DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR DISEASE CONTROL AND PREVENTION


Committees on Appropriations of the House of Representatives and the Senate,
Committee on Energy and Commerce of the House of Representatives,
and
Committee on Health, Education, Labor, and Pensions of the Senate


Report to Congress on

Paycheck Protection Program and Health Care Enhancement Act
Disaggregated Data on U.S. Coronavirus Disease 2019 (COVID-19) Testing

2nd 30-Day Update

*Robert R. Redfield MD*

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Robert R. Redfield, MD
Director
Centers for Disease Control and Prevention
Administrator
Agency for Toxic Substances and Disease Registry
Department of Health and Human Services

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# Contents

## Overview

The Paycheck Protection Program and Health Care Enhancement Act, in appropriating supplemental funds to the Department of Health and Human Services (HHS) for coronavirus response, states, in part:

> *Provided further*, That not later than 21 days after the date of enactment of this Act, the Secretary, in coordination with other appropriate departments and agencies, shall issue a report on COVID–19 testing: *Provided further*, That such report shall include data on demographic characteristics, including, in a de-identified and disaggregated manner, race, ethnicity, age, sex, geographic region and other relevant factors of individuals tested for or diagnosed with COVID–19, to the extent such information is available: *Provided further*, That such report shall include information on the number and rates of cases, hospitalizations, and deaths as a result of COVID–19: *Provided further*, That such report shall be submitted to the Committees on Appropriations of the House and Senate, and the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate, and updated and resubmitted to such Committees, as necessary, every 30 days until the end of the COVID–19 public health emergency first declared by the Secretary on January 31, 2020 (P.L. 116-139, Division B, Title I, Page 7)

The Centers for Disease Control and Prevention (CDC) prepared this 30-day update report in response to this request from the House and Senate Appropriations Committees, the House Committee on Energy and Commerce, and the Senate Committee on Health, Education, Labor, and Pensions.

## Key Findings

- CDC is continuing to make progress to ensure key data are available to identify those most affected by this pandemic
    - From April 23 to June 23, 2020, the proportion of cases with complete information on race increased by 29% (42% to 54%) and the proportion with complete information on ethnicity increased by 49% (35% to 52%).
    - Additionally, CDC has developed methodology to better understand the disproportionate impact on communities of color and inform public health efforts to respond to the pandemic and protect vulnerable communities.
- The number of COVID-19 cases continues to increase in the U.S.
    - As of July 13, 2020, 3,296,599 cases have been reported, including 134,884 deaths.
    - 42 jurisdictions have each reported more than 10,000 cases each
- COVID-19 continues to disproportionately impact some populations
    - Infection rates are highest among non-Hispanic Native Hawaiian/Other Pacific Islanders (887.9 per 100,000 population) and among American Indian/Alaska Natives (701.7 per 100,000 population)
    - Hospitalization rates are highest among American Indian/Alaskan Natives (244.7 per 100,000) and Non-Hispanic Blacks (185.3 per 100,000 population)

o   Death rates are highest among non-Hispanic blacks (64.6 per 100,000)
*   Although people aged 75 and older have the highest case rates per 100,000 cases are rapidly increasing among Americans aged 18-44 with over 125,000 cases reported among this age group during the week of July 5 alone.

## Executive Summary

This report contains data on demographic characteristics, including data on race, ethnicity, age, sex, geographic region and other relevant factors of individuals tested for or diagnosed with COVID-19. It also includes information on the number and rates of cases, hospitalizations, and deaths as a result of COVID-19. CDC values this additional data, and the opportunity to target critical COVID-19 interventions. CDC is working quickly with states, cities and territories, tribes and other partners to improve data collection and reporting accordingly and provides Congress with the information available at this time. CDC looks forward to providing more complete information in forthcoming reports.

In addition to presenting Congress with data about cases, hospitalizations and deaths, particularly among different racial/ethnic groups, this report provides a snapshot of the progress made by reporting entities toward more complete demographic data to increase our collective understanding of the impact of COVID-19[1]. This report contains the data we currently have available from reporting entities, describes efforts to obtain additional data requested by Congress, and demonstrates our commitment to modernize CDC's data collection systems. Appendix A provides detailed information on the data sources used to collect patient demographic data, and web links throughout the document are provided for the convenience of the reader, since some data elements are regularly updated.

To ensure cases are reported with the information needed to better monitor disease incidence and trends, CDC has been working with state, local, and territorial health departments to improve the completeness of key demographic variables that they report to CDC, including race and ethnicity. Over 96% of case reports include documented age and sex and although there is still more work to be done to ensure complete race and ethnicity data in the case report forms, from April 2 to June 23, the proportion of case reports with complete information on race increased from 21% to 54% and the case reports with complete information on ethnicity increased from 18% to 52%. Currently total proportion of case reports with complete race *and* ethnicity is 47.8%.

In the June 2020 Report to Congress, CDC reported a total of 2,063,812 cases of COVID-19 in the U.S. and 115,271 deaths. These numbers were as of June 14, 2020. As of July 13, 2020, there are a total of 3,296,599 cases of COVID-19 in the U.S. including 134,884 deaths. The highest number of case reports continue to be in the 75 and over age group and the case rate per 100,000 population in those 75 and over is 1132.4 per 100,000 population. However, recent data suggests

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[1] Please note that some web links default to a main page, and some of the specific demographic data are presented on subsequent pages. CDC's web page is being updated dynamically as we receive new data and feedback from website users, so links and presentation may change.

that younger Americans, ages 18-44 now have the highest number of reported probable and confirmed cases of COVID-19. While non-Hispanic Whites had the highest numbers of cases at 4460,377, and non-Hispanic Native Hawaiian/Other Pacific Islanders had the lowest numbers at 5,206 cases, non-Hispanic Native Hawaiian/Other Pacific Islanders had the highest case rates per 100,000 population at 887.9 per 100,000 compared to 233.0 per 100,000 population in non-Hispanic Whites. Hispanics or Latinos and non-Hispanic Blacks also had high case rates per 100,000 population at 689.9 per 100,000 and 617.4 per 100,000 respectively.

Using the data from CDC's COVID-NET collaboration of hospitals that represent 10% of the US population, hospitalization rates among non-Hispanic American Indian/Alaska Natives are approximately 4.5 times that of non-Hispanic White people at 244.7 per 100,000 population, and non-Hispanic Black people have a rate approximately 3.5 times that of non-Hispanic White people at 185.3 per 100,000 population.

Using national death certificate data, the death rate per 100,000 population was highest for non-Hispanic Blacks at 64.6 deaths per 100,000 population. This is more than 2 times the death rate per 100,000 for Hispanic or Latinos at 32.4 per 100,000 population, non-Hispanic Whites at 30.8 per 100,000 population, non-Hispanic Asians at 30.1 deaths per 100,000 population and non-Hispanic American Indian or Alaska Natives at 36.7 deaths per 100,000 population. Non-Hispanic Native Hawaiian or Other Pacific Islander had the lowest death rates at 4.0 per 100,000 population.

Since the last report to the Committees, CDC has added one new section to highlight progress made to better describe efforts to monitor and mitigate the effects of this pandemic. The new "County Level Analysis" section summarizes a new method of identifying geographic areas where different racial and ethnic groups might be disproportionately affected by COVID-19. Using reported case data, we identified counties with a recent high burden of COVID-19 cases (more than 100 new cases per 100,000 population in the past two weeks) and outlined some of the counties where non-Hispanic Blacks and Hispanics or Latinos may be experiencing increased risk of COVID-19. In addition, CDC continues to refine methodologies for providing Congress with data indicating counties that represent locations in which different racial and ethnic groups live and will update our methodology and provide more data when available.

Finally, the "Looking Forward" section of the report outlines specific projects what CDC is undertaking to address health disparities among racial/ethnic groups.


## Data Completeness

CDC uses four primary sources of data in this report. The first three are used to describe cases, hospitalizations and deaths, and include: National Notifiable Diseases Surveillance System (NNDSS) through which jurisdictions report cases to CDC; the Coronavirus Disease 2019 (COVID-19)-Associated Hospitalization Surveillance Network (COVID-NET), a population-based surveillance system that collects data on laboratory-confirmed COVID-19-associated hospitalizations; and the National Vital Statistics System (NVSS) that contains death certificate data from state vital statistics offices. The fourth source is COVID-19 laboratory testing data that

are reported to CDC and some commercial laboratories.  Please see Appendix A for additional information about the sources of data in this report.

## Case Report Data

Case-based reporting helps to determine case numbers, estimate infection rates, trends over time, geographic distributions and outbreaks. CDC relies on state, local, and territorial health departments to voluntarily report case data.  Missing data for some questions in the form create a challenge in understanding whether the subset of data received are representative of the U.S. population.  While some data fields are reliably reported (state, county, age, sex are ~93-100% complete), others are less reliably completed.

To date, CDC has received a total of 2,179,338 case reports, of which 47.8% contain race/ethnicity data.  Figure 1, below, shows the improvement in the percent of case reports with complete race and ethnicity from April 2 to April 23 to June 23.  Overall, from April 2 to April 23, there was a significant improvement in completeness of race and ethnicity in the case reports, from 21% to 42% for race and from 18% to 35% for ethnicity.  Between April 23 and June 23 there have been additional improvements to completeness of race ethnicity in the case reports with complete information on race increasing from 42% to 54%, and complete information on ethnicity increasing from 35% to 52%. However, further improvements are needed to fully understand the disease burden of COVID-19 among specific race/ethnicities and CDC continues to work with its state, local and territorial partners to improve case reporting. Additional information about the case report data can be found in Appendix A.

**Figure 1: Percent of COVID-19 Case Reports with complete Race and Ethnicity data, April 2 and July 11, 2020, National Notifiable Diseases Surveillance System**
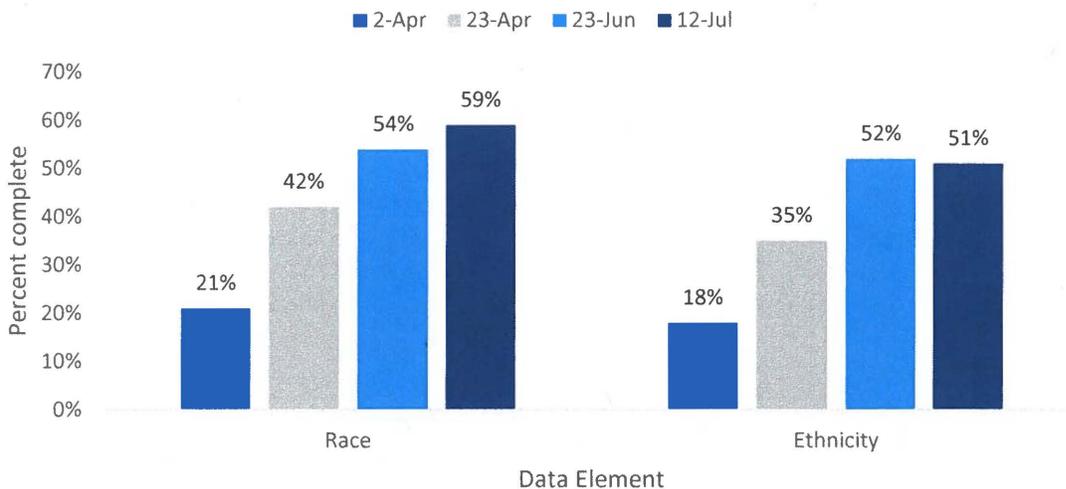
## COVID-NET Data

COVID-NET is a population-based surveillance system that collects data on laboratory-confirmed COVID-19-associated hospitalizations among children and adults through a network of over 250 acute-care hospitals in 14 states. Completeness of race and ethnicity is 93% as of June 20. This system produces high-quality information on hospitalizations rates and risk factors for hospitalizations, as the data have high completion rates of key risk factors, such as race and ethnicity, and surveys a population similar to the US population in terms of key risk factors. Additional information about COVID-NET can be found in Appendix A.

**Figure 2: Percent of COVID-19 Hospitalizations with complete Race/Ethnicity data, March 1-July 4, 2020, COVID-NET**
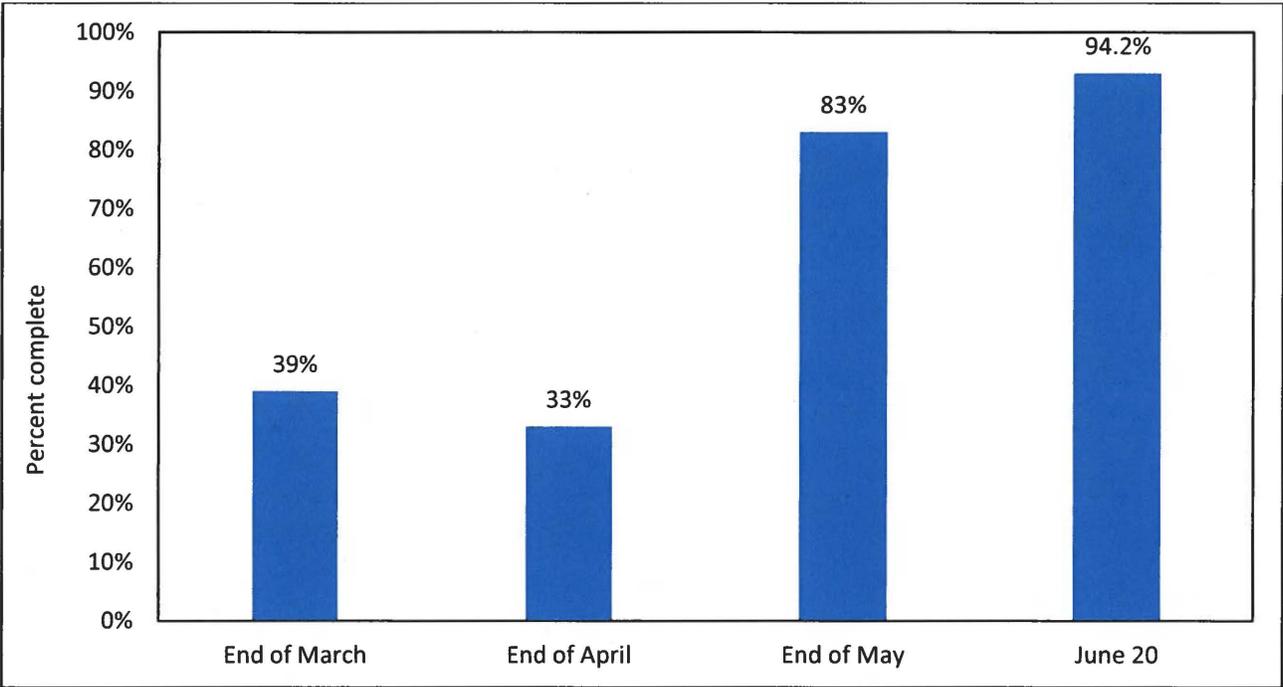


## Mortality Data

CDC's National Center for Health Statistics (NCHS) collects death certificate data from state vital statistics offices for all deaths occurring in the United States. Provisional counts for COVID-19 deaths are based on mortality data in the NVSS. Current estimates indicate that about 20%-30% of death certificates have issues with completeness, primarily due to delays in reporting. It takes time for death certificates to be completed, registered, and coded and the timeliness varies from state to state. Currently, NCHS receives information on approximately 60% of deaths within about 10 days of the date of death. However, it can take as little as 1 week

and as much as 8 weeks (sometimes more) for NCHS to receive information from the death certificates registered by the states. These data are updated as more information becomes available. Additional information about mortality data can be found in Appendix A.

## Trends in Reported Cases

COVID-19 is a nationally notifiable condition, with state, local, and territorial health departments *voluntarily* sending case reports to CDC to help monitor and mitigate the adverse effects of this pandemic. Case report forms are completed by a clinician or health department and are sent to CDC by State Health Departments. Case report forms have a standardized case definition and defined demographic and clinical variables however, completion of demographic data, including race/ethnicity is voluntary. Case report data provide insight into the number of diagnosed infections and allow for the estimation of diagnosis rates, as well as the ability to monitor trends over time, including geographic distributions and outbreaks. It is important to note that there is no mandate requiring that all data fields, including race/ethnicity is complete in the case report form. Additional information about the case report data can be found in Appendix A.

### *All Cases*

As of June 28, 2020, 2,459,472 probable and confirmed cases of COVID-19 in the U.S. including 124,976 deaths had been reported. The cumulative case rate is 661.1 per 100,000 population. Figure 3, below, displays the number of new probable and confirmed COVID-19 cases reported each day in the U.S. since the beginning of the outbreak. Data on cases and deaths are updated daily on CDC's website.

**Figure 3: Daily number of reported COVID-19 cases through 07/12/2020, United States**

The map below highlights areas of the country with the greatest number of COVID-19 cases



— 7-day moving average
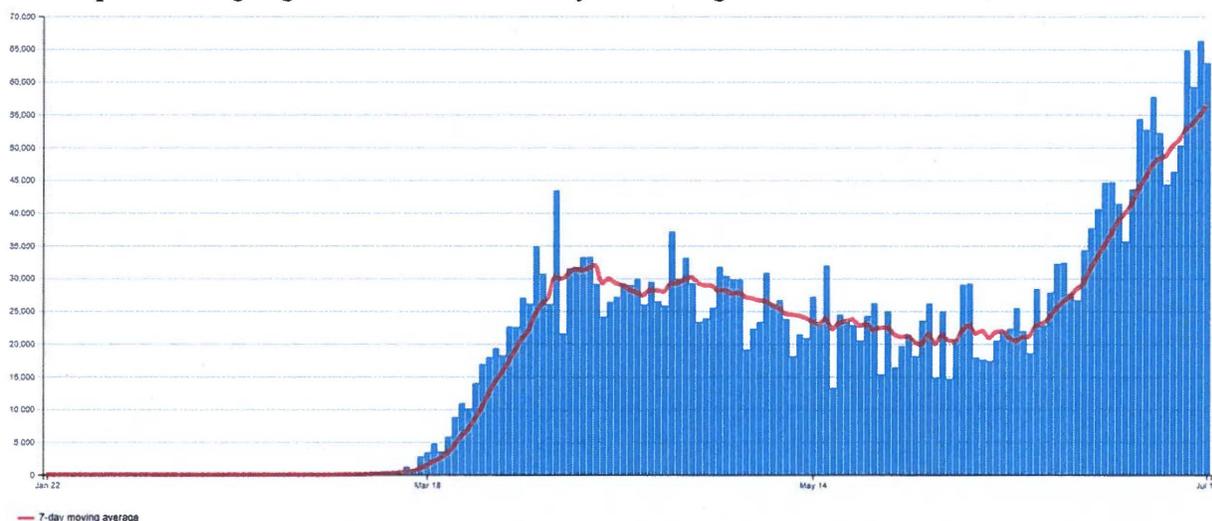
reported. As of July 12, 2020, 42 reporting jurisdictions each reported more than 10,000 cumulative cases of COVID-19. These jurisdictions include Alabama, Arkansas, Arizona,

California, Colorado, Connecticut, District of Columbia, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Mississippi, Nebraska, Nevada,  New Jersey, New Mexico, New York, New York City, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virginia, Washington and Wisconsin.  California reported the highest number of cases at 312,344 and Florida reporting the second highest number of cases with 250,984 cases.

Seven jurisdictions, including American Samoa, Guam, the Marshall Islands, the Federated States of Micronesia, the Commonwealth of the Northern Mariana Islands, Palau and the U.S. Virgin Islands reported fewer than 1,000 cases. American Samoa, the Federated States of Micronesia, the Commonwealth of the Northern Mariana Islands, and Palau each reported zero cases. This map is updated daily.

**Map 1: COVID-19 case rate reported to the CDC, by state/territory through July 12, 2020**
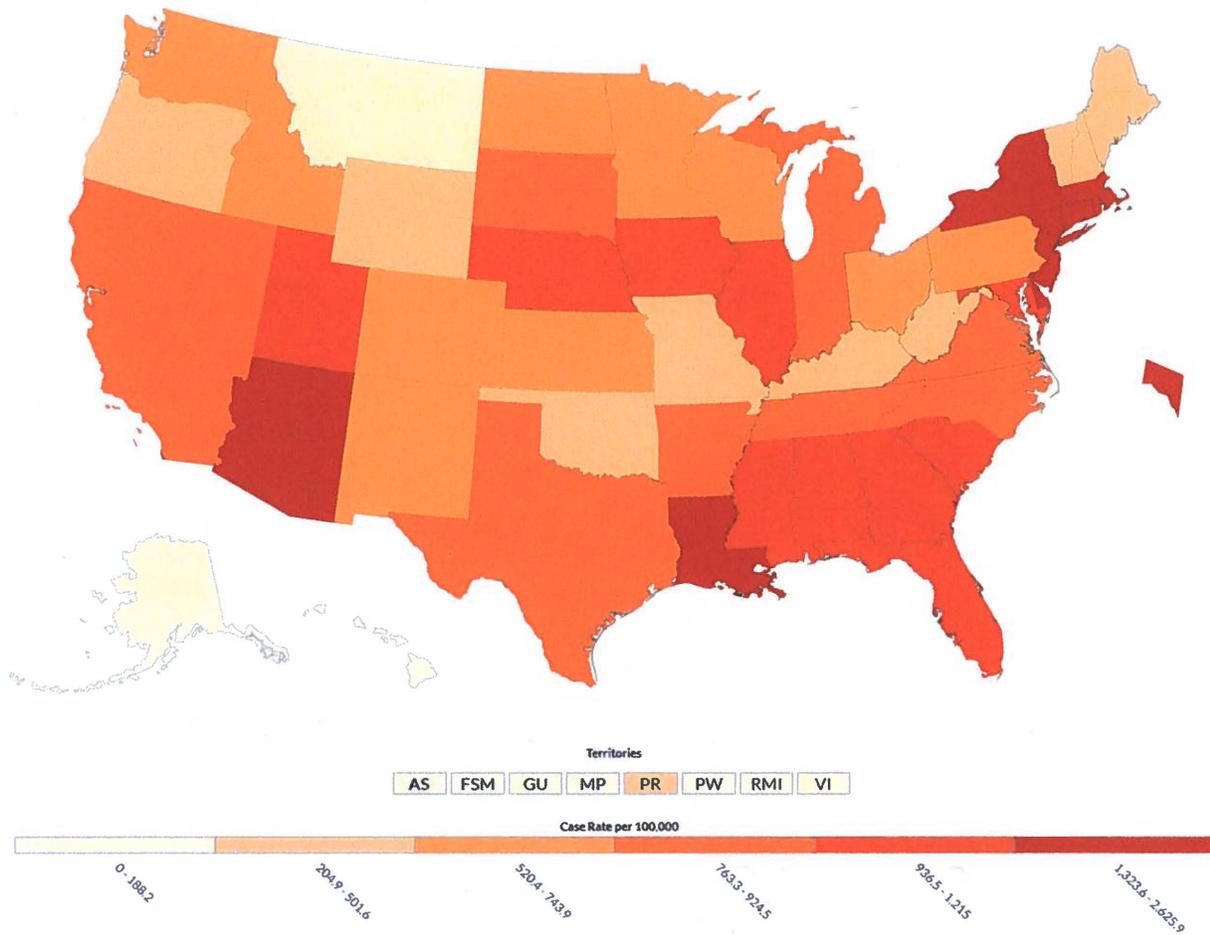


*Cases by Sex*
Table 1, below, outlines the breakdown of cases by sex.  Among the cases for which sex was reported, there were a similar number of cases in men and women with 1,231,689 in men and

1,299, 513 in women.  The cumulative COVID-19 case rate is 787.9 cases per 100,000 population and it is similar among females at 782.7 per 100,000 and males at 764.4 per 100,000 population.

**Table 1: Cumulative number of COVID-19 cases by sex, through July 12, 2020**

| Sex | Number of Cases | Percent of Total | Cases per 100,000 |
|---|---|---|---|
| Female | 1,299,513 | 50.4 | 782.7 |
| Male | 1,231,689 | 47.8 | 764.4 |
| Unknown* | 46,482 | 1.8 | -- |
| Total | 2,577,684 | -- | 787.9 |

\* Indicates unknown sex in the case report form.
Data source for table: DCIPHER line list data.

### *Cases by Age*

Table 2, below, outlines the breakdown of cases by age group.  The greatest number of cases occurred in those ages 18-44 years with a total of 1,130,683 reported cases, followed closely by those ages 45-64 years with 793,433 cases.  Conversely, when looking at cases per 100,000 population, those age 75 and over had the highest rate of cases at 1132.4 per 100,000 population, followed by those ages 18-44 at 962.8 per 100,000 population.

**Table 2: COVID-19 cases by age group, through Jul 12, 2020**

| Age | Number of Cases | Cases per 100,000 |
|---|---|---|
| 0-17 years | 152,590 | 207.9 |
| 18-44 years | 1,130,683 | 962.8 |
| 45-64 years | 793,433 | 945.6 |
| 65-74 years | 221,119 | 725.2 |
| ≥75 years | 248,430 | 1132.4 |
| Unknown age | 31,429 | |

Data source for table: DCIPHER line list.

It is important to note that early on in the outbreak Americans ages 45-64 initially had more probable or confirmed cases of COVID-19 than younger cohorts, but recent data suggests that younger Americans, ages 18-44 now have the highest rates of probable or confirmed cases of COVID-19. Figure 4, below, outlines that probable and confirmed cases were similar for ages 18-44 and 45-64 from early March through mid-April but has risen significantly for the 18-44 age group since early June.

**Figure 4: COVID-19 cases by age group and week reported, through Jul 12, 2020**
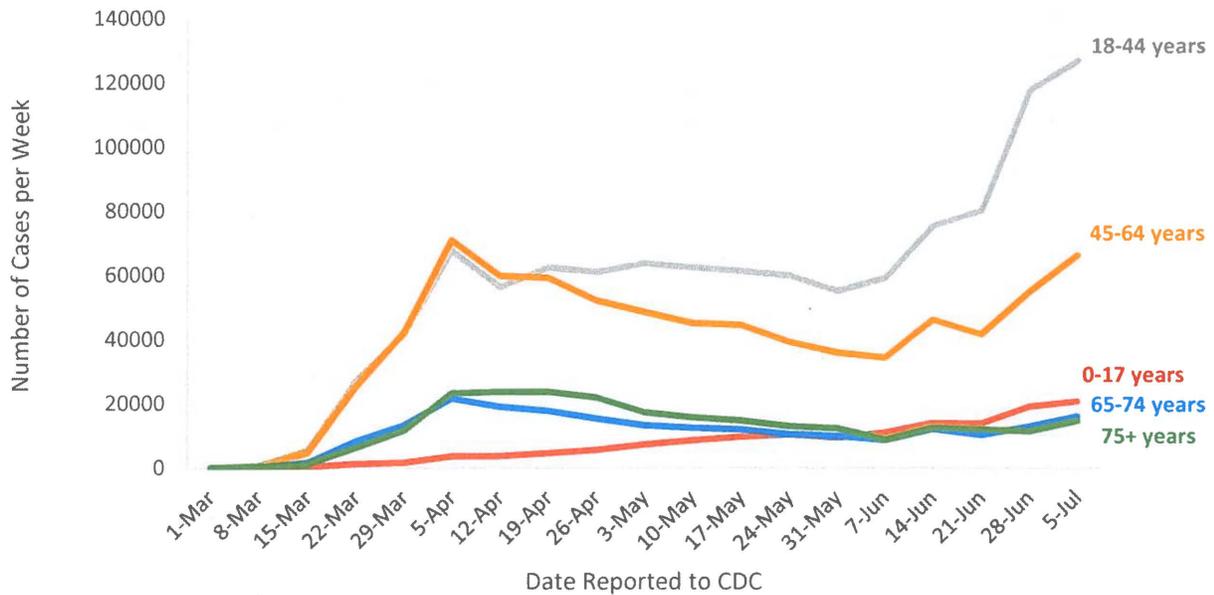


*Cases by Race/Ethnicity*

Figure 5 below shows the distribution of cases by race/ethnicity of reported to CDC from the National Notifiable Diseases Surveillance System. It is important to clarify that approximately 51.5% of cases had unknown race/ethnicity, and that these data represent just under half of the total case reports.

Overall, distribution of reported cases was highest in non-Hispanic Whites at 460,377 cases while 413,069 were among Hispanics or Latinos. There were 252,511 cases among non-Hispanic Blacks, while there were 50,742 cases among non-Hispanic Asians. There were 16,962 cases among non-Hispanic American Indian/Alaska Natives and 5,206 cases among non-Hispanic Native Hawaiian/Other Pacific Islanders. Non-Hispanic Native Hawaiian/Other Pacific Islanders had the highest case rate at 887.9 per 100,000, followed by American Indian/Alaska Natives at 701.7 per 100,000. Hispanic or Latinos also had a high case rate at 689.9 per 100,000. Non-Hispanic Blacks also had a high case rate at 617.4 per 100,000 population. Non-Hispanic Asians and Non-Hispanic Whites had the lowest number of cases per 100,000 population at 270.9 per 100,000 population and 233.0 per 100,000 population, respectively.

**Figure 5: COVID-19 cases by race and ethnicity, through July 12, 2020**
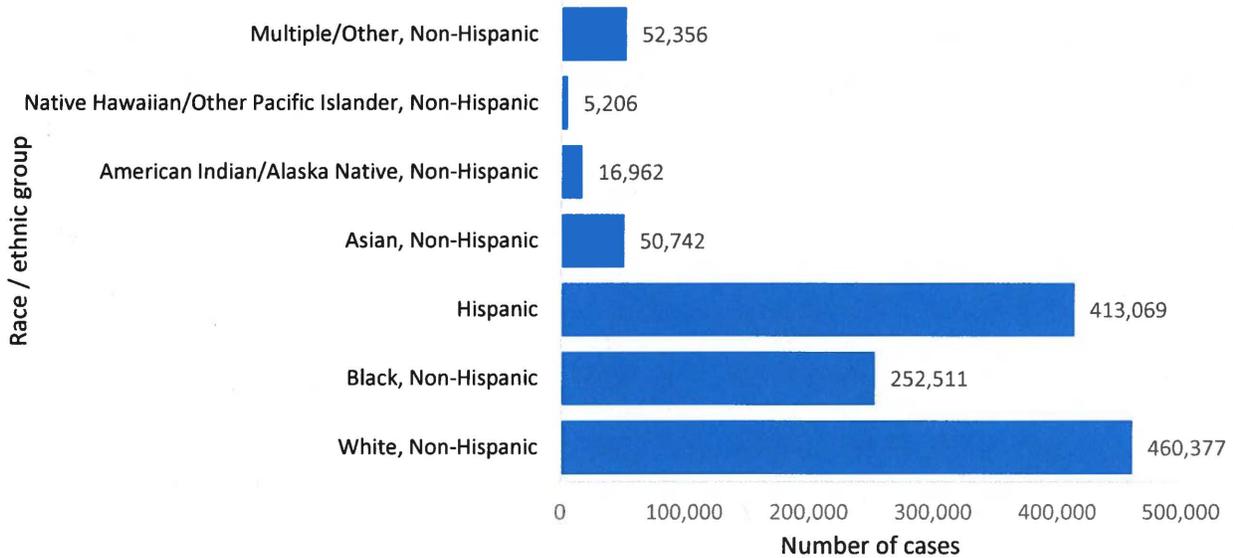


### Cases by Race/Ethnicity and Age Group
Figure 6, below, shows the cumulative age distributions of reported COVID-19 cases broken down by race/ethnicity. Approximately 0.2% of case reports were missing age.

Looking across all race/ethnicities, the highest number of cases were distributed among Hispanic or Latino adults ages 18-44, at 210,343 cases. There were also a high number of cases distributed among non-Hispanic Whites ages 18-44 with 156,111 cases. Similarly, there were a high number of cases distributed among the 45-64 age group for both non-Hispanic Whites and Hispanic or Latinos, with 134,670 cases and 120,319 cases respectively. For all race/ethnicities, the lowest number of cases were distributed among children ages 0-17 years.

Non-Hispanic Blacks ages 75 years and older had the highest rate per 100,000 at 1414.9 per 100,000 population. Hispanic or Latinos ages 45-64 years had the second highest rate per 100,000 population at 1009.7 per 100,000 population and non-Hispanic Black ages 65-74 years at 962.4 per 100,000 population.

**Figure 6: COVID-19 cases by race and ethnicity and age group, through July 11, 2020**

Legend: ■ 75+ ■ 65-74 ▦ 45-64 ■ 18-44 ■ 0-17

**Non-Hispanic White**
- 91,986
- 56,084
- 134,670
- 156,111
- 15,326

**Native Hawaiian/Other Pacific Islander**
- 166
- 289
- 1,176
- 2,026
- 281

**Multiple/Other**
- 6,874
- 5,332
- 16,007
- 21,020
- 2,787

**Hispanic**
- 17,205
- 22,521
- 120,319
- 210,343
- 35,904

**Black**
- 25,616
- 28,490
- 83,435
- 99,441
- 11,488

**Asian**
- 5,482
- 4,894
- 16,741
- 21,126
- 2,184

**American Indian/Alaska Native**
- 959
- 1,318
- 5,135
- 7,689
- 1,815

X-axis: Number of cases (0, 50,000, 100,000, 150,000, 200,000, 250,000)

## Hospitalizations

COVID-19 hospitalizations are reported through CDC's Coronavirus Disease 2019 (COVID-19)-Associated Hospitalization Surveillance Network (COVID-NET), which is a population-based surveillance system that collects data on laboratory-confirmed COVID-19-associated hospitalizations among children and adults through a network of over 250 acute-care hospitals in

14 states. COVID-19-associated hospitalization rates by race and ethnicity are calculated using hospitalized COVID-NET cases with known race and ethnicity for the numerator and National Center for Health Statistics (NCHS) bridged-race population estimates for the denominator. Rates are adjusted to account for differences in age distributions within race and ethnicity strata in the COVID-NET catchment area. More information about COVID-NET can be found in Appendix A.

### *Overall Hospitalizations*

A total of 34,791 laboratory-confirmed COVID-19-associated hospitalizations were reported by sites between March 1, 2020 and July 4, 2020 to the COVID-NET system. The overall cumulative hospitalization rate was 107.2 per 100,000 population.

### *Hospitalizations by Sex*

Figure 7 shows the distribution of hospitalizations by sex. Men had a slightly higher number of hospitalizations than women, with 17,940 men hospitalized and 16,834 women hospitalized. The rate of hospitalization among men was 112.7 per 100,000 population and the rate of hospitalization among women was 101.7 per 100,000.

**Figure 7: COVID-NET Number of COVID-19 Hospitalizations by Sex, through July 4, 2020**
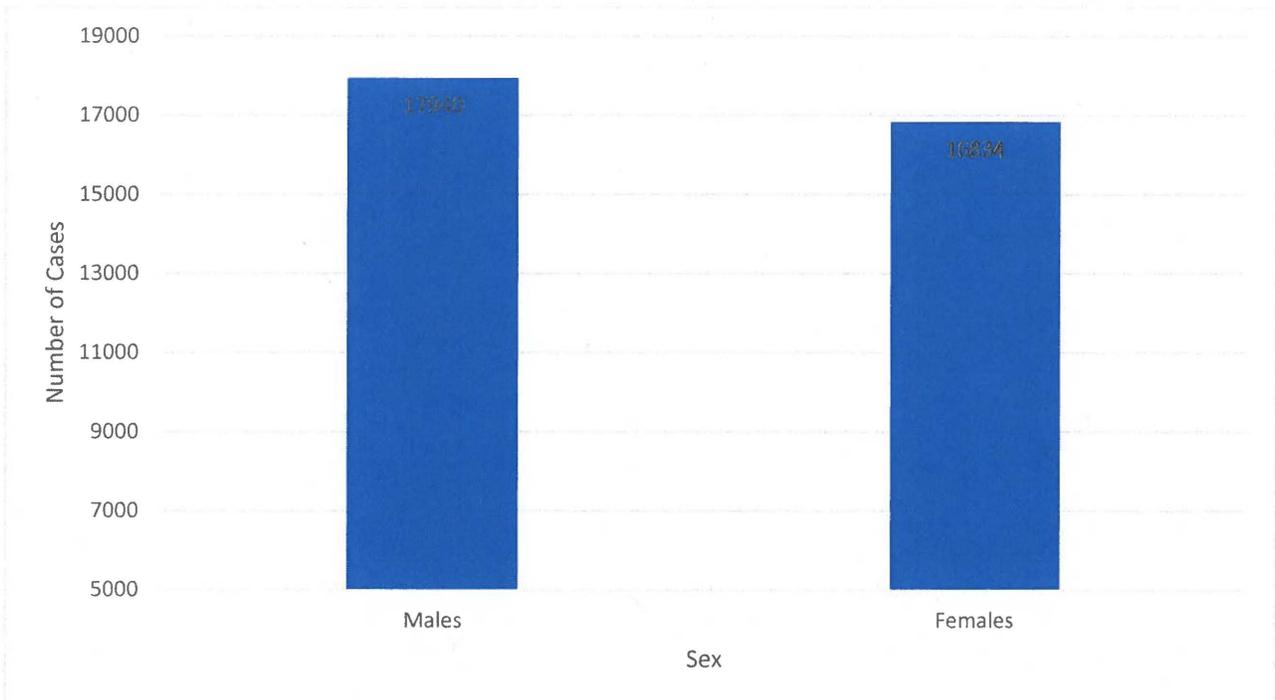


### *Hospitalizations by Age*

Figure 8, below, outlines the laboratory confirmed COVID-19 associated hospitalizations over time with the most recent data available through July 4. There were 185 hospitalizations among children ages 0-4 and 234 hospitalizations among children ages 5-17. Among adults ages 18-49

13

years, there were 9,595 hospitalizations, and among adults ages 50-64 years, there were 10,022 hospitalizations. Hospitalizations were highest among those ages 65 and over at 14,755. For children ages 0-4 years, the hospitalization rate was 9.4 per 100,000. For children ages 5-17 years, the hospitalization rate was slightly lower, at 4.4 per 100,000, while the hospitalization rates for adults ages 18-49 years was 66.7 per 100,000. Hospitalization rates for ages 50-64 years was 161.7 per 100,000 and were highest for ages 65 years and older at 316.9 per 100,000.

**Figure 8: Number of hospitalized patients by age group; COVID-NET Hospitalization data, through July 4, 2020**
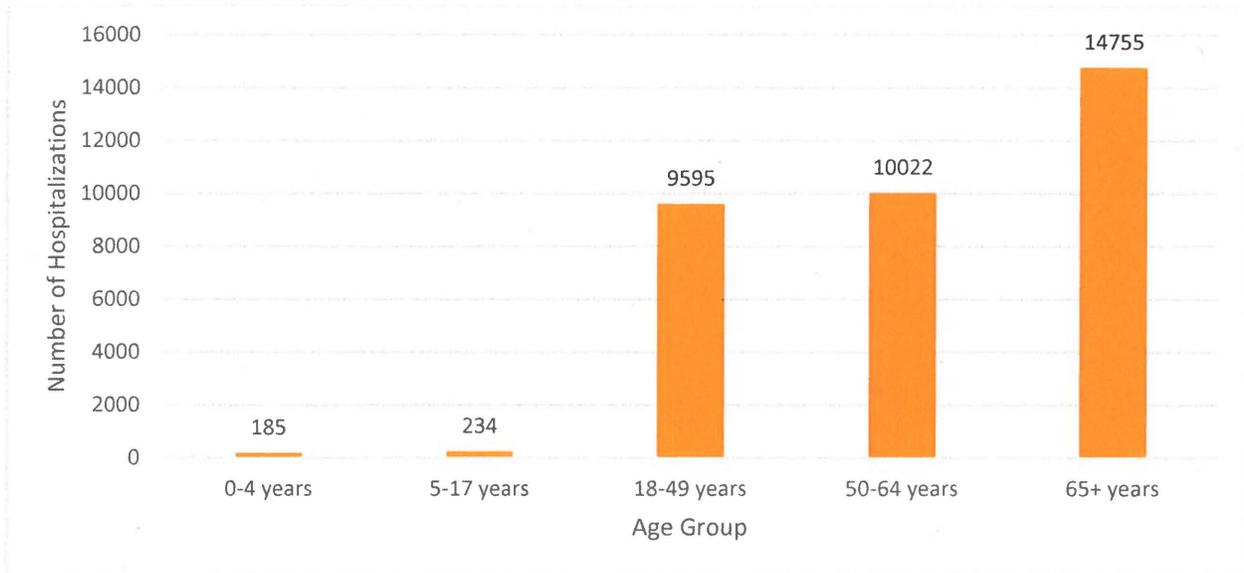


### Hospitalizations by Race/Ethnicity

Figure 9, below, shows the distribution of hospitalizations by race/ethnicity. Among the 34,791 laboratory-confirmed COVID-19-associated hospitalized cases, 32,766 (94.1%) had information on race and ethnicity. There were 10,680 hospitalizations among non-Hispanic Blacks, and 10,564 among non-Hispanic Whites. There were 7,352 hospitalizations among Hispanic or Latinos, and 1,556 hospitalizations among non-Hispanic Asian Pacific Islanders. The number of hospitalizations among non-Hispanic American Indian or Alaska Natives was 523.

Hospitalization rates were highest for non-Hispanic American Indian or Alaska Natives at 244.7 per 100,000 population. The hospitalization rate for non-Hispanic Blacks was 185.3 per 100,000 population, and for Hispanics or Latinos was 162.3 per 100,000 population. Hospitalization rates were lowest for non-Hispanic Whites at 55.3 per 100,000 population and non-Hispanic Asian Pacific Islanders at 54.2 per 100,000 population.

14

**Figure 9: COVID-NET Number of Hospitalizations by Race/Ethnicity, through July 4, 2020**
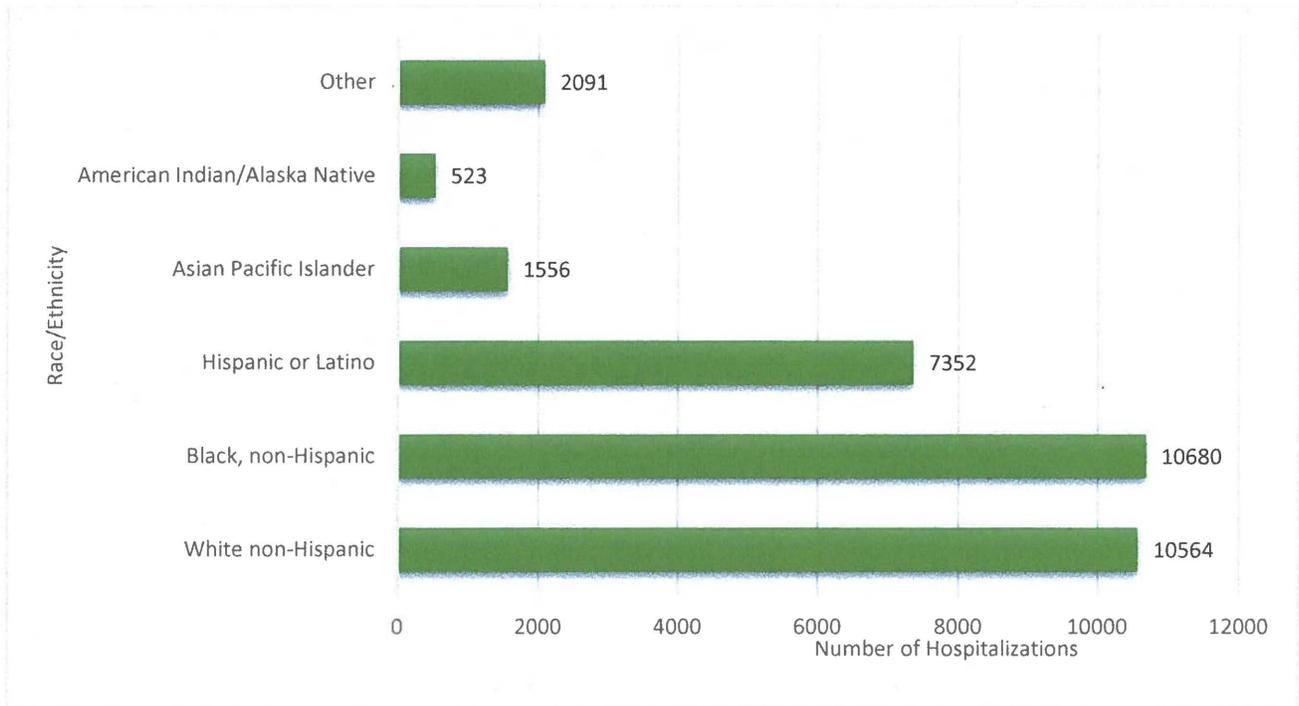


* Other category includes multiple races (n=59) and Unknown race/ethnicity (n=2032).
** The COVID-NET data is collected through retrospective medical chart review and the NHOPI category cannot be easily distinguished from other Asian Pacific Islanders in the medical charts. The protocol for COVID-NET data collection underwent OMB review and was approved prior to deployment in March 2020.

*Hospitalizations by Race/Ethnicity and Age Group*

Figure 10 below shows the distribution of age among hospitalized cases by race/ethnicity. The highest distribution of hospitalizations for those ages 65 and over were among White, non-Hispanics with 6,658 hospitalizations and Black, non-Hispanics with 4,466 hospitalizations. For those ages 50-64, the highest distribution of hospitalizations was among Black, non-Hispanics with 3,485 hospitalizations and White, non-Hispanics with 2,469 hospitalizations. For those ages 18-49, the highest distribution of hospitalizations was among Hispanics and Latinos at 3,682 hospitalizations and Black, non-Hispanics at 2,625 hospitalizations.

**Figure 10: Distribution of age among cases hospitalized with laboratory-confirmed SARS-CoV-2 infection by race and ethnicity\* — COVID-NET, through July 4**

Non-Hispanic Blacks ages 65 and over have the highest hospitalization rates per 100,000 population at 1362.8 per 100,000 population. This is more than 7 times the hospitalization rate for their non-Hispanic, White counterparts. Non-Hispanic American Indian or Alaska Natives ages 65 and over have the second highest hospitalization rates per 100,000 population at 601.8 per 100,000 population – more than three times that of their non-Hispanic White counterparts. Among those ages 50-64 years, non-Hispanic Blacks and non-Hispanic American Indian or Alaska Natives have the highest rates of hospitalizations per 100,000 population, at 607.4 per 100,000 and 484.8 per 100,000 respectively. For non-Hispanic Blacks ages 50-64 years, this is 10 times higher than the hospitalization rate for their White counterparts. Similarly, for non-Hispanic American Indian or Alaska Natives the hospitalization rate is more than eight times that for their non-Hispanic White counterparts. Table 3, below, outlines the hospitalization rates per 100,000.

**Table 3: Hospitalization rates per 100,000 population by age and race and ethnicity — COVID-NET, through June 27, 2020**

| Age Group | NH American Indian or Alaska Native | NH Black | Hispanic or Latino | NH Asian or Pacific Islander | NH White |
|-----------|-------------------------------------|----------|--------------------|------------------------------|----------|
| 0-17y | 5.9 | 7.1 | 12.2 | 3.4 | 1.4 |
| 18-49y | 196.2 | 119.1 | 139 | 30.2 | 17.4 |
| 50-64y | 484.8 | 607.4 | 212.1 | 98.5 | 60.4 |
| 65+y | 601.8 | 1362.8 | 221.1 | 221 | 194.3 |

## Deaths

The provisional counts for coronavirus disease (COVID-19) deaths are based on a current flow of mortality data in the National Vital Statistics System (NVSS). NVSS captures all deaths from all causes across every state in the nation to track the characteristics of those dying in the United States, help determine life expectancy, and allow comparisons of death trends with other countries.

National provisional counts include deaths occurring within the 50 states and the District of Columbia. It can take several weeks for death records to be submitted to National Center for Health Statistics (NCHS), processed, coded, and tabulated. Therefore, the data will likely not include all deaths that occurred during a given time period, especially for the more recent time periods. Death counts for earlier weeks are continually revised and may increase or decrease as new and updated death certificate data are received from the states by NCHS. COVID-19 death counts shown here may differ from other published sources, as data currently are lagged by an average of 1–2 weeks. Appendix B shows the current total deaths, confirmed deaths and probable deaths by jurisdiction.

### *All Deaths*
As of July 12, 2020, there were a total of 134,884deaths in the U.S. from COVID-19. While deaths continue to decline overall, the recent uptick in cases may lead to an increase in death counts due to COVID-19.

## Deaths by Sex

Figure 12, below, shows the COVID-19 deaths by sex. There were 53,470 reports of COVID-19 related deaths in females and 61,268 in males. The death rate among females is 32.2 deaths per 100,000 population and the death rate among males is 38.0 per 100,000 population.

**Figure 12: Provisional COVID-19 deaths by sex reported through July 8, 2020 (n = 114,738)**
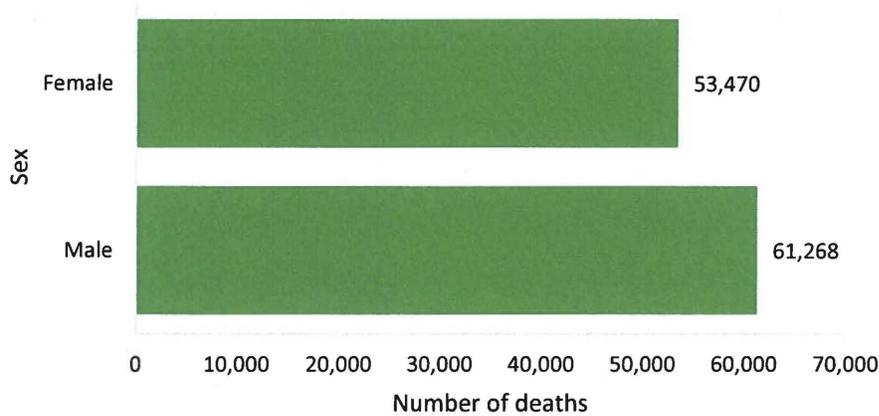


## Deaths by Age Group

Figure 13, below, shows provisional death counts through July 8, 2020. The distribution of deaths continues to be highest among the elderly with the greatest number of deaths in those age 75 and older at 68,414 deaths, followed by those age 65-74 years at 23,866 deaths and 45-64 years at 19,458 deaths, respectively. Deaths continue to be the lowest among those under age 35 years, with just 30 deaths among those ages 0-14 years and 2,970 deaths among those ages 15-44. Deaths per 100,000 population are highest for those 75 years and over at 311.8 per 100,000 population. This is almost 4 times higher than the deaths per 100,000 population for those age 65-74 years at 78.3 per 100,000 population and 13 times higher than the deaths per 100,000 population for those age 45-64 years at 23.2 per 100,000 population.

**Figure 13: Provisional COVID-19 deaths by age group reported through July 8, 2020 (n = 114,738)**
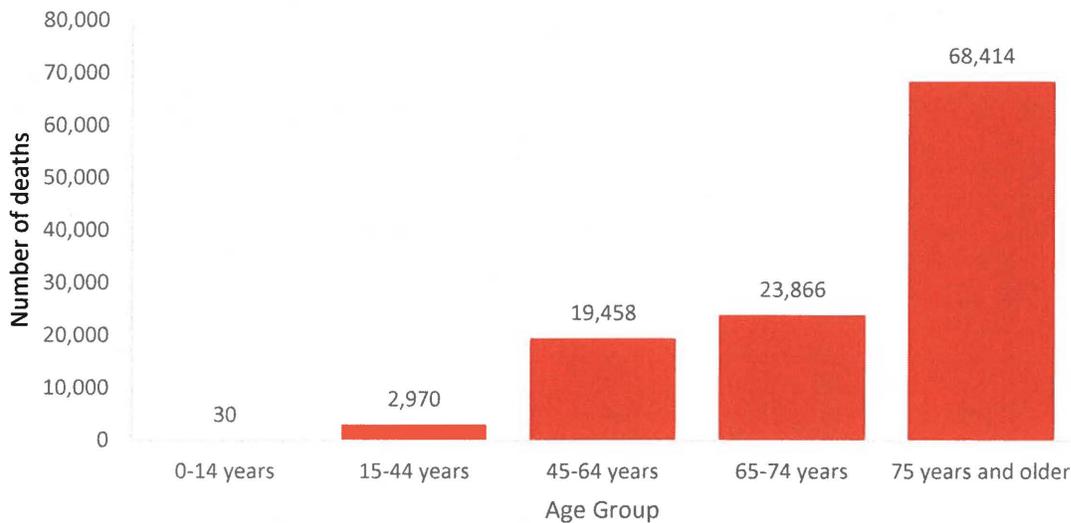


*Deaths by Race/Ethnicity*

Figure 14 shows the distribution of provisional deaths by race/ethnicity from NCHS. Distribution of deaths was highest among non-Hispanic Whites with 60,862 deaths, while there were 26,462 deaths among non-Hispanic Blacks, and 19,409 deaths among Hispanic or Latinos. Distribution of deaths was lowest among non-Hispanic Native Hawaiian or Other Pacific Islanders at 127 deaths. There were 5,629 deaths among non-Hispanic Asians and 888 deaths among non-Hispanic American Indian or Alaska Natives. The death rate per 100,000 population was highest for non-Hispanic Blacks at 64.6 deaths per 100,000 population. This is 2 times the death rate for Hispanic or Latinos at 32.4 per 100,000 population, non-Hispanic Whites at 30.8 per 100,000 population, and non-Hispanic Asians at 30.1 deaths per 100,000 population. It is just over 1.75 times the death rate for non-Hispanic American Indian or Alaska Natives at 36.7 deaths per 100,000 population. Non-Hispanic Native Hawaiian, or Other Pacific Islanders had the lowest death rates at 4.0 per 100,000 population.

**Figure 14: Provisional COVID-19 deaths by race and ethnicity reported through July 8, 2020 (n = 114,741)**
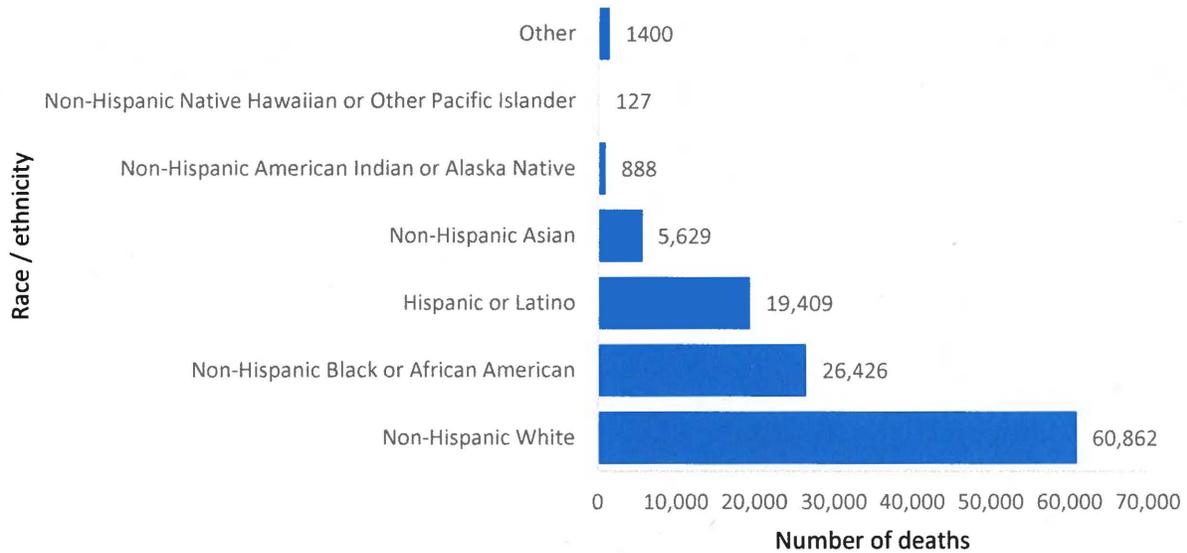


* Other category includes multiple races (n=251) and Unknown race/ethnicity (n=1121).

## *Deaths by Race/Ethnicity and Age Group*

Table 4 highlights the number of deaths by race/ethnicity and age group. The highest number of deaths was distributed among non-Hispanic Whites over age 75 years with 44,381 deaths, and non-Hispanic Blacks over age 75 years with 12,246 deaths. Non-Hispanic Asians over 75 had just 3,076 deaths. However, non-Hispanic Blacks over age 75 had the highest death rate at 676.4 per 100,000 population. Hispanic or Latinos over age 75 also had a high death rate at 444.9 deaths per 100,000, followed by non-Hispanic Asians over age 75 at 325.2 deaths per 100,000 population.

**Table 4: Provisional COVID-19 deaths and death rates per 100,000 by race/ethnic group and age category, reported through July 8, 2020**

| Race/Ethnicity | Age Group | Deaths | Percent by Race/Ethnic Group | Deaths Per 100,000 |
|---|---|---|---|---|
| Non-Hispanic White | 0–14 years | 8 | 0.0% | 0.0 |
| | 15–44 years | 451 | 0.7% | 0.6 |
| | 45–64 years | 5,613 | 9.2% | 10.1 |
| | 65–74 years | 10,409 | 17.1% | 45.4 |
| | 75 years and older | 44,381 | 72.9% | 258.4 |
| Black | 0–14 years | 10 | 0.0% | 0.1 |
| | 15–44 years | 924 | 3.5% | 5.2 |
| | 45–64 years | 6,234 | 23.6% | 61.9 |

20

| | | | | |
|---|---|---|---|---|
| | 65–74 years | 7,012 | 26.5% | 236.9 |
| | 75 years and older | 12,246 | 46.3% | 676.4 |
| Hispanic or Latino | 0–14 years | 9 | 0.0% | 0.1 |
| | 15–44 years | 1,311 | 6.8% | 4.6 |
| | 45–64 years | 5,864 | 30.2% | 49.2 |
| | 65–74 years | 4,504 | 23.2% | 167.9 |
| | 75 years and older | 7,721 | 39.8% | 444.9 |
| Asian | 0–14 years | 1 | 0.0% | 0.0 |
| | 15–44 years | 132 | 2.3% | 1.5 |
| | 45–64 years | 1,098 | 19.5% | 23.6 |
| | 65–74 years | 1,322 | 23.5% | 92.9 |
| | 75 years and older | 3,076 | 54.6% | 325.2 |
| American Indian/Alaska Native | 0–14 years | 1 | 0.1% | 0.2 |
| | 15–44 years | 91 | 10.2% | 8.8 |
| | 45–64 years | 301 | 33.9% | 51.1 |
| | 65–74 years | 203 | 22.9% | 110.9 |
| | 75 years and older | 292 | 32.9% | 281.0 |
| Native Hawaiian or Other Pacific Islander | 0–14 years | 1 | 0.8% | 0.8 |
| | 15–44 years | 22 | 17.3% | 8.0 |
| | 45–64 years | 47 | 37.0% | 35.4 |
| | 65–74 years | 32 | 25.2% | 86.9 |
| | 75 years and older | 25 | 19.7% | 125.1 |
| More than one race | 0–14 years | 0 | 0.0% | 0.0 |
| | 15–44 years | 13 | 4.6% | 0.8 |
| | 45–64 years | 58 | 20.6% | 11.4 |
| | 65–74 years | 62 | 22.0% | 45.2 |
| | 75 years and older | 149 | 52.8% | 200.7 |
| Unknown | 0–14 years | 0 | 0.0% | |
| | 15–44 years | 26 | 2.3% | |
| | 45–64 years | 243 | 21.7% | |
| | 65–74 years | 322 | 28.8% | |
| | 75 years and older | 527 | 47.1% | |

Data source for table: NCHS Provisional Death Counts.

## Testing

Laboratory data serves not only as important information to support decision-making related to the public health emergency, but also as a critical piece to better understand the impact on socially vulnerable populations. Laboratory testing data, in conjunction with case reports and other data, also provide vital guidance for mitigation and control activities. As of July 12, 2020 CDC received reports for 41,761,392 diagnostic tests from public health departments, hospitals, and commercial laboratories. Of these, 3,754,729 (9%) were positive for COVID-19. Diagnostic test data are compiled from a number of sources, including commercial, hospital and public

health laboratories. Not all tests are directly reported to CDC, and there is currently no breakdown of race/ethnicity for testing numbers. However, on June 4, 2020, HHS issued new guidance under the CARES Act that specifies additional demographic data, including patient race and ethnicity that must be reported to HHS by laboratories along with COVID-19 test results by August 1, 2020. Under this new guidance, we expect to gain more critical information about those testing positive for COVID-19.

It is also important to note that the number of positive tests in a state is not equal to the number of cases, as one person may be tested more than once. For that reason, CDC distinguishes between testing data and case report data on its website. The daily count of cases, found here is based on case report data, not on testing data. Public health laboratories in all 50 states, Washington DC, Guam, Puerto Rico, and United States Virgin Islands are now testing for SARS-CoV-2. Additional information about testing is available on CDC's website.

## County Level Analysis

A key characteristic of the COVID-19 pandemic in the United States is the disproportionate burden the disease has had on racial and ethnic minorities. Long-standing systemic health and social inequities have put some members of racial and ethnic minority groups at increased risk of getting COVID-19 or experiencing severe illness, regardless of age. For example, national hospitalization data show that non-Hispanic black people, Hispanics and Latinos, and American Indians/Alaska Natives are hospitalized at higher rates from COVID-19 than non-Hispanic white people.

Data on racial and ethnic disparities for local jurisdictions are integral to providing local support. There is increasing congressional interest for CDC to report data on specific geographical areas where different racial and ethnic groups may be disproportionately affected by COVID-19. CDC is currently working with state, local and territorial health department to improve completeness of demographic data; however, currently only 48% of cases have complete information race/ethnicity. While completeness of the data reported to CDC improves, CDC has developed methodology to identify geographic areas where different racial and ethnic groups might be disproportionately affected by COVID-19. Using reported case data, we identified counties with a recent high burden of COVID-19 cases (more than 100 new cases per 100,000 population in the past two weeks). Using census data, we identified counties where a large proportion (≥30%) of the population was a specific race/ethnic group. For each race/ethnic group, we mapped counties that had a large proportion of that group stratified by whether it was a high burden county. Additionally, for each race/ethnic group, we identified the ten counties with the highest two-week cumulative incidence.

This methodology allows us to better understand the dynamics of this disproportionate impact on communities of color and is critical to public health efforts to respond to the pandemic and protect vulnerable communities. It aims to examine how these racial and ethnic disparities appear at the county level and overlaid that data with county populations with a large proportion of a single demographic characteristic. CDC is working to provide these data routinely.

This analysis uses COVID-19 case counts and Census populations at the county level to identify where racial and ethnic groups of interest might be disproportionately affected by COVID-19. We identified areas with a recent high burden of COVID-19 cases and mapped them to counties where groups of interest comprised a large proportion of the county population.

Recent high burden was defined as more than 100 new cases per 100,000 population in the past two weeks. Large proportion was defined as 30% or more of the county population[2]. Data presented here are based on cases reported through July 11, 2020.

### *Counties with Recent High Burden of COVID-19 (June 28–July 11, 2020)*

As of July 11, 2020, 1,400 (44.6%) counties had a recent high burden of COVID-19 cases. The map below shows the location of these counties in orange. The map below shows the location of these counties in orange. Many of these counties are designated as rural and are noted below. Across the country, there are more than 17 million people who live in rural counties without a Rural Health Clinic (RHC), more than 15 million in rural counties without a Federally Qualified Health Center (FQHC), and nearly 4.5 million in rural counties without an acute care hospital[3]. Most counties noted as rural are designated as health professional shortage areas for primary care and many rural counties rate high on vulnerability in CDC's Social Vulnerability Index. Many rural counties do not have a physician, and many rural hospitals have closed, making access to care difficult.

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[2] A 30% cutoff was chosen as a proportion where the group of interest could be the highest proportion of the county population, although this varied by county.
[3] From: https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2018/01/AccesstoPrimaryCare.pdf

**Map 2: Counties with Recent High Burden of COVID-19, June 28-July 11, 2020**
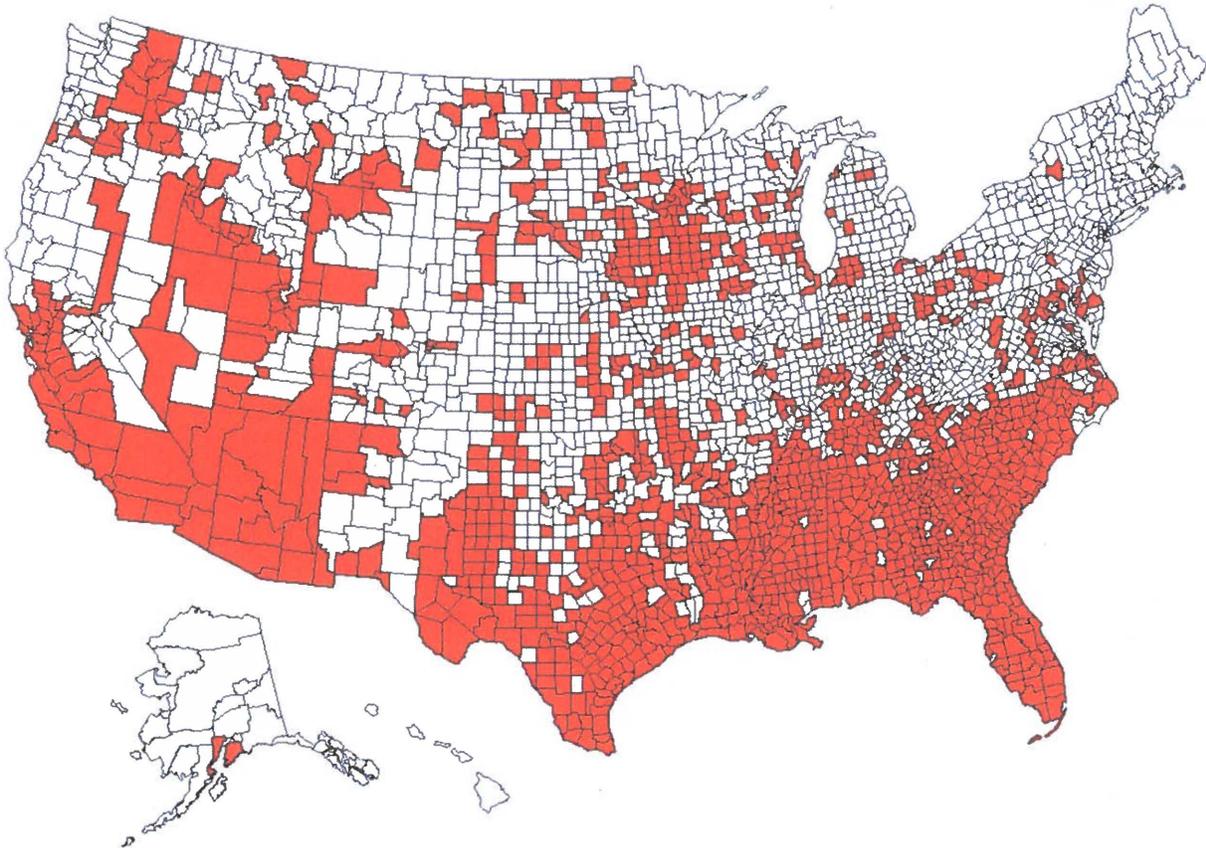


*Distribution of Recent High Burden Counties Across Race/Ethnicity Groups*
Compared with the U.S.-wide distribution, counties with large non-Hispanic black, large
Hispanic, large non-Hispanic Asian, or large non-Hispanic American Indian or Alaska Native
populations had a higher proportion of counties with recent high burden of COVID-19 cases.
Counties with large non-Hispanic black populations[4] had the highest proportion at 87.9%,
compared with the U.S.-wide proportion of 44.6%.

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[4] Large proportion of non-Hispanic black populations defined as 30% or more of the population.

**Figure 15: Distribution of Recent High Burden Counties Across Race/Ethnicity Groups**
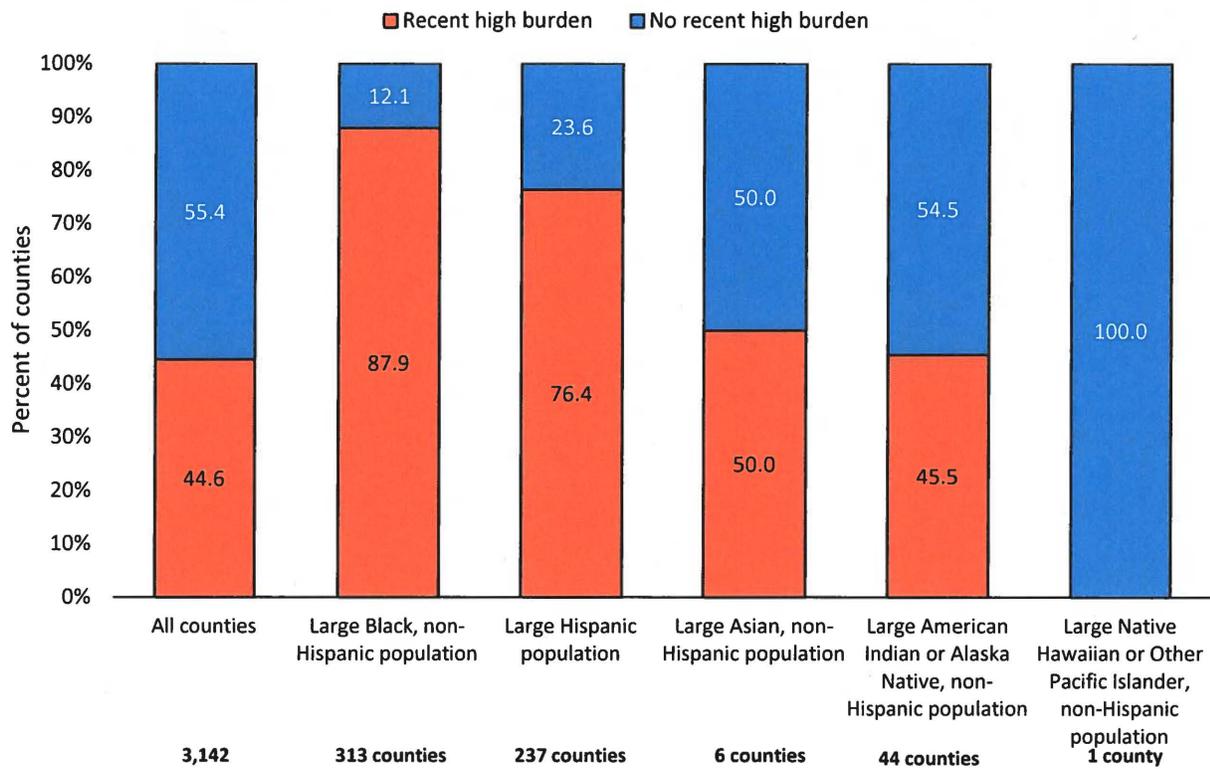


This report focuses on the three minority groups for which counties with large group populations had a recent high burden of COVID-19 cases.

***Counties with Large <u>non-Hispanic Black</u> Populations and Recent High Burden***
Among 313 counties that were 30% or more non-Hispanic black, 275 (87.9%) had recent high burden of COVID-19 cases. These counties with recent high burden are highlighted in orange below. Counties in blue are counties with large non-Hispanic black populations but do not have high burden.

**Map 3: Counties with Large <u>non-Hispanic Black</u> Populations and Recent High Burden**
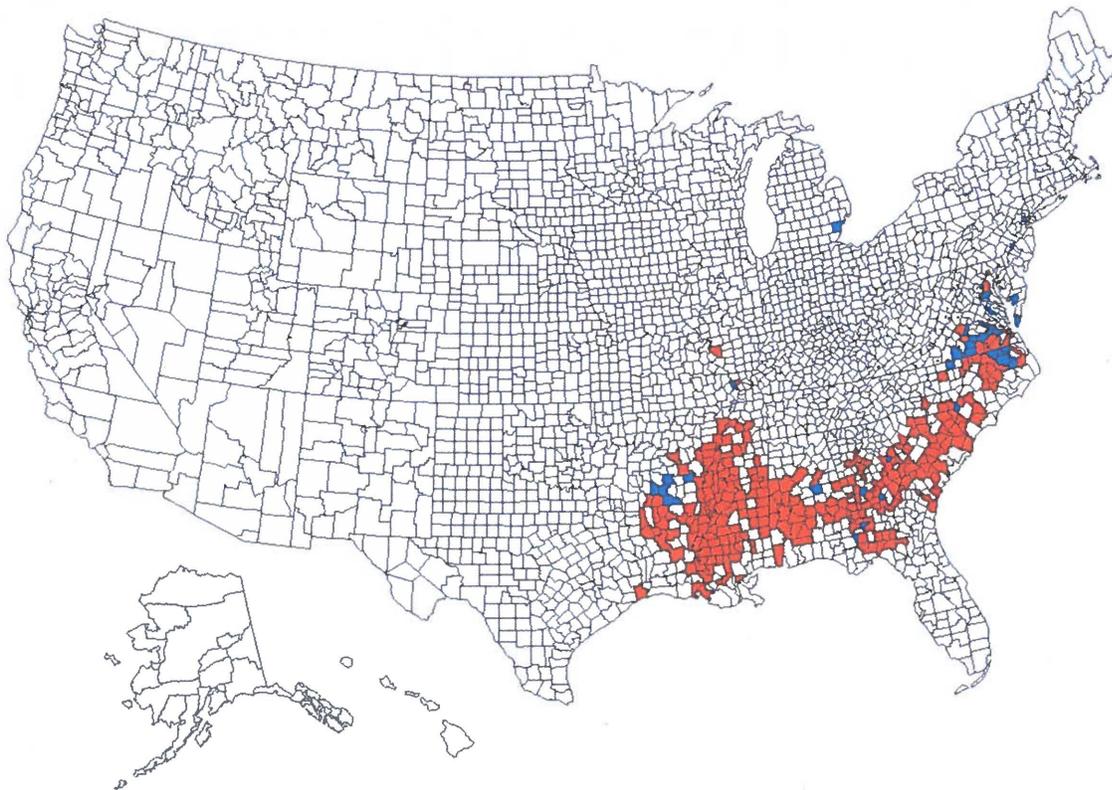


Below are the top 10 counties with large non-Hispanic black populations and recent high burden of COVID-19. Counties are ranked by two-week cumulative incidence of COVID-19. Predominant group is starred (*) for the 8 counties where the non-Hispanic black population is the largest proportion of the county population. Nine of the 10 counties in Table 5, below, are rural. Iberia Parish, LA is a metropolitan county.

**Table 5: Top 10 U.S. Counties with Large, non-Hispanic Black Populations and Recent High Burden of COVID-19**

| County | New cases per 100,000 population in the past 2 weeks | Percent of population non-Hispanic black | Non-Hispanic black predominant group |
|---|---|---|---|
| Lee, AR | 2214.80 | 53.9% | * |
| Stewart, GA | 1645.43 | 40.4% | * |
| Grenada, MS | 1453.34 | 42.4% | |
| Perry, AL | 1378.56 | 67.5% | * |
| Claiborne, MS | 999.78 | 85.4% | * |
| Sunflower, MS | 952.01 | 73.2% | * |
| Covington, MS | 907.02 | 35.6% | |
| Iberia Parish, LA | 871.15 | 32.1% | |
| Chicot, AR | 862.23 | 53.4% | * |
| Madison, FL | 760.97 | 37.3% | |

***Counties with Large <u>Hispanic or Latino</u> Populations and Recent High Burden***

Among 237 counties that are 30% or more Hispanic or Latino, 181 (76.4%) have recent high burden of COVID-19 cases. These counties with recent high burden are highlighted in orange below. These counties with recent high burden are highlighted in orange below. Counties in blue are counties with large Hispanic populations but do not have high burden.

**Map 4: Counties with Large <u>Hispanic</u> Populations and Recent High Burden**
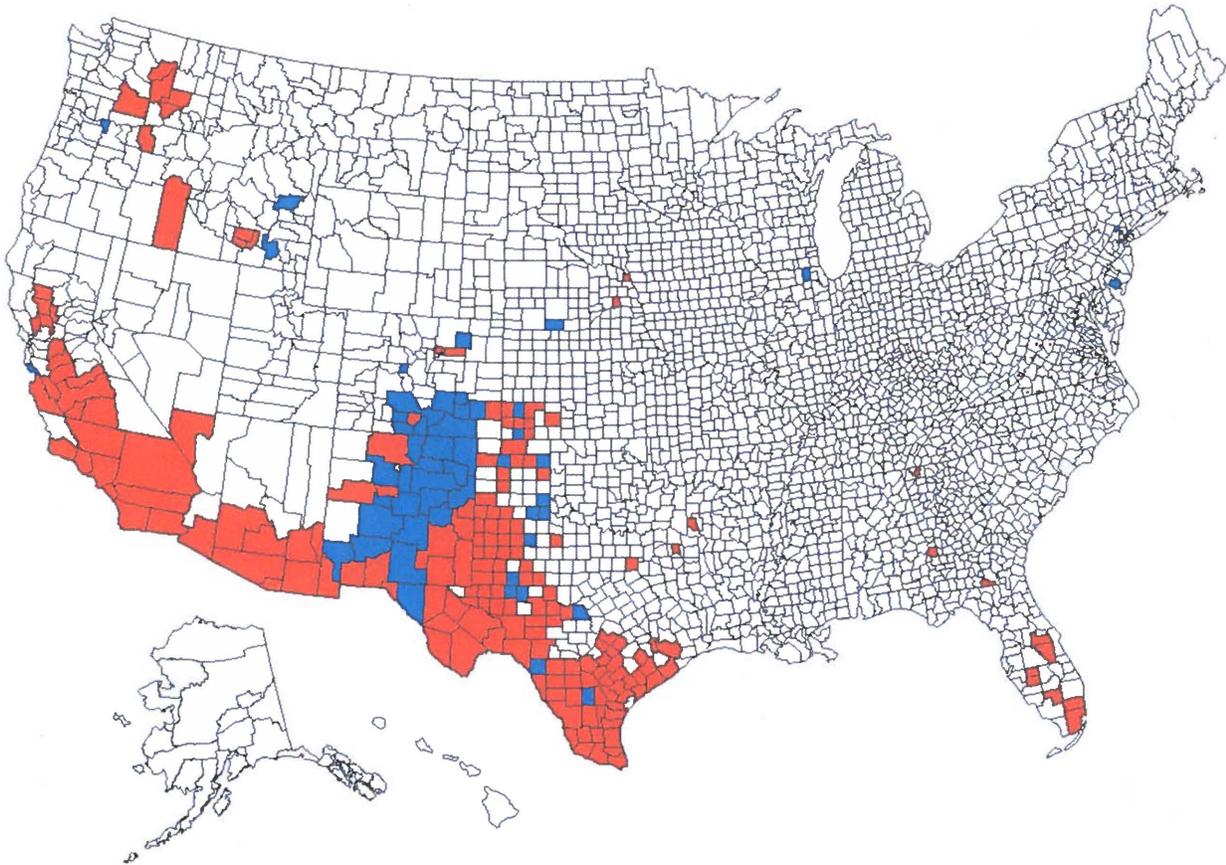


Below are the top 10 counties with large Hispanic or Latino populations and recent high burden of COVID-19. Counties are ranked by two-week cumulative incidence of COVID-19. Predominant group is starred (*) for the 5 counties where the Hispanic group is the largest proportion of the county population. Of the counties listed below, 6 of the 10 are rural. Of the remaining 4 counties, Nueces, Miami-Dade, and Imperial are metropolitan counties with Census tracts identified as rural. Victoria County in Texas is metropolitan.

**Table 6: Top 10 U.S. Counties with Large, non-Hispanic Black Populations and Recent High Burden of COVID-19**

| County | New cases per 100,000 population in the past 2 weeks | Percent of population Hispanic | Hispanic predominant group |
|---|---|---|---|
| Scurry, TX | 1713.51 | 40.6% | |
| Stewart, GA | 1645.43 | 31.5% | |
| Hale, TX | 1560.74 | 59.7% | * |
| Victoria, TX | 1296.25 | 47.4% | * |
| Yuma, AZ | 1195.50 | 64.3% | * |
| Nueces, TX | 1151.92 | 64.2% | * |
| Santa Cruz, AZ | 1092.21 | 83.4% | * |
| Miami-Dade, FL | 1061.20 | 69.1% | * |
| Matagorda, TX | 1017.73 | 42.9% | |
| Imperial, CA | 982.25 | 84.6% | * |

### *Counties with Large <u>non-Hispanic American Indian and Alaska Native</u> Populations and Recent High Burden*

Among 44 counties that are 30% or more non-Hispanic American Indian and Alaska Native, 20 (45.5%) have recent high burden of COVID-19 cases. These counties with recent high burden are highlighted in orange below. Counties in blue are counties with large non-Hispanic American Indian and Alaska Native populations but do not have high burden.

**Map 5: Counties with Large <u>non-Hispanic American Indian and Alaska Native</u> Populations and Recent High Burden**
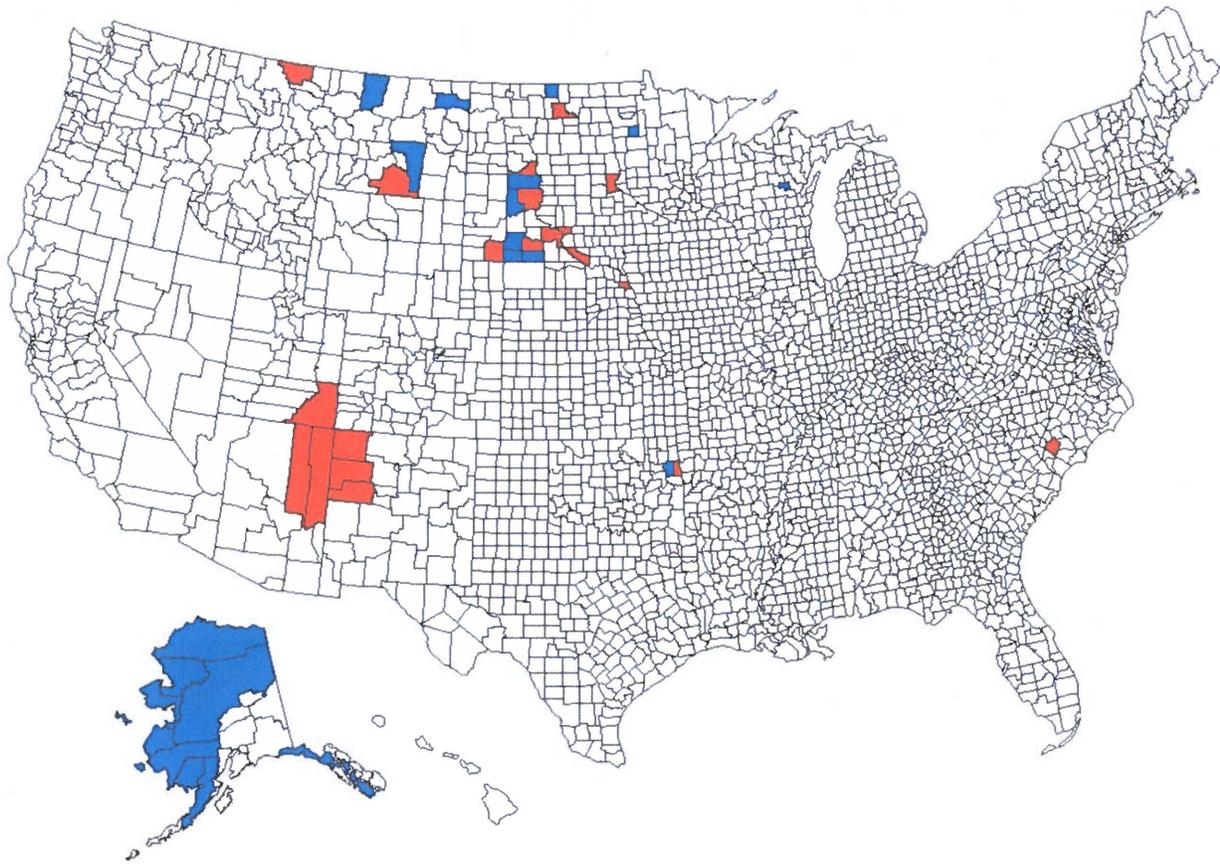


Below are the top 10 counties with large non-Hispanic American Indian and Alaska Native populations and recent high burden of COVID-19. Counties are ranked by two-week cumulative incidence. Predominant group is starred (*) for the 8 counties where the non-Hispanic American Indian and Alaska Native group is the largest proportion of the county population. All counties in Table 6, below, are rural.

**Table 7: Counties with Large <u>non-Hispanic American Indian and Alaska Native</u> Populations and Recent High Burden**

| County | New cases per 100,000 population in the past 2 weeks | Percent of population non-Hispanic American Indian or Alaska Native | Non-Hispanic American Indian or Alaska Native predominant group |
|---|---|---|---|
| Thurston, NE | 1163.91 | 55.0% | * |
| Navajo, AZ | 798.59 | 43.7% | * |
| Buffalo, SD | 687.62 | 77.1% | * |
| Lyman, SD | 654.28 | 37.3% | |
| Dewey, SD | 491.19 | 70.4% | * |
| San Juan, UT | 427.21 | 47.4% | * |
| McKinley, NM | 421.91 | 73.9% | * |
| Apache, AZ | 419.11 | 73.2% | * |
| Robeson, NC | 348.17 | 39.8% | * |
| Sioux, ND | 344.19 | 78.1% | * |

*Future Reporting on Geographic Disparities by Race and Ethnicity*

CDC is continuing to review the availability of data to identify geographic locations that reflect a disproportionate burden of COVID-19 among racial and ethnic minorities. This report will be updated every 30 days with new information and as more complete data become available.

CDC will be pursuing several steps to improve future reporting, including:
- Continuing to push for technical innovations to improve case report completeness
- Augmenting the available case report data through methods such as mathematical imputation
- Adjusting the methodology to evaluate the best approach to define and identify counties with large proportions of groups of interest
- Developing new data visualizations to display information about counties with both high recent burden of COVID-19 and high proportions of racial and ethnic minority population groups

## Looking Forward

CDC's Chief Health Equity Office ensures an all-of-response approach to identifying and addressing COVID-19 health disparities. CDC is implementing a health equity strategy to ensure that key data are available to identify those most affected by this pandemic and that programs— such as those culturally and linguistically responsive, high impact programs that are tailored to address the unique circumstances of groups at increased risk for COVID-19 - are implemented.

The health equity strategy prioritizes:
- Expanding the evidence base to increase our understanding of the factors that lead to the disproportionate burden of COVID-19 in some populations.

- Expanding testing, contact tracing, isolation options, and preventive care and disease management in populations at increased risk for COVID-19.
- Expanding programs and practice activities to support essential and frontline workers to prevent spread of COVID-19.
- Expanding cultural responsiveness and application of health equity principles among an increasingly diverse COVID-19 responder workforce.

CDC is supporting local activities in some African American communities – as well as Hispanic/Latino, Asian American, American Indian and Alaska Native, and Native Hawaiian and other Pacific Islander communities. Community capacity must be strengthened nationwide to support and advance these types of activities. For example, *"A Southern Strategy for addressing COVID-19 among non-Hispanic Blacks and/or African Americans living in the southeast region of the United States"* is mobilizing African American communities at high-risk for COVID-19 morbidity and mortality to adopt and sustain community mitigation strategies to prevent COVID-19 in New Orleans, LA, Albany, GA, and Jackson, MS. Specifically, these strategies include testing for COVID-19, facilitating contact tracing, promoting face coverings and social distancing, and identifying mental health issues associated with COVID-19. Academic institutions with strong, documented community partnerships with the African American community in each city will leverage their influence and expertise in collaboration with trusted community organizations and leaders to implement project activities. This includes creating a 3-state consortium inclusive of community partners to share strategies, tackle barriers, and craft lessons learned that can be replicated across the southeastern region. Over time, this broad-based community engagement and collaboration aims to ensure equitable access to testing, health care, and future COVID-19 vaccines.

CDC looks forward to sharing our progress on the Southern Strategy project and will provide an update in a future Report to Congress.

# Appendix A: Sources of Data for Race and Ethnicity

CDC's surveillance strategy relies on reporting from multiple partners including states, hospitals, labs, nursing homes and others. Receiving data from multiple sources enables CDC to compile a more complete and textured picture of the epidemiology of this virus and its spread. Below is a description of the sources of data used in this report, the reporting entity, and the strengths and limitations of the sources for race and ethnicity data.

| | Case-based reporting | COVID-NET Hospitalization Data | Laboratory Data | NVSS Mortality Data |
|---|---|---|---|---|
| Description | COVID-19 cases are reported to CDC through a standardized, response-initiated case report form and populates the National Notifiable Diseases Surveillance System (NNDSS). Cases are reported to CDC using a standardized case definition and defined demographic and clinical variables. A confirmed case is defined as confirmed COVID-19 illness if SARS-CoV-2 RNA is detected in a specimen from the patient using rRT-PCR test[5]. | Data set of laboratory-confirmed COVID-19-associated hospitalizations in children (people younger than 18 years) and adults used to estimate age-specific hospitalization rates on a weekly basis and describe characteristics of people hospitalized with COVID-19. | Data set of lab test results | National Vital Statistics System (NVSS) data includes national-level mortality data with detailed demographic data |
| Method of Reporting | Either aggregate case count or detailed line level | Cases are identified by reviewing hospital, laboratory, and admission databases and infection control logs for patients hospitalized with a documented positive SARS-CoV-2 test. | Either aggregate case count or detailed line level | Either aggregate case count or detailed line level |
| Strengths | Utilizes a standard case report form that includes | Population based and represents 10% of the U.S. | | Death counts for earlier weeks are continually revised |

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[5] Stokes EK, Zambrano LD, Anderson KN, et al. Coronavirus Disease 2019 Case Surveillance — United States, January 22–May 30, 2020. MMWR Morb Mortal Wkly Rep 2020;69:759–765. DOI: http://dx.doi.org/10.15585/mmwr.mm6924e2

|  |  |  |  |  |
|---|---|---|---|---|
|  | important demographic variables such as race/ethnicity<br><br>Completeness of Race/ethnicity data reported by states is improving | population (32 million people)<br><br>93% completeness for race/ethnicity. |  | and updated death certificate data are received regularly. |
| Limitations | Case report form requires additional time to complete by clinician or health department<br><br>Case report forms are not completed by clinicians or health departments for every case<br><br>Extent and level and completeness varies;<br><br>While reporting of cases is required, reporting of demographic data is not currently mandated | COVID-NET hospitalization data are preliminary and subject to change as more data become available. In particular, 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 | Data streams from commercial, hospital, and public health labs are incomplete.<br><br>Diagnostic test data are compiled from a number of sources, not all tests are directly reported to CDC,<br><br>/Currently no breakdown of race/ethnicity for testing data reported to CDC. | It can take several weeks for death records to be submitted coded, and tabulated. States report at different rates.<br><br>Race/ethnicity is usually completed by funeral director<br><br>Race/ethnicity requires information from family member or close contact to deceased<br><br>20-30% of the data is missing critical information such as race/ethnicity at a given point in time. Data may be updated at a later date. |
| Other | More information about case reporting can be found here. | More information about COVID-NET can be found here. | All laboratories will be required to report specific demographic data, including race/ethnicity, on COVID tests to HHS per guidance issued by HHS on June 4, 2020. beginning on August 1, 2020. This new requirement originates from an authority established by Section 18115 of the CARES Act More information | Data are provisional and updated on an ongoing basis. It takes extra time to code COVID-19 deaths. While 80% of deaths are electronically processed and coded within minutes, most deaths from COVID-19 must be coded by a person, which takes an average of 7 days. More information about NVSS mortality data for COVID-19 can be found here and |

| | | | about laboratory testing can be found here. | information about the death data quality is also available. |
|---|---|---|---|---|

# Appendix B: Case and Death Count by Jurisdiction Table*

This table shows COVID-19 cases and deaths reported by U.S. States, the District of Columbia, New York City and other U.S.-affiliated jurisdictions through CDC Case Report Forms. Confirmed and probable cases and deaths are provided when available, and when not available, this is designated by N/A (not available). New York State's case and death counts do not include New York City's counts as it is a separate reporting jurisdiction. Total case counts are reported by all jurisdictions. Case counts and deaths for some jurisdictions appear significantly lower than aggregate data estimates reported to CDC daily by phone. This data can be found here.

| Jurisdiction | Abbrev | Total Cases | Confirmed Cases | Probable Cases | Total Deaths | Confirmed Deaths | Probable Deaths |
|---|---|---|---|---|---|---|---|
| Alabama | AL | 53,587 | 52,908 | 679 | 1,121 | 1,093 | 28 |
| Alaska | AK | 1,479 | 0 | 0 | 17 | 0 | 0 |
| American Samoa | AS | 0 | N/A | N/A | N/A | N/A | N/A |
| Arizona | AZ | 122,467 | 121,758 | 709 | 2,237 | 2,114 | 123 |
| Arkansas | AR | 28,367 | 0 | 0 | 321 | 0 | 0 |
| California | CA | 320,804 | 0 | 0 | 7,017 | 0 | 0 |
| Colorado | CO | 36,913 | 33,911 | 3,002 | 1,725 | 1,398 | 327 |
| Connecticut | CT | 47,287 | 45,308 | 1,979 | 4,348 | 3,476 | 872 |
| Delaware | DE | 12,879 | 11,898 | 981 | 517 | 459 | 58 |
| District of Columbia | DC | 10,847 | 0 | 0 | 568 | 0 | 0 |
| Florida | FL | 266,119 | 0 | 0 | 4,242 | 0 | 0 |
| Georgia | GA | 116,926 | 0 | 0 | 3,001 | 0 | 0 |
| Guam | GU | 312 | 0 | 0 | 5 | 0 | 0 |
| Hawaii | HI | 1,115 | 0 | 0 | 19 | 0 | 0 |
| Idaho | ID | 10,902 | 10,163 | 739 | 102 | 82 | 20 |
| Illinois | IL | 155,048 | 153,916 | 1,132 | 7,388 | 7,187 | 201 |
| Indiana | IN | 51,612 | 0 | 0 | 2,760 | 2,567 | 193 |
| Iowa | IA | 35,171 | 0 | 0 | 750 | 0 | 0 |
| Kansas | KS | 18,611 | 18,611 | 0 | 284 | 0 | 0 |
| Kentucky | KY | 19,389 | 18,562 | 827 | 625 | 621 | 4 |
| Louisiana | LA | 78,122 | 0 | 0 | 3,416 | 3,308 | 108 |
| Maine | ME | 3,558 | 3,159 | 399 | 114 | 0 | 0 |
| Marshall Islands | RMI | 0 | N/A | N/A | N/A | N/A | N/A |
| Maryland | MD | 73,527 | 0 | 0 | 3,325 | 3,194 | 131 |
| Massachusetts | MA | 111,597 | 105,629 | 5,968 | 8,325 | 8,110 | 215 |
| Michigan | MI | 76,776 | 69,338 | 7,438 | 6,314 | 6,068 | 246 |
| Micronesia | FSM | 0 | N/A | N/A | N/A | N/A | N/A |
| Minnesota | MN | 42,772 | 0 | 0 | 1,542 | 1,504 | 38 |
| Mississippi | MS | 36,680 | 36,354 | 326 | 1,250 | 1,228 | 22 |
| Missouri | MO | 27,443 | 0 | 0 | 1,069 | 0 | 0 |
| Montana | MT | 1,841 | 1,841 | 0 | 31 | 31 | 0 |
| Nebraska | NE | 21,172 | 0 | 0 | 285 | 0 | 0 |
| Nevada | NV | 27,894 | 0 | 0 | 617 | 0 | 0 |
| New Hampshire | NH | 6,054 | 0 | 0 | 391 | 0 | 0 |
| New Jersey | NJ | 175,298 | 0 | 0 | 15,541 | 13,594 | 1,947 |
| New Mexico | NM | 15,028 | 0 | 0 | 545 | 0 | 0 |
| New York (excluding NYC) | NY | 182,655 | 0 | 0 | 8,746 | 0 | 0 |
| New York City | NYC | 220,819 | 216,199 | 4,620 | 23,323 | 18,708 | 0 |
| North Carolina | NC | 85,701 | 0 | 0 | 1,503 | 0 | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| North Dakota | ND | 4,334 | 0 | 0 | 87 | 0 | 0 |
| Northern Marianas | MP | 33 | 33 | 0 | 2 | 2 | 0 |
| Ohio | OH | 65,592 | 61,669 | 3,923 | 3,058 | 2,801 | 257 |
| Oklahoma | OK | 19,934 | 19,789 | 145 | 441 | 441 | 0 |
| Oregon | OR | 12,170 | 12,170 | 0 | 234 | 234 | 0 |
| Palau | PW | 0 | N/A | N/A | N/A | N/A | N/A |
| Pennsylvania | PA | 95,742 | 93,015 | 2,727 | 6,911 | 0 | 0 |
| Puerto Rico | PR | 10,010 | 2,811 | 7,199 | 167 | 71 | 96 |
| Rhode Island | RI | 17,312 | 0 | 0 | 976 | 0 | 0 |
| South Carolina | SC | 56,648 | 56,485 | 163 | 961 | 950 | 11 |
| South Dakota | SD | 7,499 | 0 | 0 | 109 | 108 | 1 |
| Tennessee | TN | 61,960 | 61,443 | 517 | 741 | 714 | 27 |
| Texas | TX | 258,658 | 0 | 0 | 3,192 | 0 | 0 |
| Utah | UT | 30,177 | 29,933 | 244 | 216 | 216 | 0 |
| Vermont | VT | 1,296 | 0 | 0 | 56 | 0 | 0 |
| Virgin Islands | VI | 181 | 0 | 0 | 6 | 0 | 0 |
| Virginia | VA | 71,642 | 68,814 | 2,828 | 1,968 | 1,861 | 107 |
| Washington | WA | 40,656 | 0 | 0 | 1,438 | 0 | 0 |
| West Virginia | WV | 4,244 | 4,128 | 116 | 96 | 0 | 0 |
| Wisconsin | WI | 39,877 | 36,448 | 3,429 | 820 | 820 | 0 |
| Wyoming | WY | 1,862 | 1,506 | 356 | 21 | 21 | 0 |
| TOTAL | - | 3,296,599 | 1,347,799 | 50,446 | 134,884 | 82,981 | 5,032 |

*Data are reported voluntarily to CDC by each jurisdiction's health department
Data source for table: HHS Protect Aggregate case count data.