

BILL ANALYSIS

C.S.H.B. 995
By: Wray
Judiciary & Civil Jurisprudence
Committee Report (Substituted)

BACKGROUND AND PURPOSE

According to interested parties, the law relating to medical power of attorney is in need of clarification to reflect contemporary developments in case law. C.S.H.B. 995 seeks to revise such law to clarify the effect of the dissolution, annulment, or voiding of the marriage of a principal whose spouse is the principal's agent and to make changes relating to the form of a medical power of attorney and related disclosure statement.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

C.S.H.B. 995, effective January 1, 2018, amends the Health and Safety Code to remove from the events that trigger the revocation of a medical power of attorney the divorce of the principal and spouse if the spouse is the principal's agent and to establish that an agent's authority under a medical power of attorney is revoked if the agent's marriage to the principal is dissolved, annulled, or declared void unless the medical power of attorney provides otherwise. The bill revises the statutory form for a medical power of attorney to incorporate the statutory form of the related disclosure statement.

C.S.H.B. 995 requires the executive commissioner of the Health and Human Services Commission to adopt all rules necessary to implement the bill's provisions, including the form necessary to comply with the bill's changes to the statutory form for a medical power of attorney, not later than December 1, 2017.

C.S.H.B. 995, effective January 1, 2018, repeals Sections 166.162 and 166.163, Health and Safety Code, relating to the disclosure statement concerning the medical power of attorney.

EFFECTIVE DATE

Except as otherwise provided, September 1, 2017.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 995 may differ from the original in minor or nonsubstantive ways, the following comparison is organized and formatted in a manner that indicates the substantial differences

between the introduced and committee substitute versions of the bill.

INTRODUCED

SECTION 1. The heading to Section 166.155, Health and Safety Code, is amended.

SECTION 2. Section 166.155, Health and Safety Code, is amended.

SECTION 3. Section 166.164, Health and Safety Code, is amended to read as follows: Sec. 166.164. FORM OF MEDICAL POWER OF ATTORNEY. The medical power of attorney ~~may~~ ~~must~~ be in ~~substantially~~ the following form: MEDICAL POWER OF ATTORNEY DESIGNATION OF HEALTH CARE AGENT.

I, _____ (insert your name) appoint:
Name: _____

Address: _____

Phone _____

_____ as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This medical power of attorney takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician.

LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT ARE _____ AS FOLLOWS: _____

DESIGNATION OF ALTERNATE AGENT.

(You are not required to designate an alternate agent but you may do so. An alternate agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved, annulled, or declared void unless this document provides otherwise.)

HOUSE COMMITTEE SUBSTITUTE

SECTION 1. Same as introduced version.

SECTION 2. Same as introduced version.

SECTION 3. Section 166.164, Health and Safety Code, is amended to read as follows: Sec. 166.164. FORM OF MEDICAL POWER OF ATTORNEY. The medical power of attorney ~~may~~ ~~must~~ be in ~~substantially~~ the following form: MEDICAL POWER OF ATTORNEY DESIGNATION OF HEALTH CARE AGENT.

I, _____ (insert your name) appoint:
Name: _____

Address: _____

Phone _____

_____ as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This medical power of attorney takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician.

LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT ARE _____ AS FOLLOWS: _____

DESIGNATION OF ALTERNATE AGENT.

(You are not required to designate an alternate agent but you may do so. An alternate agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved, annulled, or declared void unless this document provides otherwise.)

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following persons to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

A. First Alternate Agent

Name: _____

Address: _____

Phone _____

B. Second Alternate Agent

Name: _____

Address: _____

Phone _____

The original of this document is kept at:

The following individuals or institutions have signed copies:

Name: _____

Address: _____

Name: _____

Address: _____

DURATION.

I understand that this power of attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the power of attorney. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent continues to exist until the time I become able to make health care decisions for myself.

(IF APPLICABLE) This power of attorney

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following persons to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

A. First Alternate Agent

Name: _____

Address: _____

Phone _____

B. Second Alternate Agent

Name: _____

Address: _____

Phone _____

The original of this document is kept at:

The following individuals or institutions have signed copies:

Name: _____

Address: _____

Name: _____

Address: _____

DURATION.

I understand that this power of attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the power of attorney. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent continues to exist until the time I become able to make health care decisions for myself.

(IF APPLICABLE) This power of attorney

ends on the following date: _____
PRIOR DESIGNATIONS REVOKED.
I revoke any prior medical power of attorney.

[ACKNOWLEDGMENT _____ OF]
DISCLOSURE STATEMENT.

THIS MEDICAL POWER OF ATTORNEY IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance with your wishes, including your religious and moral beliefs, when you are unable to make the decisions for yourself. Because "health care" means any treatment, service, or procedure to maintain, diagnose, or treat your physical or mental condition, your agent has the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery, or abortion. A physician must comply with your agent's instructions or allow you to be transferred to another physician.

Your agent's authority is effective when your doctor certifies that you lack the competence to make health care decisions.

Your agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent has the same authority to make decisions about your health care as you would have if you were able to make health care decisions for yourself.

It is important that you discuss this document with your physician or other health care provider before you sign the document to ensure that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not

ends on the following date: _____
PRIOR DESIGNATIONS REVOKED.
I revoke any prior medical power of attorney.

[ACKNOWLEDGMENT _____ OF]
DISCLOSURE STATEMENT.

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Your agent's authority is effective when your doctor certifies that you lack the competence to make health care decisions.

Your agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent has the same authority to make decisions about your health care as you would have if you were able to make health care decisions for yourself.

It is important that you discuss this document with your physician or other health care provider before you sign the document to ensure that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not

understand, you should ask a lawyer to explain it to you.

The person you appoint as agent should be someone you know and trust. The person must be 18 years of age or older or a person under 18 years of age who has had the disabilities of minority removed. If you appoint your health or residential care provider (e.g., your physician or an employee of a home health agency, hospital, nursing facility, or residential care facility, other than a relative), that person has to choose between acting as your agent or as your health or residential care provider; the law does not allow a person to serve as both at the same time.

You should inform the person you appoint that you want the person to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions that you intend to have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf.

Once you have signed this document, you have the right to make health care decisions for yourself as long as you are competent, and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing your agent or your health or residential care provider orally or in writing or by your execution of a subsequent medical power of attorney. Unless you state otherwise in this document, your appointment of a spouse is revoked if your marriage is dissolved, annulled, or declared void.

This document may not be changed or modified. If you want to make changes in this document, you must execute a new medical power of attorney.

You may wish to designate an alternate agent in the event that your agent is unwilling, unable, or ineligible to act as your agent. Any alternate agent you designate has the same authority as the agent to make health care decisions for you.

THIS POWER OF ATTORNEY IS NOT VALID UNLESS:

- (1) YOU SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED

understand, you should ask a lawyer to explain it to you.

The person you appoint as agent should be someone you know and trust. The person must be 18 years of age or older or a person under 18 years of age who has had the disabilities of minority removed. If you appoint your health or residential care provider (e.g., your physician or an employee of a home health agency, hospital, nursing facility, or residential care facility, other than a relative), that person has to choose between acting as your agent or as your health or residential care provider; the law does not allow a person to serve as both at the same time.

You should inform the person you appoint that you want the person to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions that you intend to have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf.

Once you have signed this document, you have the right to make health care decisions for yourself as long as you are able to make those decisions, and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing your agent or your health or residential care provider orally or in writing or by your execution of a subsequent medical power of attorney. Unless you state otherwise in this document, your appointment of a spouse is revoked if your marriage is dissolved, annulled, or declared void.

This document may not be changed or modified. If you want to make changes in this document, you must execute a new medical power of attorney.

You may wish to designate an alternate agent in the event that your agent is unwilling, unable, or ineligible to act as your agent. If you designate an alternate agent, the alternate agent has the same authority as the agent to make health care decisions for you.

THIS POWER OF ATTORNEY IS NOT VALID UNLESS:

- (1) YOU SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED

BEFORE A NOTARY PUBLIC; OR
(2) YOU SIGN IT IN THE PRESENCE OF
TWO COMPETENT ADULT
WITNESSES.

THE FOLLOWING PERSONS MAY NOT
ACT AS ONE OF THE WITNESSES:

- (1) the person you have designated as your agent;
- (2) a person related to you by blood or marriage;
- (3) a person entitled to any part of your estate after your death under a will or codicil executed by you or by operation of law;
- (4) your attending physician;
- (5) an employee of your attending physician;
- (6) an employee of a health care facility in which you are a patient if the employee is providing direct patient care to you or is an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility; or
- (7) a person who, at the time this medical power of attorney is executed, has a claim against any part of your estate after your death.

By signing below, I acknowledge that [~~I have been provided with a disclosure statement explaining the effect of this document.~~] I have read and understand the [~~that~~] information contained in the above disclosure statement.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY. YOU MAY SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC OR YOU MAY SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES.)

SIGNATURE ACKNOWLEDGED BEFORE NOTARY

I sign my name to this medical power of attorney on _____ day of _____ (month, year) at

(City and State)

(Signature)

(Print Name)

BEFORE A NOTARY PUBLIC; OR
(2) YOU SIGN IT IN THE PRESENCE OF
TWO COMPETENT ADULT
WITNESSES.

THE FOLLOWING PERSONS MAY NOT
ACT AS ONE OF THE WITNESSES:

- (1) the person you have designated as your agent;
- (2) a person related to you by blood or marriage;
- (3) a person entitled to any part of your estate after your death under a will or codicil executed by you or by operation of law;
- (4) your attending physician;
- (5) an employee of your attending physician;
- (6) an employee of a health care facility in which you are a patient if the employee is providing direct patient care to you or is an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility; or
- (7) a person who, at the time this medical power of attorney is executed, has a claim against any part of your estate after your death.

By signing below, I acknowledge that [~~I have been provided with a disclosure statement explaining the effect of this document.~~] I have read and understand the [~~that~~] information contained in the above disclosure statement.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY. YOU MAY SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC OR YOU MAY SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES.)

SIGNATURE ACKNOWLEDGED BEFORE NOTARY

I sign my name to this medical power of attorney on _____ day of _____ (month, year) at

(City and State)

(Signature)

(Print Name)

State of Texas
County of _____
This instrument was acknowledged before
me on _____ (date) by
_____ (name of person
acknowledging).

NOTARY PUBLIC, State of Texas
Notary's printed name:

My commission expires:

OR
SIGNATURE IN PRESENCE OF TWO
COMPETENT ADULT WITNESSES

I sign my name to this medical power of
attorney on _____ day of _____
(month, year) at

(City and State)

(Signature)

(Print Name)

STATEMENT OF FIRST WITNESS.

I am not the person appointed as agent by
this document. I am not related to the
principal by blood or marriage. I would not
be entitled to any portion of the principal's
estate on the principal's death. I am not the
attending physician of the principal or an
employee of the attending physician. I have
no claim against any portion of the
principal's estate on the principal's death.
Furthermore, if I am an employee of a
health care facility in which the principal is
a patient, I am not involved in providing
direct patient care to the principal and am
not an officer, director, partner, or business
office employee of the health care facility or
of any parent organization of the health care
facility.

Signature: _____

Print
Name: _____

Date: _____

Address: _____

SIGNATURE OF SECOND WITNESS.

Signature: _____

State of Texas
County of _____
This instrument was acknowledged before
me on _____ (date) by
_____ (name of person
acknowledging).

NOTARY PUBLIC, State of Texas
Notary's printed name:

My commission expires:

OR
SIGNATURE IN PRESENCE OF TWO
COMPETENT ADULT WITNESSES

I sign my name to this medical power of
attorney on _____ day of _____
(month, year) at

(City and State)

(Signature)

(Print Name)

STATEMENT OF FIRST WITNESS.

I am not the person appointed as agent by
this document. I am not related to the
principal by blood or marriage. I would not
be entitled to any portion of the principal's
estate on the principal's death. I am not the
attending physician of the principal or an
employee of the attending physician. I have
no claim against any portion of the
principal's estate on the principal's death.
Furthermore, if I am an employee of a
health care facility in which the principal is
a patient, I am not involved in providing
direct patient care to the principal and am
not an officer, director, partner, or business
office employee of the health care facility or
of any parent organization of the health care
facility.

Signature: _____

Print
Name: _____

Date: _____

Address: _____

SIGNATURE OF SECOND WITNESS.

Signature: _____

Print
Name: _____
Date: _____
Address: _____

Print
Name: _____
Date: _____
Address: _____

SECTION 4. Sections 166.162 and 166.163, Health and Safety Code, are repealed.

SECTION 4. Same as introduced version.

SECTION 5. Not later than March 1, 2018, the executive commissioner of the Health and Human Services Commission shall adopt all rules necessary to implement this Act.

SECTION 5. Not later than December 1, 2017, the executive commissioner of the Health and Human Services Commission shall adopt all rules necessary to implement this Act, including the form necessary to comply with the changes in law made by this Act to Section 166.164, Health and Safety Code.

No equivalent provision.

SECTION 6. The change in law made by this Act to Section 166.164, Health and Safety Code, does not affect the validity of a document executed under that section before January 1, 2018. A document executed before the effective date of this section is governed by the law in effect immediately before the effective date of this Act, and the former law continues in effect for that purpose.

SECTION 6. This Act takes effect September 1, 2017.

SECTION 7. (a) Except as provided by Subsection (b) of this section, this Act takes effect September 1, 2017.
(b) Sections 1, 2, 3, 4, and 6 of this Act take effect January 1, 2018.