Illinois Health and Hospital Association

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WRITTEN TESTIMONY

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Sub-Chairman Cunningham, Sub-Vice-Chair Castro and members of the Senate AI and Social Media Subcommittee, my name is Karen Harris, Senior Vice President and General Counsel at the Illinois Health and Hospital Association (IHA). On behalf of Illinois' more than 200 hospitals and nearly 40 health systems, IHA thanks you for the opportunity to provide input. Illinois hospitals and health systems embrace innovation that improves patient outcomes, lowers cost, and expands access to care. As you consider new AI legislation, we urge you to prioritize balanced rules that protect patients while enabling clinically beneficial uses of AI.

It is imperative that legislation addressing AI be drafted with an eye to the future. Early laws aimed at emerging and evolving technologies have sometimes produced significant unintended consequences when innovation evolved faster than the statutes governing them. As a result, any AI policy should be treated as living policy and approached with a willingness to reconsider and revise legislation based on how AI technology develops, is deployed/used and how it performs. This includes mechanisms for periodic review, clear criteria for revisions, and processes to update definitions and scope as technology and clinical practice evolve.

Wherever possible, IHA believes AI statutes should employ common definitions across topics, industry and laws to reduce confusion and support compliance. At the same time, AI regulation in clinical settings must be tailored to healthcare. Patient care and health data are already governed by robust federal and state frameworks, most notably the Health Insurance Portability and Accountability Act (HIPAA). Lack of consistency in AI legislation risks creation of duplicative or conflicting obligations for providers already subject to strict regulatory standards.

Regulations must also strike the right balance between safeguards and innovation. Overly broad liability or prescriptive bans risk impeding tools already being utilized to improve safety—such as medication interaction alerts, which have successfully prevented serious injuries, complications and potential deaths. In our efforts to regulate and adopt reasonable guardrails for emerging AI, we must avoid unintentionally limiting or altering what has already been successfully deployed in clinical practice.

To illustrate how these principles should inform statute drafting, we offer comments on several bills currently under consideration.

SB 2875, SB 3890, and SB 2273 (Health or Consumer Data Privacy) raise the related concern of duplication with HIPAA. Much of what these Acts seek to regulate is already covered by HIPAA, and, if enacted, would potentially conflict with or add unnecessary additional requirements. Instead of imposing secondary, overlapping regulations, a reasonable path forward would be to exempt HIPAA covered entities and their business associates, or to limit the Acts to entities not subject to HIPAA.

SB 2993 (AI-Prescribing Medication), which would amend the Medical Practice Act to address AI in prescribing, highlights the need for clarity so regulation does not impede tools that improve safety. Hospitals' electronic medical record (EMR) systems already use AI to flag contraindications when prescribing medications, and these systems have demonstrably prevented harm. Enacting vague standards such as "full control and responsibility" will create uncertainty that could discourage clinicians from using these helpful, potentially life-saving tools. IHA recommends explicitly clarifying that existing AI usage is not within the bill's scope or prohibitions.

SB 3601 (Professional AI Oversight Act), seeks to impose new disclosure requirements on licensed professionals, including health care providers, that utilize artificial intelligence interactions with clients. Every time a licensed professional uses AI in a client interaction they would need to disclose -- either verbally at the start of oral exchanges or in writing before initiating written communications— that AI is being used. However, AI is already built into electronic medical record (EMR) systems. Thus, for example, if as part of a patient visit the physician enters a new prescription into the patient's medical record, the physician would first need to explain that the EMR system uses AI to flag contraindicated medicine interactions. While transparency in healthcare is vital; this bill's disclosure requirements neither adds value or provides critical transparency to patients.

SB 3702 (Registered Nurse Use of AI), which addresses registered nurse use of AI, incorporates many constructive clarifications—such as clarifying that AI usage does not diminish or waive any existing confidentiality or privacy obligation under existing laws. However, it is potentially too prescriptive. For example, the bill requires patient "consent" to the use of transcription AI tools, rather than a simple notice that such tools are being used to benefit patients by ensuring that patient encounters are accurately documented. Similarly, the bill's prohibitions against the use of AI for direct patient care should be looked at more closely to ensure that they make sense. Moreover, there needs to be recognition that while today's AI may not be at the level where it can be used for direct patient care, tomorrow's AI may soon make some direct patient care activities more feasible.

Across these and other proposals, IHA and the hospital community support measured, forward-thinking AI guardrails that protect patients while enabling innovation that improves care delivery. We stand ready to work with the Committee and other stakeholders to refine these bills—narrowing scope where appropriate, clarifying ambiguous standards, aligning

enforcement with agency expertise, and building in mechanisms to ongoing review and revision as technology and clinical evidence change.

Thank you.