One Year In: NH Healthcare Surrogacy Decision-Making Law

By Katherine M. Hanna and Jason D. Gregoire

Adults have the right to make their own health care decisions, unless they are incapacitated. Until 2015, the only people who were able to make health care decisions for an incapacitated adult in New Hampshire were an agent appointed under a durable power for attorney for health care (DPOA-H), or a guardian appointed by the Circuit Court-Probate Division.

Given that most New Hampshire residents did not execute DPOA-H documents, providers and families were frequently forced to petition the Probate Division to appoint a guardian over the incapacitated person, an expensive and time-consuming process. Accordingly, during the 2015 legislative session, the General Court passed RSA 137-J:34-37, which allows a physician or nurse practitioner (APRN) to appoint a surrogate decision-maker from a priority list of eligible candidates, if they determine that a patient lacks capacity and: a) the incapacitated person lacks a valid DPOA-H and living will; b) the incapacitated person lacks a legal guardian; and/or c) the incapacitated person's authorized agent or guardian is incapacitated, not available, or refuses to act.

This article describes the operation of the New Hampshire surrogacy decision-making law, answers frequently asked questions, identifies ambiguities in the law, and discusses best practices for health care providers.

Operation of the Law

Once a physician or APRN has determined that a person lacks capacity and does not have an appointed agent or guardian available to make decisions, then the physician or APRN must make a "reasonable inquiry" as to the availability of possible surrogates. RSA 137-J:35, I(a)-(j) contains the following list of potential surrogates in order of priority: a) spouse or common law spouse; b) adult son or daughter; c) either parent; d) adult brother or sister; e) adult grandchildren; f) grandparent; g) adult aunt, uncle, niece or nephew; h) close friend; i) agent with a financial power of attorney or conservator of estate; or j) guardian of the estate.

If more than one person occupies a given category (e.g., two adult children), all of them must be identified as surrogates with equal standing to make decisions. If the appointed surrogates disagree about a particular health care decision, a majority shall control unless a minority party institutes guardianship proceedings.

Surrogacy does not take effect until the physician or APRN documents the surrogate's name, address, phone number, and relationship to the patient in the medical record. The surrogate must make a good faith effort to explore all avenues reasonably available to discern the desires of the patient.

The surrogacy lasts for 90 days, un-

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Frequently Asked Questions & Answers

What follows is a list of frequently asked questions and answers based on our experiences advising clients on the surrogacy law.

Q. Does this law apply to incapacitated minors?

A. No.

Q. The law does not mention stepchildren, stepparents, or half siblings. How should providers treat these categories in terms of surrogacy priority?

A. Regardless of whether the Legislature deliberately or inadvertently omitted these classes of relatives in the priority order for potential surrogates, the fact remains that pursuant to current New Hampshire law, they do not qualify to act as "surrogates."

Q. RSA 137-J:35, I requires a physician or APRN to conduct a "reasonable inquiry" as to the availability of potential surrogates. What is a "reasonable inquiry"?

A. New Hampshire law is silent on this issue, but the Illinois surrogacy law contains a similar requirement and defines "reasonable inquiry" as "including, but not limited to, identifying a member of the patient's family or other health care agent by examining the patient's personal effects or medical records. If a family member or other health care agent is identified, an attempt to contact that person by telephone must be made within 24 hours after a determination."

Q. RSA 137-J:37, I states that a patient can object to the selection or continued decision-making of a surrogate even he or she is incapacitated? Is that correct?

A. Yes. The right to object to a surrogate when incapacitated resembles the opt-out requirement in the NH DPOA-H form. The legal presumption is that the principal, even if incapacitated, may override his or her agent at any time, unless he or she checks a box to the contrary.

Q. What rights do divorced parents have with respect to surrogate decision-making?

A. Divorced parents of an adult are in the same priority category and have equal standing.

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nationwide, and Liberty claims in its response brief that "Vermont's reporting requirements concern the core of what ERISA plans do" and "interfere with nationally uniform plan administration."

ERISA establishes federal fiduciary standards for private pension plans. Congress passed ERISA in 1974 after a wave of investigations reported post-war generations of employees were enrolled in underfunded pension plans. Industry, however, was reluctant to agree to federal regulation unless free from state interference. Thus, ERISA includes a very broad "preemption" clause voiding all state laws to the extent that they "relate to" employer-sponsored benefit plans, whether they do so explicitly or have a substantial financial or administrative impact on benefit plans. *See* Section 514, 29 USC section 1144(a). Although ERISA focuses on pension plans, self-funded employee health benefit plans fall under ERISA's jurisdiction, leaving states with little say in how self-funded plans are administered.

Liberty lost its original challenge in the district court, but the Second Circuit reversed, and Vermont appealed to the United States Supreme Court. Vermont was joined by the United States in arguing that its claims reporting requirement "enables it to populate a database that is designed as a tool to assess and improve healthcare outcomes for Vermont residents," and the requirements do not have the requisite "connection" to ERISA plans to warrant preemption.

"States are uniquely positioned to improve quality of care and to control costs through the collection and publication of claims data," the United States argues in its *amicus* brief. "If States are unable to acquire such data from self-insured ERISA healthcare plans, their databases will be significantly less comprehensive and thus not as useful in developing health policy at both the state and national levels."

In one of the numerous *amicus* briefs filed in support of Vermont's position, the National Association of Health Data Organizations (NAHDO) casts doubt on Liberty's argument that APCD reporting is "onerous." National and uniform standards under the Health Insurance Portability and Accountability Act (HIPAA) already govern data aggregation programs, and data submission is part of the routine course of business for insurers and third-party administrators, NAHDO argues. Further, NAHDO states, Liberty's arguments fly in the face of "the long-standing consensus position of employers and business groups… that access to independent sources of claims and eligibility data is critical for health care reform."

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>
> – United States *amicus* brief
> *Gobeille v. Liberty Mutual Insurance Company*

If Liberty prevails, the impact on state data collection efforts will be substantial. More than 60 percent of employees who receive insurance through their employers are covered by self-funded insurance plans, and that percentage is growing. "Self-insured" means employers pay for each health claim as it is incurred, instead of paying a fixed premium to an insurance carrier. Self-insured employers typically hire a "third party administrator," often an insurance company, to administer the plan and claims process. Employers who choose to "self-fund" offer health benefit plans regulated by ERISA and the US Department of Labor, not state insurance departments.

During the argument Dec. 2, the justices seemed universally concerned about the states' interests in promoting health reform. However, Justices Samuel Alito and Antonin Scalia questioned why the Affordable Care Act amended ERISA by requiring additional health care claims reporting, but did not clarify whether state APCDs were "saved" from preemption. So too, many of the justices struggled with how each state could adopt a claims reporting statute, yet not cause "overly burdensome" regulation of self-insured benefit plans.

Justice Elena Kagan noted that there is value to states being able to consider their own health care needs, and "all the data that's being requested is data that Blue Cross Blue Shield generates anyway."

Justice Stephen Breyer asked whether perhaps the US Department of Labor could require ERISA plans to make such submissions to the states. When Liberty's counsel suggested Vermont could simply collect the data directly from the clinics and hospitals, however, Justice Anthony Kennedy argued back, noting it would certainly be a lot easier to "ask" health insurers for the data than "15 doctors in one small town…" Dec. 2, 2015, US Supreme Court Oral Argument Transcript.

The case will be decided by June 2016. The State of New Hampshire pleads that in passing ERISA, "Congress cannot have intended to eliminate state innovations like using transparency and market competition to control health costs." Health cost transparency is one of the few tools remaining to states, New Hampshire argued, "but these gains will be lost" if the Supreme Court finds that Vermont's law is preempted.

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less the person regains decision-making capacity, the Circuit Court-Probate Division appoints a guardian of the person, or the patient is determined to be near death, in which case the surrogacy automatically extends.

Surrogacy may be extended for successive 90-day periods, if the physician or APRN documents the extension in the medical record. Notably, however, the Legislature did not intend for surrogacy to be a long-term, decision-making measure. Therefore, guardianship proceedings should be initiated if it appears that the patient is going to lack capacity long-term.

Best Practices for Health Care Providers

It is important to remember that, like intestate succession, surrogacy should serve as a last resort – a backstop if all else fails. As a result, providers should encourage competent adults to execute DPOA-H and living will documents while they have capacity to avoid utilization of the surrogacy system and the appointment of "long lost Aunt Ethel" as a decision-maker. The Foundation for Healthy Communities (FHC) website has a wealth of free information, including free DPOA-H and living will forms, in addition to helpful materials on the surrogacy decision-making law, including a form surrogacy policy. See **http://www.healthynh.com**.

Because most New Hampshire residents have not executed a DPOA-H or living will, providers and facilities should adopt a surrogacy policy and train physicians, APRNs, and staff on the operation of the policy and RSA 137-J:34-37. The existence of clear policies and procedures will serve to avoid any confusion if a surrogate must be appointed.

These policies and procedures should encourage health care facilities and providers to obtain biographical information upon admission or arrival at your hospital or practice, in order to know whom to contact and how to contact them should the need for surrogacy arise. These policies should also contain a detailed description of how to determine capacity and to ensure that a physician or APRN has actually declared the patient incapacitated before designating a surrogate.

The health care surrogacy decision-making law has helped many providers, facilities, and families to avoid the time-consuming and expensive guardianship process and to secure prompt and sound decision-making in times of emergency or the need for informed consent.

Although RSA 137-J:34-37 contains some ambiguities that need to be fixed, this surrogacy system beats the old system under which providers were stuck in limbo between running to court and incurring thousands of dollars in legal fees, or improperly relying on unauthorized family members.

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