
Wisconsin Legislative Council

MINUTES



STUDY COMMITTEE ON THE USE OF ARTIFICIAL INTELLIGENCE IN HEALTH CARE

Room 411 South, State Capitol
Madison, WI
September 9, 2026
9:00 a.m. – 4:55 p.m.

CALL TO ORDER AND ROLL CALL

Chair Cabral-Guevara called the meeting to order and determined that a quorum was present.

COMMITTEE MEMBERS PRESENT:	Sen. Rachael Cabral-Guevara, Chair; Sen. Sarah Keyeski; Rep. Mike Bare; and Public Members Polly Anderson, Phillip Blair, Dr. Justin Boge, Glenn Martin Fung, Matthew Harris, David Hoffert, Frank Liao, Krister Mattson, Madeline Nevermann, Julie Pawola, and Erin Skold.
COMMITTEE MEMBERS EXCUSED:	Rep. Adam Neylon, Vice Chair, and Public Member Dr. Mark Huth.
COUNCIL STAFF PRESENT:	Margit Kelley, Principal Attorney; and Emily Hicks and Patrick Ward, Senior Staff Attorneys.
APPEARANCES:	Jordan Francis, Senior Policy Counsel for U.S. Legislation, Future of Privacy Forum; Frank B. Meyers, Director, Regulatory Innovation and Member Services, Federation of State Medical Boards (FSMB) (via videoconference); Dr. Richard Bruce, Professor of Radiology and Vice Chair of Informatics, School of Medicine and Public Health, University of Wisconsin (UW)-Madison; Sara Kroenke, DNP, RN, CPHQ, Clinical Informatics Nurse Specialist, UnityPoint Health – Meriter; Dr. Ramsey G. Larson, Family Medicine, Fort HealthCare; Sara Scheu, Transformation Business Partner, Marshfield Clinic; Dr. Nicole Mubanga, Chief Medical Officer, Outreach Community Health Centers; Dr. Jackie Gerhart, Chief Medical Officer, Epic; Karen Hay, Global Digital Transformation Executive, and Jeff Szczerbinski, Partner – State of Wisconsin, Salesforce; Deepak Arora, Founder & CEO, Wearable Technologies, Inc.; and Nick Myers, Director of AI Innovation, Recovery.com.

APPROVAL OF THE MINUTES OF THE AUGUST 13, 2026, MEETING

Representative Bare moved, seconded by Mr. Mattson, to approve the minutes of the August 13, 2026, meeting. The motion was approved by unanimous consent.

PRESENTATION BY JORDAN FRANCIS, SENIOR POLICY COUNSEL FOR U.S. LEGISLATION, FUTURE OF PRIVACY FORUM

Mr. Francis presented on the U.S. consumer privacy law landscape. Mr. Francis began by noting the many facets of the health data ecosystem, including traditional patient interactions, consumer health wearables and apps, health privacy laws, general consumer data privacy laws, genetic nondiscrimination laws, and artificial intelligence (AI) tools and automated processes. Mr. Francis noted that the United States is a global outlier without a general consumer data privacy law, and that states have stepped in to provide a complex framework for comprehensive consumer privacy laws. Mr. Francis noted some recent state legislative trends, including broadening applicability thresholds, expanding sensitive data categories, and requiring “data minimization.”

In response to questions from committee members, Mr. Francis said that a comprehensive consumer data privacy law could provide a foundation for consumers to more comfortably use AI resources for health and well-being. In response to questions regarding variations in states’ consumer data privacy laws, Mr. Francis noted that the Connecticut model is most commonly used among other states’ approaches and that a congressional proposal incorporates some core, common concepts used in many states’ data privacy legislation. During questions regarding state disclosure requirements, Mr. Francis noted that a number of studies show consumer “consent fatigue” can cut against the utility of disclosure requirements. Mr. Francis suggested that a “consumer expectations model,” like California’s, could require a business to actually consider the consumer’s experience when designing notifications and disclosures of the use of AI.

PRESENTATION BY FRANK B. MEYERS, DIRECTOR, REGULATORY INNOVATION AND MEMBER SERVICES, FSMB

Mr. Meyers presented on the use of AI in medical practice. Mr. Meyers started his presentation by noting that patients and practitioners are already using some legitimate AI resources, but that there are issues when a tool gets something wrong or when a tool is posing as a credentialed practitioner. Mr. Meyers identified certain policies from FSMB, California, and Texas that encourage or require a licensed practitioner to disclose when the licensed practitioner is using AI for certain patient communications or in diagnosing or treating a patient. Mr. Meyers noted that another approach, enacted in six states, provides a regulatory “sandbox” to pilot a waiver for AI activities that would otherwise require action by a licensed clinician. Lastly, Mr. Meyers noted that FSMB is in the midst of an AI workgroup that is expected to report practical guidance to state medical boards in April 2027.

In response to questions from committee members, Mr. Meyers talked about the complexity in determining liability for AI actions, but noted that even if a physician is using an AI tool, the physician remains responsible for the clinical notes and medical care provided. He further noted that an AI developer may have product liability issues depending on how an AI tool is designed or marketed. In another discussion, Mr. Meyers noted that health care services are governed by the laws where the patient is located.

PRESENTATIONS BY HEALTH CARE PRACTITIONERS

Dr. Richard Bruce, Professor of Radiology and Vice Chair of Informatics, School of Medicine and Public Health, UW-Madison

Dr. Bruce, a radiologist, provided a brief history of medical imaging, beginning with Wilhelm Röntgen’s discovery of X-rays in 1895 and provided some comparisons for current advancements to practice with the development of nuclear magnetic resonance machines. Dr. Bruce described a number of AI

successes in radiology practice, such as improved image quality, lower radiation doses, and real-time quality checks. Dr. Bruce stated that 80 percent of all devices approved by the U.S. Food and Drug Administration that contain AI are in radiology and provided some examples forecasting how AI could be used in the future.

Sara Kroenke, DNP, RN, CPHQ, Clinical Informatics Nurse Specialist, UnityPoint Health – Meriter

Ms. Kroenke stated that the top two considerations for health care organizations in implementing AI are cost and ethics. Ms. Kroenke described a framework for distinguishing types of AI use, with the highest level of caution for AI that communicates directly with patients and presents itself in place of a health care professional; moderate caution for AI predictive analytic services; and high value with low concerns for AI text assistants and ambient scribe solutions.

Ms. Kroenke noted that two risks of AI in health care are the use of patient information in ways that do not align with consumer preference and the retention of clinical recordings, leading to distrust of both AI and health care. Ms. Kroenke noted that, to address those concerns, legislative opportunities with a long-term view could include encouraging providers to clearly explain how AI may use patient information; requiring disclosure or consent when AI is used beyond operational purposes; limiting clinical recording retention periods; preserving clear human accountability for clinical decisions and patient communications; requiring vendor accountability and transparency regarding intended use of an AI tool, known limitations, data retention, model training, and significant model updates; and requiring multidisciplinary governance of AI within a health care organization. Lastly, Ms. Kroenke noted that there are research gaps on how AI is used in health care and suggested that the committee consider supporting funding for research of health care AI tools.

Dr. Ramsey G. Larson, Family Medicine, Fort HealthCare

Dr. Larson, a family medicine physician, provided some background on how he uses AI in his clinical practice and described a number of benefits from using AI. Dr. Larson provided a number of suggestions for legislation, noting that Wisconsin should be focusing on protecting patients. Dr. Larson's suggestions for possible legislation included prohibiting AI from doing any of the following tasks: (1) being licensed to practice medicine; (2) representing itself as a credentialed health care professional; (3) making independent patient care decisions; (4) autonomously prescribing medications; or (5) making decisions at any point of care. Dr. Larson further suggested that legislation could specify that licensed health care practitioners retain final clinical authority and should disclose the use of AI to patients.

Dr. Larson responded to a number of questions about approaches to licensing practitioners and regulating AI, AI industry practices, benefits of disclosing the use of AI, and standards of practice.

PRESENTATIONS BY REPRESENTATIVES OF HOSPITALS AND CLINICS

Sara Scheu, Transformation Business Partner, Marshfield Clinic

Ms. Scheu provided the perspective of a health system that deploys AI. Ms. Scheu began by noting that the clinic's health system has made commitments to the following standards for the use of AI: (1) human judgment, where people remain responsible for consequential decisions; (2) safety and monitoring, with performance and effects monitored over time; (3) transparency and trust, so patients may understand when AI is meaningfully present in the patient's care; and (4) practical, aligned regulation, with rules that are risk-based, technology-neutral, and consistent across state lines.

Ms. Scheu described four AI use cases, with four different risk profiles, noting that any risk level is in the task and not the category of technology. Ms. Scheu discussed AI use cases for chat and workflow

assistants compliant with the Health Insurance Portability and Accountability Act of 1996, ambient listening to support clinical documentation, care gap closure for follow-up or preventative care, and inbox management to route messages to appropriate persons.

Dr. Nicole Mubanga, Chief Medical Officer, Outreach Community Health Centers

Dr. Mubanga briefly described the Outreach Community Health Center's work with underserved populations and the operational challenges in the community health center sector. Dr. Mubanga noted that community health centers have a number of reasons to adopt AI, including improved speed and accuracy of documentation, improved patient and provider satisfaction, and more direct engagement with patients during visits. However, Dr. Mubanga also noted that there are serious reasons for hesitancy, including cost and security; safety; and accuracy risks. Dr. Mubanga noted that for a behavioral health patient, even a simple disclosure of the use of an AI-assisted recording can compromise the therapeutic relationship and is, therefore, not always used. Dr. Mubanga stated that when an AI scribe is used, the center's policy is to obtain a general consent to the use of AI as part of the general consent-to-treat intake at the front desk. Consent to the use of AI is then obtained verbally, again, before each visit. Dr. Mubanga discussed the health center's typical process for adopting an AI tool, beginning with a clinical review of the impact on clinical practice; an operational review of how it would fit in existing systems and be used; and a fiscal review of start-up and continuing costs. She noted that some shared resources for electronic health records are available for community health centers, but that community health centers are not provided access to the full tools.

Dr. Mubanga closed her presentation by highlighting the absolute need to protect the privacy of patient information. Additionally, she requested that any regulations allow compliance to be realistic for the size of a provider; preserve flexibility in patient-appropriate disclosure and consent rather than a fixed script; protect a practitioner's clinical judgement to override, edit, or decline AI output; and to fund or facilitate shared resources for small and safety net providers.

PRESENTATIONS BY REPRESENTATIVES OF TECHNOLOGY DEVELOPERS

Dr. Jackie Gerhart, Chief Medical Officer, Epic

Dr. Gerhart provided background on Epic's principles, including to design health care technology in collaboration with users, as well as Epic's priorities in helping clinicians with their jobs and helping patients be healthy. Dr. Gerhart cited recent data showing that one in three adults are using AI for health questions, but that three in four worry about privacy; that patients are three times more likely to trust an AI agent within a clinical system than a public chatbot; and that larger shares of younger adults, Black and Hispanic adults, and those who are uninsured are turning to AI for mental health advice. Dr. Gerhart provided information on the history and spectrum of AI tools and noted that evaluation, monitoring, and measurement are needed for responsible deployment. Dr. Gerhart highlighted certain beneficial performance outcomes from three of Epic's AI tools, including time savings on patient visit documentation and communications, decreases in billing and customer service messages, and increased approval rates for electronic prior authorizations.

Dr. Gerhart and committee members engaged in discussion on a number of topics, including upcoding concerns, prior authorization assistance, procedures for opting in or out of sharing health data, costs of using AI tools, disclosure of the use of AI to patients, and limits and governance strategies.

Karen Hay, Global Digital Transformation Executive, and Jeff Szczerbinski, Partner – State of Wisconsin, Salesforce

Ms. Hay and Mr. Szczerbinski noted that Salesforce has more than 30 patient-care AI tools that work well, particularly when a human is in the loop. Ms. Hay and Mr. Szczerbinski provided some examples

where AI tools are promising, including high patient and practitioner satisfaction when using AI tools for the following situations: (1) for repetitive documentation and clinical notes; (2) for automated and personalized instructions for transitions in care; (3) for automated care plan reminders; (4) for assistance in forecasting demand and supply; and (5) for the use of nonclinical and administrative AI tools to reduce difficulties in scheduling and to provide around-the-clock care management assistance. Ms. Hay and Mr. Szczerbinski noted some technical barriers when using AI in health care, including the lack of interoperability for data, historical biases inherent in the data, users' technical exhaustion in clicking through multiple screens, and the trust gap for high-stakes tasks. Ms. Hay and Mr. Szczerbinski recommended the following three core pillars for state legislative consideration: (1) supporting interoperability through open standards; (2) providing meaningful human participation where no decisions are made by automation alone and meaningful explanations of AI influence are provided to patients; and (3) establishing strong data protections and security standards.

Deepak Arora, Founder & CEO, Wearable Technologies, Inc.

Mr. Arora briefly described the four AI use cases that his company has, or is developing, to help when someone needs to be remotely monitored by a care provider. He described the company's wearable products, where the AI runs locally in the device. Mr. Arora stated that an individual's data generally stays in the device, without cloud storage, and is transmitted to a care provider only to the extent needed for appropriate alerts. Mr. Arora described the company's governance practices, including having a dedicated compliance team and audit trails, thorough documentation of what an AI tool is for, what data it touches, and the lines it is not allowed to cross, and a policy of using tools only to spot patterns that a care provider can review and use to make health care decisions. Mr. Arora noted that consumer data privacy bills might not affect smaller start-up businesses like his. Mr. Arora made a number of recommendations, including aligning Wisconsin law with other states; providing a supervised place, such as Utah's sandbox, for test runs; and requiring a person to stay accountable for every diagnosis, prescription, and treatment decision.

Nick Myers, Director of AI Innovation, Recovery.com

Mr. Myers described Recovery.com's development of AI tools that provide access, screening, and navigation to help people find addiction and mental health treatment. Mr. Myers noted that about half of people who need mental health care are untreated and noted the access and capacity benefits from using AI augmentation. However, Mr. Myers cited some real harms that come from the use of AI for addiction and mental health treatment, including deaths, safety failures, sycophancy, and use of AI companions for mental health support. Mr. Myers noted that the worst harms cluster around AI autonomy, particularly autonomous consumer chatbots acting as unlicensed therapists. Mr. Myers suggested that guardrails should regulate the use of AI and outcomes, should borrow from peer states, and should leave open a path for compliance. He recommended the following: (1) that a human should make the final call on coverage denials; (2) that AI should be banned from posing as a licensed practitioner; and (3) that sensitive data should be protected, with protocols for data sharing disclosure and consent. Lastly, Mr. Myers recommended protecting patients and staying open for innovation through a small state AI office or sandbox that has expertise and is dedicated to keeping pace with a fast-moving technology.

ADJOURNMENT

The meeting adjourned at 4:55 p.m.

MSK:kp