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WISCONSIN SUPREME COURT

Case No. 2020AP000765-OA

WISCONSIN LEGISLATURE,

Petitioner,

v.

Secretary-Designee ANDREA PALM, JULIE WILLEMS VAN DIJK, and NICOLE SAFAR, in Their Official Capacities as Executives of Wisconsin Department of Health Services,

Respondents.

BRIEF OF WISCONSIN PUBLIC HEALTH ASSOCIATION, WISCONSIN NURSES ASSOCIATION, WISCONSIN CHAPTER OF AMERICAN ACADEMY OF PEDIATRICS AND OTHER HEALTHCARE *AMICI CURIAE*

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INTEREST OF *AMICI CURIAE*

Amici are associations, organizations, and individuals devoted to healthcare and advancement of medical science. Together, they represent a broad cross-section of the healthcare and medical science communities. Individually, each is committed to advancing healthcare and medical science, expanding knowledge, and providing humane care that improves health outcomes and helps people. *Amici*, identified in Appendix A, submit this brief to assist the Court in understanding the factual dimensions of the present COVID-19 pandemic.

ARGUMENT

Petitioners assert that this Court can adjudicate their petition with "no factfinding." (Pet'r Br. at 26.) But the COVID-19 pandemic is almost entirely about facts—those known and those yet to be discovered. Facts are the *sine qua non* of science. And "here, as in nearly every case, facts are

important." *D.H. Overmyer co., Inc. of Ohio v Frick Co.*, 405 U.S. 174, 178 (1972). The facts we know, along with the gaps we are still interrogating, strongly indicate two things. *First*, Wisconsin is not ready to resume pre-COVID-19 life. *Second*, forcing crisis response for COVID-19 into a lengthy emergency rulemaking process is incompatible with effective management of the epidemic. Because the human toll of mismanaging this outbreak could be devastating, this Court should allow public health experts to lead the way and dismiss the petition for an original action.

I. The COVID-19 Pandemic Presents Unprecedented Challenges and Requires Urgent Public Health Measures.

COVID-19 is caused by a highly contagious, highly pathogenic virus, SARS-CoV-2,[1] which is transmitted

[1] Steven Sanche, *et al.*, "High contagiousness and rapid spread of severe acute respiratory syndrome coronavirus 2," *Emerging Infectious Diseases* (July 2020), https://wwwnc.cdc.gov/eid/article/26/7/20-0282_article; Shikha Garg, *et al.*, "Hospitalization Rates and

primarily by respiratory droplets—usually encountered by close contact with an infected individual or by self-infecting oneself after touching a contaminated surface.[2] SARS-CoV-2 emerged in Wuhan Province, China with the first confirmed cases being reported to the World Health Organization on December 31, 2019.[3] The virus is highly infectious. That first infected individual started a chain of transmission; less than six months later, there have been over 3 million confirmed

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Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Disease 2019-COVID-NET, 14 States, March 1–30, 2020," *MMWR Morbidity and Mortality Weekly Report* 2020;69:458–464, https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm; Affidavit of Ryan P. Westergaard in Support of Respondents' Response to Petition for Original Action ("Westergaard Aff.") ¶5; Affidavit of Julie Willems Van Dijk in Support of Respondents' Response to Petition for Original Action (Van Dijk Aff.") ¶2.

[2] World Health Organization, "Modes of transmission of virus causing COVID-19: implications for IPC precaution recommendations," (Mar. 29, 2020), https://www.who.int/news-room/commentaries/detail/modes-of-transmission-of-virus-causing-covid-19-implications-for-ipc-precaution-recommendations; Westergaard Aff. ¶11.

[3] World Health Organization, "Pneumonia of unknown cause" (Jan. 5, 2020), https://www.who.int/csr/don/05-january-2020-pneumonia-of-unkown-cause-china/en/.

cases of COVID-19 in 185 countries on six continents.[4] Travelers from China and from Europe who were infected with SARS-CoV-2 brought the virus to the United States sometime in January 2020.[5] Two months after community transmission was initially documented here,[6] the U.S. has more than one million confirmed cases of COVID-19—almost one-third of all confirmed cases worldwide.[7]

SARS-CoV-2 vividly illustrates how respiratory viruses can spread like wildfire among a population without preexisting immunity. A single case can lead to two more,

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[4] Lisa Schnirring, "World's COVID-19 total tops 3 million cases," *CIDRAP News* (Apr. 27, 2020), https://www.cidrap.umn.edu/news-perspective/2020/04/worlds-covid-19-total-tops-3-million-cases.

[5] Mike Baker & Sheri Fink, "Covid-19 Arrived in Seattle. Where It Went From There Stunned the Scientists," *N.Y. Times* (Apr. 22, 2020), https://www.nytimes.com/2020/04/22/us/coronavirus-sequencing.html.

[6] Centers for Disease Control and Prevention, "CDC Confirms Possible Instance of Community Spread of COVID-19 in U.S." (Feb. 26, 2020), https://www.cdc.gov/media/releases/2020/s0226-Covid-19-spread.html.

[7] Center of Systems Science and Engineering at Johns Hopkins University, *COVID-19 Dashboard*, https://www.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ecf6.

which in turn can lead to four, then eight, sixteen, and so on. When a pathogen spreads without mitigation in a community, the number of new daily cases identified doubles rapidly. Prior to Wisconsin's Safer at Home Order, the number of confirmed COVID-19 cases was doubling every 3.4 days.[8] After Safer at Home, the doubling time is now 12 days.[9] The increased doubling time reflects the fact that social distancing interventions lower the transmission rate and reduce the number of people who are infected.[10]

The disease caused by this highly contagious virus, COVID-19, affects people of all ages, races and ethnicities,

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[8] Wisconsin Department of Health Services, "Cumulative total and newly reported COVID-19 cases by date confirmed," https://www.dhs.wisconsin.gov/covid-19/prepare.htm.

[9] *Id*.

[10] Sarah Cobey, "Modeling infectious disease dynamics," *Science* (Apr. 24, 2020), https://science.sciencemag.org/content/early/2020/04/23/science.abb5659.

socioeconomic classes, and occupations.[11] COVID-19 poses greater danger to some than to others.[12] This is true both for reasons scientists currently understand and for reasons yet unclear. Scientists are confident that people living with certain conditions face increased risks from COVID-19; these include high blood pressure, diabetes, chronic lung disease, a suppressed immune system, cancer, obesity, and older-aged individuals.[13]

That is not the whole story, however, as there have been deaths among younger individuals, including children

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[11] Indermit Gill, "Coronovirus lessons from New York and San Francisco," *Brookings* (Apr. 7, 2020), https://www.brookings.edu/blog/future-development/2020/04/07/coronavirus-lessons-from-new-york-and-san-francisco/; Westergaard Aff. ¶8.

[12] Centers for Disease Control and Prevention, "People Who Are at Higher Risk for Severe Illness," https://www.cdc.gov/coronavirus/2019ncov/need-extra-precautions/people-at-higher-risk.html; Westergaard Aff. ¶17.

[13] Westergaard Aff. ¶17; Van Dijk. Aff. ¶4.

and infants.[14] Besides the well documented and severe pneumonias seen with COVID-19, there are also blood clotting issues, which can cause heart attacks, deep vein thromboses, and neurological problems.[15] The past few days have brought new reports of severe strokes among COVID-19 patients who otherwise would not be considered at risk for such strokes.[16]

The survival rate for those infected with COVID-19 will almost certainly improve as scientists learn more from early cases. For example, using a pulse oximeter to self-

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[14] CDC COVID-19 Response Team, "Coronavirus Disease 2019 in Children—United States, February 12–April 2, 2020," *MMWR Morbidity and Mortality Weekly Report* 2020;69:422–426, https://www.cdc.gov/mmwr/volumes/69/wr/mm6914e4.htm.

[15] Ali Akbar Asadi-Pooya & Leila Simani, "Central nervous system manifestations of COVID-19: A systematic review," *Journal of Neurological Sciences* (Apr. 11, 2020), https://www.ncbi.nlm.nih.gov/pubmed/32299017; Westergaard Aff. ¶20.

[16] Ariana Eunjung Cha, "Young and middle-aged people, barely sick with covid-19, are dying of strokes," *Washington Post* (Apr. 25, 2019), https://www.washingtonpost.com/health/2020/04/24/strokes-coronavirus-young-patients/.

monitor can prevent people from seeking emergency care too late;[17] the data on strokes in young people makes hospital clinicians more attuned to this complication; lying face down improves breathing in severe COVID-19;[18] and clinical trials are ongoing for drugs like remdesivir that could help people who are seriously ill.[19] Safer at Home serves to limit the spread of SARS-CoV-2 to buy time for discovery and deployment of effective therapies, and prevent a surge of serious illnesses that could overwhelm the healthcare system.[20]

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[17] Stephanie Pappas, "Silent hypoxia may be killing COVID-19 patients. But there's hope," *Live Science* (Apr. 23, 2020), https://www.livescience.com/silent-hypoxia-killing-covid-19-coronavirus-patients.html.

[18] "Wuhan study shows lying down improves breathing in severe COVID-19, *ScienceDaily* (Mar. 24, 2020), https://www.sciencedaily.com/releases/2020/03/200324202056.htm.

[19] National Institutes of Health, "NIH clinical trial of remdesivir to treat COVID-19 begins," (Feb. 25, 2020), https://www.nih.gov/news-events/news-releases/nih-clinical-trial-remdesivir-treat-covid-19-begins.

[20] Van Dijk Aff. ¶¶12, 23, 37.

Individuals infected with SARS-CoV-2 are contagious even before they have any inkling they might be sick.[21] According to Carlos del Rio, chair of the Department of Global Health at Emory University, speaking at a briefing for the Infectious Disease Society of America, "people can start transmitting the virus 24 to 48 hours before they start showing symptoms."[22] And a significant portion of those infected—estimated to range from 25 to 50 percent—never develop symptoms of COVID-19.[23] The risk of asymptomatic infection appears to be highest in younger adults and

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[21] *See, e.g.*, Monica Gandhi, *et al.*, "Asymptomatic Transmission, the Achilles' Heel of Current Strategies to Control Covid-19," *New England Journal of Medicine* (Apr. 24, 2020), https://www.nejm.org/doi/full/10.1056/NEJMe2009758; Westergaard Aff. ¶¶7, 15.

[22] Katherine Harmon Courage, "How people are spreading covid-19 without symptoms: Silent spreaders are playing a significant role in the pandemic," *Vox* (Apr. 22, 2020), https://www.vox.com/2020/4/22/21230301/coronavirus-symptom-asymptomatic-carrier-spread.

[23] Paul G. Auwaerter, "Coronavirus COVID-19 (SARS-CoV-2)," *Johns Hopkins ABX Guide* (Apr. 27, 2020), https://www.hopkinsguides.com/hopkins/view/Johns_Hopkins_ABX_Guide/540747/all/Coronavirus_COVID_19__SARS_CoV_2_.

children.[24] This asymptomatic spread is a significant contributor to the COVID-19 pandemic.[25] By contrast, when the original "severe acute respiratory syndrome (SARS)—the cousin to this new coronavirus—emerged in 2002, Asian countries were able to stop it because people became physically ill roughly at the same time they became contagious. That made it far easier to isolate and prevent the spread of disease."[26]

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[24] Joseph T. Wu, *et al.*, "Estimating clinical severity of COVID-19 from the transmission dynamics in Wuhan, China," *Nature Medicine* 2020;26:506-10, https://www.nature.com/articles/s41591-020-0822-7.

[25] *See, e.g.*, Courage, *supra*, n.22 ("60 percent of personnel aboard the aircraft carrier *Theodore Roosevelt* who tested positive for the coronavirus appeared healthy at the time, Reuters reported. Other data—from Iceland and elsewhere—have uncovered similar patterns."); Tapiwa Ganyani, *et al.*, "Estimating the generation interval for COVID-19 based on symptom onset data," *medRxiv* (March 8, 2020), https://www.medrxiv.org/content/10.1101/2020.03.05.20031815v1. ("Proportion of pre-symptomatic transmission was 48% for Singapore and 62% for Tianjin, China."); Westergaard Aff. ¶15.

[26] William Wan, *et al.*, "States' rush to reopen is a deadly error, models and experts warn," *Washington Post* (Apr. 22, 2020), https://www.washingtonpost.com/health/2020/04/22/reopening-america-states-coronavirus/.

Even assuming some degree of immunity in those who have recovered—a point that remains controversial[27]—available data suggest that the vast majority of Wisconsinites remain susceptible to SARS-CoV-2. Consider: nearly 4 in 5 people remain susceptible in New York City, which over the past six weeks has had the highest total number and highest rate of infection of any place in the United States.[28] It follows that the percentage of Wisconsinites who remain susceptible is almost certainly higher than in New York.[29]

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[27] "Experts react to WHO clarification of their statement on 26/04/20 about immunity passports," *Science Media Centre* (Apr. 26, 2020), https://www.sciencemediacentre.org/expert-reaction-to-who-clarification-of-their-statement-on-26-04-20-about-immunity-passports/; Van Dijk Aff. ¶5.

[28] J. David Goodman & Michael Rothfeld, "1 in 5 New Yorkers May Have Had Covid-19, Antibody Tests Suggest," *N.Y. Times* (Apr. 23, 2020), https://www.nytimes.com/2020/04/23/nyregion/coronavirus-antibodies-test-ny.html.

[29] Justin D. Silverman, *et al.*, "Using influenze surveillance networks to estimate state-specific case detection rates and forecast SARS-CoV-2 spread in the United States," (Apr. 3, 2020), https://www.medrxiv.org/content/10.1101/2020.04.01.20050542v3.full.pdf.

Given all of these challenges, and in the absence of a vaccine, several measures are necessary to contain COVID-19. Each of these has one feature in common: time. We need time to reduce the rate of new infections, time to track down and eradicate the infections that already exist, and time to scale-up our healthcare system's ability to provide quality care to COVID-19 patients.

First, there is the urgent need to limit new infections. The most effective way to prevent transmission of COVID-19 is to adopt effective preventive behaviors—forms of what is now widely known as "social distancing"—that reduce the rate of infection while public health agencies work to stop the disease's spread.[30] Social distancing is a blunt instrument that causes social and economic disruption, but it is essential to

[30] James Rogers, "Coronavirus social distancing buying valuable time for scientists in hunt for cure: Biochemist," *FOXNews* (Apr. 8, 2020), https://www.foxnews.com/science/coronavirus-social-distancing-buying-valuable-time-for-scientists-in-their-hunt-for-a-cure-biochemist; Westergaard Aff. ¶¶25-27.

save lives until there is the capacity to test everyone with symptoms, conduct rapid contact tracing, and offer voluntary isolation to individuals who test positive.[31]

Second, stopping the spread of existing disease involves a method called "contact tracing" In the current context, contact tracing involves asking a person confirmed to have COVID-19 about everyone with whom they came in contact during the previous 1-2 weeks. All of those people are tested for COVID-19. Anyone found to be positive is asked to self-isolate and then asked to recall everyone with whom they came in contact over the past 1-2 weeks. These new contacts are then tested for COVID-19. This process is repeated until all test results among contacts are negative. Effective contact tracing takes training and is labor- and time-intensive, and it

[31] Van Dijk Aff. ¶23.

requires widespread access to testing for all symptomatic individuals and identified contacts.[32]

Third, addressing the challenges posed by COVID-19 requires improving the preparedness of our healthcare system. Hospitals and healthcare systems are constrained by finite supplies of personal protective equipment (PPE), testing reagents, swabs, ICU care, and respiratory support.[33] While the capacity for PPE, testing, and tracking cases is improving gradually, it remains uneven across Wisconsin.[34] There are potential therapeutic developments that could gradually improve the situation. Expert advice and peer-reviewed publications on how to best support patients with COVID-19 who need respiratory support and/or management of clotting issues are both changing and being updated on a daily/weekly

[32] Westergaard Aff. ¶41.

[33] Westergaard Aff. ¶23.

[34] Van Dijk Aff. ¶24.

basis because the tempo and type of damage caused by COVID-19 differs from that seen with other coronaviruses or influenza.[35]

Additionally, the medical community is learning about the risks and benefits of repurposed and investigational medications and treatments (*e.g.*, remdesivir, tocilizumab, and convalescent plasma).[36] Better guidance on treatment and new investigational medications will likely be available in the coming months but is unlikely to be a primary tool in preventing the spread of infections and will offer therapy only to those already infected.[37]

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[35] John J. Marini & Luciano Gattinoni, "Management of COVID-19 Respiratory Distress," *JAMA* (Apr. 24, 2020), https://jamanetwork.com/journals/jama/fullarticle/2765302.

[36] Jonathan Grein, *et al*., "Compassionate Use of Remdesivir for Patients with Severe Covid-19," *New England Journal of Medicine* (Apr. 10, 2020), https://www.nejm.org/doi/full/10.1056/NEJMoa2007016

[37] Haiou Zhou, *et al*. "Updated approaches against SARS-Co-V-2," *American Society for Microbiology* (Mar. 23, 2020), https://aac.asm.org/content/early/2020/03/18/AAC.00483-20.abstract.

II. Wisconsin Is Not Out of the Woods with Respect to COVID-19.

The first COVID-19 case was confirmed in Wisconsin on February 5, 2020.[38] More than a month passed before confirmation of another case on March 9.[39] Throughout the remainder of March, new cases of COVID-19 in Wisconsin increased rapidly, with more new cases reported almost every day in March than the day before.[40] As of April 28, nearly 6,300 Wisconsinites have tested positive for COVID-19 and 300 have died of the disease.[41]

In Wisconsin, the greatest number of cases of COVID-19 thus far identified is in Milwaukee County, which, as of

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[38] Westergaard Aff. ¶28.

[39] *Id.* ¶29.

[40] Will Cushman & Hannah Haynes, "What The COVID-19 Pandemic Looks Like In Wisconsin: Maps And Charts," *WisCONTEXT*, https://www.wiscontext.org/what-covid-19-pandemic-looks-wisconsin-maps-and-charts.

[41] Wisconsin Department of Health Services, "COVID-19 (Coronavirus Disease)," https://www.dhs.wisconsin.gov/covid-19/index.htm.

April 28, has the highest number of cases (2,791) and deaths (164) of any county in Wisconsin.[42] The African-American community has been hit particularly hard which highlights the existing issues of health disparities in Milwaukee County.[43] More than half (86 of 164) of deaths resulting from COVID-19 in Milwaukee County were suffered by individuals whose race is classified as black alone,[44] meaning they are overrepresented by a factor of 2 compared to the County's racial makeup.[45]

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[42] Wisconsin Department of Health Services, "COVID-19: County Data," https://www.dhs.wisconsin.gov/covid-19/county.htm.

[43] *See Milwaukee County COVID-19 Dashboard*, https://www.arcgis.com/apps/opsdashboard/index.html#/018eedbe075046779b8062b5fe1055bf; *see also* Ashley Luthern, "UWM report finds 'disturbing patterns,' links to racial inequality and segregation in the spread of COVID-19 in Milwaukee," *Milwaukee Journal Sentinel* (Apr. 21, 2020), https://www.jsonline.com/story/news/health/2020/04/21/racial-inequality-segregation-linked-covid-19-spread-milwaukee-county-wisconsin-uwm/2997085001/.

[44] *See Milwaukee County COVID-19 Dashboard*, *supra*, n.43.

[45] *See* QuickFacts, Milwaukee County, Wisconsin, https://www.census.gov/quickfacts/fact/table/milwaukeecountywisconsin/RHI225218#RHI225218.

The rest of Wisconsin is not immune. Cases of COVID-19 have been confirmed in all but six Wisconsin counties.[46] For the first three weeks of April, the daily number of new cases appeared to plateau at approximately 150 new cases per day.[47] April 22—the day after Petitioners filed this case—was the first date that the number of confirmed new COVID-19 cases in Wisconsin exceeded 200.[48] In the week since, Wisconsin has seen a spike in new cases, with record highs for the number of new cases in a day set on April 22 (225 new cases), then on April 24 (304 new cases), and again on April 25 (331 new cases).[49] In the week before this case was filed, the highest number of new cases in

[46] Westergaard Aff. ¶30.

[47] *See* Cushman & Haynes, *supra*, n.40.

[48] *Id.*

[49] *Id.*

any day was 170; in the week since this case was filed, that is the lowest number of new cases on any day.[50]

The recent spike in cases arises primarily—but not exclusively—around Green Bay.[51] As a result, Brown County is the new focal point of infection in Wisconsin and now has the highest rate of infection in the state.[52] The outbreak in Brown County is concentrated around three meat packing plants.[53] Such facilities require workers to operate in close proximity to one another, which makes them particularly

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[50] *Id.*

[51] Doug Schneider, "Brown County seemed a step ahead of the coronavirus; suddenly, it wasn't," *Green Bay Press-Gazette* (Apr. 25, 2020), https://www.greenbaypressgazette.com/story/news/2020/04/25/brown-county-coronavirus-how-cluster-covid-19-developed/3000721001/.

[52] Julia Marshall, "Brown County has highest COVID-19 infection rate in Wisconsin, surpassing Milwaukee County," *TMJ4* (Apr. 26, 2020), https://www.tmj4.com/news/coronavirus/brown-county-has-highest-covid-19-infection-rate-in-wisconsin-surpassing-milwaukee-county.

[53] Haley Miller & Maria Perez, "Surge in Wisconsin coronavirus cases linked to Green Bay meatpacking plant," *Milwaukee Journal Sentinel* (Apr. 23, 2020), https://www.jsonline.com/story/news/2020/04/23/coronavirus-cases-linked-green-bay-meatpacking-plant-spike/3007750001/.

vulnerable to spreading SARS-CoV-2.[54] A concentrated outbreak in Darien also centers around a food-processing facility.[55]

Factories are not unique. Crowded institutions where people are in close proximity—schools, nursing homes, dormitories, homeless shelters, prisons, and residential care facilities—are places where SARS-CoV-2 can easily spread. So, too, for sites of gatherings, like restaurants, bars, movie theaters, sporting events, houses of worship, and concerts. People in any of these settings have families, friends, and social circles, where introduction of the infection would spread widely without infection control.[56] Safer at Home

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[54] *Id.*

[55] Jonah Beleckis, "Birds Eye plant suspends most operations after COVID-19 cases identified," *Beloit Daily News* (Apr. 19, 2020), https://www.beloitdailynews.com/news/local-news/birds-eye-plant-suspends-most-operations-after-covid-19-cases-identified/article_5990e9a8-3d3c-5216-ac94-81ee20d19ef1.html.

[56] Westergaard Aff. ¶37.

seeks to ensure that, when outbreaks occur at institutions, the limitations on discretionary gatherings mitigate the spread into the local community and any other community that one of the contagious individuals might otherwise unwittingly infect.[57]

SARS-CoV-2's specific characteristics—highly transmissible, asymptomatic spread—make it possible for COVID-19 to spike in areas that have been relatively quiet (including rural areas) quickly after introduction. People may work in more urban areas and then return home to rural areas, potentially spreading the virus in their home communities before they ever develop symptoms of COVID-19.

The likelihood that asymptomatic spread will generate new COVID-19 outbreaks around the state at times and in places that are not entirely predictable means that

[57] Van Dijk Aff. ¶25.

identification and contact tracing are key to controlling the pandemic.[58] As addressed above, while testing capacity is increasing, there are real challenges—including asymptomatic spread—to using testing as the primary safeguard of public health. Contact tracing is an essential complement to expanded testing.

The stakes of rolling back social distancing before Wisconsin has ample testing and contact-tracing resources could be dire.[59] The oft-stated goal of social distancing has been to "flatten the curve" by slowing the spread of viral infection so that the medical needs of those who develop acute COVID-19 symptoms do not overwhelm the existing healthcare infrastructure. This curve-flattening effort has, thus

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[58] Westergaard Aff. ¶¶41-42.

[59] Lauren Anderson, "Medical College of Wisconsin model shows hospitals would fill in a month if all social distancing ended May 26," *BizTimes* (Apr. 22, 2020), https://biztimes.com/models-show-hospitals-would-fill-in-a-month-if-all-social-distancing-ended-may-26/; Van Dijk Aff. ¶¶30-31.

far, proven largely successful in several parts of Wisconsin.[60] But even this "success" story has a devastating human toll. With a flattening curve, 300 lives of Wisconsinites have still been lost already, more are seriously ill, and many more are infected with SARS-CoV-2 but do not know it. Moreover, a curve that is relatively flat now does not mean that the danger of such a surge does not still exist.[61]

Wisconsin's healthcare system—comprising public and private hospitals, clinics, and residential facilities—has a finite number of hospital beds, ICU rooms, and mechanical ventilators to serve the health needs of Wisconsinites.[62] If there is a surge in the number of people who become sick because of COVID-19, the healthcare system can become

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[60] *Id.* ¶27.

[61] *Id.* ¶29 & Exh. B; Stephen M. Kissler, *et al.*, "Projecting the transmission dynamics of SARS-CoV-2 through the postpandemic period," *Science* (Apr. 14, 2020), https://science.sciencemag.org/content/early/2020/04/24/science.abb5793.

[62] Van Dijk Aff. ¶8.

overwhelmed, particularly in rural areas, where the system is less robust.[63] If the demand for healthcare exceeds the capacity a health system, patients will not be able to get the care they need, either for COVID-19 or other significant medical conditions.[64]

Entities in Wisconsin's healthcare system are trying to decide when and how to resume some of their normal non-emergency operations, including life-saving and life-altering treatments, elective procedures, and routine (but important) care.[65] These decisions cannot be made until there are decreased and stable numbers of COVID-19 cases, especially in light of ongoing shortages of PPE for healthcare workers.

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[63] *Id.* ¶¶7, 25.

[64] Seyed M. Moghadas, *et al*. "Projecting hospital utilization during the COVID-19 outbreaks in the United States," *Proceedings of the National Academy of Sciences* (Apr. 21, 2020), https://www.pnas.org/content/117/16/9122.short.

[65] Shamane Mills, "Despite Pandemic, Surgeries Back On At Some Wisconsin Hospitals," *WPR* (Apr. 23, 2020), https://www.wpr.org/despite-pandemic-surgeries-back-some-wisconsin-hospitals.

Accordingly, any actions that exacerbate the risk of a spike in COVID-19 cases will, unintentionally but necessarily, set back progress toward resuming full healthcare operations.

III. Wisconsin's Emergency Rulemaking Process Is Incompatible with the Realities of the Current COVID-19 Pandemic.

Petitioners assert that Wisconsin's Emergency Rulemaking Process is the proper mechanism for facilitating the public health response to COVID-19. (Pet'r Br. at 27-39.) The specific factual characteristics of SARS-CoV-2 are irreconcilable with the time necessary for emergency rulemaking in Wisconsin. As illustrated in Appendix B, the emergency rulemaking process takes a minimum of 20 days, even if everything falls just so and no actor raises any impediment to the process. (In practice, everything rarely falls just so, and the process can be extended significantly.) In legal terms, 20 days may represent a quick response, but it is

insufficient for fighting a contagious and rapidly changing pandemic.

Consider first the exigency created by contagion. To take just one recent example, on April 6, Brown County had 39 confirmed cases of COVID-19.[66] Twenty days later, on April 26, that number was 776.[67] Both numbers, as discussed above, almost certainly understate the extent of infection, and therefore of asymptomatic spread, in Brown County. But even if they did not, the rapid increase—nearly 20-fold in 20 days—illustrates how rapidly circumstances change and how vital it is for public health responses to be flexible and adaptable. That need is incompatible with the emergency rulemaking process, which must start anew each time that circumstances change the scope of the proposed rulemaking.

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[66] "Brown County confirms one more positive COVID-19 case," FOX11 (Apr. 7, 2020), https://fox11online.com/news/coronavirus/brown-county-confirms-one-more-positive-covid-19-case.

[67] Marshall, *supra*, n.54.

SARS-CoV-2's pathogenicity—that is, the degree to which it causes disease—also creates exigency. Indeed, a quarter of COVID-19 patients require hospitalization.[68] And COVID-19's fatality rate exceeds that of the seasonal flu by a factor of 10 or 20.[69] These realities threaten to ravage both Wisconsin's healthcare system and Wisconsinites themselves. They require constant vigilance and quick response. It is unsurprising that, in March, Wisconsin had "a window of only two or three days for significant mitigation measures to be imposed that would avoid an unsustainable surge of cases."[70] Wisconsin will likely face this situation again, as "second waves" of the COVID-19 epidemic crest.[71]

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[68] Van Dijk Aff. ¶7.

[69] Westergaard Aff. ¶19.

[70] Van Dijk Aff. ¶21.

[71] *Id.* ¶35.

As discussed above, with effective case identification and contact tracing, the transmission of SARS-CoV-2 can be mitigated until Wisconsin's healthcare system is prepared to more effectively test and treat those who develop COVID-19.[72] Until then, maintaining public health will require a coordinated governmental response. Wisconsin's emergency rulemaking process is not equal to this task.

Protecting public health during a pandemic requires nimble government action responsive to rapidly changing facts. The best example coincides with this lawsuit. For four weeks—from March 25 to April 21—Wisconsin's daily reports of new COVID-19 cases fluctuated within a fairly narrow range, averaging 148.7 new cases per day.[73] The numbers varied, including a low of 87 (on April 13) and a then-record high of 199 (on April 1), but the general trend,

[72] *Id.* ¶¶37, 40-41.

[73] *See* Cushman & Kenneally, *supra*, n.40.

after weeks of steady increases, suggested a plateau of approximately 150 new cases per day, with the numbers generally decreasing in the week before this lawsuit was filed.[74] But the next day, Wisconsin's new cases jumped to an all-time high, which was broken two days later and again the day after that with a record more than double the prior plateau.[75] The primary contributor to the increase was the outbreak in the Green Bay area, which bears no connection to this lawsuit. But the stark, sudden, unanticipated jump demonstrates how quickly facts evolve during a pandemic and how nimbly government must be able to respond.

Other historical examples underscore the point. The 1918 influenza epidemic "arrived in each community under different circumstances, and the timing, duration, and severity of the onslaught varied from town to town and region to

[74] *See id.*

[75] *See id.*

region."[76] Wisconsin nonetheless "responded with one of the most comprehensive anti-influenza programs in the nation."[77] Dr. Cornelius A. Harper, Wisconsin's State Health Officer (precursor to the Secretary of DHS), took the unprecedented step of ordering "all schools, theaters, moving picture houses, other places of amusement and public gatherings," including churches and saloons, closed "for an indefinite period of time."[78] Notably, "nowhere except in Wisconsin was such an order issued statewide or in such a comprehensive fashion."[79] As a result, Wisconsin "emerged from the epidemic with one of the lowest death rates in the nation."[80]

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[76] Steven B. Burg, "The Virus that Shut Down Wisconsin: The Great Flu Pandemic of 1918," *Wisconsin Magazine of History* (Autumn 2000), https://www.wiscontext.org/virus-shut-down-wisconsin-great-flu-pandemic-1918.

[77] *Id.*

[78] *Id.*

[79] *Id.*

[80] *Id.*

There are more recent examples as well. In 2013, prompt public health response at the state and local level averted a crisis and contained an outbreak of multidrug-resistant tuberculosis.[81] And the H1N1 swine flu pandemic of 2009 stands as an example of how the Wisconsin's governmental response can, and does, calibrate to the specific facts and needs of each situation.

Both history and current circumstances make clear that public health requires nimble governance, willing and able to respond promptly as circumstances change and new facts arise. Ossification of that process can only serve to diminish public health outcomes. The emergency rulemaking process serves Wisconsin well in many areas, but not this one. That is why the Legislature has never seen fit to revise Chapter 252

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[81] *See* Richard Knox, "Tuberculosis Outbreak Shakes Wisconsin City," *NPR* (July 18, 2013), https://www.npr.org/sections/health-shots/2013/07/18/200871130/tuberculosis-outbreak-shakes-wisconsin-city.

for the purpose of limiting DHS's authority during public health emergencies.

Dated: April 29, 2020.

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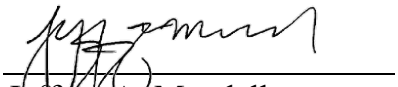
CERTIFICATIONS

I certify that the foregoing brief conforms to the rules contained in Wis. Stat. § (Rule) 809.19(8)(b) and (c) for a brief produced with a proportional serif font. The length of the foregoing brief, exclusive of the caption, Table of Contents, and Table of Authorities is 4371 words.

I further certify that when an electronic copy of this brief is submitted to this Court, it will comply with the requirements of Wis. Stat. § (Rule) 809.19(12) and will be identical in content to the text of the paper copy of the brief. A copy of this certificate is included with the paper copies of this brief that are submitted for filing with the Court and served on all opposing parties.

Dated: April 29, 2020.



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Appendix B: Flowchart of Emergency Rulemaking Process in Wis. Stat. § 227.24

This flowchart illustrates the emergency rulemaking process in Wis. Stat. § 227.24. Most steps are required; steps that may or may not occur are graphically differentiated.

1. Draft a statement of scope for the emergency rule
Required by § 227.24(1)(e)1d
Must include all elements listed in § 227.135(1)
No activity toward drafting emergency rule until statement of scope is approved (§ 227.24(1)(e)1d)

Necessary time depends. Statement of scope must be complete and withstand scrutiny. If, at any point, statement is not approved, agency must begin anew. When complete, proceed to step 2.

2. Obtain gubernatorial approval for the statement of scope
Required by § 227.24(1)(e)1d
Requires DOA determination that agency has explicit authority to act as proposed (§ 227.135(2))
Then requires approval by Governor before agency can take next step (§ 227.135(2))

With coordination among the agency, DOA, and the Governor's office, this could be done in 1 day. When complete, proceed to step 3.

3. Submit statement of scope for publication in Administrative Register[1]
Required by § 227.24(1)(e)1d
LRB publishes the Administrative Register only on Mondays
Agency must simultaneously send to DOA Secretary, Clerks of the Legislature (§ 227.135(3))

Because the Administrative Register is published only once a week and requires some lead time, this step will take at least 1-2 days and possibly up to a week to complete. When complete, go to step 4 if necessary or, if neither chairperson of JCRAR requests a hearing, skip to step 5.

[1] Note that an agency may "promulgate a rule as an emergency rule without complying with the notice, hearing, and publication requirements under this chapter if preservation of the public peace, health, safety, or welfare necessitates putting the rule into effect prior to the time it would take effect if the agency complied with the procedures." Wis. Stat. § 227.24(1)(a). A closer examination of the statute, however, suggests that this and other publication requirements is applicable. To give just one example, an emergency rule cannot take effect prior to publication in the *Wisconsin State Journal*, which suggests that publication is not waivable, at least practically. *See* Wis. Stat. § 227.24(1)(c).

4. If directed to do so, hold preliminary public hearing
Required by § 227.24(1)(e)1d
Can be requested by either chairperson of JCRAR (§ 227.136(1))
Notice of hearing must be published at least 3 days in advance (§ 227.136(2)-(3))

If a public hearing is requested, that will delay the process by anywhere from several days to several weeks. A public notice of the hearing must be published, and then the individual or body that needs to act in step 5 must review all of the public comments or feedback.

5. Obtain approval for the statement of scope from individual or body with policy-making powers over the subject matter of the proposed rule
Required by § 227.24(1)(e)1d
Approval cannot be given until at least 10 days after statement of scope is published in Administrate Register (§ 227.135(2))
If a preliminary hearing is held, approval cannot be given until hearing is complete and individual or body has reviewed public comments or feedback submitted (§ 227.135(2))

Without a preliminary public hearing, this step takes at least 10 days after the completion of step 3. With a preliminary public hearing, add several additional days or weeks. When complete, proceed to step 6.

6. Draft proposed emergency rule
Other than the statement of scope, *no work* on the emergency rule can begin until step 5 is complete (§§ 227.24(1)(e)1d, 227.24(1)(e)1g)
Agency must also prepare a plain-language analysis of the rule (§ 227.24(1)(e)1m)
Agency must also prepare a fiscal analysis of the rule (§ 227.24(1)(e)2)

Drafting the proposed emergency rule will necessarily take time. Given the prohibition on advance preparation, drafting any rule of even moderate complexity will take multiple days. Once the proposed emergency rule is drafted, it can be forwarded to the Governor for step 7.

7. Submit proposed emergency rule to the Governor for approval
Required by § 227.24(1)(e)1g
Governor has discretion to approve or reject emergency rule (§ 227. 24(1)(e)1g)
Agency cannot begin step 8 until Governor approves in writing (§ 227.24(1)(e)1g)

As with step 2, with coordination, this could be done fairly quickly. Note that the statute does not provide for gubernatorial amendment of the proposed emergency rule, only approval or rejection. If and when the Governor approves in writing, proceed to step 8.

8. Publish the emergency rule in the *Wisconsin State Journal*
Required by § 227.24(1)(c)
Emergency rule cannot take effect until publication (§ 227.24(1)(c))

This requires coordination with the Wisconsin State Journal and depends on the newspaper's schedule, but in any event cannot take less than 3-4 days of lead time.

When this step is complete, the emergency rule goes into effect. Nonetheless, the agency has more work to do and must proceed to step 9.

9. File the emergency rule with the LRB
Required by (§ 227.24(3m))
Agency must mail a copy of the emergency rule to the Clerks of the Legislature (§ 227.24(3))
Filing with LRB must be accompanied by a statement of emergency finding (§ 227.24(3))

10. Submit the emergency rule to the Small Business Regulatory Review Board
Required by § 227.24(3m)
Must be done on same day agency files the emergency rule with LRB (§ 227.24(3m))
If the emergency rule will have a significant economic impact on a substantial number of small business, Board may submit to agency and Legislative Council suggested changes to the emergency rule (§ 227.24(3m))

11. Mail the fiscal estimate to every member of the Legislature with copy to LRB
Required by § 227.24(1)(e)2
Must be done no later than 10 days after the emergency rule is published (§ 227.24(1)(e)2)

12. Hold a public hearing on the emergency rule
Required by § 227.24(4)
Hearing must occur within 45 days of emergency rule's promulgation (§ 227.24(4))

13. Seek JCRAR extension of the emergency rule if necessary
Provided for in § 227.24(2)
Agency must send JCRAR written request 30 days before expiration (§ 227.24(2)(am))
Extensions cannot exceed 60 days at a time or 120 days total (§ 227.24(2)(a))
Requires evidence that agency cannot promulgate permanent rule (§ 227.24(b)(2))