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Testimony in SUPPORT of SB1323 SD2
RELATING TO HEALTH CARE

REPRESENTATIVE GREGG TAKAYAMA, CHAIR
REPRESENTATIVE SUE L. KEOHOKAPU-LEE LOY, VICE CHAIR
HOUSE COMMITTEE ON HEALTH

Hearing Date and Time: March 19, 2025, 9:05 a.m. Location: Room 329 and Video

Fiscal Implications: Undetermined.

Department Position: The Department of Health (Department) supports this measure.

Department Testimony: The Adult Mental Health Division (AMHD) provides the following testimony on behalf of the Department.

SB 1323 SD2 seeks to adopt the Uniform Health-Care Decisions Act (2023) with amendments to replace HRS chapters 327E and 327G. The State of Hawaii previously adopted the 1993 version of the Uniform Health-Care Decisions Act, as HRS chapter 327E. The 2023 revision of the Uniform Health-Care Decisions Act and accompanying modifications designed for our State intends to improve the flexibility, ease-of-implementation, and individual preferences for decisions involving guardianship, surrogacy, and advance health care or mental health care directives.

The Department appreciates the ongoing collaborative effort to improve the system of mental health care in our islands.

Thank you for the opportunity to testify on this measure.

WRITTEN TESTIMONY OF
THE DEPARTMENT OF THE ATTORNEY GENERAL
KA ʻOIHANA O KA LOIO KUHINA
THIRTY-THIRD LEGISLATURE, 2025

ON THE FOLLOWING MEASURE:
S.B. NO. 1323, S.D. 2, RELATING TO HEALTH CARE.

BEFORE THE:
HOUSE COMMITTEE ON HEALTH

DATE: Wednesday, March 19, 2025 **TIME:** 9:05 a.m.

LOCATION: State Capitol, Room 329

TESTIFIER(S): **WRITTEN TESTIMONY ONLY.**
(For more information, contact Anne E. Lopez, Attorney General, at 808-586-1282)

Chair Takayama and Members of the Committee:

The Department of the Attorney General supports this bill.

Currently, two separate chapters of the Hawaii Revised Statutes (HRS), chapters 327E and 327G, HRS, provide a legal framework for advance health-care directives. The purpose of this bill is to update and consolidate our current laws by adopting a modified version of the Uniform Health-Care Decisions Act (2023), as promulgated by the Uniform Laws Commission, which reflects a better understanding of capacity and reduces barriers to creating advance directives relating to general health care and mental health.

Below, we have identified some of the key updates in this bill. The Department consulted and worked with Hawaii Healthcare Systems Corporation (HHSC) on the suggested amendments to this bill, attached to this testimony. We have relied on the expertise of stakeholders and do not have any legal concerns with the proposed revisions.

1. **Simplifying the requirements to execute a power of attorney for health care:** The bill reduces the number of witnesses required to create a power of attorney instruction from two witnesses or a notarization to one witness.
2. **Clarifying and safeguarding an individual's right to receive treatment during a psychiatric or psychological event:** The bill explicitly permits an

individual to include a an enforceable instruction in their advance mental health-care directive. While current law allows an individual to create an advance mental health-care directive, it does not clearly address the enforceability of treatment instructions contained in the advance mental health-care directive during psychiatric or psychological events, nor does it provide any safeguards to ensure that the individual instructed such treatment. This bill provides those safeguards missing in the current law to ensure the instruction was consented to by the individual by requiring the signatures of two in-person witnesses in the advance mental-health care directive. Those safeguards make the treatment instructions enforceable during psychiatric or psychological events, even if the individual refuses treatment due to their medical condition.

3. **Streamlining capacity determinations:** The bill reduces the requirement for determining an individual's capacity from two separate examinations by health-care providers to a single examination conducted at the same time the determination of capacity is made. Under current law, two health-care providers must conduct separate examinations to determine capacity without a requirement that those examinations occur when the patient presents with the same symptoms. The bill streamlines this process, requiring only one contemporaneous examination while allowing for additional examinations by another provider if needed. If the individual disagrees with the initial determination of incapacity, an examination by another provider may be conducted to confirm or reassess the determination of incapacity.
4. **Expanding capacity determination health-care providers:** The bill allows an advance practice registered nurse (APRN) with advanced education and specialized clinical training to determine whether an individual has capacity. Under current law, only a physician or a licensed psychologist can make that determination. The addition of APRNs will enhance accessibility to timely capacity assessments while maintaining high professional standards.
5. **Making it easier for sample forms to be updated:** The bill shifts the responsibility of creating and updating sample forms for advance health-care

directives from statutory inclusion to the Department of Health (in consultation with the Department of the Attorney General). This change ensures that the sample forms can be updated promptly to address evolving community needs. The current statutory forms, based on the previous Uniform Health-Care Decisions Act (1993), do not reflect a modern understanding of capacity, treatment options, or accessibility, creating unnecessary barriers for individuals seeking to create an advance health-care directive.

This bill maintains two key aspects of Hawaii's current law that are not found in the Uniform Health-Care Decisions Act (2023):

1. **Default surrogate as an authorized Medicaid representative:** In 2018, chapter 327E, HRS, was amended to allow a default surrogate to act as an authorized representative for Medicaid purposes. The bill preserves this authority to ensure continuity in health-care decision making for individuals relying on Medicaid.
2. **Default surrogate selection process:** When Hawaii adopted the Uniform Health-Care Decisions Act (1993), it created a process for choosing a default surrogate by requiring a physician, or their designee, to locate interested persons and have those persons choose a default surrogate from amongst themselves. This process has been effective, as reported by medical providers, and reflects Hawaii's unique cultural context, including the recognition of "hanai" relationships.

Pursuant to the Hawaii Health Systems Corporation's requests, the Department suggests the following amendments to the bill:

1. On page 12, line 17 (section -4(b)(3), HRS), remove the word "signed" so that the sentence reads as follows:

   (3) Documented in a record [~~signed~~] by the health-care professional making the finding that includes an opinion of the cause, nature, and probable duration of the lack of capacity.

2. On page 14, line 3, through page 16, line 8 (section -5, HRS), remove subsections (c)-(f).

3. On page 28, lines 7-15 (section -12(f), HRS), amend paragraphs (5) and (6), and insert a new paragraph (7) to read as follows:

   (5) If the person is not a family member or cohabitant, a statement describing how the person exhibited special care and concern for the individual who lacks capacity and is familiar with the individual's personal values; [~~and~~]
   (6) Affirmation that the person understands that the health care professional will reasonably rely on the person's representations in the declaration to assist in providing medical treatment[~~.~~] ; and
   (7) A statement that the declaration was provided under the penalty of law.

4. On page 32, lines 3-5 (section -14(a)(2), HRS), remove "and, if the individual objects to the finding, the finding is confirmed under section -5(d)(4)."

5. On page 36, line 20, through page 37, line 8 (section -18(a), HRS), remove:

   , or the individual objects under section -5(c) to the finding of lack of capacity under section -4(b). The power shall resume if:
   (1) The power ceased because the individual objected under section -5(c); and
   (2) The finding of lack of capacity is confirmed under section -5(d)(4) or a court finds that the individual lacks capacity to make a health care decision.

6. On 41, lines 8-13 (section -19(b), HRS), remove subsection (b).

7. On 43, lines 12-14 (section -21(c)(3), HRS), remove "and that the individual may object under section -5(c) to the finding under section -4(b)."

8. On 50, line 3 (section 24(c), HRS), change "$50,000" to "$5,000."

Additionally, we met with Hawaii Disability Rights Center and discussed how the concerns set out in their prior testimony can be addressed in the forms to be developed and used for the health care directives, rather than in the bill. We believe that they are in agreement with that approach.

We believe this bill introduces significant and meaningful updates to the laws regarding advance health-care directives and advance mental health-care directives. These changes will make it easier for individuals and their family to use these tools to provide appropriate care and decision-making. We respectfully ask the Committee to pass this bill with the suggested amendments. Thank you for the opportunity to provide testimony.

Page 12, line 17.

§ -4 Presumption of capacity; overcoming presumption. (a) An individual shall be presumed to have capacity to make or revoke a health care decision, health care instruction, and power of attorney for health care unless:

(1) A court has found the individual lacks capacity to do so; or

(2) The presumption is rebutted under subsection (b).

(b) Subject to sections -5 and -6, a presumption under subsection (a) may be rebutted by a finding that the individual lacks capacity:

(1) Subject to subsection (c), made on the basis of a contemporaneous examination by any of the following health care professionals:

(A) A physician;

(B) A psychologist; or

(C) An advanced practice registered nurse;

(2) Made in accordance with accepted standards of the profession and the scope of practice of the health care professional making the finding and to a reasonable degree of certainty; and

(3) Documented in a record [~~signed~~] by the health care professional making the finding that includes an

opinion of the cause, nature, extent, and probable duration of the lack of capacity.

(c) The finding under subsection (b) shall not be made by:

(1) A family member of the individual presumed to have capacity;

(2) The cohabitant of the individual or a family member of the cohabitant; or

(3) The individual's surrogate or a family member of the surrogate.

(d) If the finding under subsection (b) was based on a condition the individual no longer has or a responsible health care professional subsequently has good cause to believe the individual has capacity, the individual shall be presumed to have capacity unless a court finds the individual lacks capacity pursuant to section -6 or the presumption is rebutted under subsection (b).

Page 13, line 14, through Page 16, line 8.

§ -5 Notice of finding of lack of capacity~~; right to object~~. (a) As soon as reasonably feasible, a health care professional who makes a finding under section -4(b) shall inform the individual about whom the finding was made or the individual's responsible health care professional of the finding.

(b) As soon as reasonably feasible, a responsible health care professional who is informed of a finding under section -4(b) shall inform the individual about whom the finding was made and the individual's surrogate.

[~~(c) An individual found under section -4(b) to lack capacity may object to the finding:~~

~~(1) By orally informing a responsible health care professional;~~

~~(2) In a record provided to a responsible health care professional or the health care institution in which the individual resides or is receiving care; or~~

~~(3) By another act that clearly indicates the individual's objection.~~

~~(d) If the individual objects under subsection (c), the individual shall be treated as having capacity unless:~~

~~(1) The individual withdraws the objection;~~

~~(2) A court finds the individual lacks the presumed capacity;~~

~~(3) The individual is experiencing a health condition requiring a decision regarding health care treatment to be made promptly to avoid imminent loss of life or serious harm to the health of the individual; or~~

~~(4) Subject to subsection (c), the finding is confirmed by a second finding made by a health care professional authorized under section -4(b)(1) who:~~

~~(A) Did not make the first finding;~~

~~(B) Is not a family member of the health care professional who made the first finding; and~~

~~(C) Is not the cohabitant of the health care professional who made the first finding or a family member of the cohabitant.~~

~~(c) A second finding that the individual lacks capacity under subsection (d)(4) shall not be sufficient to rebut the presumption of capacity if the individual is requesting the provision or continuation of life-sustaining treatment and the finding is being used to make a decision to withhold or withdraw the treatment.~~

~~(f) As soon as reasonably feasible, a health care professional who is informed of an objection under subsection (c) shall:~~

~~(1) Communicate the objection to a responsible health care professional; and~~

~~(2) Document the objection and the date of the objection in the individual's medical record or communicate the objection and the date of the objection to an administrator with responsibility for medical records~~

~~of the health care institution providing health care to the individual, who shall document the objection and the date of the objection in the individual's medical record.~~]

Page 28, lines 7-15.

§ -12 Default surrogate. (a) A default surrogate may make a health care decision for an individual who lacks capacity to make health care decisions and for whom an agent, or guardian authorized to make health care decisions, has not been appointed or is not reasonably available.

(b) Upon determination that an individual lacks capacity to make health care decisions, a responsible health care professional or the responsible health care professional's designee shall make reasonable efforts to notify the individual of the individual's lack of capacity to make health care decisions. If the individual has not appointed an agent and the individual retains capacity under section -3(a)(1) and (2)(C), the individual may identify a person to act as a default surrogate.

(c) Unless the individual has an advance health care directive that indicates otherwise or the person identified by the individual under subsection (b) is designated as a default surrogate, the responsible health care professional or the responsible health care professional's designee shall make

reasonable efforts to locate as many interested persons as practicable, and the responsible health care professional or the responsible health care professional's designee may rely on the interested persons to notify other family members or interested persons. Upon locating interested persons, the responsible health care professional or the responsible health care professional's designee shall inform the interested persons of the individual's lack of capacity and that a default surrogate should be selected for the individual.

(d) Interested persons shall make reasonable efforts to reach a consensus as to who among them shall act as the individual's default surrogate. If the person selected to act as the individual's default surrogate is disqualified or becomes disqualified under section -13, the interested persons shall make reasonable efforts to reach consensus as to who among them shall act as the individual's default surrogate.

The person selected to act as the individual's default surrogate shall be the person who has a close relationship with the individual and who is the most likely to be currently informed of the individual's wishes regarding health care decisions.

(e) If any of the interested persons disagrees with the selection of the default surrogate or the health care decision by the default surrogate, or, if after reasonable efforts the

interested persons are unable to reach a consensus as to who should act as the default surrogate, any of the interested persons may seek guardianship of the individual by initiating guardianship proceedings pursuant to chapter 551 or chapter 560, as applicable. Only interested persons involved in the discussions to choose a default surrogate may initiate such proceedings with regard to the individual.

(f) A responsible health care professional may require a person who assumes authority to act as a default surrogate to provide a signed declaration in a record under penalty of law stating facts and circumstances reasonably sufficient to establish the authority. The signed declaration shall include the following:

(1) The name of the person who seeks to assume the authority to act as a default surrogate;

(2) An affirmation that the person understands that the statements and affirmations are made under the penalty of law;

(3) An affirmation that the person had a relationship with the individual who lacks capacity before the individual becoming incapacitated;

(4) A statement defining that relationship, including identifying the relationship of the person to the individual;

(5) If the person is not a family member or cohabitant, a statement describing how the person exhibited special care and concern for the individual who lacks capacity and is familiar with the individual's personal values; [~~and~~]

(6) Affirmation that the person understands that the health care professional will reasonably rely on the person's representations in the declaration to assist in providing medical treatment[~~.~~]; and

(7) A statement that the declaration was provided under the penalty of law.

(g) If a responsible health care professional reasonably determines that a person who assumed authority to act as a default surrogate is not willing or able to comply with a duty under section -17 or fails to comply with the duty in a timely manner, the professional may request interested persons to choose another default surrogate.

(h) A health care decision made by a default surrogate shall be effective without judicial approval.

(i) As used in this section, unless the context clearly requires otherwise, "interested persons" means any of the individual's family members or any adult who has exhibited special care and concern for the individual and who is familiar with the individual's personal values.

Page 32, lines 3-5.

§ **-14 Revocation.** (a) An individual may revoke the appointment of an agent, the designation of a default surrogate, or a health care instruction in whole or in part, unless:

(1) A court finds the individual lacks capacity to do so;

(2) The individual is found under section -4(b) to lack capacity to do so [~~and, if the individual objects to the finding, the finding is confirmed under section -5(d)(4)~~]; or

(3) The individual created an advance mental health care directive that includes the provision under section -9(d) and the individual is experiencing the psychiatric or psychological event specified in the directive.

(b) Revocation under subsection (a) may be by any act of the individual that clearly indicates that the individual revokes the appointment, designation, or instruction, including an oral statement to a health care professional.

(c) Except as provided in section -10, an advance health care directive of an individual that conflicts with another advance health care directive of the individual shall revoke the earlier directive to the extent of the conflict.

(d) Unless otherwise provided in an individual's advance health care directive appointing an agent, the appointment of a

spouse or civil union partner of an individual as agent for the individual shall be revoked if:

(1) A petition for annulment, divorce, legal separation, or termination has been filed and not dismissed or withdrawn;

(2) A decree of annulment, divorce, legal separation, or termination has been issued;

(3) The individual and the spouse or civil union partner have agreed in a record to a legal separation; or

(4) The spouse or civil union partner has abandoned or deserted the individual for more than one year.

Page 36, line 20 through Page 37, line 8.

§ -18 Powers of agent and default surrogate. (a) Except as provided in subsection (c), the power of an agent or default surrogate shall commence when the individual is found under section -4(b) or by a court to lack capacity to make a health care decision. The power shall cease if the individual later is found to have capacity to make a health care decision[~~, or the individual objects under section -5(c) to the finding of lack of capacity under section -4(b). The power shall resume if :~~

~~(1) The power ceased because the individual objected under section -5(c); and~~

~~(2) The finding of lack of capacity is confirmed under section -5(d)(4) or a court finds that the individual lacks capacity to make a health care decision.~~]

(b) An agent or default surrogate may request, receive, examine, copy, and consent to the disclosure of medical and other health care information about the individual if the individual would have the right to request, receive, examine, copy, or consent to the disclosure of the information.

(c) A power of attorney for health care may provide that the power of an agent under subsection (b) commences on appointment.

(d) If no other person is authorized to do so, an agent or default surrogate may apply for private health insurance and benefits on behalf of the individual. An agent or default surrogate who may apply for insurance and benefits shall not, solely by reason of the power, have a duty to apply for the insurance or benefits.

A default surrogate may act as a medicaid authorized representative, pursuant to federal and state medicaid laws relating to authorized representatives, on the individual's behalf for the purposes of medicaid, including assisting with, submitting, and executing a medicaid application, redetermination of eligibility, or other on-going

medicaid-related communications with the department of human services. For the purposes of medicaid, the default surrogate may access medicaid records of the individual on whose behalf the default surrogate is designated to act. For a default surrogate to be able to act under this subsection, the default surrogate shall agree to be legally bound by the federal and state authorities related to authorized representatives, including maintaining the confidentiality of any information provided by the department of human services, in compliance with all state and federal confidentiality laws.

The default surrogate's status as an authorized representative for the purposes of medicaid shall terminate when revoked by an individual who no longer lacks capacity, upon appointment or availability of another agent or guardian, or upon the individual's death.

(e) An agent or default surrogate shall not consent to voluntary admission of the individual to a facility for mental health treatment unless:

(1) Voluntary admission is specifically authorized by the individual in an advance health care directive in a record; and

(2) The admission is for no more than the maximum of the number of days specified in the directive or thirty days, whichever is less.

(f) An agent or default surrogate may consent to placement of the individual in a nursing home without specific authorization by the individual; provided that if the placement is intended to be for more than one hundred days an agent or default surrogate shall not consent to placement of the individual in a nursing home if:

(1) An alternative living arrangement is reasonably feasible;

(2) The individual objects to the placement; or

(3) The individual is not terminally ill.

Nothing in this subsection shall prevent an agent or default surrogate from consenting to placement of the individual in a nursing home for more than one hundred days if the individual specifically authorizes the agent or default surrogate to do so in an advance health care directive in a record.

Page 41, lines 8-13.

§ -19 Limitation on powers. (a) If an individual has a long-term disability requiring routine treatment by artificial nutrition, hydration, or mechanical ventilation and a history of using the treatment without objection, an agent or default surrogate shall not consent to withhold or withdraw the treatment unless:

(1) The treatment is not necessary to sustain the individual's life or maintain the individual's well-being;

(2) The individual has expressly authorized the withholding or withdrawal in a health care instruction that has not been revoked; or

(3) The individual has experienced a major reduction in health or functional ability from which the individual is not expected to recover, even with other appropriate treatment, and the individual has not:

(A) Given a direction inconsistent with withholding or withdrawal; or

(B) Communicated by verbal or nonverbal expression a desire for artificial nutrition, hydration, or mechanical ventilation.

[~~(b) A default surrogate shall not make a health care decision if, under other laws of this State, the decision:~~

~~(1) May not be made by a guardian; or~~

~~(2) May be made by a guardian only if the court appointing the guardian specifically authorizes the guardian to make the decision.~~]

Page 43, lines 12-14.

§ -21 Duties of health care professional, responsible health care professional, and health care institution. (a) A

responsible health care professional who is aware that an individual has been found under section -4(b) or by a court to lack capacity to make a health care decision shall make a reasonable effort to determine if the individual has a surrogate.

(b) If possible before implementing a health care decision made by a surrogate, a responsible health care professional as soon as reasonably feasible shall communicate to the individual the decision made and the identity of the surrogate.

(c) A responsible health care professional who makes or is informed of a finding that an individual lacks capacity to make a health care decision or no longer lacks capacity, or that other circumstances exist that affect a health care instruction or the authority of a surrogate, as soon as reasonably feasible, shall:

(1) Document the finding or circumstance in the individual's medical record; and

(2) If possible, communicate to the individual and the individual's surrogate the finding or circumstance [~~and that the individual may object under section -5(c) to the finding under section -4(b)~~].

(d) A responsible health care professional who is informed that an individual has created or revoked an advance health care

directive, or that a surrogate for an individual has been appointed, designated, or disqualified, or has withdrawn, shall:

(1) Document the information as soon as reasonably feasible in the individual's medical record; and

(2) If evidence of the directive, revocation, appointment, designation, disqualification, or withdrawal is in a record, request a copy and, on receipt, cause the copy to be included in the individual's medical record.

(e) Except as provided in subsections (f) and (g), a health care professional or health care institution providing health care to an individual shall comply with:

(1) A health care instruction given by the individual regarding the individual's health care;

(2) A reasonable interpretation by the individual's surrogate of an instruction given by the individual; and

(3) A health care decision for the individual made by the individual's surrogate in accordance with sections -17 and -18 to the same extent as if the decision had been made by the individual at a time when the individual had capacity.

(f) A health care professional or a health care institution may refuse to provide health care consistent with a health care instruction or health care decision if:

(1) The instruction or decision is contrary to a policy of the health care institution providing care to the individual and the policy was timely communicated to the individual with capacity or to the individual's surrogate;

(2) The care would require health care that is not available to the professional or institution; or

(3) Compliance with the instruction or decision would:

(A) Require the professional to provide care that is contrary to the professional's religious belief or moral conviction and if other law permits the professional to refuse to provide care for that reason;

(B) Require the professional or institution to provide care that is contrary to generally accepted health care standards applicable to the professional or institution; or

(C) Violate a court order or other law.

(g) A health care professional or health care institution that refuses to provide care under subsection (f) shall:

(1) As soon as reasonably feasible, inform the individual, if possible, and the individual's surrogate of the refusal; and

(2) Immediately make a reasonable effort to transfer the individual to another health care professional or health care institution that is willing to comply with the instruction or decision and provide life-sustaining care and care needed to keep or make the individual comfortable, consistent with accepted medical standards to the extent feasible, until a transfer is made.

Page 50, line 3.

§ **-24 Prohibited conduct; damages.** (a) A person shall not:

(1) Intentionally falsify, in whole or in part, an advance health care directive;

(2) For the purpose of frustrating the intent of the individual who created an advance health care directive or with knowledge that doing so is likely to frustrate the intent:

(A) Intentionally conceal, deface, obliterate, or delete the directive or a revocation of the directive without consent of the individual who created or revoked the directive; or

(B) Intentionally withhold knowledge of the existence or revocation of the directive from a responsible health care professional or health care

institution providing health care to the individual who created or revoked the directive;

(3) Coerce or fraudulently induce an individual to create, revoke, or refrain from creating or revoking an advance health care directive or a part of a directive; or

(4) Require or prohibit the creation or revocation of an advance health care directive as a condition for providing health care.

(b) An individual who is the subject of conduct prohibited under subsection (a), or the individual's estate, has a cause of action against a person that violates subsection (a) for statutory damages of $25,000 or actual damages resulting from the violation, whichever is greater.

(c) Subject to subsection (d), an individual who makes a health care instruction, or the individual's estate, has a cause of action against a health care professional or health care institution that intentionally violates section -21 for statutory damages of [~~$50,000~~] $5,000 or actual damages resulting from the violation, whichever is greater.

(d) An emergency department of a health care institution or health care professional who is an emergency medical services personnel or first responder personnel shall not be liable under subsection (c) for a violation of section -21(e) if:

(1) The violation occurs in the course of providing care to an individual experiencing a health condition for which the professional reasonably believes the care is appropriate to avoid imminent loss of life or serious harm to the individual or providing care;

(2) The failure to comply is consistent with accepted standards of the profession of the professional; and

(3) The provision of care does not begin in a health care institution in which the individual resides or was receiving care.

(e) In an action under this section, a prevailing plaintiff may recover reasonable attorney's fees, court costs, and other reasonable litigation expenses.

(f) A cause of action or remedy under this section shall be in addition to any cause of action or remedy under other law.

SB-1323-SD-2
Submitted on: 3/14/2025 6:57:57 PM
Testimony for HLT on 3/19/2025 9:05:00 AM

Submitted By	Organization	Testifier Position	Testify
Louis Erteschik	Hawaii Disability Rights Center	Comments	Remotely Via Zoom

Comments:

We oppose the so called Ulysses clause. It is nothing more than an attempt to get people to waive their legal and constitutional rights against involuntary medication. Aside from being bad policy, we question its validity and legality. If the individual changes their mind at the moment it would otherwise occur, we believe it may be unenforceable and would still require a Court order. We also question if the person who would administer the medication is really going to want to follow through without legal intervention.

At the Hearing before the Senate Health and Human Services Committee it was stated by the Deputy Attorney General that this was already current law and this bill merely provided additional procedural protections in the form of requiring witnesses. In discussions with the Deputy torney General our belief is that the current law merely contains general language which allows an individual to consent to a variety of treatment. This bill, however contains much more specific language which provides that the individual is waiving the right to revoke the consent. While we continue to oppose that, if the Legislature is inclined to support the provision we believe it would be appropriate to contain some sort of very clear language in the bill indicating that the person may be waiving their legal rights and any form which is ultimately developed by the state should state that in clear, plain language.

We continue to stand on our position and would urge caution before the Legislature incorporates this provision into Hawaii law.

March 19, 2025 at 9:05 am
Conference Room 329

House Committee on Health

To: Chair Gregg Takayama
Vice Chair Sue L. Keohokapu Lee-Loy

From: Paige Choy
AVP, Government Affairs
Healthcare Association of Hawaii

Re: Submitting Comments
SB 1323 SD 2, Relating to Health Care

The Healthcare Association of Hawaii (HAH), established in 1939, serves as the leading voice of healthcare on behalf of 170 member organizations who represent almost every aspect of the health care continuum in Hawaii. Members include acute care hospitals, skilled nursing facilities, home health agencies, hospices, assisted living facilities and durable medical equipment suppliers. In addition to providing access to appropriate, affordable, high-quality care to all of Hawaii's residents, our members contribute significantly to Hawaii's economy by employing over 30,000 people statewide.

Thank you for the opportunity to provide comments on this measure, which seeks to update the Uniform Health Care Decisions Act. While we appreciate efforts to clarify the decision-making framework for incapacitated patients, our members have concerns that some of the proposed changes could create confusion, delay necessary treatment, and increase liability risks for healthcare providers.

Under the proposed amendments, a patient is presumed to have capacity unless a physician makes a documented determination otherwise. However, if the patient objects to the finding of incapacity, providers must then treat them as if they have capacity, regardless of medical judgment. This structure introduces ambiguity into clinical decision-making, potentially requiring providers to act against their professional assessments of a patient's ability to make informed choices.

Additionally, the exceptions outlined in the amendments may create more issues than they resolve. Specifically, one exception allows providers to disregard a patient's objection to an incapacity determination only when:

1. The patient has a health condition requiring prompt treatment to avoid imminent loss of life or serious harm; and
2. A second healthcare professional confirms the lack of capacity.

This requirement for a second physician's confirmation could be impractical in urgent care settings and may lead to unnecessary delays in providing lifesaving or stabilizing treatment. In many scenarios, obtaining a second opinion in a timely manner is not feasible, particularly in rural or resource-limited settings. Requiring an additional medical determination in these cases may prevent providers from acting in a patient's best interest when time is of the essence.

Furthermore, the exception itself could expose providers to legal risk. The language requiring treatment only in cases of "imminent loss of life or serious harm" is subjective and may invite litigation. If a provider determines that urgent treatment is necessary and overrides a patient's objection, they could later face claims that the condition was not actually "imminent" or that the patient's objections should have been honored. This uncertainty places an undue burden on providers who are simply trying to act in accordance with medical best practices and protect patient well-being.

Lastly, we have concerns regarding the penalties, which can include a $50,000 fee for violations of certain sections. This seems like a particularly onerous penalty for healthcare providers who often work under zero or negative margins. We would suggest that penalties be removed or significantly lowered in this measure.

While we support efforts to ensure patient autonomy, these proposed changes could make clinical decision-making more cumbersome. We urge reconsideration of those particular amendments to ensure that providers can act in the best interests of patients without undue procedural burdens or legal risk. Thank you for the opportunity to submit comments.

TESTIMONY OF THE
COMMISSION TO PROMOTE UNIFORM LEGISLATION

on SB1323, SD2

RELATING TO HEALTH CARE (Adopts the Uniform Health-Care Decisions Act (2023) with amendments to replace chapters 327E and 327G, HRS. Effective 12/31/2050.)

BEFORE THE HOUSE COMMITTEE ON HEALTH

DATE: Wednesday, March 19, 2025, at 9:05 a.m.

PERSON SUBMITTING TESTIMONY:
PETER HAMASAKI, Commission to Promote Uniform Legislation

Chair Takayama, Vice-Chair Keohokapu-Lee Loy and Members of the Committee on Health:

My name is Peter Hamasaki, and I am a member of the State of Hawai'i Commission to Promote Uniform Legislation. Thank you for this opportunity to provide testimony in **support** of Senate Bill No. 1323, Senate Draft 2. This bill is the companion to House Bill No. 1004, which this committee passed in February, 2025.

Hawai'i previously adopted the Uniform Law Commission's ("ULC") 1993 version of Uniform Health-Care Decisions Act ("UHCDA"). Senate Bill No. 1323, Senate Draft 2, replaces the 1993 UHCDA with the updated version of the UHCDA which was approved by the ULC in 2023.

The 2023 UHCDA enables individuals to appoint agents to make health care decisions for them should they become unable to make those decisions for themselves, to provide their health-care professionals and agents with instructions about their values and priorities regarding their health care, and to indicate particular medical treatment they do or do not wish to receive. It also authorizes certain people to make health-care decisions for individuals incapable of making their own decisions but who have not appointed agents, thus avoiding the need to appoint a guardian or otherwise involve a court in most situations. In addition, it sets forth the related duties and powers of agents and health-care professionals, and provides protection in the form of immunity to both

under specified circumstances

Like the 1993 version adopted previously adopted by Hawai‘i, the 2023 UHCDA’s goals include: (1) acknowledging the right of a competent individual to make decisions about the provision, withdrawal or withholding of health care; (2) providing a single statute to govern both the appointment of a health-care agent and the recording of an individual’s wishes regarding their health care; (3) simplifying and facilitating the making of an advance health-care directive; (4) ensuring that decisions about an individual’s health care will be governed, to the extent possible, by the individual’s own desires; (5) addressing compliance with an individual’s instructions by health-care institutions and professionals; and (6) providing a procedure for resolution of disputes.

Some of the key benefits of the 2023 UHCDA are that it:

- ***Reduces unnecessary barriers to the execution of advance directives:*** By making it easier to create an advance directive, the 2023 UHCDA seeks to reduce the number of Americans who lack an advance directive. The 2023 UHCDA also authorizes the use of mental health care, or psychiatric, advance directives in a way that helps resolve conflicts between competing advance directives.
- ***Clarifies when agents may act:*** The 2023 UHCDA adds provisions clearly indicating when a surrogate’s power commences and addresses what happens if a patient objects to a surrogate making a decision for them. It also allows an individual to specifically authorize their appointed agent to obtain health information while the individual has capacity, thus allowing the agent to assist the individual in making health-care decisions.
- ***Clarifies agents’ powers and gives individuals the option to authorize special powers.*** For example, to reduce the likelihood that an individual’s health-care needs will go unmet due to financial barriers, the 2023 UHCDA authorizes a surrogate to apply for health insurance for a patient who does not have another fiduciary authorized to do so. It also provides that an agent has only those powers that are expressly authorized in the power of attorney that appointed the agent.
- ***Modernizes default surrogate provisions:*** The 2023 UHCDA updates the

priority list in the 1993 version to reflect a broader array of relationships, family structures, and living arrangements.

- ***Brings the definition of capacity and approaches to capacity determinations in line with modern practice:*** A surrogate's authority to make health-care decisions for a patient typically commences when the patient lacks capacity to make decisions for themselves. The 2023 UHCDA modernizes the definition of capacity to focus on an individual's *functional* abilities and clarifies that an individual may lack capacity to make one decision yet retain capacity to make others. The 2023 UHCDA also expands the list of health-care professionals who may determine that an individual lacks capacity.

The commission also offers the following comments on Senate Bill No. 1323, Senate Draft 2, for the committee's consideration.

- Section -2 contains a definition for "advance practice registered nurse"; we note that "advance practice registered nurse" also is defined in section 457-2, HRS, and the committee may wish to have a single, consistent definition.
- Section -11 provides for the Department of Health, in consultation with the Department of the Attorney General, to develop model forms. We note that the 2023 UHCDA contains an optional form, and we hope that this form will be considered in developing forms for Hawai'i.

A summary of the UHCDA prepared by the ULC is attached for the committee's additional information and reference.

Thank you very much for this opportunity to offer written testimony in support of this measure.

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UNIFORM HEALTH-CARE DECISIONS ACT (2023)

The Uniform Health-Care Decisions Act ("UHCDA") was promulgated by the Uniform Law Commission ("ULC") in 2023, reflecting a multiyear collaborative and non-partisan process to modernize and expand on the Uniform Health-Care Decisions Act approved by the ULC in 1993 ("1993 Act"). This Act enables individuals to appoint agents to make health-care decisions for them if they cannot make those decisions for themselves, provide their health-care professionals and surrogates with instructions about their values and priorities regarding health care, and indicate particular medical treatment they do or do not wish to receive. It also authorizes certain people to make health-care decisions for those incapable of making their own decisions who have not appointed an agent, thus avoiding the need to appoint a guardian or otherwise involve a court in most situations. In addition, it sets forth the related duties and powers of surrogates and health-care professionals, and provides protection in the form of immunity to both under specified circumstances. The Act seeks to improve upon the 1993 Act by drawing on decades of experience and knowledge about how people make health-care decisions and about the challenges associated with creating and using advance directives.

This Act shares the key goals of the 1993 Act, including: (1) acknowledging the right of a competent individual to make decisions about the provision, withdrawal or withholding of health care; (2) providing a single statute to govern the appointment of a health-care agent and the recording of an individual's wishes regarding the individual's own health care; (3) simplifying and facilitating the making of an advance health-care directive; (4) ensuring that decisions about an individual's health care will be governed, to the extent possible, by the individual's own desires; (5) addressing compliance with an individual's instructions by health-care institutions and professionals; and (6) providing a procedure for resolution of disputes.

The new Act reflects substantial changes in how health care is delivered, increases in non-traditional familial relationships and living arrangements, the proliferation of the use of electronic documents, the growing use of separate advance directives exclusively for mental health care, and other recent developments.

A state enacting it would repeal any statute governing the issues addressed in this Act, including the 1993 Act. Below are several key improvements of the Uniform Health-Care Decisions Act:

- This Act incorporates approaches designed to facilitate the use of advance directives. This is important because, although all states have enacted statutes enabling the use of advance directives, many adult Americans have never made one. Without an advance directive, individuals' wishes are less likely to be honored. In addition, their health-care professionals, family, and friends may struggle to determine how to make health-care decisions for them and to identify what decisions to make. The Act therefore seeks to reduce the number of Americans who lack an advance directive by reducing unnecessary barriers to execution of these documents.

- This Act adds clarity around when a surrogate may act by specifying when the surrogate's power commences. Patients, surrogates, and health-care professionals are all disadvantaged when it is unclear

whether a surrogate has authority to make decisions. In addition, it addresses an issue on which state statutes are typically silent: what happens if patients object to a surrogate making a decision for them.

- This Act adds provisions to guide determinations of incapacity, which is important because a surrogate's authority to make health-care decisions for a patient typically commences when the patient lacks capacity to make decisions. The Act modernizes the definition of capacity so that it accounts for the functional abilities of an individual and clarifies that the individual may lack capacity to make one decision but retain capacity to make other decisions. In addition, recognizing the growth of allied health professions, and that a variety of health-care professionals may have training and expertise in assessing capacity, the Act expands the list of health-care professionals who are recognized as being able to determine that an individual lacks capacity.

- This Act authorizes the use of advance directives exclusively for mental health care. Since the 1993 Act, many states have authorized such advance directives, sometimes called "psychiatric advance directives." Among other things, these allow individuals with chronic mental health challenges to provide specific instructions as to their preferences for mental health care and to choose to allow those instructions to be binding in the event of an acute mental health crisis.

- This Act modernizes default surrogate provisions that allow family members and certain other people close to a patient to make decisions in the event the patient lacks capacity and has not appointed a health-care agent. The new default surrogate provisions update the priority list in the 1993 Act to reflect a broader array of relationships and family structures. They also provide additional options to address disagreements among default surrogates who have equal priority.

- This Act clarifies the duties and powers of surrogates. For example, to reduce the likelihood that an individual's health-care needs will go unmet due to financial barriers, the Act authorizes a surrogate to apply for health insurance for a patient who does not have another fiduciary authorized to do so. It also provides that an agent only possesses those powers expressly authorized in the power of attorney that appointed the agent.

- This Act includes an optional model form that is designed to be readily understandable and accessible to diverse populations. The form gives individuals the opportunity to readily share information about their values and goals for medical care. Thus, it addresses a common concern raised by health-care professionals in the context of advance planning: that instructions included in advance directives often focus exclusively on preferences for particular treatments, and do not provide health-care professionals or surrogates with the type of information about patients' goals and values that could be used to make value-congruent decisions when novel or unexpected situations arise. The form addresses these concerns by providing options for individuals to indicate goals and values, in addition to specific treatment preferences.

For further information about the Uniform Health-Care Decisions Act, please contact Legislative Counsel Haley Tanzman at (312) 450-6620 or htanzman@uniformlaws.org.