WISCONSIN HOSPITAL ASSOCIATION

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To: **Members of the Wisconsin State Legislature**

From: **Jon Hoelter, WHA VP Federal Affairs & Advocacy**
Abbey Rude, WHA VP Government Relations

Date: **November 12, 2025**

Re: Responding to Concerns Voiced about AB 598/SB 578

WHA has been made aware of concerns that have been brought up regarding the next-of-kin legislation (NOK), AB 598/SB 578. We wanted to be sure you were aware of how the legislation in nearly all cases contemplates and at times directly responds to concerns that have been aired.

It is worth noting that this legislation is nearly identical (see attached Legislative Council memo which concurs with that assessment) to last year's next-of-kin legislation which passed the Assembly unanimously, with the main change being a new process to expedite temporary guardianships. That process requires physicians to fill out a form documenting when they have determined someone to lack medical capacity when the NOK authority is activated.

Additionally, this legislation maintains the 3-year sunset provision negotiated during the legislative process last session. This sunset will require the legislature to pass another statute within 3 years to reauthorize this authority, which will also allow the legislature to identify any concerns that come to fruition and consider how to best to address them.

Concern:

How does this impact people with disabilities?

It does not. Like 50.06 (the current next-of-kin statute that we are trying to improve so that it works again), the bill expressly says the next-of-kin process is not available for individuals diagnosed as developmentally disabled or having a mental illness at the time of the proposed admission. This was a request from disability rights groups that was honored by the bill authors.

Concern:

Wisconsin is the only state allowing the NOK financial decision-making powers.

This is a mischaracterization of the bill. This legislation copies the same language (highlighted below) from the existing 50.06(5)(a), which states: ". . .*an individual who consents to an admission under this section may, for the incapacitated individual, make health care decisions to*

the same extent as a guardian of the person may and authorize expenditures related to health care to the same extent as a guardian of the estate may. . ."

The only addition in the legislation is allowing the NOK to assist an incapacitated patient in applying for Medicaid, which was a clarification requested by DHS and supported by WHA.

Concern:

Hospitals will choose the patient representative from a list set in statute.

Families will choose the patient representative, starting with a hierarchy that already exists in statute – the same next-of-kin hierarchy that is used for organ donation and hospice.

Concern: No hard deadline or formal process for re-evaluating whether the patient can make their own medical decision.

- Under SB 578/AB 598, nursing homes are required to have a physician assess patients every 30 days for the first three months and every 60 days thereafter.
- Unlike guardianship, where a patient who regains decision-making ability must receive approval through a court process to have the guardianship removed, SB 578/AB 598 would maintain the ability for a decisional person to immediately begin making their own decisions regarding a post-acute placement.
- SB 578/AB 598 also clarifies that an individual, patient representative, or facility staff may request a reevaluation of the individual's incapacity at any time and that patient representative's authority ends if the individual is no longer determined to be incapacitated.

Concern: This bill sets no limits on how long a patient representative can make decisions on behalf of the individual.

The bill specifically requires the NOK's authority to end upon any of the following events:

- A court appoints a guardian to make such decisions for the incapacitated individual.
- The incapacitated individual is discharged to a setting that is not a nursing home or facility.
- A health care power of attorney that was not identified when the patient's representative was established is identified.
- The incapacitated individual is determined to no longer be incapacitated.

The time-limited nature of the current 50.06 statute was identified as a major barrier to successful transitions to SNF and CBRF care, because it led to uncertainty over whether the NOK would be allowed to continue helping their loved one with care decisions if the court had not appointed a guardian before the time limit expired, or if the court appointed someone other than the NOK. This legislation is designed to create more certainty for post-acute care facilities that are otherwise willing to accept these patients.

Concern: This bill does not require the patient to be informed of or object to a NOK placement.

This legislation keeps the same requirements of existing statute 50.06(d) intact, which allows an incapacitated individual to verbally object to or otherwise actively protest the admission to a facility, in which case the county APS must come within 72 hours to investigate. If the objection is not withdrawn, the facility must make arrangements to discharge the individual to another site of care within 72 hours. Hospital staff are also in continuous communication with patients and their families regarding their care options and planned care transitions.

Concern: This bill goes beyond what certain states like Illinois, Indiana, and Michigan allow their next-of-kin to do on behalf of patients.

Both the Illinois and Indiana laws currently have broader statutory provisions than the proposed Wisconsin changes, and Michigan is in the process of updating its surrogate decision-making statute.

- **The Indiana State Department of Health writes:**
  If you do not have an advance directive and are unable to choose medical care or treatment, Indiana law decides who can do this for you. Indiana Code § 16-36 allows any member of your immediate family (meaning your spouse, parent, adult child, brother, or sister) or a person appointed by a court to make the choice for you. If you cannot communicate and do not have an advance directive, your physician will try to contact a member of your immediate family. Your health care choices will be made by the family member that your physician is able to contact.
- 2022 Indiana Code Title 16. Health Article 36. Medical Consent Chapter 1. Health Care Consent 16-36-1-1.
  "Health Care"

  Sec. 1. As used in this chapter, "health care" means any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition. The term includes admission to a health care facility.

- The Illinois Guardianship and Advocacy Commission states in its "Guide to Adult Guardianship in Illinois," the following:
  Under amendments to the Health Care Surrogate Act adopted in 1998, surrogates are authorized to make all kinds of medical decisions… the law empowers surrogates, and guardians acting as surrogates, to make nearly all medical decisions without court review.

- The patient advocate designation law and forms used in Michigan, do not require the principal to specifically call out authority of the patient advocate to place the principal into long term care. In Michigan, hospitals do not encounter the issue often seen in Wisconsin which is a completed HCPOA but the authority to place in long term care was not granted.

- Second, hospitals' experience with obtaining guardianship in Michigan (at least the Upper Peninsula) has been far easier than in Wisconsin. In Michigan, the typical process is to simply direct the proposed guardian to the register in probate office where they are often able to obtain guardianships without involving attorneys. Michigan also does not require anything like protective placement as Wisconsin law currently requires. While the MI process is not perfect, it is much easier, less costly, quicker and, and there does not appear to be any greater risks or worse outcomes for patients than in Wisconsin.
- Even so, Michigan is in the process of updating it's surrogate decision-making law in a way that would expressly provide even more abilities to surrogates than the limited provisions included in AB 598/SB 578, in recognition of the challenges that remain in the current process.

Concern: The legislation does not establish a process for contesting the appointment of a patient representative whose decisions or priorities conflict with those of the individual.

There are at least 3 ways the legislation considers this concern.

1. The bill references 42 CFR 483.10 (b) (6) which is a federal Medicare condition of participation for nursing homes related to resident's rights, and states:
   If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns in the manner required under State law.
2. The bill requires a NOK to sign a written statement under oath that they agree to exercise the degree of care, diligence, and good faith that an ordinarily prudent person exercises in his or her own affairs. However, any person may petition the court to review whether the NOK is doing so, and the court is granted oversight to direct the NOK to stop making decisions that have given cause for concern.
3. The bill preserves the ability of anyone to petition the court for guardianship, which supersedes and nullifies the NOK decision-making authority.

It's important to remember that nursing homes and CBRFs are already heavily regulated entities. These regulations exist to protect vulnerable populations under their care. This legislation presents no further risks to patients than already exists for patients transferred to nursing homes and CBRFs under a court ordered guardianship.

Under current law, patients will eventually get to a nursing home or CBRF under a guardianship; this legislation simply aims to remove the unnecessary delay that occurs due to the requirement to seek a guardianship. These delays have real and significant impacts on patients who must remain in the most restrictive setting (a hospital) when more appropriate care could be provided in a less restrictive post-acute setting.

Concern:

This legislation does not get at the root causes of why there are post-acute care delays, such as inadequately staffed nursing homes and assisted living facilities, and a workforce shortage.

WHA has always maintained that this legislation cannot and will not fix the myriad challenges hospitals encounter with helping patients obtain post-acute care. But, it will address the issue of incapacitated patients experiencing significant delays due to the construct of the current 50.06 statute. WHA members that operate in other states do not experience the extensive delays that we see in Wisconsin, due to current law.

This needs to change.