020 party primary runoff election because of COVID-19. No other reason, including 'other', was cited by more than a fifth of non-White voters for sitting out the July election. The proportion of non-White voters who did not vote in the July election because of COVID-19 approaches 45%.

We might expect that persons who are most vulnerable to COIVD-19 (i.e., persons 65 and older, disabled or who know someone who contracted the virus) would be more likely to cite COVID-19 as a reason for not voting in July's election. This was not the case. Among voters most vulnerable to COVID-19 (i.e., who reported knowing someone who had contracted COVID-19, who have a disability or are 65 or older), the proportion who cited the virus as a reason for not voting was only 33%, 36% and 23% respectively. These proportions are substantially below the share of non-White voters who reported not voting because of COVID-19.

Expectations for voting in the 2020 Presidential

In Harris County, there were safety mitigations to protect voters and poll workers during the July election that have been proposed for the November Presidential elections. These include:

- PPE for poll workers (masks, gloves and face shields)
- Hand sanitizer stations
- Finger coverings for voters
- Masks for voters
- Floor plan to maximize social distancing
- Plexiglas barrier at check-in desk

Survey respondents were asked how each of these precautions at in-person polling locations would affect their decision to vote in-person in the November 2020 election.²

Actions for Making Voting Safer for Voters and Poll Workers (% Column)

		Column
	No impact	24.00%
PPE for poll workers	Minimal impact	17.70%
	Substantial impact	58.30%
	No impact	26.00%
Hand sanitizer	Minimal impact	22.90%
	Substantial impact	51.10%
	No impact	33.40%
Finger coverings	Minimal impact	26.80%
	Substantial impact	39.80%
	No impact	27.10%
Masks for voters	Minimal impact	17.80%
	Substantial impact	55.10%
	No impact	23.60%
Maximum social distancing	Minimal impact	17.60%
	Substantial impact	58.90%
	No impact	29.50%
Plexiglas barrier at check-in	Minimal impact	25.40%
UCON	Substantial impact	45.1%

 $^{^{2}}$ This question was asked only of voters (N=4,456) who reported that they were not eligible and did not intend to vote by mail in November. Only persons over 65, disabled or out of the jurisdiction on Election Day can vote by mail in Texas. All survey respondents who reported they intended to vote by mail in the November election were over 65 and/or disabled.

The most impactful precautions proposed for the November Presidential election are maintaining maximum social distancing and providing personal protective equipment for poll workers. Fifty-nine percent of respondents who will be voting in-person in the November election reported that maximum social distancing would substantially impact their decision to vote in-person, on or before Election Day. Adequate personal protective equipment for poll workers was cited by 58% of respondents as substantially impacting their decision to vote in-person. Facemasks for voters were cited by 55% of registered voters as substantially impacting their decision to vote in-person. About half (51%) of respondents said hand sanitizer would substantially impact their decision to vote in-person on or before Election Day. Less than half (40%) of survey respondents thought providing finger covers for voters and Plexiglas barriers (45%) at check-in desks would have a substantial impact on their decision to vote in-person.

Actions for Making Voting Safer for Voters and Poll Workers by Race/Ethnicity (% Column)

		White	African- American	Hispanic	Asian	Other
	No impact	25.10%	12.80%	23.70%	7.60%	38.00%
PPE for poll workers	Minimal impact	20.30%	10.70%	14.20%	8.70%	16.80%
	Substantial impact	<u>54.60%</u>	<u>76.50%</u>	<u>62.20%</u>	<u>83.70%</u>	<u>45.20%</u>
	No impact	28.10%	16.10%	21.40%	10.40%	38.60%
Hand	Minimal impact	25.50%	14.00%	18.50%	18.50%	22.90%
santuzer	Substantial impact	<u>46.40%</u>	<u>69.90%</u>	<u>60.20%</u>	<u>71.10%</u>	<u>38.60%</u>
	No impact	36.60%	17.20%	29.10%	14.70%	45.20%
Finger coverings	Minimal impact	19.50%	12.00%	15.30%	17.00%	16.90%
	Substantial impact	<u>33.20%</u>	<u>66.80%</u>	<u>49.50%</u>	<u>58.20%</u>	<u>32.40%</u>

Actions for Making Voting Safer for Voters and Poll Workers by Race/Ethnicity (% Column)

		White	African- American	Hispanic	Asian	Other
	No impact	28.60%	15.60%	25.30%	9.90%	41.00%
Masks for	Minimal impact	19.50%	12.00%	15.30%	17.00%	16.90%
voters	Substantial impact	<u>51.90%</u>	<u>72.40%</u>	<u>59.40%</u>	<u>73.10%</u>	<u>42.20%</u>
	No impact	24.80%	12.60%	22.60%	8.70%	36.50%
Maximum social distancing floor plan	Minimal impact	19.20%	12.60%	14.20%	12.20%	18.80%
	Substantial impact	<u>56.00%</u>	<u>74.80%</u>	<u>63.20%</u>	<u>79.10%</u>	<u>44.60%</u>
	No impact	31.50%	14.90%	27.10%	10.50%	45.00%
Plexiglas barrier at check-in desk	Minimal impact	28.10%	20.20%	19.10%	26.70%	21.30%
	Substantial impact	<u>40.40%</u>	<u>64.90%</u>	<u>53.80%</u>	<u>62.80%</u>	<u>33.60%</u>

Non-White voters rate the importance of each of the COVID-19 mitigations to make in-person voting safer significantly higher than White voters do. Moreover, only 56% of White voters reported that proper social distancing substantially impacted their decision to vote in-person compared to 75% of African-American voters, 63% of Hispanic voters and 79% of Asian-American voters.

Where and when voters anticipate voting in November

Early voting is the overwhelming preference for voting in the November President election for all racial groups.

Likelihood to Voting in the November Election by Race for all COVID-19 Threat Levels

		White Column %	African- American Column %	Hispanic Column %	Asian Column %	Other Column %
How likely are you	Early Voting	80.4%	91.4%	79.1%	82.1%	74.8%
to vote in the Nov.	Election Day	17.3%	7.0%	17.8%	13.3%	22.6%
election?	Not vote	2.2%	1.6%	3.2%	4.6%	2.6%

The modal reason for voting in-person early was the expectation that there would be shorter lines at early voting locations.

Reasons for voting in-person early in the November Election (%)

Shorter lines	76.1%
More days to vote	56.7%
Locations more convenient	38.6%
Larger locations	13.3%
Other	10.9%

IV. Conclusion

There is substantial evidence that in-person voters in Harris County are concerned about COVID-19 and voting safety. The actions taken by election officials to provide adequate social distancing and other mitigations at in-person polling locations is significantly consequential to decisions voters make about whether, when, and where to vote. All findings reported above are significantly greater for non-White voters, including African-Americans, Hispanics and Asian-Americans.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on the 26th day of August 2020.

Robert M. Stein

EXHIBIT A

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CURRICULUM VITAE July, 2020

ROBERT M. STEIN Lena Gohlman Fox Professor of Political Science Rice University Houston, Texas 77251 713-348-2795 Email: Stein@rice.edu

Place of birth: New York, N.Y.

Married, two children

Education

B.A., Ohio Wesleyan University, Delaware, Ohio, 1972.

M.A., University of Wisconsin-Milwaukee, Milw., Wisc., 1974

Ph.D., University of Wisconsin-Milwaukee, Milw., Wisc., 1977

Fields of Specialization

Elections and election administration, Federalism and intergovernmental relations, state and local government, urban politics and public policy.

Teaching Positions

Lena Gohlman Fox Professor of Political Science, 1996

Fellow, James A. Baker III Institute for Public Policy, 2006

Professor, Department of Political Science, Rice University, 1989-1996.

Visiting Associate Professor and research scientist, Workshop in Political Theory-Public Policy and Department of Political Science, Indiana University, 1987-1988.

Associate Professor, Department of Political Science, Rice University, 1983-1989.

Assistant Professor, Department of Political Science, Rice University, 1979-1983.

Assistant Professor, University of Georgia, 1977-1978.

Robert M. Stein Department of Political Science

Administrative positions

Faculty Director, Center for Civic Engagement, Rice University 2007- present

Dean, School of Social Sciences, Rice University, 1996 - 2006

Interim Dean, School of Social Sciences, Rice University, 1995 - 1996

Chair, Department of Political Science, Rice University, 1994 - 1995

Director, Policy Studies Program (undergraduate major), Rice University, 1987-1995

Director, Graduate Studies, Department of Political Science, Rice University, 1987-1991.

Chair, Department of Political Science, Rice University, 1984-86

Director, Rice Institute of Policy Analysis Public Opinion Poll, 1983-present.

Political analyst, KHOU-TV, Houston, Tx. 1983- present

Fellowships, awards, and offices

Outstanding reviewer award, Political Research Quarterly 2010.

Best paper award on Federalism and Intergovernmental Relations for "Inter-Local Cooperation and the Distribution of Federal Grants," by The section on Federalism and Intergovernmental Relations, American Political Science Association, 2004 (with Kenneth Bickers)

President, Urban Politics Subsection, American Political Science Association, 1999-2000.

Recipient, George R. Brown Award for Superior Teaching, Rice University, 1998.

President, Southwestern Political Science Association, 1998.

Recipient, Outstanding Mentor of Women in Political Science Award, Women's Caucus for Political Science, American Political Science Association, 1996.

Special book award from the Urban Politics and Policy Section of the American Political Science Association for, <u>Urban Alternatives: Private and Public Markets in the Provision of Local Services</u>, 1991.

Research fellowship, Indiana University, Workshop in Political Theory and Public Policy, 1987-1988.

Recipient, George R. Brown Award for Superior Teaching, Rice University, 1987.

Fellowship, U.S. Advisory Commission on Intergovernmental Relations, 1978-1979.

Research Grants and Contracts

Optimizing vote-by-mail implementations on consumer grade equipment, Funded by NSF 2033923, 7/1/2020-6/30/2021, co-PI, \$200,000.

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Robert M. Stein Department of Political Science

Making voting safe for voters and poll workers: Meeting the challenge of the COVID-19 Virus, Funded Rice University, COVID-19 Initiative, 5/1/2020-12/31/2020, PI, \$45,300.

Election Day Vote Centers in Harris County, Texas. Funded by the Arnold Foundation, May 2019 – December 2020, \$100,000.

Hurricane Harvey: Longitudinal Survey, Funded by the National Science Foundation, January 2018 – December 2021, SBER1760292, \$200,000. Co-PI

Urban Flooding: Identifying where it floods and evaluating remedies. May 2018-September 2019. Kinder Institute, Ken Kennedy Institute and Office or Research, Rice University, \$74,450 Co-PI

2016 City of Houston Citizen Survey, September 2016-January 2017, City of Houston, \$23,500

Vote by mail, September 2014-September 2015, Pew Charitable Trusts, \$48,000.

Saturday Run-off Election Exit Poll Survey, City of Houston, October-November, 2013. \$4,000.

Prioritizing and selecting bridge management actions for heightened truck loads and natural hazards in light of funding allocation patterns, National Science Foundation, September 2012 - August, 2015. co-PI (\$1.2 million)

Phase 2 Development and enhancement of online storm risk calculator tool for public usage, City of Houston, Office of Public Safety and Homeland Security, November, 2012 - June 2013. co-PI (\$189,000)

NetSE: Large Urban-Scale Polymorphic Wireless Networks: Community-Driven Assessment, Design and Access, National Science Foundation, September 2010-2013, co-PI (\$1.9 million)

Development and enhancement of online storm risk calculator tool for public usage, City of Houston, Office of Public Safety and Homeland Security, January, 2011 - June 2011. co-PI (\$309,000)

Increasing turnout among the less engaged: A study of Election Day vote centers, Pew Charitable Trusts, September, 2007 – May, 2009, PI (\$260,000)

Independent Response of Complex Urban Infrastructures Subjected to Multiple Hazards, National Science Foundation, October 2007 – October 2010, co-PI (\$20,000)

Program evaluation, City of Houston, SAFEclear, traffic incident management program, July 2006-January 2008. PI (\$20,000)

Program evaluation, City of Houston, SAFEclear, traffic incident management program, February 2005-December 2005. PI (\$20,000)

Program Utilization Among Households Eligible for Head Start Enrollment, funded by the Harris County Department of Education, June, 2001. PI (\$15,000)R

The Changing Structure of Federal Aid and the Politics of the Electoral Connection. Funded by the National Science Foundation 2001-2002. SES0095997 Co-PI, January 2001-January 2003. PI (\$230,000)

Greater Harris County 9-1-1 Emergency Network Data Archive and Analysis January, 2000- January 2001. PI (\$15,000)

Evaluation of Greater Harris County Emergency Network: Round II, funded by the Greater Harris. PI County Emergency Network, September, 1993 - January, 1994. (\$5,000)

Evaluation of Greater Harris County 9-1-1 Emergency Network, funded by the Greater Harris County Emergency Network, January, 1992-July, 1993. PI (\$5,000)

Selective Universalization of Domestic Public Policy. Funded by the National Science Foundation (SES8921109) 1990-1992. PI (\$185,000)

Contracting for Municipal Services. Funded by the U.S. Advisory Commission on Intergovernmental Relations. January, 1986-1990.PI

The Fiscal Austerity and Urban Innovation. Funded by the U.S. Department of Housing and Urban Development. September, 1983-1985. PI

Research Associate, Field Network Evaluation Study of the Reagan Domestic Program. Princeton Urban and Regional Center, Princeton University. Funded by the Ford Foundation. 1982-1984. PI

Research Associate, Field Network Evaluation Study of the Community Development Block Grant: Round 8. Funded by the U.S. Department of Housing and Urban Development. Summer, 1982. PI

The Structural Character of Federal Grants-in-Aid. Funded by the U.S. Department of Housing and Urban Development. 1982-83. PI

The Allocation of Federal Grants-in-Aid. Funded by the U.S. Advisory Commission on Intergovernmental Relations. 1979-1981. PI

The Allocation of State-Local Aid: An Examination of Within State Variation. Funded by the U.S. Advisory Commission on Intergovernmental Relations. 1979-1981. PI

Editorial Positions

editorial board member, Journal of Election Technology and Systems, 2013-2016

editorial board member, American Political Science Review, 2001-2007

Executive Committee, American Politics, American Political Science Review, 2004-2007

editorial board member, American Journal of Political Science, 1994-1998

editorial board member, Journal of Politics, 1994-1998

editorial board member, Social Science Quarterly. 1993-present

editorial board member, State and Local Government Review. 1987-1992.

editorial board member, Urban Affairs Review (formerly, Urban Affairs Quarterly) 1996-2000.

referee, <u>American Political Science Review</u>, <u>American Politics Quarterly</u>, <u>Journal of Urban Affairs</u>, <u>Urban Affairs</u> <u>Quarterly</u>, <u>Publius</u>, National Science Foundation.

Books

<u>Perpetuating the Pork Barrel: Policy Subsystems and American Democracy</u>, Cambridge University Press, 1995, with Kenneth N. Bickers.

Robert M. Stein Department of Political Science Page 5

Federal Domestic Outlays, 1983-1990. M.E. Sharp, 1991, with Kenneth N. Bickers

Urban Alternatives: Public and Private Markets in the Provision of Local Services, Pittsburgh Press, 1990.

Articles

"How Human Factors Can Help Preserve Democracy in the Age of Pandemics". <u>Human Factors</u>, forthcoming, With Philip Kortum, Claudia Zeigler Aceyman, Elizabeth Vann and Dan Wallach.

"How to Measure and Assess the Turnout Effects of Election Reforms," forthcoming, <u>Journal of Political</u> <u>Institutions and Political Economy.</u> With Andrew Menger.

"Choosing the less convenient way to vote: An anomaly in vote by mail elections," forthcoming, <u>Political</u> <u>Research Quarterly</u>. With Andrew Menger. Online first https://journals.sagepub.com/doi/full/10.1177/10659129198900009

"Waiting to vote in the 2016 Presidential Election: Evidence from a multi-jurisdiction Study," forthcoming, <u>Political Research Quarterly</u>. With Charles Stewart, Christopher Mann and others. Online first https://journals.sagepub.com/doi/full/10.1177/1065912919832374

"This Way Out," <u>Scientific American</u>, October 2018. Pp. 76-79. With Leonardo Duenas-Osorio and Devika Subramanian.

"Pedagogical Value of Polling-Place Observation by Students." <u>PS: Political Science & Politics</u>, 51:831-837 (October 2018). With Mann, Christopher B., Gayle A. Alberda, Nathaniel A. Birkhead, Yu Ouyang, Chloe Singer, Charles Stewart, Michael C. Herron, et al. <u>https://doi.org/10.1017/S1049096518000550</u>.

"Reducing the undervote with vote by mail," <u>American Politics Research.</u> 46(6):1039-1064 (September 2018). With Andrew Menger and Greg Vonnahme.

"Enlisting the public in facilitating election administration: A field experiment," <u>Public Administration Review</u>, 78(6):892-903 (December 2018), with Andrew Menger.

"Survey Experiments with Google Consumer Surveys: Promise and Pitfalls for Academic Research in Social Science." <u>Political Analysis</u> 24(3):256-373 (September 2016), with Philip Santaso and Randolph Stevenson.

"Election Administration During National Disasters and Emergencies: Hurricane Sandy and the 2012 Election." <u>Election Law Journal</u> 14:1-8 (January 2016).

"The social and private benefits of preparing for natural disasters," <u>International Journal of Mass Emergencies and Disasters</u>. 32:459-483 (August 2014), with Birnur Buzcu-Guven, Leonardo Dueñas-Osorio, Devika Subramanian.

"Building and validating geographically refined hurricane wind risk models for residential structures," <u>Natural</u> <u>Hazards Review</u>, 15(3):1-10 (November 2014), with Devika Subramanian, Leonardo Dueñas-Osorio, Josue Salazar

"How risk perceptions influence evacuations from hurricanes and compliance with government directives," <u>Policy</u> <u>Studies Journal,</u> 41(2):319-341 (April 2013), with Birnur Buzcu-Guven, Leonardo Dueñas-Osorio, Devika Subramanian, and David Kahle

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"Early voting and campaign news coverage," <u>Political Communication</u>, 30:278-396 (April 2013), with Johanna Dunaway

"The effect of election day vote centers on voter participation," <u>Election Law Journal</u>, 11(4):291-301 (September 2012) with Greg Vonnahme.

"Where, when and how we vote: Does it matter?" <u>Social Science Quarterly</u>.93(3):693-712.. (September 2012) with Greg Vonnahme.

"Prospectus for the Future Administration of Elections," <u>Baker Center Journal of Applied Public Policy</u> 4(1):45-57. (Spring, 2012)

"Engineering-based hurricane risk estimates and comparison to perceived risks in storm-prone areas," <u>Natural Hazards Review</u>, 13(1):1-12 (Spring 2012). with Leonardo Duenas-Osorio, Devika Subramanian and Birnur Girnur.

"Voting at non-precinct polling places: A review and research agenda," <u>Election Law Journal</u>, 10:307-11 (October 2011) with Greg Vonnahme.

"Interface network models for complex urban infrastructure systems." Journal of Infrastructure Systems, 17(4): 138-150 (2011), with Winkler, J., L. Dueñas-Osorio, R. Stein, and D. Subramanian.

"Performance assessment of topological diverse power systems subjected to hurricane events," <u>Reliability</u> <u>Engineering and System Safety</u>, 95:323-336. (April 2010). with James Winkler, Leonardo Duenas-Osorio and Devika Subramanian.

"Who evacuates when hurricanes approach? The role of risk, information and location," <u>Social Science Quarterly</u>. 91:816-834.(September 2010). With Leonardo Duenas-Osorio and Devika Subramanian

"Crunching collisions," <u>Roads and Bridges</u> 13:2 (April 2009), with Robert Dahnke, Ben Stevenson, and Tim Lomax.

"Voting technology, election administration and voter performance," <u>Election Law Journal</u>, 7:123-135 (April 2008) with Greg Vonnahme, Michael Byrne and Daniel Wallach.

"Engaging the unengaged voter: Voter centers and voter turnout," <u>Journal of Politics.</u> 70:487-497 (April 2008) with Greg Vonnahme.

"Assessing the Micro-Foundations of the Tiebout Model," <u>Urban Affairs Review</u>, 42:57-80 (September 2006), with Kenneth Bickers and Lapo Salucci.

"Who is Held Responsible When Disaster Strikes? The Attribution of Responsibility for a Natural Disaster in an Urban Election," <u>Journal of Urban Affairs</u>, 28:43-54 (2006) with Kevin Arceneaux.

"Voting for Minority Candidates in Multi-Racial/Ethnic Communities," <u>Urban Affairs Review</u>, 41:157-181 (November 2005) with Stacy Ulbig and Stephanie Post.

"Inter-Local Cooperation and the Distribution of Federal Grant Awards," <u>Journal of Politics</u>, 66:800-22 (August 2004) with Kenneth Bickers.

"Language Choice, Residential Stability, and Voting among Latino-Americans," <u>Social Science Quarterly</u>, 84:412-24, (June 2003), with Martin Johnson and Robert Wrinkle.

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"Public Support for Term Limits: Another Look at Conventional Thinking." <u>Legislative Studies Quarterly</u>, 27:459-480. (August 2002) with Martin Johnson and Stephanie Shirley Post.

"Contextual Data and the Study of Elections and Voting Behavior: Connecting Individuals to Environments." <u>Electoral Studies</u>, 21:63-77 (March 2002), with Martin Johnson, W. Phillips Shivley. Also appearing in *The Future of Electoral Studies*. Mark N. Franklin and Christopher Wlezien, eds. Oxford: Elsevier Press (2003).

"The Congressional Pork Barrel in a Republican Era," <u>Journal of Politics</u>, 62:1070-1086 (November, 2000) with Kenneth Bickers.

"State Economies, Regional Governance, and Urban-Suburban Economic Dependence," <u>Urban Affairs Review</u>, 36:46-60 (Spring, 2000) with Stephanie Shirley Post.

"Reconciling Context and Contact Effects on Racial Attitudes," <u>Political Research Quarterly</u>. 53:285-303 (June, 2000), with Stephanie Shirley Post and Allison Rinden.

"The Micro Foundations of the Tiebout Model," <u>Urban Affairs Review</u> 34:76-93 (September, 1998) with Kenneth Bickers.

"Early Voting," Public Opinion Quarterly. 62:57-70 (Spring, 1998).

"Voting Early, But Not Often," <u>Social Science Quarterly</u> 78:657-677 (September, 1997) with Patricia Garcia-Monet.

"Building Majority Coalitions for Sub-majority Benefit Distributions," <u>Public Choice</u> 91:229-249 (June, 1997). with Kenneth Bickers.

"The Electoral Dynamics of the Federal Pork Barrel," <u>American Journal of Political Science</u>, 40:1300-1326 (November, 1996) with Kenneth Bickers.

"Privatization and the Arrangement of City Services," Estudios De Economia, 23:323 (August, 1996)

"A Portfolio Theory of Policy Subsystems," <u>Administration and Society</u>, 26:158-184 (August, 1994). with Kenneth Bickers

"Congressional Elections and the Pork Barrel," Journal of Politics, 56:377-399 (November 1994)

"Explaining State Aid Allocations: Targeting Within Universalism," <u>Social Science Quarterly</u>, 75:524-540 (September, 1994) with Keith E. Hamm

"Universalism and the Electoral Connection: A Test and Some Doubts," <u>Political Research Quarterly</u>, 47:295-318 (June, 1994) with Kenneth N. Bickers.

"Response to Weingast's 'Reflections on Distributive Politics and Universalism," <u>Political Research</u> <u>Quarterly</u>: 47:329-334 (June, 1994) with Kenneth N. Bickers.

"Arranging City Services," Journal of Public Administration: Research and Theory 3:66-93 (January, 1993).

"Alternative Means of Delivering Municipal Services: 1982-1988," <u>Intergovernmental Perspective</u>. 19:27-30 (Winter, 1993).

"A Federalist Explanation of Municipal Elections," <u>The Midsouth Political Science Journal</u>. 13:211-229 (June, 1992) with Cheryl Young.

"The Budgetary Effects of Municipal Service Contracting: A Principal-Agent Explanation," <u>American Journal of</u> Political Science. 34:471-502 (May, 1990).

"Economic Voting for Governor and U.S. Senator: The Electoral Consequences of Federalism," Journal of Politics 52:29-54 (February, 1990).

"Market Maximization of Individual Preferences and Metropolitan Municipal Service Responsibility," <u>Urban</u> <u>Affairs Quarterly</u> 24:86-116 (September, 1989).

"A Comparative Analysis of the Targeting Capacity of State and Federal Intergovernmental Aid Allocations: 1977-1982," <u>Social Science Quarterly</u> 68:447-466 (Sept., 1987). With K. Hamm.

"Tiebout's Sorting Hypothesis," Urban Affairs Quarterly, 22:199-225 (Sept., 1987).

"Federal Aid and The Mobilization of Black Political Influence." <u>Research in Urban Policy</u>, 2:97-117. (1986) with K. Hamm.

"The Fiscal Impact of U.S. Military Assistance Programs, 1967-1976." <u>The Western Political Quarterly</u>, 38:27-43 (March, 1985). with R. Stoll and M. Ishimatsu.

"Municipal Public Employment: An Examination of Intergovernmental Influences." <u>American Journal of</u> <u>Political Science</u>, 28:636-653 (November, 1984).

"State Regulation and the Political Consequences of Municipal Fiscal Stress." Publius, 14:41-54 (Spring, 1984).

"Implementation of Federal Policy: An Extension of the 'Differentiated Theory of Federalism'," <u>Research in Urban</u> <u>Policy</u>, 3:341-348 (1984)

"The Structural Character of Federal Aid: An Examination of Fiscal Impact," <u>Research in Urban Economics</u>, 4:167-186 (Fall, 1984).

"Trends and Prospects in State and Local Finance," <u>Journal of Urban Economics</u>, 14:224-241 (September, 1983) with P. Mieszkowski.

"An Analysis of Support for Tax Limitation Referenda," <u>Public Choice</u>, 40:187-194 (Winter, 1983) with K. Hamm and P. Freeman.

"The Political Economy of Municipal Functional Responsibility," <u>Social Science Quarterly</u>, 63:530-549 (September, 1982).

"The Effects of Reagan Domestic Budget Cuts: The Case of Houston," <u>Texas Business Review</u>, 13:11-18. (Oct.-Nov., 1982) with S.A. MacManus.

"The Targeting of State Aid: A Comparison of Grant Delivery Mechanisms," <u>Urban Interest</u>, 2:47-59 (Spring, 1981).

"The Allocation of Federal Aid Monies: The Synthesis of Demand-Side and Supply-Side Explanations," <u>American Political Science Review</u>, 75:334-343 (June, 1981).

"Functional Integration at the Substate Level: A Policy Perspective," <u>Urban Affairs Quarterly</u>, 16:211-233 (December, 1980).

"Federally Mandated Substate Regional Government: The Maintenance of Governmental Structures," <u>Urban</u> <u>Interest</u>, 1:74-82 (Spring, 1980).

"Federal Categorical Aid: Equalization and the Application Process," <u>Western Political Quarterly</u>, 32: 396-408 (December, 1979)

"The Electability of Women Candidates: The Effects of Sex Role Stereotyping, "Journal of Politics, 41:513-524 (May, 1979) With R. Hedlund, K. Hamm, and P. Freeman.

"Regional Planning Assistance: Its Distribution to Local Governments and its Relationship to Local Grant Getting," <u>The Journal of the American Institute of Planners</u>, 43:871-891 (July, 1977) With B. Hawkins.

Chapters in edited volumes

"Polling Place Quality," in Kathleen Hale and Bridgett A. King, eds., *The Future of Election Administration*, Palgrave. 2019: 83-100

"Help America Vote Act of 2002" in *Voting and Political Representation in America: Issues and Trends* Edited by Mark P. Jones. Forthcoming, 2019 Santa Barbara, CA: ABC-CLIO

"Convenience modes of voting" in *Voting and Political Representation in America: Issues and Trends* Edited by Mark P. Jones Forthcoming, 2019 Santa Barbara, CA: ABC-CLIO

"Polling Place Practices,", in *Electoral Performance*, Charles Stewart III and Barry Burden, eds. Cambridge University Press, 2014:166-187. With Greg Vonnahme

"Early, Absentee, and Mail-in Voting," in *Handbook of American Elections and Political Behavior*, ed. Jan Leighley, Oxford University Press, 2010:182-199. with Greg Vonnahme.

"The Political Market for Intergovernmental Cooperation," in *Self-Organizing Federalism: Collaborative Mechanisms to Mitigate Institutional Collective Action Dilemmas*, eds., Richard C. Feiock and John T. Scholz. Cambridge University Press. 2010:161-178.. With Kenneth N. Bickers and Stephanie Post

"Local Services, Provision and Production," in <u>Encyclopedia of Public Administration and Public Policy</u>, New York, Marcel Dekker, 2003: 734-748.

"The Politics of Revenue and Spending Policies," in John Pelissero, ed. <u>Cities, Politics, and Policy</u>. Washington, D.C.: CQ Press. 2002:217-236.

"Implications for Citizen Participation," in Paul Schumacher and Burdette Loomis eds. <u>Choosing a President</u> <u>The Electoral College and Beyond.</u> New York, Catham House, 2002 with Paul Johnson, Daron Shaw and, Robert Weissberg. Pp. 125-142

"Devolution and the Challenge for Local Governance,", in Ronald E. Weber and Paul Brace, eds. <u>Change and</u> <u>Continuity in American State and Local Politics</u> New York, Catham House. 2000:21-33

"Contracting for Municipal Services," in P. Seidenstat, S. Hakim and G. Bowman eds. <u>Privatization of the Justice</u> <u>System</u>, McFarland and Co. Publishers. 1992: 82-107, with Delores Martin.

"Urban Public Policy Under Fiscal Stress: A Comparison of Spending and Employment Decisions," pp. 111-144, in Mark Gottdiner (ed.) <u>Cities Under Fiscal Stress</u>, Sage, 1986 with M. Neiman and E. Sinclair.

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Robert M. Stein Department of Political Science

"The Texas Response to Reagan's New Federalism Programs: The Early Years," pp. 124-159 in, L. Bender and J. Stever, (eds.) <u>Managing the New Federalism</u>, Denver: Westview Press, 1986 with S.A. MacManus.

"Implementation of federal policy: An extension of the 'differentiated theory of federalism.' " pp. 341-348. in Terry Nichols Clark (ed). <u>Research in Urban Policy</u> Chicago: JAI Press, 1985

"Policy Implementation in the Federal Aid System: The Case of Grant Policy," pp. 125-155 in, G. Edwards (ed.) <u>Public Policy Implementation</u>, JAI Press, 1984.

"The Allocation of State Aid to Local Governments: An Examination of Interstate Variations," pp. 202-225. in, U.S. Advisory Commission on Intergovernmental Relations, <u>The Federal Influence on State and Local Roles in the Federal System</u>, U.S. Government Printing Office, 1982.

"The Impact of Federal Grant Programs on Municipal Functions: An Empirical Analysis," pp. 65-122 in, U.S. Advisory Commission on Intergovernmental Relations, <u>The Federal Influence on State and Local Roles in the Federal System</u>, U.S. Government Printing Office, 1981

"The Impact of Socio-Economic Environment on Revenue Policies," pp. 133-172. in, R. Bingham, B. Hawkins, and F. Hebert, <u>The Politics of Raising State and Local Revenues</u>, Praeger, 1978 with R. Bingham, B. Hawkins, and R. Robertson.

"Grant Seeking and the Allocation of Federal Grant-in-Aid Monies: The Case of Southeastern Wisconsin," pp. 199-219 in, John P. Blair and Ronald S. Edari, (eds.), <u>Milwaukee's Economy: Federal Programs, Local Resources and Community Action</u>, Federal Reserve Bank of Chicago, 1978

"Substate Regionalism: Another View From the States," pp. 69-102 in, Charles Tyer (ed.) <u>Substate Regionalism</u> in the United States: Perspectives and Issues, University of South Carolina Press, 1978

Recent papers, completed manuscripts, conference papers and invited presentations

"Choosing the less convenient way to vote: An anomaly in vote by mail elections," Election Science Meeting, June 2019, University of Pennsylvania, Phila., PA

"Compositional effects of vote by mail elections," presented at VBMcon: A Conference to discuss vote by mail election reform, June 20, 2019, Washington, D.C.

"Vote fraud and errant voting," Invited presentation at Department of Political Science, University of Nebraska, Lincoln, NE. April 25, 2013.

"Polling place practices," Prepared for presentation at the Measure of Elections Conference, June 18-19, 2012, Massachusetts Institute of Technology, Boston, MA

"Where, when and how we vote: Does it matter?" presented at the Scottish National Election Commission, Strathclyde University, Glasgow, Scotland. November 12-15, 2010.

"The future of elections," presented at the *Future of Governance Conference*, Howard Baker Institute of Government, University of Tennessee, Knoxville, Tx. October 14-15, 2010.

"Cost of elections," Presented at the 2010 Meeting of the Midwest Political Science Association, Chicago, Ill. April 3-5, 2000 with Greg Vonnahme.

"Early voting and campaign news coverage," 2010 Meeting of the American Political Science Association,

Washington, D.C., Sept 1-3.

"The cost of elections." Report prepared for the Pew Charitable Trusts, 2009. With Greg Vonnahme.

"The effects of early voting on congressional campaign expenditures." Presented at the 2009 Meeting of the Midwest Political Science Association, Chicago, Ill. April 13-15, 2000 With Marvin McNeese

"The effects of Election Day vote centers on voter experiences." Presented at the 2008 Meeting of the Midwest Political Science Association, Chicago, Ill. April 3-5, 2008. With Greg Vonnahme

Whither the Challenger: Congressional Elections in Metropolitan America, Presented at the 2005 Meetings of the American Political Science Association, Washington, D.C., September 1-3, with Kenneth Bickers.

Assessing the Micro-Foundations of the Tiebout Model Presented at the 2005 Meetings of the Midwest Political Science Meetings, Chicago, Ill. April 2-5, with Kenneth Bickers and Lapo Salucci.

Electoral Reform, Party Mobilization and Voter Turnout Presented at the 2004 Meetings of the Midwest Political Science Meetings, Chicago, Ill. April 21-23, with Jan Leighley, Chris Owens.

The Role of Candidates and Parties in Linking Electoral Reforms with Voter Participation. Presented at the 2003 Meetings of the Midwest Political Science Meetings, Chicago, Ill. April 21-23, with Jan Leighley, Chris Owens.

Voting for Minority Candidates in Multi-Racial/Ethnic Communities. Presented at the 2003 Meetings of the Midwest Political Science Meetings, Chicago, Ill. April 21-23, with Stacy Ulbig and Stephan Post.

The within congressional district electoral connection. Presented at the 2002 Meetings of the American Political Science Association, Boston, MA August 28-September 2, with Kenneth Bickers.

Who Will Vote? The Accessibility of Intention to Vote and Validated Behavior at the Ballot Box, Presented at the 2001 Meetings of the American Political Science Association, San Franciso, CA., August 28-September 2, with Martin Johnson

Contextual Explanations of Presidential Vote Choice, Presented at the 2001 Meeting of the Midwest Political Science Association, Chicago, Illinois, April 13-15, with W.Philps Shivley and Martin Johnson.

The Changing Structure of Federal Aid and the Politics of the Electoral Connection Coalitions. Presented at the 2000 Meetings of the American Political Science Association, Washington, D.C., September 1-4. With Kenneth Bickers.

Accessibility and Contextual Explanations of White Racial Attitudes. Presented at the 2000 Meetings of the American Political Science Association, Washington, D.C., September 1-4. With W.Philps Shivley and Martin Johnson

Information, Persuasion and Orphaned Voters. Presented at the 1999 Meeting of the American Political Science Association, Atlanta, GA., September 1-4. With Martin Johnson

The Federal Pork Barrel and the Formation of Intergovernmental Grant-Seeking Coalitions Presented at the 1999 Meeting of the American Political Science Association, Atlanta, GA., September 1-4. With Kenneth Bickers.

The Congressional Pork Barrel in a Republican Era. Presented at the 1999 Meeting of the Midwest Political Science Association, Chicago, Illinois, April 13-15. With Kenneth Bickers

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The Local Public Goods Market: A Definition, Measure, and Test, Presented at the 1998 Meeting of the American Political Science Association, Boston, MA, Sept. 3-6 10-12. With Stephanie Shirley Post.

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Recent expert testimony

Expert Report in the case of Mark Wandering Medicine et al. v. Linda McCulloch et al. [voting rights case in the state of Montana] February-June, 2014.

Expert Report in the Thomas Poor Bear, et al vs. The County of Jackson, South Dakota [voting rights case in the state of South Dakota]. June-November, 2015

Expert Report in the case of Martin Cowen, et al. vs Brian P. Kemp [ballot access case]. January-May, 2018

Exhibit 5

Centers for Disease Control and Prevention



Morbidity and Mortality Weekly Report

October 16, 2020

Race, Ethnicity, and Age Trends in Persons Who Died from COVID-19 — United States, May–August 2020

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During February 12–October 15, 2020, the coronavirus disease 2019 (COVID-19) pandemic resulted in approximately 7,900,000 aggregated reported cases and approximately 216,000 deaths in the United States.* Among COVID-19-associated deaths reported to national case surveillance during February 12-May 18, persons aged ≥ 65 years and members of racial and ethnic minority groups were disproportionately represented (1). This report describes demographic and geographic trends in COVID-19-associated deaths reported to the National Vital Statistics System[†] (NVSS) during May 1-August 31, 2020, by 50 states and the District of Columbia. During this period, 114,411 COVID-19-associated deaths were reported. Overall, 78.2% of decedents were aged \geq 65 years, and 53.3% were male; 51.3% were non-Hispanic White (White), 24.2% were Hispanic or Latino (Hispanic), and 18.7% were non-Hispanic Black (Black). The number of COVID-19-associated deaths decreased from 37,940 in May to 17,718 in June; subsequently, counts increased to 30,401 in July

[†] https://www.cdc.gov/nchs/nvss/deaths.htm.

and declined to 28,352 in August. From May to August, the percentage distribution of COVID-19–associated deaths by U.S. Census region increased from 23.4% to 62.7% in the South and from 10.6% to 21.4% in the West. Over the same period, the percentage distribution of decedents who were Hispanic increased from 16.3% to 26.4%. COVID-19 remains a major public health threat regardless of age or race and ethnicity. Deaths continued to occur disproportionately among older persons and certain racial and ethnic minorities, particularly among Hispanic persons. These results can inform public health messaging and mitigation efforts focused on prevention and early detection of infection among disproportionately affected groups.

In NVSS data, confirmed or presumed COVID-19–associated deaths are assigned the *International Classification of Diseases, Tenth Revision* code U07.1 as a contributing or underlying cause of death on the death certificate. The underlying cause of death is the condition that began the chain of events ultimately leading to the person's death. COVID-19 was the underlying cause for approximately 92% of COVID-19–associated deaths and was a contributing cause for approximately 8% during the investigation period (*2*). NVSS data in this report exclude deaths among residents of territories and foreign countries.

Using NVSS data from May 1 through August 31, 2020, CDC tabulated the numbers and percentages of COVID-19–associated deaths by age, sex, race and ethnicity (categorized as Hispanic, White, Black, non-Hispanic Asian [Asian], non-Hispanic American Indian or Alaska Native [AI/AN], non-Hispanic Native Hawaiian or other Pacific Islander [NHPI], non-Hispanic multiracial [multiracial], and unknown), U.S. Census region,[§] and location of death



^{*}CDC official counts of cases and deaths, released daily at https://covid.cdc. gov/covid-data-tracker/, are aggregate counts from reporting jurisdictions. Throughout the COVID-19 pandemic, and separately from the NVSS, CDC has been tracking both aggregate and individual (i.e., line-listed) counts of cases and deaths. For aggregate counts, from January 22 to March 2, 2020, CDC provided laboratory confirmation for all U.S. confirmed cases. Starting March 3, jurisdiction partners validated aggregate counts each night for report released at 12 p.m. the following day by CDC. For individual counts, jurisdiction partners electronically submit standardized information for individual cases of COVID-19 to CDC. From April 14, aggregate and individual counts included confirmed and probable cases and deaths, according to the Council of State and Territorial Epidemiologists (CSTE) position statement Interim 20-ID-01 (https://cdn.ymaws.com/www.cste.org/resource/resmgr/2020ps/interim-20id-01_covid-19.pdf; https://wwwn.cdc.gov/nndss/conditions/coronavirusdisease-2019-covid-19/case-definition/2020/). On August 5, CSTE published an updated position statement, Interim 20-ID-02, to clarify the interpretation of antigen detection tests and serologic test results within the case classification (https://wwwn.cdc.gov/nndss/conditions/coronavirus-disease-2019-covid-19/ case-definition/2020/08/05/).

[§] U.S. Census Bureau regions are Northeast, Midwest, South, and West. https:// www2.census.gov/geo/pdfs/maps-data/maps/reference/us_regdiv.pdf.

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(e.g., hospital, nursing home or long-term care facility, or residence). Because only 0.5% of COVID-19 decedents were either NHPI or multiracial, and counts <10 are suppressed in NVSS to maintain confidentiality, these groups were combined into one group for analyses. Age, race and ethnicity, and place of death were unknown for two (<0.01%), 465 (0.4%), and 46 (0.04%) deaths, respectively. To describe changes in demographic features over time, percentages of deaths among two age groups (\geq 65 years and <65 years), racial and ethnic groups, and U.S. Census region were calculated for each month. R statistical software (version 3.6.3; The R Foundation) was used to tabulate death counts and generate histograms. This activity was reviewed by CDC and was conducted consistent with applicable federal law and CDC policy.

During May 1–August 31, 2020, a total of 114,411 COVID-19–associated deaths were reported to NVSS (Table). The number of COVID-19–associated deaths decreased from 37,940 in May to 17,718 in June; subsequently, counts increased to 30,401 in July and declined to 28,352 in August. Among decedents, the majority were male (53.3%), White (51.3%), aged ≥65 years (78.2%), and died in an inpatient health care setting (64.3%). Overall, 24.2% of decedents were Hispanic, 18.7% were Black, 3.5% were Asian, 1.3% were AI/AN, and 0.5% were either NHPI or multiracial. During the period studied, the largest percentage of COVID-19–associated deaths occurred in the South Census region (45.7%), followed by the Northeast (20.5%), the West (18.3%), and the Midwest (15.5%). Twenty-two percent of decedents died in a nursing home or long-term care facility.

During May–August 2020, the percentage of COVID-19– associated deaths occurring in the South increased from 23.4% in May to 62.7% in August, and in the West from 10.6% to 21.4%; the percentages occurring in the Northeast decreased from 44.2% in May to 4.0% in August, and in the Midwest declined from 21.8% to 11.8% (Figure 1). The percentage of decedents aged ≥65 years decreased from 81.8% to 77.6%, and the percentage of deaths occurring in nursing homes or longterm care facilities decreased from 29.8% to 16.6% (Figure 1).

From May to August, the percentage of decedents who were White decreased from 56.9% to 51.5%, and the percentage who were Black decreased from 20.3% to 17.4%, whereas the percentage who were Hispanic increased from 16.3% to 26.4% (Figure 2). Hispanics were the only racial and ethnic group among whom the overall percentage of deaths increased. Among persons aged \geq 65 years, the monthly percentage of Hispanic decedents increased in the South (from 10.3% to 21.7%) and West (from 29.6% to 35.4%) and decreased in the Northeast

TABLE. Demographic characteristics of persons who died because
of COVID-19* (N = 114,411) — National Vital Statistics System (NVSS),
United States, May 1–August 31, 2020 [†]

Characteristic	Deaths, [§] %
Age group, yrs	
<1	<0.1
1–4	<0.1
5–17	<0.1
18–29	0.5
30–39	1.4
40–49	3.5
50–64	16.4
65–74	21.7
75–84	26.0
≥85	30.4
Unknown	<0.1
Sex	
Male	53.3
Female	46.7
Other	0.0
Race/Ethnicity	
White, non-Hispanic	51.3
Hispanic or Latino	24.2
Black, non-Hispanic	18.7
Asian, non-Hispanic	3.5
American Indian or Alaska Native, non-Hispanic	1.3
Other, non-Hispanic [¶]	0.5
Unknown race/ethnicity	0.4
U.S. Census region of residence	
South	45.7
Northeast	20.5
West	18.3
Midwest	15.5
Place of death	
Health care setting, inpatient	64.3
Nursing home or long-term care facility	21.5
Decedent's home	5.2
Hospice facility	3.7
Health care setting, outpatient or emergency department	3.1
Other	2.0
Health care setting, dead on arrival	0.1
Unknown	<0.1

Abbreviation: COVID-19 = coronavirus disease 2019.

* Deaths with confirmed or presumed COVID-19, coded to *International Classification of Diseases, Tenth Revision* code U07.1. These data exclude deaths among foreign residents and territories.

[†] NVSS data from August are incomplete given reporting lags.

[§] Percentages may not sum to 100 because of rounding. For two (<0.01%) COVID-19 deaths, age was unknown. Sex and region were known for all decedents. For 465 (0.4%) deaths, race or ethnicity were unknown. For 46 (0.04%) deaths, place of death was unknown.

Other race/ethnicity includes persons who were non-Hispanic Native Hawaiian or other Pacific Islander or were non-Hispanic multiracial.

(from 11.3% to 9.3%) and Midwest (from 7.8% to 4.2%). The monthly percentage of Hispanic decedents aged <65 years increased in the South (from 29.2% to 38.1%) and West (from 51.8% to 62.3%) and decreased in the Northeast (from 34.9% to 30.7%) and Midwest (31.1% to 20.4%)(Supplementary Figure, https://stacks.cdc.gov/view/cdc/95229).

See e.g., 45 C.F.R. part 46.102(l)(2), 21 C.F.R. part 56; 42 U.S.C. §241(d); 5 U.S.C. §552a; 44 U.S.C. §3501 et seq.
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FIGURE 1. Monthly COVID-19-associated deaths* as a percentage of all deaths, by U.S. Census region, all ages (A), and for persons aged \geq 65 years or persons of any age who died in a nursing home or long-term care facility (B) (N = 114,411) — National Vital Statistics System, United States, May 1–August 31, 2020



Abbreviation: COVID-19 = coronavirus disease 2019.

* Age data were missing for two (<0.01%) COVID-19 deaths, and place of death data were missing for 46 (0.04%) deaths. Total numbers of deaths might vary because of suppression of counts with <10 deaths.





Abbreviations: Al/AN = American Indian or Alaska Native; COVID-19 = coronavirus disease 2019; NH = non-Hispanic; NHPI = Native Hawaiian or other Pacific Islander. * Race or ethnicity data were unknown for 465 (0.4%) deaths. Total numbers of deaths might vary because of suppression of counts with <10 deaths.

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Summary

What is already known about this topic?

Persons aged \geq 65 years and members of minority racial and ethnic groups are disproportionately represented among COVID-19–associated deaths.

What is added by this report?

Analysis of 114,411 COVID-19–associated deaths reported to National Vital Statistics System during May–August 2020, found that 51.3% of decedents were non-Hispanic White, 24.2% were Hispanic or Latino (Hispanic), and 18.7% were non-Hispanic Black. The percentage of Hispanic decedents increased from 16.3% in May to 26.4% in August.

What are the implications for public health practice?

These results can inform public health messaging and mitigation efforts focused on prevention and early detection of infection among disproportionately affected groups so as to minimize subsequent mortality.

Discussion

Based on NVSS data on 114,411 persons who died from COVID-19 in the United States during May-August 2020, the predominant U.S. Census regions shifted from the Northeast to the South and West. The majority of COVID-19-associated deaths occurred among White persons (51.3%), but Black and Hispanic persons were disproportionately represented. Although a small decrease (2.9 percentage points between May and August) in decedents who were Black was observed, Black persons still accounted for 18.7% of overall deaths despite representing just 12.5% of the U.S. population (3). Similarly, Hispanic persons were disproportionately represented among decedents: 24.2% of decedents were Hispanic compared with 18.5% of the U.S. population. In addition, the percentage of decedents who were Hispanic increased 10.1 percentage points from May through August. Whereas Hispanic persons accounted for 14% of COVID-19-associated deaths in the United States during February 12-May 18, 2020 (1), that percentage increased to approximately 25% in August. Although there has been a geographic shift in COVID-19-associated deaths from the Northeast to the West and South, where Hispanic persons account for a higher percentage of the population, this analysis found that ethnic disparities among decedents in the West and South increased during May-August, 2020, suggesting that the geographic shift alone does not entirely account for the increase in percentage of Hispanic decedents nationwide. Disparities in COVID-19 incidence and deaths among Hispanic persons and other underrepresented racial and ethnic groups are well documented (4-6) and might be related to increased risk for exposure to SARS-CoV-2, the virus that causes COVID-19. Inequities in the social determinants of health can lead to increased risk for SARS-CoV-2 exposure among some racial and ethnic groups. For example, persons from

underrepresented racial and ethnic groups might be more likely to live in multigenerational and multifamily households, reside in congregate living environments, hold jobs requiring in-person work (e.g., meatpacking, agriculture, service, and health care), have limited access to health care, or experience discrimination (5,6). Differences in the prevalence of underlying conditions (e.g., diabetes and obesity) among racial and ethnic groups might also be associated with increased susceptibility to COVID-19–associated complications and death (4).

The shift in COVID-19-associated deaths during May-August 2020 from the Northeast (where 17.1% of the U.S. population resides) into the South and West (where 38.3% and 23.9% of the U.S. population resides, respectively)** is consistent with recent findings documenting the emergence of COVID-19 hotspots^{††} in these regions during June-July 2020 (7). The decreasing percentage of deaths occurring among persons aged ≥ 65 years and persons in nursing homes, which were important sites of COVID-19-associated deaths early in the pandemic, suggests a continued shift toward noninstitutionalized and younger populations. The observed geographic shifts in COVID-19-associated deaths might be related to differential implementation of community mitigation efforts throughout the nation, including earlier reopening efforts in selected jurisdictions. To prevent the spread of COVID-19, CDC continues to recommend the use of masks, frequent handwashing, and maintenance of social distancing, including avoidance of large gatherings (8).

The findings in this report are subject to at least two limitations. First, NVSS provisional death data are continually updated and subject to delays. Therefore, this report likely underestimates the number of deaths that occurred, particularly during August 2020, for which data are less complete than previous months. Furthermore, in focusing only on COVID-19–associated deaths captured by NVSS, this report did not address long-term morbidity faced by some persons who survive COVID-19 infections, nor does it account for deaths and morbidity related to the indirect effects of interrupted health care and socioeconomic disruption caused by the pandemic (*9*). For example, one report indicated that by June 30, 2020, an estimated 41% of U.S. adults had delayed or avoided medical

^{**} https://www.census.gov/popclock/print.php?component=growth&image=// www.census.gov/popclock/share/images/growth_1561939200.png.

^{††} Counties defined as hotspot counties met all four of the following criteria, relative to the date assessed: 1) >100 new COVID-19 cases in the most recent 7 days, 2) an increase in the most recent 7-day COVID-19 incidence over the preceding 7-day incidence, 3) a decrease of <60% or an increase in the most recent 3-day COVID-19 incidence over the preceding 3-day incidence, and 4) the ratio of 7-day incidence/30-day incidence exceeds 0.31. In addition, hotspots must have met at least one of the following criteria: 1) >60% change in the most recent 7-day incidence.

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care because of concerns about the pandemic, including 12% who reported having avoided urgent or emergency care (*10*).

Despite these limitations, this report provides information on how demographic and geographic factors have changed among COVID-19–associated deaths during May–August 2020. Racial and ethnic disparities among COVID-19 decedents have persisted over the course of the pandemic and continue to increase among Hispanic persons. These results can inform public health messaging and mitigation efforts focused on prevention and early detection of infection among disproportionately affected groups so as to minimize subsequent mortality.

Acknowledgments

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Exhibit 6

Please Note: This report has been corrected. The definition of pediatric obesity was incorrectly stated in the text of the report and in the Table footnote; however, the analysis was correct and the text of the report and in the Table footnote; however, based on CDC growth charts).

Morbidity and Mortality Weekly Report

Hospitalization Rates and Characteristics of Children Aged <18 Years Hospitalized with Laboratory-Confirmed COVID-19 — COVID-NET, 14 States, March 1–July 25, 2020

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On August 7, 2020, this report was posted as an MMWR Early Release on the MMWR website (https://www.cdc.gov/mmwr).

Most reported cases of coronavirus disease 2019 (COVID-19) in children aged <18 years appear to be asymptomatic or mild (1). Less is known about severe COVID-19 illness requiring hospitalization in children. During March 1-July 25, 2020, 576 pediatric COVID-19 cases were reported to the COVID-19–Associated Hospitalization Surveillance Network (COVID-NET), a population-based surveillance system that collects data on laboratory-confirmed COVID-19-associated hospitalizations in 14 states (2,3). Based on these data, the cumulative COVID-19-associated hospitalization rate among children aged <18 years during March 1-July 25, 2020, was 8.0 per 100,000 population, with the highest rate among children aged <2 years (24.8). During March 21-July 25, weekly hospitalization rates steadily increased among children (from 0.1 to 0.4 per 100,000, with a weekly high of 0.7 per 100,000). Overall, Hispanic or Latino (Hispanic) and non-Hispanic black (black) children had higher cumulative rates of COVID-19-associated hospitalizations (16.4 and 10.5 per 100,000, respectively) than did non-Hispanic white (white) children (2.1). Among 208 (36.1%) hospitalized children with complete medical chart reviews, 69 (33.2%) were admitted to an intensive care unit (ICU); 12 of 207 (5.8%) required invasive mechanical ventilation, and one patient died during hospitalization. Although the cumulative rate of pediatric COVID-19-associated hospitalization remains low (8.0 per 100,000 population) compared with that among adults (164.5),* weekly rates increased during the surveillance period, and one in three hospitalized children were admitted to the ICU, similar to the proportion among adults. Continued tracking of SARS-CoV-2 infections among children is important to characterize morbidity and mortality. Reinforcement of prevention efforts is essential in congregate settings that serve children, including childcare centers and schools.

* https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html.

COVID-NET conducts population-based surveillance for laboratory-confirmed COVID-19-associated hospitalizations in 99 counties[†] in 14 states (California, Connecticut, Colorado, Georgia, Iowa, Maryland, Michigan, Minnesota, New Mexico, New York, Ohio, Oregon, Tennessee, and Utah), representing all 10 U.S. Department of Health and Human Services regions (2,3). Laboratory-confirmed COVID-19associated hospitalizations among residents in a predefined surveillance catchment area who had a positive SARS-CoV-2 molecular test during hospitalization or up to 14 days before admission are included in surveillance. SARS-CoV-2 tests are ordered at the discretion of the treating health care provider. Trained surveillance officers perform medical chart abstractions for all identified cases. Patients aged <18 years hospitalized with COVID-19 during March 1-July 25, 2020, were included in this analysis. Weekly and cumulative COVID-19-associated hospitalization rates were calculated using the number of catchment area residents hospitalized with COVID-19 as the numerator and the National Center for Health Statistics vintage 2019 bridged-race postcensal population estimates as the denominator.[§] Descriptive analyses were conducted using all

[†]Counties in COVID-NET surveillance: California (Alameda, Contra Costa, and San Francisco counties); Colorado (Adams, Arapahoe, Denver, Douglas, and Jefferson counties); Connecticut (New Haven and Middlesex counties); Georgia (Clayton, Cobb, DeKalb, Douglas, Fulton, Gwinnett, Newton, and Rockdale counties); Iowa (one county represented); Maryland (Allegany, Anne Arundel, Baltimore, Baltimore City, Calvert, Caroline, Carroll, Cecil, Charles, Dorchester, Frederick, Garrett, Harford, Howard, Kent, Montgomery, Prince George's, Queen Anne's, St. Mary's, Somerset, Talbot, Washington, Wicomico, and Worcester counties); Michigan (Clinton, Eaton, Genesee, Ingham, and Washtenaw counties); Minnesota (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties); New Mexico (Bernalillo, Chaves, Dona Ana, Grant, Luna, San Juan, and Santa Fe counties); New York (Albany, Columbia, Genesee, Greene, Livingston, Monroe, Montgomery, Ontario, Orleans, Rensselaer, Saratoga, Schenectady, Schoharie, Wayne, and Yates counties); Ohio (Delaware, Fairfield, Franklin, Hocking, Licking, Madison, Morrow, Perry, Pickaway, and Union counties); Oregon (Clackamas, Multnomah, and Washington counties); Tennessee (Cheatham, Davidson, Dickson, Robertson, Rutherford, Sumner, Williamson, and Wilson counties); and Utah (Salt Lake County).

https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/purposemethods.html.

Summary

What is already known about this topic?

Most reported SARS-CoV-2 infections in children aged <18 years are asymptomatic or mild. Less is known about severe COVID-19 in children requiring hospitalization.

What is added by this report?

Analysis of pediatric COVID-19 hospitalization data from 14 states found that although the cumulative rate of COVID-19–associated hospitalization among children (8.0 per 100,000 population) is low compared with that in adults (164.5), one in three hospitalized children was admitted to an intensive care unit.

What are the implications for public health practice?

Children are at risk for severe COVID-19. Public health authorities and clinicians should continue to track pediatric SARS-CoV-2 infections. Reinforcement of prevention efforts is essential in congregate settings that serve children, including childcare centers and schools.

available data; however, for clinical interventions, treatments, and outcomes, only those hospitalizations with complete medical chart review and a discharge disposition (i.e., discharged alive or died during hospitalization) were included. Obesity was defined as body mass index $(kg/m^2) \ge 95$ th percentile for age and sex based on CDC growth charts among children aged ≥ 2 years; this was not evaluated for children <2 years. All analyses were conducted using SAS statistical software (version 9.4; SAS Institute). COVID-NET activities were determined by CDC to be public health surveillance. Participating sites obtained approval for COVID-NET surveillance from their respective state and local Institutional Review Boards, as required.

During March 1–July 25, 576 children hospitalized with COVID-19 were reported to COVID-NET. Infants aged <3 months accounted for 18.8% of all children hospitalized with COVID-19 (Table). The median patient age was 8 years (interquartile range [IQR] = 9 months–15 years), and 292 (50.7%) were males. Among 526 (91.3%) children for whom race and ethnicity information were reported, 241 (45.8%) were Hispanic, 156 (29.7%) were black, 74 (14.1%) were white; 24 (4.6%) were non-Hispanic Asian or Pacific Islander; and four (0.8%) were non-Hispanic American Indian/Alaska Native.

The cumulative COVID-19–associated hospitalization rate among children aged <18 years during the surveillance period was 8.0 per 100,000 and was highest among children aged <2 years (24.8); rates were substantially lower in children aged 2–4 years (4.2) and 5–17 years (6.4) (Figure 1). Overall weekly hospitalization rates among children increased steadily

during the surveillance period (from 0.1 to 0.4 per 100,000, with a weekly high of 0.7 per 100,000; trend test, p<0.001) (Figure 1). COVID-19–associated hospitalization rates were higher among Hispanic and black children than among white children (Figure 2); the rates among Hispanic and black children were nearly eight times and five times, respectively, the rate in white children.

Among 222 (38.5%) of 576 children with information on underlying medical conditions, 94 (42.3%) had one or more underlying conditions (Table). The most prevalent conditions included obesity (37.8%), chronic lung disease (18.0%), and prematurity (gestational age <37 weeks at birth, collected only for children aged <2 years) (15.4%). Hispanic and black children had higher prevalences of underlying conditions (45.7% and 29.8%, respectively) compared with white children (14.9%). Reported signs and symptoms upon hospital admission differed by age: fever or chills were the most common sign and symptom overall (54%) and were most prevalent among children aged <2 years (74.6%). Gastrointestinal symptoms, including nausea or vomiting, abdominal pain, or diarrhea, were reported by 42% of hospitalized children overall.

A medical chart review was completed for 208 (36.1%) children. Median duration of hospitalization was 2.5 days (IQR = 1-5 days). Among 67 children who had a chest radiograph during hospitalization, 44 (65.7%) radiographs showed an infiltrate or consolidation. Among 14 children with chest computed tomography results available, ground-glass opacities (a nonspecific sign indicating infection or alveolar disease) was reported in 10. COVID-19 investigational treatments were only administered to 12 (5.8%) children, all aged 5–17 years; nine received remdesivir. Intravenous immunoglobulin was received by 14 of 208 (6.7%) children. Sixty-nine children (33.2%) were admitted to the ICU for a median of 2 days (IQR = 1-5 days). Invasive mechanical ventilation was required by 12 (5.8%) of 207 children. Since June 18, a discharge diagnosis of multisystem inflammatory syndrome in children (MIS-C) has been systematically collected**; overall, nine (10.8%) of 83 children with completed chart reviews for whom information about MIS-C was systematically collected received a diagnosis of MIS-C. Among 208 children with a discharge disposition, one child (0.5%) with multiple underlying conditions died during hospitalization.

Discussion

Since March 1, 2020, COVID-NET has identified 576 pediatric COVID-19–associated hospitalizations. Although the cumulative COVID-19–associated hospitalization rate among children is low compared with that among adults,

⁹US Department of Health and Human Services, Title 45 Code of Federal Regulations 46, Protection of Human Subjects.

^{**} MIS-C is a hyperinflammatory condition that can affect multiple organs in a child who has a current or recent infection with SARS-CoV-2.

TABLE. Demographic and clinical characteristics of children aged <18 years hospitalized with COVID-19 — COVID-NET, 14 States,* March 1– July 25, 2020[†]

All ages 0-2 yrs 2-4 yrs 5-17 yrs Age group (N = 576) - </th <th></th>	
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	5)
NH Black 156/526 (29.7) 38/162 (23.5) 17/46 (37.0) 101/318 (31	2) 2)
Hispanic or Latino 241/526 (45.8) 73/162 (45.1) 18/46 (39.1) 150/318 (47	2)
NH American Indian/Alaska Native 4/526 (0.8) 0/162 () 0/46 () 4/318 (1-)	-) 3)
NH Asian or Pacific Islander 24/526 (4.6) 13/162 (8.0) 3/46 (6.5) 8/318 (2	5)
Multiple races 3/526 (0.6) 0/162 (5)
Unknown 24/526 (4.6) 9/162 (5.6) 2/46 (4.3) 13/318 (4	Í)
Any underlying condition (N = 222) 94/222 (42.3) 14/65 (21.5) 9/24 (37.5) 71/133 (53	4)
Obesity ⁵ 42/111 (37.8) N/A 6/18 (33.3) 36/93 (38	7)
Chronic lung disease 40/222 (18.0) 2/65 (3.1) 4/24 (16.7) 34/133 (25	, 5)
Asthma 30/222 (13.5) 1/65 (1.5) 0/24 (0) 29/133 (21	3)
Prematurity (gestational age <37 weeks) [¶] 10/65 (15.4) 10/65 (15.4) N/A N	Á
Neurologic disorder 31/222 (14.0) 6/65 (9.2) 7/24 (29.2) 18/133 (13	5)
Immunocompromised condition 12/222 (5.4) 0/65 () 2/24 (8.3) 10/133 (7	5)
Feeding tube dependent 12/222 (5.4) 4/65 (6.2) 3/24 (12.5) 5/133 (3)	3)
Chronic metabolic disease 10/222 (4.5) 1/65 (1.5) 0/24 () 9/133 (6)	3)
Diabetes mellitus 6/222 (2.7) 0/65 () 0/24 () 6/133 (4	5)
Blood disorders 8/222 (3.6) 0/65 () 0/24 () 8/133 (6))
Sickle cell disease 5/222 (2.3) 0/65 () 0/24 () 5/133 (3)	3)
Cardiovascular disease 7/222 (3.2) 2/65 (3.1) 2/24 (8.3) 3/133 (2	3)
Congenital heart disease 4/222 (1.8) 2/65 (3.1) 1/24 (4.2) 1/133 (0	3)
Any underlying condition by race/ethnicity (N = 94)	
NH White 14/94 (14.9) 4/14 (28.6) 0/9 (—) 10/71 (14	I)
NH Black 28/94 (29.8) 3/14 (21.4) 2/9 (22.2) 23/71 (32	1)
Hispanic or Latino 43/94 (45.7) 7/14 (50) 6/9 (66.7) 30/71 (42)	3)
NH American Indian/Alaska Native 2/94 (2.1) 0/14 () 0/9 () 2/71 (2	3)
NH Asian or Pacific Islander 3/94 (3.2) 0/14 () 0/9 () 3/71 (4	2)
Multiracial 1/94 (1.1) 0/14 () 1/9 (11.1) 0/71 (-	-)
Unknown 3/94 (3.2) 0/14 () 0/9 () 3/71 (4	<u>2</u>)
Signs and symptoms (N = 224)	
Fever/chills 121/224 (54.0) 50/67 (74.6) 13/24 (54.2) 58/133 (43	5)
Inability to eat/poor feeding ¹¹ 22/67 (32.8) 22/67 (32.8) N/A N	A
Nausea/vomiting 69/224 (30.8) 14/67 (20.9) 6/24 (25.0) 49/133 (36	3)
Cough 66/224 (29.5) 17/67 (25.4) 3/24 (12.5) 46/133 (34	5)
Nasal congestion/rhinorrhea 53/224 (23.7) 22/67 (32.8) 5/24 (20.8) 26/133 (19))
Shortness of breath/respiratory distress 50/224 (22.3) 9/67 (13.4) 2/24 (8.3) 39/133 (29	3) 2)
Abdominal pain 42/224 (18.8) 2/07 (3.0) 3/24 (12.5) 3/133 (2/	5))
$\frac{27/224(12.1)}{19/133(14)} = \frac{208}{100} \text{ median days} (IOR) = \frac{25(1-5)}{25(1-5)} = \frac{2(1-2)}{2(1-2)} = \frac{3(1-4)}{3(1-4)} = \frac{3(1-4)}{3(1-4)$	5) 5)
Chest radiograph findings (N = 67)	~)
Infiltrate/consolidation 44/67 (65.7) 8/15 (53.3) 3/9 (33.3) 33/43 (76	7)
Bronchopneumonia/pneumonia 14/67 (20.9) 2/15 (13.3) 0/9 (—) 12/43 (27	, Э)
Pleural effusion 4/67 (6.0) 0/15 () 1/9 (11.1) 3/43 (7))
Chest CT findings (N = 14)	~
Ground glass opacities 10/14 (71.4) 1/1 (100.0) 1/1 (100.0) 8/12 (66	7)
Infiltrate/consolidation 7/14 (50.0) 0/1 (—) 0/1 (—) 7/12 (58	3)
Bronchopneumonia/pneumonia 4/14 (28.6) 0/1 () 0/1 () 4/12 (33	3)
Pleural effusion 3/14 (21.4) 0/1 () 3/12 (25))

See table footnotes on the next page.

TABLE. (*Continued*) Demographic and clinical characteristics of children aged <18 years hospitalized with COVID-19 — COVID-NET, 14 States,* March 1–July 25, 2020[†]

No./Total no. (%)				
Characteristic	All ages	0–2 yrs	2–4 yrs	5–17 yrs
COVID-19 investigational treatment (N = 208)**				
Received treatment	12/208 (5.8)	0/61 (—)	0/24 (—)	12/123 (9.8)
Remdesivir	9/208 (4.3)	0/61 (—)	0/24 (—)	9/123 (7.3)
Azithromycin ^{††}	6/208 (2.9)	0/61 (—)	0/24 (—)	6/123 (4.9)
Hydroxychloroquine	4/208 (1.9)	0/61 (—)	0/24 (—)	4/123 (3.3)
Convalescent plasma	1/208 (0.5)	0/61 (—)	0/24 (—)	1/123 (0.8)
Lopinavir-ritonavir ^{§§}	1/208 (0.5)	0/61 (—)	0/24 (—)	1/123 (0.8)
ICU admission (N = 208)	69/208 (33.2)	19/61 (31.1)	9/24 (37.5)	41/123 (33.3)
ICU length of stay median days (IQR)	2 (1–5)	1 (1–3)	2 (2–5)	3.5 (1–7)
Interventions (N = 208) ^{¶¶}				
Invasive mechanical ventilation***	12/207 (5.8)	0/61 (—)	4/24 (16.7)	8/122 (6.6)
BIPAP/CPAP***	8/207 (3.9)	2/61 (3.3)	2/24 (8.3)	4/122 (3.3)
High flow nasal cannula***	5/207 (2.4)	1/61 (1.6)	1/24 (4.2)	3/122 (2.5)
Systemic steroids	19/208 (9.1)	1/61 (1.6)	4/24(16.7)	14/123 (11.4)
IVIG	14/208 (6.7)	1/61 (1.6)	5/24 (20.8)	8/123 (6.5)
Vasopressor	10/208 (4.8)	0/61 (—)	0/24 (—)	10/123 (8.1)
New clinical discharge diagnoses (N = 208)				
Pneumonia	23/208 (11.1)	2/61 (3.3)	2/24 (8.3)	19/123 (15.4)
Multisystem inflammatory syndrome in children (MIS-C) ^{†††}	9/83 (10.8)	1/15 (6.7)	5/15 (33.3)	3/53 (5.7)
Acute respiratory failure	10/208 (4.8)	0/61 (—)	3/24 (12.5)	7/123 (5.7)
Acute kidney injury	6/208 (2.9)	0/61 (—)	0/24 (—)	6/123 (4.9)
Diabetic ketoacidosis	6/208 (2.9)	0/61 (—)	0/24 (—)	6/123 (4.9)
Acute respiratory distress syndrome	4/208 (1.9)	1/61 (1.6)	0/24 (—)	3/123 (2.4)
Died during hospitalization (N = 208)	1/208 (0.5)	0/61 (—)	0/24 (—)	1/123 (0.8)

Abbreviations: BIPAP = bilevel positive airway pressure; CT = computed tomography; CPAP = continuous positive airway pressure; COVID-19 = coronavirus disease 2019; COVID-NET = COVID-19–Associated Hospitalization Surveillance Network; ICU = intensive care unit; IQR = interquartile range; IVIG = intravenous immune globulin; N/A = not applicable; NH = non-Hispanic.

* California, Connecticut, Colorado, Georgia, Iowa, Maryland, Michigan, Minnesota, New Mexico, New York, Ohio, Oregon, Tennessee, and Utah.

⁺ Analyses were conducted on all available data; however, for hospitalization length of stay, radiology findings, treatments, ICU admission, interventions, new clinical diagnoses, and outcome, only cases with a complete medical chart review and a discharge disposition (i.e. discharged alive or died during hospitalization) were included.

[§] Obesity was defined as body mass index (kg/m²) ≥95th percentile for age and sex based on CDC growth charts among children aged ≥2 years; this was not evaluated for children <2 years.</p>

[¶] Data collected only on children aged <2 years.

** Not mutually exclusive treatment categories.

⁺⁺ Given with at least one other COVID-19 investigational treatment.

^{§§} Not given for human immunodeficiency virus infection.

^{¶¶} Two hospitalized children received extracorporeal membrane oxygenation (1 each aged <2 years and 5–17 years). None received renal replacement therapy.

*** Highest level of respiratory support for each case that needed respiratory support.

⁺⁺⁺ Since June 18, a discharge diagnosis of multisystem inflammatory syndrome in children (MIS-C) was systematically collected through COVID-NET.

weekly hospitalization rates in children increased during the surveillance period. Children can develop severe COVID-19 illness; during the surveillance period, one in three children were admitted to the ICU. Hispanic and black children had the highest rates of COVID-19–associated hospitalization.

Continued surveillance will allow for further characterization of the burden and outcomes of COVID-19–associated hospitalizations among children. These data will help to better define the clinical spectrum of disease in children and the contributions of race and ethnicity and underlying medical conditions to hospitalizations and outcomes.

Reasons for disparities in COVID-19-associated hospitalization rates by race and ethnicity are not fully understood. This report found the highest rates of COVID-19-associated hospitalization among Hispanic children. Similarly, a recent study from the Baltimore-District of Columbia region found a higher prevalence of SARS-CoV-2 infection in the Hispanic community compared with that in other racial and ethnic communities (4). Although hospitalization rates were lower for Hispanic persons than for black and white persons, hospitalized Hispanic patients were more likely to be younger (aged <44 years) (4). It has been hypothesized that Hispanic adults might be at increased risk for SARS-CoV-2 infection because they are overrepresented in frontline (e.g., essential and direct-service) occupations with decreased opportunities for social distancing, which might also affect children living in those households (4). During the 2009 influenza A H1N1 pandemic, pediatric mortality rates also were higher among underrepresented ethnic groups in a study from England (5).

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Morbidity and Mortality Weekly Report



FIGURE 1. Cumulative (A) and weekly (B) COVID-19–associated hospitalization rates^{*,†} among children aged <18 years, by age group — COVID-NET, 14 states[§], March 1–July 25, 2020¹

See footnotes on the next page.

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Morbidity and Mortality Weekly Report

Abbreviation: COVID-NET = Coronavirus Disease 2019–Associated Hospitalization Surveillance Network.

* Number of children in each age group hospitalized with COVID-19 per 100,000 population.

- ⁺ Figure B shows the 3-week moving average of weekly hospitalization rates for children in each age group hospitalized with COVID-19 per 100,000 population. A trend test was conducted using weighted linear regression, where the weight for each MMWR week was the inverse of the variance. Trend test overall (<18 years): p-value <0.001.
- [§] Counties included in COVID-NET surveillance: California (Alameda, Contra Costa, and San Francisco counties); Colorado (Adams, Arapahoe, Denver, Douglas, and Jefferson counties); Connecticut (New Haven and Middlesex counties); Georgia (Clayton, Cobb, DeKalb, Douglas, Fulton, Gwinnett, Newton, and Rockdale counties); Iowa (one county represented); Maryland (Allegany, Anne Arundel, Baltimore, Baltimore City, Calvert, Caroline, Carroll, Cecil, Charles, Dorchester, Frederick, Garrett, Harford, Howard, Kent, Montgomery, Prince George's, Queen Anne's, St. Mary's, Somerset, Talbot, Washington, Wicomico, and Worcester counties); Michigan (Clinton, Eaton, Genesee, Ingham, and Washtenaw counties); Minnesota (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties); New Mexico (Bernalillo, Chaves, Dona Ana, Grant, Luna, San Juan, and Santa Fe counties); New York (Albany, Columbia, Genesee, Greene, Livingston, Monroe, Montgomery, Ontario, Orleans, Rensselaer, Saratoga, Schenectady, Schoharie, Wayne, and Yates counties); Ohio (Delaware, Fairfield, Franklin, Hocking, Licking, Madison, Morrow, Perry, Pickaway and Union counties); Oregon (Clackamas, Multnomah, and Washington counties); Tennessee (Cheatham, Davidson, Dickson, Robertson, Rutherford, Sumner, Williamson, and Wilson counties); and Utah (Salt Lake County).
- [¶] Data are preliminary, and case counts and rates for recent hospital admissions are subject to lag. As data are received each week, previous case counts and rates are updated accordingly.

FIGURE 2. Cumulative COVID-19-associated hospitalization rates* among children aged <18 years, by age group and race/ethnicity — COVID-NET, 14 states[†], March 1–July 25, 2020^{S,¶}



Abbreviation: COVID-NET = Coronavirus Disease 2019–Associated Hospitalization Surveillance Network.

*Number of children aged <18 years hospitalized with COVID-19 per 100,000 population.

- [†] Counties included in COVID-NET surveillance: California (Alameda, Contra Costa, and San Francisco counties); Colorado (Adams, Arapahoe, Denver, Douglas, and Jefferson counties); Connecticut (New Haven and Middlesex counties); Georgia (Clayton, Cobb, DeKalb, Douglas, Fulton, Gwinnett, Newton, and Rockdale counties); lowa (one county represented); Maryland (Allegany, Anne Arundel, Baltimore, Baltimore City, Calvert, Caroline, Carroll, Cecil, Charles, Dorchester, Frederick, Garrett, Harford, Howard, Kent, Montgomery, Prince George's, Queen Anne's, St. Mary's, Somerset, Talbot, Washington, Wicomico, and Worcester counties); Michigan (Clinton, Eaton, Genesee, Ingham, and Washtenaw counties); Minnesota (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties); New Mexico (Bernalillo, Chaves, Dona Ana, Grant, Luna, San Juan, and Santa Fe counties); New York (Albany, Columbia, Genesee, Greene, Livingston, Monroe, Montgomery, Ontario, Orleans, Rensselaer, Saratoga, Schenectady, Schoharie, Wayne, and Yates counties); Ohio (Delaware, Fairfield, Franklin, Hocking, Licking, Madison, Morrow, Perry, Pickaway and Union counties); Oregon (Clackamas, Multnomah, and Washington counties); Tennessee (Cheatham, Davidson, Dickson, Robertson, Rutherford, Sumner, Williamson, and Wilson counties); and Utah (Salt Lake County).
- [§] Data are preliminary, and case counts and rates for recent hospital admissions are subject to lag. As data are received each week, prior case counts and rates are updated accordingly. As of July 25, 2020, 50 (8.7%) of 576 pediatric hospitalized cases were missing data on race and ethnicity.
- Rates are not shown among non-Hispanic Asian or Pacific Islanders and non-Hispanic American Indian/Alaska Natives because of small case counts, leading to unstable estimates. All non-Hispanic American Indian/Alaska Native hospitalized children were aged 5–17 years.

Forty-two percent of children in this analysis had one or more underlying medical conditions, with higher prevalences among Hispanic and black children. This suggests that the presence of underlying conditions place children at higher risk for COVID-19-associated hospitalizations and that observed disparities might in part be related to the higher prevalence of underlying conditions among hospitalized Hispanic and black children compared with those among white children. This study, along with other studies of hospitalized children with COVID-19, found that obesity was the most prevalent underlying medical condition (6,7). Childhood obesity affects almost one in five U.S. children and is more prevalent in black and Hispanic children (8); therefore, understanding the underlying pathophysiologic association between obesity and SARS-CoV-2 infection is important to identifying possible clinical interventions and preventive strategies to reduce the risk for hospitalization.

This report and others have found that, although one third of children hospitalized with COVID-19 were admitted to the ICU, the case-fatality rate remains low, even among children hospitalized with more severe COVID-19-associated complications, such as MIS-C (6,7,9). By comparison, among U.S. children hospitalized with seasonal influenza virus infection, estimates of ICU admissions have ranged from 16% to 25% among hospitalized children without and with underlying medical conditions, respectively, and reports of in-hospital deaths also are rare (<1%) (10). The percentage of ICU admission was similar among children (33.2%) and adults (32.0%) reported to COVID-NET; however, invasive mechanical ventilation was required less frequently in children (5.8%) than in adults (18.6%) (3). Continued monitoring of hospitalizations, ICU admissions, and mortality among children is important to understand potential risk factors for severe outcomes.

The findings in this report are subject to at least five limitations. First, laboratory confirmation is dependent on clinician-ordered SARS-CoV-2 molecular testing. Rates

likely are underestimates; cases can be missed because of test availability, test performance, and provider or facility testing practices. Second, hospitalization rates by age group and race/ ethnicity are preliminary and might change as additional cases are identified during the surveillance period. Third, analysis of interventions, treatments, and outcomes was based on a convenience sample of children with a final disposition and complete chart reviews. A higher proportion of included children were aged <6 months, and two sites contributed more than half of cases; however, compared with other single-center or state-based studies, COVID-NET is more geographically and racially diverse (2). Approximately 60% of pediatric hospitalizations reported to COVID-NET have not had a chart review, and this sample might be biased. In the future, COVID-NET plans to have complete, population-based data on hospitalized children. Finally, COVID-NET did not systematically collect information on MIS-C until June 18. In addition, given that molecular tests can miss approximately half of patients with MIS-C despite serologic or epidemiologic evidence of a past SARS-CoV-2 infection (9), COVID-NET surveillance likely underestimates the percentage of MIS-C cases among SARS-CoV-2 infections in children.

Using a multisite, geographically diverse network, this report found that children with SARS-CoV-2 infection can have severe illness requiring hospitalization and intensive care. Improved understanding of the social determinants of health is needed to inform and reduce disparities as evidenced by pediatric COVID-19-associated hospitalization rates. Similar to the general population, children should be encouraged to wash their hands often and continue social distancing, and children aged ≥ 2 years should wear a mask when around persons outside of their families to reduce the risk for SARS-CoV-2 infection and transmission to others. Ongoing monitoring of hospitalization rates, clinical characteristics, ICU admission, and outcomes in the pediatric population is important to further characterize the morbidity and mortality of COVID-19 in children.

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Exhibit 7





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THE COLOR OF CORONAVIRUS: COVID-19 DEATHS BY RACE AND ETHNICITY IN THE U.S.



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You value and rely on the work of the APM Research Lab. And we rely on you, especially

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Our ongoing Color of Coronavirus project monitors how and where COVID-19 mortality is inequitably impacting certain communities—to guide policy and community responses to these disproportionate deaths. **The coronavirus has claimed more than 217,000 American lives through Oct. 13, 2020—about 22,000 more than our last update four weeks ago, averaging nearly 800 deaths per day.** We know the race and ethnicity for 97% of the cumulative deaths in the United States.

Our latest update reveals continued wide disparities by race, most dramatically for Black and Indigenous Americans. We also adjust these mortality rates for age, a common and important tool that health researchers use to compare diseases that affect age groups differently. This results in even larger mortality disparities observed between Black, Indigenous and other populations of color relative to Whites, who experience the lowest age-adjusted rates nationally. Age-adjusting elevates the mortality rate for Latinos more than any other group—revealing that COVID-19 is stealing far more Latino lives than we would expect despite this group's relative youthfulness.

New with this update, we present mortality data over time for all states—not just cumulatively—to help us monitor the virus' changing impacts throughout fall and winter.

See our work cited in Forbes, CNN, NBC News, Vox, JAMA, Politico, Newsweek, Al Jazeera, the Washington Post, The Hill, The Guardian, the New York Times and numerous other outlets.

The APM Research Lab has independently compiled these death statistics. (Learn more about how.) The result is the most robust and up-to-date portrait of COVID-19 mortality by race available anywhere, with a lens on inequitable deaths. We

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have been tracking these deaths for six months now, revealing COVID-19's growing toll on all Americans, but with the heaviest losses among Black and Indigenous Americans.

Black & Indigenous Americans experience highest death tolls from COVID-19

Cumulative actual COVID-19 mortality rates per 100,000, by race and ethnicity, April 13-Oct. 13, 2020



Note: All intervals are 14 days apart, except for 5/11-5/26, which is a 15-day period. 9/1 and 9/29 data has been interpolated. Pacific Islander data prior to 10/13 did not include Hawaii, as it was not releasing data; its inclusion resulted in an overall drop in the Pacific Islander rate, which begins a new series at 10/13.

Source: APM Research Lab · Get the data · Created with Datawrapper

KEY FINDINGS (from data through Oct. 13):

- These are the documented, nationwide actual mortality impacts from COVID-19 data (aggregated from all U.S. states and the District of Columbia) for all race groups:
 - 1 in 920 Black Americans has died (or 108.4 deaths per 100,000)
 - 1 in 1,110 Indigenous Americans has died (or 90.0 deaths per 100,000)
 - 1 in 1,360 Latino Americans has died (or 73.5 deaths per 100,000)
 - 1 in 1,450 Pacific Islander Americans has died (or 68.9 deaths per 100,000).

Note that this rate declined slightly from our prior update due to the new inclusion of data for the state of Hawaii, which was not previously available, in its calculation. Case 5:20-cv-00830 cdvB-19 Decrementer By face Fileethild y 20 APO Researce Lab of 136

- 1 in 1,840 White Americans has died (or 54.4 deaths per 100,000)
- 1 in 2,200 Asian Americans has died (or 45.4 deaths per 100,000)
- **Black Americans** continue to experience the highest actual COVID-19 mortality rates nationwide—two or more times as high as the rate for Whites and Asians, who have the lowest actual rates.

If they had died of COVID-19 at the same actual rate as White Americans, about 21,800 Black, 11,400 Latino, 750 Indigenous and 65 Pacific Islander Americans would still be alive.

- Adjusting the data for age differences in race groups widens the gap in the overall mortality rates between all other groups and Whites, who have the lowest rate. Compared to Whites, the latest U.S. age-adjusted COVID-19 mortality rate for:
 - Blacks is 3.2 times as high
 - Latinos is 3.2 times as high
 - Indigenous people is 3.1 times as high
 - Pacific Islanders is 2.4 times as high, and
 - Asians is 1.2 times as high.

Adjusted for age, other racial groups are this many times more likely to have died of COVID-19 than White Americans

Reflects mortality rates calculated through Oct. 13.

BLACK					3.2
LATINO					3.2
INDIGENOUS				3.	.1
PACIFIC ISLANDER			2.4		
ASIAN		1.2			
WHITE	1				
Indirect age-adjustment has been used.					

Source: APM Research Lab • Get the data • Created with Datawrapper

(A fuller discussion of our indirectly age-adjusted rates follows.)

HOW TO EXAMINE THE DATA:

1. EXPLORE CUMULATIVE MORTALITY RATES BY GEOGRAPHY, COMPARING GROUPS

We've presented the data we've collected for the nation overall and each state as:

- Actual mortality rates expressed per 100,000;
- Age-adjusted mortality rates per 100,000; and
- Total deaths experienced by each racial and ethnic group

2. EXPLORE NUMBER OF DEATHS OR RATES OVER TIME, COMPARING GROUPS

Explore **actual mortality rates** and **total deaths by race and ethnicity** for any state or Washington, D.C., beginning in early June 2020.

3. EXPLORE CUMULATIVE FINDINGS BY GROUP, COMPARING GEOGRAPHIES

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Examine the differences for one group at a time across all states with available data. For each group, we provide contextual data and a visual comparison against White Americans' rates using the age-adjusted data, to examine where disparities relative to Whites are the greatest.

INDIGENOUS AMERICANS | ASIAN AMERICANS | BLACK AMERICANS | LATINO AMERICANS |

WHITE AMERICANS | NATIVE HAWAIIAN & OTHER PACIFIC ISLANDER AMERICANS

For more context about the shortcomings of some of the data, please read our note about Indigenous, Pacific Islander, Multiracial and Other Race Americans. If you'd like to examine the percentage of deaths compared to the percentage of population by racial group for each state (which previously appeared on this site), you can find this data in our complete data file.

+ UNDERSTANDING AGE-ADJUSTED MORTALITY RATES

Click to read more

CUMULATIVE MORTALITY RATES:

Review cumulative mortality rates—both actual and age-adjusted—for the District of Columbia or any state by changing the dropdown menu below. Rates were not calculated when there were fewer than 15 deaths for a particular group (resulting in a "0" value in the graph below). Rates for Indigenous and Pacific Islander residents could only be calculated for some states. Additionally, rates were not calculated for multiracial people, nor those identified as "Other" race.

SEARCH BY STATE

(Use Shift + Ctrl to select more than one state)



VIEW THE AGE-ADJUSTED RATES

COVID-19 DEATHS PER 100,000 PEOPLE, THROUGH OCT. 13, 2020



* Includes all available data from Washington, D.C., and the 50 states. Users are cautioned that the Indigenous rate is calculated from just 36 states reporting Indigenous deaths, and the Pacific Islander rate from just 16 states reporting such deaths. States employ varying collection methods regarding ethnicity data. Denominator is built from data aggregated from each state, aligned with their method. Users are cautioned that states do not uniformly report Indigenous, Pacific Islander and other deaths, and many of these deaths are represented in "Other" race.

ACTUAL MORTALITY RATES OVER TIME

SEARCH BY STATE



RATES OF DEATH FROM COVID-19 (PER 100,000 PEOPLE) IN ALL STATES, JUNE 9-OCT. 13, 2020



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Notes: The nationwide rate for Pacific Islanders declined slightly between 9/15 and 10/13 due to the new inclusion of data for the state of Hawaii, which was not previously available, in its calculation. Rates are only calculated for groups with 15 or more deaths. All intervals are two weeks apart. Data for 9/1 and 9/29 has been interpolated. Users are cautioned that both estimates of deaths and rates graphed over time have slight idiosyncrasies including occasional reductions. We capture data at a point in time, after which provisional data sometimes gets back-revised by states. Deaths by race may move downward as states reclassify data after review. Data for states that post only percentages are more prone to rounding errors, as we have had to estimate number of deaths. Furthermore, many states have improved their reporting processes over time. For all these reasons, all data should be considered approximate. Data for Florida, Indiana, Kansas, Kentucky, Nevada, the balance of New York outside of New York City, Pennsylvania and Texas was newly obtained from the CDC for the 10/13 update; for Indiana, Kansas, Kentucky and Louisiana, this change resulted in the race groups becoming non-Hispanic (previously Hispanic ethnicity was overlapping). Some other states have changed their treatment of ethnicity over time; we have updated denominators accordingly. Please contact us for additional details.

COUNTS OR ESTIMATES OF DEATHS BY RACE & ETHNICITY

Explore how the distribution of American lives lost varies by race and ethnicity, beginning with totals in early June. Select a state to see the cumulative trend graphed similarly.

SEARCH BY STATE





CUMULATIVE U.S. COVID-19 DEATHS BY RACE/ETHNICITY IN ALL STATES, JUNE 9-OCT. 13, 2020

Notes: All intervals are two weeks apart. Data for 9/1 and 9/29 has been interpolated. Users are cautioned that both estimates of deaths and rates graphed over time have slight idiosyncrasies including occasional reductions. We capture data at a point in time, after which provisional data sometimes gets back-revised by states. Deaths by race may move downward as states reclassify data after review. Data for states that post only percentages are more prone to rounding errors, as we have had to estimate number of deaths. Furthermore, many states have improved their reporting processes over time. For all these reasons, all data should be considered approximate. Data for Florida, Indiana, Kansas, Kentucky, Nevada, the balance of New York outside of New York City, Pennsylvania and Texas was newly obtained from the CDC for the 10/13 update; for Indiana, Kansas, Kentucky and Louisiana, this change resulted in the race groups becoming non-Hispanic (previously Hispanic ethnicity was overlapping). A small amount of double-counting of individuals occurs in this graph in states where Latino ethnicity is reported overlapping with

Users can examine the cumulative death totals, grouped by racial and ethnic group, for their state(s) of interest below. Depending on the geography, the "Other" group in this graph may include Indigenous people, Native Hawaiian or other Pacific Islanders, Multiracial people, those identified as "Other" race, and in a few cases, Asians. (This is due to uneven reporting by states.) Please see the notes below the graph, or request **our complete data file** for additional information.

SEARCH BY STATE







COVID-19 DEATHS BY RACE AND ETHNICITY, THROUGH OCT. 13, 2020

* Includes all available data from Washington, D.C., and the 50 states. States employ varying collection methods regarding ethnicity data. Our sum is built from data aggregated from each state, aligned with their method. Users are cautioned that states do not uniformly report Indigenous, Pacific Islander and other deaths, and many of these deaths are represented in "Other" race.

FOCUS ON INDIGENOUS AMERICANS

Lives lost to date

• 1,886 Indigenous Americans are known to have lost their lives to COVID-19 through Tuesday, Oct. 13. This is an increase of 243 deaths among Indigenous

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people compared to our last report four weeks earlier, and includes data from three additional areas (the balance of New York outside of New York City, Texas and Vermont).

(Note: This total is a known under-count. Numerous states report Indigenous deaths in the Other category, so we cannot see those numbers uniquely.)

 Indigenous Americans have experienced 1.2% of the deaths of known race (in 36 states reporting one or more Indigenous deaths), but represent 0.8% of the population in those states.

Actual mortality rate

For each 100,000 Americans (of their respective group), about 90 Indigenous people have died from the coronavirus, a mortality rate well above Asians (45) and Whites (54), and somewhat above Pacific Islanders (69) and Latinos (74). Only Blacks (108) have a higher actual mortality rate.

(Note: Users are cautioned that the overall mortality rate for Indigenous people was constructed from 36 states reporting such deaths, while most other rates reflect additional geographies in the U.S.)

Age-adjusted mortality rate

- Nationwide, Indigenous people are 3.1 times more likely to have died than Whites, when age is taken into account.
- Adjusted for age, Arizona, New Mexico and (especially) Mississippi have seen the greatest absolute disparities in COVID-19 mortality rates between their White and Indigenous residents. Mississippi has experienced 87 deaths among its Indigenous residents, which number fewer than 13,000 statewide.
- The graph below shows age-adjusted COVID-19 mortality rates for Indigenous residents compared to White residents by state, sorted from the largest to smallest gap. Rates are calculated for all states with 15 or more deaths. In every state shown, Indigenous mortality outpaces White mortality.

Indigenous vs White Americans: Age-adjusted COVID-19 mortality rates, through Oct. 13

Deaths per 100,000 of each group. For all U.S. states with available data, where 15 or more known deaths have occurred for both groups. Sorted from largest to smallest absolute disparity between Indigenous people and Whites.

INDIGENOUS WHITE

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Mississippi	62
New Mexico	314 16
Arizona	318 45
Utah	268 13
Wyoming	187 4
South Dakota	149 21
Montana	134 7
North Dakota	139 25
Minnesota	135 29
US TOTAL	121 40
Washington	81 22
Texas	70 33
Wisconsin	47 18
Oklahoma	47 22
Michigan	64 38
Florida	57 34
Alaska	28 5
North Carolina	45 24
California	42 22
New York	94 87

Indirect age-adjustment has been used. All additional deaths reported below the threshold of 15 per state have been used in the calculation of the U.S. total.

Source: APM Research Lab • Get the data • Created with Datawrapper

FOCUS ON ASIAN AMERICANS

Lives lost to date

- 8,182 Asian Americans are known to have lost their lives to COVID-19 through Tuesday, Oct. 13. This is an increase of 884 deaths among Asians compared to our last report four weeks earlier.
- Nationwide Asian Americans have experienced 4.0% of all deaths of known race, while they represent 5.7% of the population.

(Notes: Missouri and South Carolina include Asians in their "Other" category. Arizona, Connecticut, Delaware, Idaho, Michigan, Oklahoma and Wisconsin report deaths for Asians and Pacific Islanders jointly, so they are presented together for those states.)

Actual mortality rate

• For each 100,000 Americans (of their respective group), about 45 Asians have died from the coronavirus, a mortality rate slightly below Whites (54), somewhat below Pacific Islanders (69) and Latinos (74), and half or less than half the rates for Indigenous people (90) and Blacks (108).

Age-adjusted mortality rate

- Nationwide, Asians are 1.2 times more likely to have died than Whites, when age is taken into account.
- Adjusted for age, Minnesota, Nebraska and (especially) New York state have seen the greatest absolute disparities in COVID-19 mortality rates between their White and Asian residents.
- Of note, Asian mortality rates are lower than Whites in nine states, most dramatically in Massachusetts and Connecticut.
- The graph below shows age-adjusted COVID-19 mortality rates for Asian residents compared to White residents by state, sorted from the largest to smallest (or negative) gap. Rates are calculated for all states with 15 or more deaths.

Asian vs White Americans: Age-adjusted COVID-19 mortality rates, through Oct. 13

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Deaths per 100,000 of each group. For all U.S. states with available data, where 15 or more known deaths have occurred for both groups. Sorted from largest to smallest (negative) absolute disparity between Asians and Whites.

ASIAN	WHITE		
New York	149 87		
Nebraska	80 19		
Minnesota	76 29		
Utah	52 13		
Arkansas	70 32		
Nevada	65 28		
Wisconsin	51 18		
lowa	65 32		
Kentucky	47 23		
Oklahoma	45 22		
Colorado	50 28		
Illinois	62 41		
Pennsylvania	58 43		
US TOTAL	49 40		
California	30 22		
Washington	28 22		
Virginia	34 29		
Missouri	29 24		
Oregon	13 9		
North Carolina	28 24		
Florida	37 34		
Tennessee	31 29		
Michigan	41 38		
Maryland	42 40		

Texas	32 33
Indiana	40 43
Ohio	28 31
Georgia	45 53
New Jersey	120 130
Arizona	32 45
Louisiana	65 81
Massachusetts	72 106
Connecticut	47 90

Indirect age-adjustment has been used. All additional deaths reported below the threshold of 15 per state have been used in the calculation of the U.S. total.

Source: APM Research Lab · Get the data · Created with Datawrapper

FOCUS ON BLACK AMERICANS

Lives lost to date

- 43,844 Black Americans are known to have lost their lives to COVID-19 through Tuesday, Oct. 13. This is an increase of 4,126 deaths among Blacks compared to our last report four weeks earlier.
- Nationwide, Black Americans have experienced 20.8% of all deaths of known race, but represent 12.4% of the population.

Actual mortality rate

• For each 100,000 Americans (of their respective group), about 108 Blacks have died from the coronavirus, the highest actual mortality rate of all groups—above Asians (45), Whites (54), Pacific Islanders (69), Latinos (74) and Indigenous people (90).

Case 5:20-cv-00830 cb/P-1 claemumanate58/ Eace Endedhild/20A20 Reseage L97 of 136 Age-adjusted mortality rate

- Nationwide, Blacks are 3.2 times more likely to have died than Whites, when age is taken into account.
- Adjusted for age, New Jersey, Michigan and New York state have seen the greatest absolute disparities in COVID-19 mortality rates between their White and Black residents.
- The graph below shows age-adjusted COVID-19 mortality rates for Black residents compared to White residents by state, sorted from the largest to smallest gap. Rates are calculated for all states with 15 or more deaths. In every state shown, Black mortality outpaces White mortality.

Black vs White Americans: Age-adjusted COVID-19 mortality rates, through Oct. 13

Deaths per 100,000 of each group. For all U.S. states with available data, where 15 or more known deaths have occurred for both groups. Sorted from largest to smallest absolute disparity between Blacks and Whites.

BLACK WH	E
New York	314 87
Michigan	215 38
New Jersey	273 130
Connecticut	232 90
Louisiana	198 81
Massachusetts	219 106
District of Columb	137 32
Pennsylvania	146 43
Mississippi	160 62
Minnesota	125 29
Illinois	136 41
Indiana	136 43
Wisconsin	107 18
US TOTAL	128 40

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lowa	32
Florida	111 34
Rhode Island	144 71
Missouri	94 24
Georgia	124 53
Nevada	90 28
South Carolina	99 37
Maryland	101 40
Kansas	79 19
Arkansas	87 32
Colorado	82 28
Tennessee	83 29
Alabama	86 31
Texas	79 33
Delaware	91 45
Nebraska	64 19
Arizona	89 45
California	59 22
Ohio	64 31
Virginia	60 29
North Carolina	55 24
Kentucky	53 23
Washington	41 22
Oklahoma	32 22

Indirect age-adjustment has been used. All additional deaths reported below the threshold of 15 per state have been used in the calculation of the U.S. total.

Source: APM Research Lab • Get the data • Created with Datawrapper

FOCUS ON LATINO AMERICANS

Lives lost to date

- 43,953 Latino Americans are known to have lost their lives to COVID-19 through Tuesday, Oct. 13. This is an increase of 5,257 deaths among Latinos compared to our last report four weeks earlier.
- Latino Americans have experienced 20.9% of all deaths of known race, but represent 18.3% of the population.

Actual mortality rate

For each 100,000 Americans (of their respective group), about 74 Latinos have died from the coronavirus, a mortality rate considerably above Asians (45) and Whites (54), slightly above Pacific Islanders (69), somewhat below Indigenous people (90) and well below Blacks (108).

Age-adjusted mortality rate

- Nationwide, Latinos are 3.2 times more likely to have died than Whites, when age is taken into account.
- Adjusted for age, New Jersey, the District of Columbia and (especially) New York state have seen the greatest absolute disparities in COVID-19 mortality rates between their White and Latino residents.
- The graph below shows age-adjusted COVID-19 mortality rates for Latino residents compared to White residents by state, sorted from the largest to smallest gap. Rates are calculated for all states with 15 or more deaths. In every state shown, Latino mortality outpaces White mortality.

Latino vs White Americans: Age-adjusted COVID-19 mortality rates, through Oct. 13

Deaths per 100,000 of each group. For all U.S. states with available data, where 15 or more known deaths have occurred for both groups. Sorted from largest to smallest absolute disparity between Latinos and Whites.

LATINO	WHITE	
New York		322 87
District of Colu	mbia	194 32
New Jersey		272 130
Maryland		165 40
Illinois		159 41
Nebraska		127 19
Texas		140 33
Missouri		119 24
Arizona		139 45
Tennessee		121 29
Arkansas		119 32
lowa		119 32
US TOTAL		126 40
Delaware		122 45
Wisconsin		95 18
Nevada		104 28
Pennsylvania		114 43
Mississippi		132 62
Minnesota		96 29
North Carolina		90 24
Washington		86 22
California		86 22
Georgia		117 53
Rhode Island		133 71
Virginia		90 29

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			•	•
Kansas	79 19			
South Carolina	93 37			
Massachusetts	160 106			
Alabama	84 31			
Utah	63 13			
Florida	83 34			
Indiana	90 43			
Idaho	73 27			
Kentucky	65 23			
Michigan	80 38			
Colorado	69 28			
Connecticut	129 90			
Oklahoma	47 22			
Louisiana	106 81			
Oregon	33 9			
Ohio	50 31			
New Mexico	27 16			

Indirect age-adjustment has been used. All additional deaths reported below the threshold of 15 per state have been used in the calculation of the U.S. total. Our prior release incorrectly attributed 18 Latino deaths to Maine.

Source: APM Research Lab • Get the data • Created with Datawrapper

FOCUS ON WHITE AMERICANS

Lives lost to date

Case 5:20-CV-00830-0KMD-1Docatusacantzer Systact Faile ethology 20/2000 Resagen 1202 of 136

- 109,137 White Americans are known to have lost their lives to COVID-19 through Tuesday, Oct. 13. This is an increase of 15,040 deaths among Whites compared to our last report four weeks earlier.
- White Americans have experienced 51.9% of all deaths with known race, but represent 61.4% of the population.

Actual mortality rate

 For each 100,000 Americans (of their respective group), about 54 Whites have died from the coronavirus, a mortality rate slightly above Asians (45), somewhat below Pacific Islanders (69) and Latinos (74), and well below Indigenous people (90) and Blacks (108).

Age-adjusted mortality rate

- Nationwide, Whites have the lowest mortality rate of all racial and ethnic groups, when age is taken into account.
- Adjusted for age, Connecticut, Massachusetts and New Jersey have experienced the highest COVID-19 mortality rate among their White residents, while Vermont, Alaska and Wyoming have experienced the lowest rates (among states with 15 or more deaths reported).
- The graph below shows age-adjusted COVID-19 mortality rates for White residents by state, sorted from the highest to lowest toll.

White Americans: Age-adjusted COVID-19 mortality rates, through Oct. 13

Deaths per 100,000. For all U.S. states with available data, where 15 or more known deaths have occurred. Sorted from highest to lowest rate.

WITHIE	
New Jersey	130
Massachusetts	106
Connecticut	90
New York	87
Louisiana	81
Rhode Island	71
Mississippi	62
Georgia	53
Arizona	45
Delaware	45
Indiana	43

WUITE

Case 5:20-cv-00830-dKMD-1DcoausacantzesCy5aceFailedenbok/20/20/2000 REsagen 1203 of 136

Pennsylvania	43
Illinois	41
Maryland	40
US TOTAL	40
Michigan	38
South Carolina	37
Florida	34
Texas	33
lowa	32
District of Columbia	32
Arkansas	32
Alabama	31
Ohio	31
Minnesota	29
Tennessee	29
Virginia	29
Nevada	28
Colorado	28
Idaho	27
New Hampshire	25
North Dakota	25
Missouri	24
North Carolina	24
Kentucky	23
California	22
Washington	22
Oklahoma	22
South Dakota	21
Kansas	19
Nebraska	19
Wisconsin	18
New Mexico	16
Utah	13
West Virginia	12
Oregon	9
Montana	7
Maine	7
Vermont	7
Alaska	5
Wyoming	4

Indirect age-adjustment has been used. Hawaii is the only state not appearing here, as it has experienced fewer than 15 deaths.

Source: APM Research Lab • Get the data • Created with Datawrapper

FOCUS ON PACIFIC ISLANDER AMERICANS

Lives lost to date

• 305 Pacific Islander Americans are known to have lost their lives to COVID-19 through Tuesday, Oct. 13. This reflects an increase of 87 deaths among Pacific Islanders compared to our last report four weeks earlier, but includes data from Hawaii for the first time (accounting for 46 deaths).

(Note: This total is a known under-count. Numerous states report Pacific Islander deaths in the Other category, so we cannot see those numbers uniquely.)

• Pacific Islander Americans have experienced 0.5% of all deaths of known race (in 16 states reporting one or more deaths), but represent 0.3% of the population in those states.

Actual mortality rate

 For each 100,000 Americans (of their respective group), about 69 Pacific Islanders have died from the coronavirus, an actual mortality rate well above Asians (45) and Whites (54), slightly below Latinos (74), somewhat below Indigenous Americans (90) and well below Blacks (108).

(Note: Users are cautioned that the overall mortality rate for Pacific Islander people was constructed from only 16 states reporting such deaths, while other rates reflect additional geographies in the U.S.)

Age-adjusted mortality rate

• Nationwide, Pacific Islanders are 2.4 times more likely to have died than Whites, when age is taken into account.

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- Adjusted for age, Arkansas has the highest COVID-19 mortality rate among its Pacific Islander residents. Forty-five Pacific Islanders are known to have died of the virus there. Fewer than 10,000 Pacific Islanders in total live in Arkansas, resulting in the exceedingly high death rate.
- The graph below shows age-adjusted COVID-19 mortality rates for Pacific Islander residents compared to White residents by state, sorted from the largest to smallest gap. Rates are calculated for all states with 15 or more deaths. In every such state, Pacific Islander mortality outpaces White mortality.

Pacific Islander vs White Americans: Age-adjusted COVID-19 mortality rates, through Oct. 13

Deaths per 100,000 of each group. For all U.S. states with available data, where 15 or more Pacific Islander deaths have occurred. Sorted from largest to smallest absolute disparity between Pacific Islanders and Whites.

PACIFIC ISLANDER		WHITE					
Arkansas	2,009 32						
Utah	179 13						
Washington	148 22						
US TOTAL	94 40						
California	62 22						
Hawaii	39						

Indirect age-adjustment has been used. All additional deaths reported below the threshold of 15 per state have been used in the calculation of the U.S. total. Hawaii has experienced fewer than 15 White deaths, so a White rate has not been calculated.

Source: APM Research Lab · Get the data · Created with Datawrapper

NOTE ABOUT INDIGENOUS, PACIFIC ISLANDER, MULTIRACIAL & OTHER RACE AMERICANS
Case 5:20-cv-00830-dt/PD-1D coall many to By Dace File ethology 20/2000 Resagen 1206 of 136

COVID-19 mortality data for Americans who are Indigenous, Native Hawaiian or Other Pacific Islanders, Some Other race, or Multiracial is inconsistently reported by many states. Users may request **our complete data file** to better understand the loss of life in these groups as well. Users are cautioned that Indigenous and Pacific Islander people appear in the "Other" group in many states, along with Multiracial Americans and in a few cases, Asian Americans. **We continue to advocate for complete, consistent reporting for all racial and ethnic groups.**

HOW DID THE APM RESEARCH LAB OBTAIN THE DATA?

The APM Research Lab has independently compiled and analyzed these mortality data for Washington, D.C. and all states. At the time of this writing, only North Dakota and West Virginia did not yet publicly release COVID-19 mortality data by race and ethnicity on their state health department websites. For these two states, we have supplemented our data file using data reported to the National Center for Health Statistics, a division of the CDC. Note that these data have some time lag and often suppress (hide) data, especially for groups other than Whites. Nonetheless, their inclusion improves the picture of COVID-19 mortality for the entire United States.

In the case where a state is publicly releasing its mortality data, but the CDC data was found to be more robust, we have also opted to use the CDC data. This is the case for the following states: Florida, Indiana, Kansas, Kentucky, Nevada, Pennsylvania and Texas, as well as the balance of New York outside of New York City (which is reported separately). The result is the most comprehensive and upto-date portrait of COVID-19 mortality by race and ethnicity for the U.S.



Source of COVID-19 mortality data by state

The CDC data is lagged and has a degree of data suppression. However, we use CDC data when states do not publicly report mortality statistics by race or when the CDC data is found to be more robust than the data found on state websites. Map: APM Research Lab · Get the data · Created with Datawrapper

Racial detail on Americans who have died of COVID-19 was available for 97% of all deaths to date—a vast improvement from the 38% that were known when our Color of Coronavirus project began tracking these data in early April.

As of Tuesday, Oct. 13, more than 217,000 Americans had died of COVID-19. Data about race and ethnicity is available for 97% of these deaths.

only source

However, it should be noted that even among states releasing COVID-19 data by the race of the deceased, the data is often incomplete or nonuniform. Numerous states release only percentages, not counts of deaths, requiring us to estimate the data rather than know precisely how communities have been affected. Many states also fail to report smaller populations uniquely, obscuring the picture for Indigenous Americans, Pacific Islanders and other groups. All of these reporting shortcomings render our picture of the virus' toll incomplete and make it more difficult to assess the disproportionate impacts on communities.

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We call on state and local health departments to release timely data about COVID-19 deaths with as complete racial and ethnic detail as is possible. As the data reporting improves, so too will our understanding of the devastating impact of this disease. This will inform states and communities about how to direct resources more equitably as well.

REQUEST OUR COMPLETE DATA FILE

SOURCES

State and local health department or other governmental reporting bodies, and the National Center for Health Statistics. In a few cases, we have upwardly revised total counts of deaths (not by race) to conform with the New York Times' latest database. Estimates from the U.S. Census Bureau's 2018 American Community Survey were used for calculations regarding population by race/ethnicity and age. Importantly, we have aligned population data with each geography's method of collecting and reporting data (i.e., if Latino ethnicity is overlapping with race groups or discrete, and whether race groups are reported "alone" or "alone or in combination"). All calculations and subsequent analysis by APM Research Lab.

NOTES

Deaths of unknown race are excluded prior to calculating percentages and rates. Presumed or probable deaths due to COVID-19 are included here in our death counts. Many of the data sources have labeled their data preliminary. In some cases, percentages will differ from those given by health departments due to our method of excluding deaths with an unknown race from the denominator before calculating percentages. Additionally states employ varying collection methods regarding ethnicity data, which results in percentages summing to more than 100%. Where states have reported only percentages, we have estimated deaths by racial subgroups; these deaths may differ by small amounts from actual due to rounding errors. States can improve this reporting by releasing complete data.

Data for Indigenous, Native Hawaiian and Other Pacific Islanders, and other races are tallied separately in some states, but exist in "other" in other states, due to inconsistent reporting among states.

Mortality rates are presented in two ways on this page: 1) As "crude" rates, meaning no adjustment has been made to standardize varying age distributions in the populations. These are labeled "actual mortality rates," as they reflect the actual death rates experienced in the population groups. 2) As indirectly age-adjusted mortality rates. Because the White population is older on balance in nearly all locations, age-adjusting generally widens disparities between Whites and other populations.

To create our age-adjusted death rates by race and ethnicity, we first calculated an "expected" death rate for each race group by state and the nation overall. We did so by multiplying the latest national age-specific death rates from COVID-19 by agespecific population shares for each race group within each of the geographies (sourced from the 2018 American Community Survey). We then divided the crude death rates for each race and geography by the expected race-based death rate we calculated (resulting in Standard Mortality Ratios), and finally multiplied by the nationwide overall crude death rate. The result is an Indirect Adjusted Death Rate (IADR) of COVID-19 by race.

We indirectly adjusted these data for age because direct age-adjustment was not possible; timely and complete COVID-19 mortality data by race and age group is not being released for all or even most states. However, users are cautioned that indirect standardization is done to approximate the impact resulting from varying age distributions in cases because age-specific death rates are not available. Indirect standardization may deviate more from directly age-adjusted rates when comparing two populations that differ significantly in their age distribution, as race groups may. For this reason, data from individual states that are directly age-adjusted should be considered superior. For more on direct and indirect methods of standardization see this CDC publication.

Thoughts? Questions?

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Exhibit 8



Centers for Disease Control and Prevention

Health Equity Considerations and Racial and Ethnic Minority Groups

Updated July 24, 2020

Print



Long-standing systemic health and social inequities have put many people from racial and ethnic minority groups at increased risk of getting sick and dying from COVID-19. The term "racial and ethnic minority groups" includes people of color with a wide variety of backgrounds and experiences. But some experiences are common to many people within these groups, and social determinants of health have historically prevented them from having fair opportunities for economic, physical, and emotional health.^[1]

There is increasing evidence that some racial and ethnic minority groups are being disproportionately affected by COVID-19. ^[2], ^[3], ^[4], ^[5], ^[6] Inequities in the social determinants of health, such as poverty and healthcare access, affecting these groups are interrelated and influence a wide range of health and quality-of-life outcomes and risks.^[1] To achieve health equity, barriers must be removed so that everyone has a fair opportunity to be as healthy as possible.

Factors that contribute to increased risk

Some of the many inequities in social determinants of health that put racial and ethnic minority groups at increased risk of getting sick and dying from COVID-19 include:

- Discrimination: Unfortunately, discrimination exists in systems meant to protect well-being or health. Examples of such systems include health care, housing, education, criminal justice, and finance. Discrimination, which includes racism, can lead to chronic and toxic stress and shapes social and economic factors that put some people from racial and ethnic minority groups at increased risk for COVID-19.^[5], ^[7], ^[8], ^[9]
- Healthcare access and utilization: People from some racial and ethnic minority groups are more likely to be uninsured than non-Hispanic whites.^[10] Healthcare access can also be limited for these groups by many other factors, such as lack of transportation, child care, or ability to take time off of work; communication and language barriers; cultural differences between patients and providers; and historical and current discrimination in healthcare systems.^[11] Some people from racial and ethnic minority groups may hesitate to seek care because they distrust the government and healthcare systems responsible for inequities in treatment^[12] and historical events such as the Tuskegee Study of Untreated Syphilis in the African American Male and sterilization without people's permission.^[13],^[14],^[15],^[16]
- Occupation: People from some racial and ethnic minority groups are disproportionately represented in essential work settings such as healthcare facilities, farms, factories, grocery stores, and public transportation.^[17] Some people who work in these settings have more chances to be exposed to the virus that causes COVID-19 due to several factors, such as close contact with the public or other workers, not being able to work from home, and not having paid sick days.^[18]
- Educational, income, and wealth gaps: Inequities in access to high-quality education for some racial and ethnic minority groups can lead to lower high school completion rates and barriers to college entrance. This may limit future job options and lead to lower paying or less stable jobs.^[19] People with limited job options likely have less flexibility to leave jobs that may put them at a higher risk of exposure to the virus that causes COVID-19. People in these situations often cannot afford to miss work, even if they're sick, because they do not have enough money saved up for essential items like food and other important living needs.

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• Housing: Some people from racial and ethnic minority groups live in crowded conditions that make it more challenging to follow prevention strategies. In some cultures, it is common for family members of many generations to live in one household. In addition, growing and disproportionate unemployment rates for some racial and ethnic minority groups during the COVID-19 pandemic^[19] may lead to greater risk of eviction and homelessness or sharing of housing.

These factors and others are associated with more COVID-19 cases, hospitalizations, and deaths in areas where racial and ethnic minority groups live, learn, work, play, and worship.^{[5],[10], [20], [21]} They have also contributed to higher rates of some medical conditions that increase one's risk of severe illness from COVID-19. In addition, community strategies to slow the spread of COVID-19 may cause unintentional harm, such as lost wages, reduced access to services, and increased stress, for some racial and ethnic minority groups.^[22]

What We Can Do

The COVID-19 pandemic may change some of the ways we connect and support each other. As individuals and communities respond to COVID-19 recommendations and circumstances (e.g., school closures, workplace closures, social distancing), there are often unintended negative impacts on emotional well-being such as loss of social connectedness and support. Shared faith, family, and cultural bonds are common sources of social support. Finding ways to maintain support and connection, even when physically apart, can empower and encourage individuals and communities to protect themselves, care for those who become sick, keep kids healthy, and better cope with stress.

Community- and faith-based organizations, employers, healthcare systems and providers, public health agencies, policy makers, and others all have a part in helping to promote fair access to health. To prevent the spread of COVID-19, we must work together to ensure that people have resources to maintain and manage their physical and mental health, including easy access to information, affordable testing, and medical and mental health care. We need programs and practices that fit the communities where racial and minority groups live, learn, work, play, and worship.

Data on COVID-19 and Race and Ethnicity

CDC resources

- CDC COVID Data Tracker
- COVID-NET: A Weekly Summary of U.S. COVID-19 Hospitalization Data
- COVIDView: A Weekly Surveillance Summary of U.S. COVID-19 Activity

Other resources

- The COVID Tracking Project's The COVID Racial Data Tracker
- Emory University's COVID-19 Health Equity Interactive Dashboard 🗹



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Last Updated July 24, 2020

Exhibit 9

1



Voting Guide

CORONAVIRUS IN TEXAS

Across Texas and the nation, the novel coronavirus is deadlier for people of color

New data on Texas coronavirus fatalities reveals stark racial disparities.

BY EMMA PLATOFF AND CARLA ASTUDILLO JULY 30, 2020 UPDATED: 7 PM



Juan Lopez wheels a stretcher out of the back of his vehicle in McAllen. Across Texas and the nation, the novel coronavirus is deadlier for communities of color and low-income communities. Image Miguel Gutierrez Jr./The Texas Tribune

Correction: On July 30, the state said an "automation error" caused approximately 225 deaths to be incorrectly added to the overall death count; a subsequent quality check by Department of State Health Services epidemiologists revealed COVID-19 was not the direct cause of death in these cases. The numbers and charts in this story have been updated to account for this error and are current as of July 30.

Texas' southernmost county, Cameron, is home to just 1.5% of the state's population, but it accounts for nearly 5% of its known COVID-19 fatalities.

Cameron County — where 89% of residents are Hispanic and nearly a third live below the poverty line — stands out as just one stark example of widespread

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disparities in COVID-19 outcomes. Across Texas and the nation, the novel coronavirus is deadlier for communities of color and low-income communities.

These disparities, and a wealth of other demographic information, became more apparent this week when <u>new tallying methods</u> at the state health agency revealed a more complete picture of who has died in Texas and where. Trends showing that Black and Hispanic individuals had been disproportionately hit by the virus were clear nationally and apparent in local snapshots, but until earlier this week, the Texas Department of State Health Services' limited demographic data had <u>clouded</u> the picture of those disparities statewide.

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Hispanic Texans make up about 40% of the state's population, but they account for 49% of its known COVID-19 fatalities. Black Texans also appear slightly overrepresented in the fatality toll, representing 14% of fatalities but just 12% of the state population. Texas reported a total of 6,274 fatalities Thursday evening.

By contrast, white and Asian Texans died at lower rates relative to their share of the state's population.

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Percentage of coronavirus deaths by race and ethnicity

Hispanic Texans make up the largest percentage of coronavirus deaths at nearly 49% while making up only about 40% of the Texas population. About 66% of Texans who have died of coronavirus were people of color.



Correction: On July 30, the state said an "automation error" caused approximately 225 deaths to be incorrectly added to the overall death count; a subsequent quality check by Department of State Health Services epidemiologists revealed COVID-19 was not the direct cause of death in these cases. The numbers in this story have been updated to account for this error and are current as of July 30.

Note: The "Other" race category includes those who were reported as multi-racial or some other race. Four deaths were either reported as unknown or the race and ethnicity category were left blank.

Source: Texas Department of State Health Services, U.S. Census Bureau 2018 population estimates Credit: Carla Astudillo

Sometimes called the great equalizer, the novel coronavirus has been anything but - a deadly reality in a state like Texas, where the Hispanic population is expected to become the largest group in the state by mid-2021.

The disparities should not have been a surprise, said Jamboor Vishwanatha, director of the Texas Center for Health Disparities at the University of North Texas Health Science Center.

"What COVID did is essentially shined a bright light on existing disparities," Vishwanatha said, citing disparities in rates of preexisting conditions like diabetes and cardiovascular issues, as well as social factors like income inequality and access to health care. "You would expect something like this to happen."

Research has found that higher-paid employees are more likely to have the option to work from home, and that Black and Hispanic employees are less likely to be able to work remotely. In Texas and across the country, front-line employees like janitors, grocery clerks and transit workers are more likely to be women and people of color, an Associated Press analysis of U.S. Census Bureau data revealed.

That's forced low-income workers and people of color to risk their health at work, exposing them to the virus while others earn a paycheck from home.

"Many of these folks, particularly early on, were exposed to the disease," Dr. Georges Benjamin, executive director of the American Public Health Association, said Wednesday at an event put on by The Academy of Medicine, Engineering and Science of Texas. The Texas Tribune thanks its sponsors. Become one.

Benjamin said a higher prevalence of chronic illnesses like hypertension and heart disease is contributing to disparities.

Geography has also played a role. Many of Texas' deadliest hot spots have emerged in communities of color: among immigrant workforces at the <u>meatpacking plants</u> in the Panhandle; in Houston, one of the country's most diverse cities; and in the Rio Grande Valley, where the population is majority Hispanic.

In general, most deaths have been recorded where most Texans live — in big cities like Houston, Dallas, San Antonio, El Paso and Austin. But some counties, like Cameron and Hidalgo in the Rio Grande Valley, are mourning an outsized number of people relative to their population. Both counties are about 90% Hispanic.

Even in bigger urban areas, some whiter, wealthier counties seem to be faring better than poorer counties with more diverse populations. Travis County has some 400,000 more residents than El Paso County but fewer deaths, according to state data. According to census data, Travis County is about half white and a third Hispanic, with a median household income around \$76,000 annually; El Paso County is 83% Hispanic, with a median household income around \$44,000 annually.

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Share of coronavirus fatalities in 10 counties with most deaths

Coronavirus deaths have been mostly reported in larger counties. However, some counties like Hidalgo and Cameron with a majority Hispanic population are overrepresented in the percentage of deaths.

County	Total deaths	Share of total deaths	Share of Texas population
Harris		19.2%	16.4%
Dallas		9.7%	9.2%
Bexar		8.7%	6.9%
Tarrant		5.7%	7.3%
Hidalgo		5.0%	3.0%
Cameron		4.8%	1.5%
El Paso		3.7%	2.9%
Travis		3.5%	4.4%
Fort Bend		2.2%	2.7%
Galveston		1.5%	1.2%

County where Hispanics make up largest population group

Correction: On July 30, the state said an "automation error" caused approximately 225 deaths to be incorrectly added to the overall death count; a subsequent quality check by Department of State Health Services epidemiologists revealed COVID-19 was not the direct cause of death in these cases. The numbers in this story have been updated to account for this error and are current as of July 30.

Source: Texas Department of State Health Services, U.S. Census Bureau 2018 population estimates Credit: Carla Astudillo

And the virus' true death toll is almost certainly higher than reported; for experts, the question is by how much.

The state may be showing a particular undercount in Hidalgo, a majority-Hispanic county in the Rio Grande Valley that is being ravaged by COVID-19. County health officials, using local medical records, report 576 deaths; the state, now relying on death certificates, revised its tally for the county down from over 450 to 312. Local officials said the difference is caused by delays in the issuance of death certificates.

Meanwhile, Vishwanatha said, access to testing has been more limited in communities of color.

Pointing to local data from North Texas, Vishwanatha said there is a disparity between communities of color and white groups not only in chance of getting infected but also in chance of dying from the disease. The gulf is even wider for mortality rate than it is for infection rate.

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"We are currently facing a critical situation where some of our communities are really suffering. We need to do everything to overcome these disparities. But hopefully this COVID situation has brought out something that we should have been tackling all along — how to overcome these chronic health disparities that our communities suffer," Vishwanatha said.

Disclosure: The UNT Health Science Center has been a financial supporter of The Texas Tribune, a nonprofit, nonpartisan news organization that is funded in part by donations from members, foundations and corporate sponsors. Financial supporters play no role in the Tribune's journalism. Find a complete list of them here.

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Exhibit 10

The Guardian



Texas closes hundreds of polling sites, making it harder for minorities to vote

Guardian analysis finds that places where black and Latino population is growing by the largest numbers experienced the majority of closures and could benefit Republicans

The fight to vote is supported by

the guardian

Richard Salame Mon 2 Mar 2020 06.00 EST About this content

Last year, Texas led the US south in an unenviable statistic: closing down the most polling stations, making it more difficult for people to vote and arguably benefiting Republicans.

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A report by civil rights group The Leadership Conference Education Fund found that 750 polls had been closed statewide since 2012.

Long considered a Republican bastion, changing racial demographics in the state have caused leading Democrats to recast Texas as a potential swing state. Texas Democratic party official Manny Garcia has called it "the biggest battleground state in the country".

The closures could exacerbate Texas's already chronically low voter turnout rates, to the advantage of incumbent Republicans. Ongoing research by University of Houston political scientists Jeronimo Cortina and Brandon Rottinghaus indicates that people are less likely to vote if they have to travel farther to do so, and the effect is disproportionately greater for some groups of voters, such as Latinxs.

"The fact of the matter is that Texas is not a red state," said Antonio Arellano of Jolt, a progressive Latino political organization. "Texas is a nonvoting state."

On a local level, the changes can be stark. McLennan county, home to Waco, Texas, closed 44% of its polling places from 2012 to 2018, despite the fact that its population grew by more than 15,000 people during the same time period, with more than two-thirds of that growth coming from Black and Latinx residents.

In 2012, there was one polling place for every 4,000 residents. By 2018 that figure had dropped to one polling place per 7,700 residents. A 2019 paper by University of Houston political scientists found that after the county's transition to vote centers, more voting locations were closed in Latinx neighborhoods than in non-Latinx neighborhoods, and that Latinx people had to travel farther to vote than non-Hispanic whites.

Some counties closed enough polling locations to violate Texas state law. Brazoria county, south of Houston, closed almost 60% of its polling locations between 2012 and 2018, causing it to fall below the statutory minimum, along with another county. In a statement, Brazoria county clerk Joyce Hudman said the closures were inadvertent, and that this would not happen again in 2020.

A Guardian analysis based on that report confirms what many activists have suspected: the places where the black and Latinx population is growing by the largest numbers have experienced the vast majority of the state's poll site closures.

The analysis finds that the 50 counties that gained the most Black and Latinx residents between 2012 and 2018 closed 542 polling sites, compared to just 34 closures in the 50 counties that have gained the fewest black and Latinx residents. This is despite the fact that the population in the former group of counties has risen by 2.5 million people, whereas in the latter category the total population has fallen by over 13,000.



A cyclist passes election signs near an early voting site in San Antonio, on 18 February 2020. Photograph: Eric Gay/AP

'Turned out to be a nightmare'

Until 2013, hundreds of counties and nine states, including Texas, with a history of severe voter suppression had to submit any changes they wanted to make to their election systems to the Department of Justice under

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the Voting Rights Act. The department sought to ensure that the changes did not hurt minority voters. But seven years ago, a supreme court ruling gutted this law and allowed these jurisdictions to operate without oversight, and now the previously mandatory racial-impact analysis is no longer performed.

The rush of poll closures in Texas cannot be attributed to any one policy. Just over half of the closures are part of a push toward centralized, countywide polling places, called "vote centers", which exist in almost a third of US states. Under countywide voting schemes, voters are no longer assigned to a polling place in their local precinct and can instead cast their ballot at any polling location in the county.

Voting rights advocates and both Republican and Democratic leaders have largely been in favor of vote centers because they can make it more convenient to vote – by allowing people to vote near work, for instance – and because they can reduce the number of people whose votes are thrown out because they went to the wrong polling place.

But Texas state law allows a county that transitions to vote centers to operate with half as many locations as they would otherwise have needed under a traditional precinct-based system.

When deciding whether to close a polling station, elected officials typically consider how many people used it, as well as factors like public transportation accessibility. Some elections administrators who agree on the importance of protecting minority voters warn against assuming that closures are automatically a bad thing.

"I'd be curious to know how many of the consolidation efforts were good faith efforts [to] ... increase the number of options for a voter but also improve the kind of polling place that a particular voter may have voted in," said Chris Davis, the Williamson County elections administrator and former president of the Texas Association of Election Administrators. He pointed out that some precinct polling places were ADA-inaccessible.

McLennan county GOP chair Jon Ker called concerns about closures impacting turnout "hogwash," saying that turnout was actually higher in his county after the number of voting locations dropped from 59 to 33. The 2018 midterm elections did indeed have higher turnout than the 2014 midterms in McLennan county, though voting also surged more broadly across the state and nation.

Mary Duty, chair of the McLennan County Democratic party, has soured on the centralization program since the county entered it in 2014. "It turned out to be kind of a nightmare," she said, pointing to large areas of the county without a voting location. And activists argue that low turnout at a particular polling place is not a reason to close it - it is a sign that the turnout itself, which is typically lower in Latinx neighborhoods, must be addressed. Closing a polling station for reasons of low turnout can have a discriminatory impact, activists say.

The 334 poll closures between 2012 and 2018 that took place outside the vote center program would by themselves still rank Texas among the biggest poll closers in the country, ahead of Arizona, Georgia, Louisiana and Mississippi.

Elections officials have cited tight budgets and difficulty recruiting poll workers as among the reasons for the reductions.

The upshot is that for many Texas voters, the ballot box is ever further away.

Democracy is in peril ...

... ahead of this year's US election. The Trump administration and its supporters are waging an aggressive campaign to discredit and suppress mail-in voting – a crucial method in the midst of a pandemic.

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This is one of a number of attempts to suppress the votes of Americans – something that has been a stain on US democracy for decades. The Voting Rights Act was passed 55 years ago to undo a web of restrictions designed to block Black Americans from the ballot box. Now, seven years after that law was gutted by the supreme court, the president is actively threatening a free and fair election.

Through our Fight to vote project, the Guardian has pledged to put voter suppression at the center of our 2020 coverage. This election will impact every facet of American life. But it will not be a genuine exercise in democracy if American voters are stopped from participating in it.

At a time like this, an independent news organisation that fights for truth and holds power to account is not just optional. It is essential. Like many other news organisations, the Guardian has been significantly impacted by the pandemic. We rely to an ever greater extent on our readers, both for the moral force to continue doing journalism at a time like this and for the financial strength to facilitate that reporting.

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Exhibit 11

An Unfortunate Legacy: COVID-19 Reveals Long-Standing Health Inequities By Sean Price Texas Medicine September 2020

texmed.org/Template.aspx





For Ogechika Alozie, MD, the COVID-19 crisis conjures up a sense of déjà vu.

Like many physicians, the El Paso infectious disease specialist – who sits on the Texas Medical Association's COVID-19 Task Force – sees disturbing parallels between COVID-19 and the HIV/AIDS pandemic that started in the early 1980s.

HIV began as a disease affecting mostly white people but settled over time into a much larger threat for Blacks and other people of color, he says. And many of the factors behind HIV's persistence in those communities have likewise fueled the rise of COVID-19 in the U.S.

"It's the same set of dynamics that come into play: lack of access to care, lack of prevention, lack of insurance," said Dr. Alozie, whose practice focuses largely on HIV patients. "It's an unfortunate legacy that we continue to perpetuate."

The website for the U.S. Centers for Disease Control and Prevention (CDC) is blunt about the impact of that legacy (<u>tma.tips/CovidMinorityGroups</u>): "History shows that severe illness and death rates tend to be higher for racial and ethnic minority populations during public health emergencies than for other populations."

That is certainly happening with COVID-19. (See "COVID-19 and Health Disparities," page 21.)

Most COVID-19 data show the long-standing social determinants of health stacked against Blacks and Hispanics in Texas, says Eduardo Sanchez, MD. (See "A Social Shift," page 24.) He is former head of the Texas Department of State Health Services (DSHS), and now chief medical officer for prevention for the American Heart Association in Dallas.

For instance, Dr. Sanchez says, people of color are statistically more likely to:

• Have low-income and "essential" jobs that often result in more direct interactions with people, increasing the likelihood of contracting COVID-19;

• Live in multi-generational or multi-family situations that can make physical distancing difficult;

Lack health insurance and easy access to health care, which means underlying medical conditions that increase the risk of severe COVID-19 are less likely to be managed well; and
Lack regular contact with a physician who can help prevent or give timely treatment for COVID-19.

Any of these factors would increase patients' health risk, but all of them together help

explain why people of color often face far more anxiety and stress about COVID-19 than their fellow Americans, Dr. Alozie says.

As with the HIV pandemic, he says physicians have tools – some of them short-term fixes and others long-term policy goals – that can help people of color cope better with COVID-19. Some are relatively easy and are already being done by many practices, while others will require rethinking the way health care is delivered.

"Inequality and racism aren't genetic, they're systemic," he said. "So it's no surprise that our health care outcomes are exactly what we create." (See "A Texas-Size Problem," June 2017 *Texas Medicine*, pages 41-47, <u>www.texmed.org/TexasProblem</u>.)

COVID-19 and Health Disparities

COVID-19 is widely acknowledged to be most deadly to people over the age of 65 with underlying health conditions like obesity, diabetes, or heart conditions, and U.S. data show the disease disproportionately affects people of color.

Age-Adjusted COVID-19 Deaths Per 100,000

Texas

Black ... 45.6 Latino ... 41.8 White ... 26.7 Asian ... 19.6 Indigenous ... 0 Pacific Islander ... 0

U.S.

Black ... 108.3 Indigenous ... 102.4 Pacific Islander ... 91.3 Latino ... 82.9 Asian ... 40.7 White ... 29.5 Source: APM Research Lab, tma.tips/CovidPer, as of Aug. 4

Confirmed Cases

Hispanic ... 39.8% White ... 26.9% Unknown ... 16.7% Black ... 14.3% Asian ... 1.9%

Other ... 0.4% Source: Statistics reported by the Texas Department of State Health Services as of Aug. 5. (tma.tips/TexasCovidCases)

U.S.

White ... 38.8% Hispanic/Latino ... 31.7% Black ... 20% Asian ... 3.7% Multiple/Other American Indian/ Alaska Native ... 1.3% Native Hawaiian/ Other Pacific Islander ... 0.3% Source: Centers for Disease Control and Prevention as of

Aug. 5 (tma.tips/USCovidCases)

Physicians reach out

Education is one of the most important short-term steps physicians can take, says Blythe Mansfield, MD, a consulting physician with Corporate Medical Advisors, a Houston company that provides medical director services.

In Black and Latino communities, she has heard wildly untrue theories concerning COVID-19. For instance, some said that only old people catch it, or that only people of Asian descent were in danger because it originated in China.

"Early on there were a lot of rumors, and education wasn't getting to the community," she said.

Physicians can help counteract those rumors by speaking up in public forums like social media and the local press, Dr. Mansfield says.

The Texas Medical Association has prepared extensive materials for physicians to use that provide accurate, science-based information for the public (<u>www.texmed.org/Coronavirus</u>).

Physicians who haven't already done so should educate their patients, says Salina Mostajabian, MD, a pediatrician at People's Community Clinic in Austin, where most patients are Latino.

Once COVID-19 hit Texas in March, the clinic quickly drew up a list of patients who would be most vulnerable to the disease – those with respiratory ailments or conditions like diabetes – and began contacting them, Dr. Mostajabian says.

"[We were] making sure that they were up-to-date on their follow-up [visits], that they had their medications available, and that they knew who to contact in the clinic in case they were sick," Dr. Mostajabian says. "And [we] let them know that they were at higher risk."

Like virtually all Texas clinics, People's scrambled to provide telemedicine services once the pandemic started.

"We've had to build up our telemedicine protocols from scratch," Dr. Mostajabian said. "That wasn't available before."

Unfortunately, many minority patients have had to build their telemedicine capabilities from scratch as well because they don't have the equipment or infrastructure to make video calls, she said.

"We have patients coming in from a wide geographic region, and in some areas internet access is an issue," she says.

In those cases, the clinic has IT experts try to contact patients to establish video links, Dr. Mostajabian says. If all else fails, they encourage patients to simply use the phone to call in.

Patients still need face-to-face visits, and that poses its own problems. Some do not have face masks or other equipment that could keep them safe, Dr. Mansfield says, so physicians may need to supply them.

Likewise, patients may need help from their physician in arranging transportation to and from office visits, Dr. Mansfield says. In many cases, patients don't have cars or are unable to drive. Patients who would normally use mass transit may face high risk of COVID-19 infection if the proper precautions aren't taken, she says.

Helping patients figure out transportation options "would remove some of the burden of getting to the doctor," Dr. Mansfield said.

Matters of trust

Even physicians who make these efforts shouldn't be surprised if they are met with skepticism at times from Black and Latino patients, says Janeana White, MD, an internal medicine and pediatric specialist who is also the medical director for disease control and clinical prevention at Harris County Public Health.

Many people in these groups frankly don't trust medicine, in part because they see very few people like themselves represented among physicians, she says. (See "The State of Physician Diversity," left.)

"If you don't see people who represent you in health care, you're going to be less likely to trust the health care system and less likely to get health care," Dr. White said.

Physicians today also must contend with a history of open discrimination against Blacks and Latinos in medicine, Dr. Mansfield says. The infamous Tuskegee syphilis experiments on African American men in Alabama between 1932 and 1972, and the research on Henrietta Lacks' cancer cells without her consent in 1951 happened decades ago, but these incidents are fresh in the minds of many people of color, she says.

So are more recent signs of bias. For instance, academic studies have shown that Blacks and Hispanics still are systematically undertreated for pain (<u>tma.tips/VirginiaPainStudy</u>).

The State of Physician Diversity

Despite aggressive efforts to recruit Blacks and Latinos as physicians in recent years, their numbers remain low compared with their representation in the population at large.

Blacks

Texas 12.08% of population

6.1% of physicians 5.02% of medical students

U.S.

13.4% of population 5% of physicians 8.4% of medical students

Latinos

Texas

39.75% of population 7.6% of physicians 15.47% of medical students U.S.

18.5% of population 5.8% of physicians 6.2% of medical students

All figures are for 2018-2019, except Texas physicians, which is 2017.

Sources: Texas Medical Association Education Department; Association of American Medical Colleges; U.S. Department of Health and Human Services; Pew Research Center; Texas Department of State Health Services; U.S. Census Bureau

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But in many cases, people of color never even make it to the physician's office, Dr.

Texans say health care is the toughest living expense for them to afford, according to a 2019 poll by the Episcopal Health Foundation. Fifty-five percent of Texans say it's difficult for them to pay for health care, including 27% who say it's "very difficult" (<u>tma.tips/TexansAffordHealthCare</u>).

Physicians should look for ways to persuade policymakers to help eliminate disparities in coverage by backing affordable health insurance options, Dr. Sanchez says.

"It doesn't take much imagination to figure out that if you don't have health insurance, you're going to delay care that needs to be addressed," he said.

Likewise, greater public health spending can stop or curtail disease outbreaks before they become epidemics, Dr. Sanchez says. In the case of COVID-19, it would have allowed for more epidemiologists to be on hand to educate both physicians and the public, and it would have allowed for faster testing and contact tracing.

In 2019, Texas tied with Kansas for 40th among the 50 states in public health care spending, according to the United Health Foundation America's Health Rankings. Texas spent about \$60 per person, below the U.S. average of \$87, the group says.

Physicians also should get a better feel for where their patients live because that shapes their health, Dr. Sanchez says.

For instance, a 2019 report by the Episcopal Health Foundation showed that just five miles to the east of the Texas Medical Center in Houston, in the predominantly Black Sunnyside neighborhood – which has faced high crime and unemployment rates – life expectancies can drop to as low as 66 years. But five miles to the west of the center in Bellaire, life expectancies in the safer, higher income, and predominantly white suburb rise to 87 years.

Those disparities show up in COVID-19 rates as well. On July 16, the 77033 ZIP code in Sunnyside had 462 reported cases of the disease, while the 77401 ZIP code in Bellaire had 59, according to the Harris County Public Health dashboard (<u>tma.tips/HarrisCovidTracker</u>). Adjusted for population differences, Sunnyside would have had just 94 cases if that ZIP code had the same COVID-19 infection rate as Bellaire did.

This kind of geographic information should have a direct bearing on how physicians treat the Black and Latino patients who live in neighborhoods similar to Sunnyside, Dr. White says.

"If you don't have safe places to walk, safe places to play, and I'm encouraging you – someone who is a diabetic – to go out and get more exercise ... then I'm writing a prescription that [the patient] can't support," Dr. White said. "We can't just look at the

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coronavirus and say, 'Here we go again,' when it comes to heath care and inequities."

Tex Med. 2020;116(9):18-23 September 2020 *Texas Medicine* <u>Contents</u> *Texas Medicine* <u>Main Page</u>

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Sean Price is a reporter for *Texas Medicine* and *Texas Medicine Today*. He grew up in Fort Worth and graduated from the University of Texas at Austin. He's worked as an award-winning writer and editor for a variety of national magazine, book, and website publishers in New York and Washington. He's also helped produce Texas-based marketing campaigns designed to promote public health. Sean lives in Austin and enjoys hiking, photography, and spending time with his wife and two sons.



More stories by Sean Price