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is appealed to the state Court of Appeals, the process can go well beyond this two-year period. As of the Summer of 2005, the CON approval process for the expansion of Good Hope Hospital in Harnett County North Carolina has been dragging on for over four years. The law has fostered a contentious political and legal battle between Good Hope and other hospitals in the area that also involves Harnett County, the Town of Lillington and the City of Dunn. While this political warfare is taking place, costing millions of dollars, the people of the area could be benefiting from additional health care facilities.

CON Process:

Task			# Days to receive feedback
Submit letter of intent			0
Review period begins			0
CON Section makes decision			90-150
Denied/Approved =>	Petitions allowable for 30 days		120-180
	Judge makes recommendation =>	CON Section makes final decision	120-450
	Denied/Approved =>	NC Court of Appeals	Indefinite?

Source: Compiled by author using information from http://facility services.state.nc.us/cnpage.htm.

An April 2005 article in the *Triangle Business Journal* tells the story of a partnership of three neurologists who have spent three years and over $250,000 in an attempt to set up an MRI imaging center

in Garner, North Carolina. In this case the CON process has led to a battle between these doctors and hospitals in the region. This is not a healthy economic contest among suppliers of a service attempting to better serve health care customers, but rather a battle to win the favor of a government bureaucracy in an attempt to gain or keep a monopolistic cartel. Out of complete frustration, this group of neurologists is giving up. Competition for MRI services is denied and potential patients in Garner and the surrounding areas are deprived of taking advantage of the alternative that this physicians group was attempting to offer.[3]

It is quite clear that all important aspects of the production, distribution, and sale of health care services in North Carolina, and most other states, have been removed from the competitive free enterprise system and placed under the authority of a command-and-control government bureaucracy. And like all other bureaucracies, it promotes factionalism and division and allows some groups and institutions to suppress the activities of others. The market is run by government fiat rather than entrepreneurial insight and patient preferences.

History, Justification, and Application of CON

The origins of CON in North Carolina, and many of the other states that have such a system, rest in a long since repealed federal government mandate. In 1974, Congress passed the National Health Planning and Resources Development Act. The Act stated that in order to receive federal funding from programs like Medicare and Medicaid, new health care facilities, and additions to existing facilities, needed approval from a state agency established to issue certificates of need. All states were told to have such programs in place by 1980.

This was seen as a way of controlling health care costs. At the time, reimbursements for services were being made on the basis of

costs of production. It was thought that facilities were being built and equipment was being purchased unnecessarily simply because the hospitals knew the facilities would ultimately be paid for through increased fees. In a market setting where health care providers need to compete for cost-conscious purchasers of services, even if those purchasers are insurance companies, higher costs cannot simply be passed along in higher prices. New facilities would be built or new equipment would be purchased only if the market prices for the services that would be generated could justify the added costs. As with any business, expansions would be made only if it was thought they could be justified by actual demand. This is what entrepreneurship is all about: spotting actual or potential unfilled demand and organizing resources in new ways in order to meet it. If the demand isn't there, losses will be incurred and plans would have to be revised.

The government payment system at the time did encourage inefficient investment because it took the risk out of the process. Costs were recouped regardless of any failure to accurately estimate demand. Indeed the so-called "cost plus" system of reimbursement took away the need to consider future demand at all. The result was a classic case of an initial government intervention into market decision-making – in this case the Medicare and Medicaid programs – creating distortions of its own, which in turn are used to justify additional interventions: the CON program. As is typical, the new interventions lead to their own set of problems.

In 1987 Congress repealed its mandate and stopped subsidizing states that implemented it. This came after the federal government abandoned its cost-based reimbursement system and switched to paying a predetermined amount based on the kind of treatment. Since that time, 15 states have dropped their CON program, allowing for competition. North Carolina is one of 35 states, plus the District of Columbia, that continues with centralized planning of the health care facilities market.

Although cost containment, as noted, was and continues to be the primary justification for CON, there are other reasons given for keeping these laws in place. The most prominent are related to the provision of care for the indigent and include the arguments that:[4]

- Removal of CON will place a greater burden on the disadvantaged. The fear is that market forces will lead to certain segments of the population and those living in rural areas, being underserved.
- Removal will favor for-profit hospitals, which may be less willing to provide indigent care.
- Removal will lead to a proliferation of "low volume" facilities, which are associated by some with lower-quality care.

As an historical footnote, in the 1960s and early 1970s, prior to the federal mandate, more than 20 states had decided to implement CON laws independently, allegedly for cost-control reasons. According to Charles Gerena, writing for the Federal Reserve Bank of Richmond, these pre-mandate laws were implemented "in response to hospital operators who favored centralized health planning."[5] This is consistent with the economics of CON, to be discussed later, which suggests that in reality, CON is a cartel enforcement device that protects incumbent providers from new entrants and competition. According to East Carolina University researchers Campbell and Fournier, "there are reasons to suspect that CON may have been adopted for other purposes...the states most likely to enact CON...were those with a highly concentrated hospital industry and increasing competitive pressures...hospitals were largely in favor of CON regulation, which is understandable considering that it protected them

North Carolina is one of 35 states, plus the District of Columbia, that continues with centralized planning of the healthcare-facilities market.

from competition."[6] Much like existing restaurant owners in our opening example, having a government bureaucracy whose goal is to protect your business from upstarts is a nice perk.

In reality, the continuation of CON regulations cannot be justified either theoretically or empirically. In fact, from the perspective of sound economics, the reverse is true. If one desired to devise a policy for any market whose purpose would be to reduce efficiency, raise costs and prices, and reduce product quality, the existing CON programs would be highly recommended.

IF YOU LIKE OPEC, YOU'LL LOVE CON

When it comes to crude oil, it is indisputable that the ability to raise prices and therefore energy costs, rests with the power to restrict output and production. When President Bush met with Prince Abdullah of Saudi Arabia on April 25, 2005 to discuss high oil prices, the question immediately turned to the Organization of Petroleum Exporting Countries (OPEC), which raises prices by restricting production. Saudi Arabia, the largest oil producer in the world and the leader of OPEC, is seen as having the power to expand production and bring prices down.

Ironically, for those who support CON laws, it is thought that medical-care markets operate in the exact opposite manner, that the way to keep costs down is to restrict the supply of medical facilities and equipment.

Ironically, for those who support CON laws, it is thought that medical-care markets operate in the exact opposite manner, that the way to keep costs down is to restrict the supply of medical facilities and equipment. For example, if one wants MRI services to be less expensive, we need to have fewer MRI machines; if we want hospital stays to be cheaper, then what is needed is fewer hospital rooms.

As pointed out by The National Academy for State Health Policy in describing CON regulations: "Efforts to control the supply of services are well demonstrated by state Certificate of Need programs, which seek to limit the acquisition and dissemination of substantial investments in technology and capacity. These limitations are imposed in an effort...to hold down the volume of services provided and the cost."[7] In fact though, it is just as wrong-headed to think that limiting the supply of health care equipment and facilities can reduce health care costs, as it would be to think that oil prices could be brought down with further reductions in oil production.

There is possibly no proposition in economics that is more accepted than the idea that if you want to reduce the cost of something, you foster an environment that encourages open competition and entrepreneurship and discourages monopoly. But the role of competition goes well beyond this. Rivalry among businesses – and health care providers are no exception – stimulates new technologies and innovative and more efficient ways of delivering goods and services to customers. Existing providers continuously have to keep their costs low and their products desirable in order to fend off potential competitors looking for an opportunity to earn profits. These potential competitors, like the neurologists discussed previously who wish to provide MRI services, are always looking for ways to outperform existing providers. According to the *Triangle Business Journal*, these doctors had planned to offer greater convenience, newer technology, and lower prices than existing MRI facilities, which are predominantly owned and operated by full-service hospitals. They planned to locate in Garner, North Carolina, which has no MRI facilities,

Rivalry among businesses – and health care providers are no exception – stimulates new technologies and innovative and more efficient ways of delivering goods and services to customers.

making these services more convenient to patients and other doctors in the community. Furthermore, according to Dr. Daljit Buttar, one of the neurologist/entrepreneurs who has been fighting for the right to compete, their plan was to charge lower prices than the hospitals and to offer a new technology that provided a better view of the body.

As noted, CON laws turn the simple economic truths about the relationship between competition and lower prices and higher quality on their head. Proponents of CON laws do not refute the economics by presenting an alternative economic framework that would explain why an actual free market in medical-care facilities and equipment would not behave as economic theory would predict. Instead they suggest that standard economics should not be used as the basis for analysis at all, even though what is being assessed is at the heart of what economic science is about – market price and output formation and the efficient allocation of scarce resources.

What is and isn't excess capacity has to be determined in the marketplace and will be revealed through the system of profit and loss.

For example, The American Health Planning Association (AHPA), in criticizing a recent report by the Federal Trade Commission (FTC), disparagingly notes that the FTC grounds its opposition to CON laws in "orthodox economic doctrine." The AHPA suggests that to rely on standard economic theory, as opposed, I presume, to some non-orthodox economic theory or possibly some other social science, is to ground the analysis in "an article of faith."[8] This would be comparable to complaining that much of medicine and the analysis of patients' conditions by doctors is grounded in "orthodox" theories of biology and human anatomy.

In large part, the idea that increased supply leads to higher prices and costs stems from a basic premise that is clearly false; namely that

service duplication within a geographical area (defined by government planners) is inefficient and therefore cost enhancing. In justifying North Carolina's law, it is stated that "the costly proliferation of *unnecessary* health service facilities results in *costly duplication* and *underuse* of facilities, with the availability of excess capacity leading to *unnecessary* use of expensive resources and *over utilization* of healthcare services"[9] [emphasis added]. First, note the presumptuous and paternalistic attitude of the legislators formulating this statement. They claim to know better than health care consumers, their doctors, and facility operators, how "necessary" facilities are and that these market participants are "overutilizing" the health care that is available to them.[10] It should also be noted that the utter confusion of this statement is demonstrated by the fact that in the same sentence, it claims the free market somehow leads to both "the *underuse* of facilities" and the "*over utilization* of healthcare services" (huh?).

But more importantly, in a fundamental sense, the statement is proclaiming that monopoly is good. Facility duplication is at the heart of competition. Indeed, the definition of a monopoly market is one where there is no duplication. And this is why customers in monopoly markets lose. They are denied the option of turning to others who are providing "duplicated" services when the monopoly providers act like monopolists. Consider once again our team of neurologists. Would there be "excess MRI capacity" if they were allowed to enter the MRI market in Wake County? Apparently, some state bureaucrats, who are not market participants themselves, believe there would be. But the concept is meaningless. For example, because many Chinese restaurants, at a point in time, have empty tables, or some movie theaters have empty chairs, it doesn't mean there is inefficient excess capacity of restaurants or theaters. The new MRI facility would lead to more choice for patients and more competition for their health care dollars. Indeed, at the lower prices that could be generated, people who might forgo MRI exams for less expensive, but also less effective methods of diagnosis, may be able to take

advantage of the more advanced technology. What is and isn't excess capacity has to be determined in the marketplace and will be revealed through the system of profit and loss. Certainly there is no way for a health care central planner to second-guess the correct result.

The Evidence on CON and Costs

Not surprisingly, the evidence matches the economic theory. Since the 1980s when states were set free from the federal requirement to have CON laws, numerous studies have examined the change in health care costs as states eliminated their laws. If CON were "working" as advertised, then one would expect to see a rise in health care costs when the laws were eliminated. But in fact this is not the case. One of the most recent and widely referenced studies was written by Duke University Professors Christopher Conover and Frank Sloan and published in 1998 in the *Journal of Health Politics, Policy, and Law.*[11]

Their results are consistent with "orthodox" economics. Output restrictions lead to higher, not lower costs, and higher profits for existing providers. The authors point out that for hospitals, CON laws resulted in a 2 percent reduction in bed supply *and* "higher costs per day and per admission, along with higher hospital profits," exactly what economic theory would predict. The study did find a modest reduction in per capita "acute care" spending, which it attributed to CON laws. Interestingly, the study "was unable to detect a statistically significant effect of removing CON on these same expenditures." But overall, the study found no decrease in per capita health care spending attributable to CON.

Overall, the study found that CON was responsible for a 13.6 percent increase in per capita spending on personal health care services.

An earlier study showed even more dramatic results. This study examined data through 1982 and found that CON was associated with a 20.6 percent increase in hospital spending and a 9 percent increase in spending on other health care. Overall, the study found that CON was responsible for a 13.6 percent increase in per capita spending on personal health care services.[12]

Over the last two decades, the Federal Trade Commission has done several studies on the impact of CON laws, both nationally and for specific states. The FTC's consistent conclusion can be summarized in the language from its most recent study released jointly with the Department of Justice in July 2004. "The Agencies believe that CON programs can pose serious competitive concerns that generally outweigh CON programs' purported economic benefits. Where CON programs are intended to control health care costs, there is considerable evidence that they can actually drive up prices by fostering anticompetitive barriers to entry."[13]

In 1989, similar testimony was given to the North Carolina Goals and State Policy Board by FTC staff. The staff testified that "evidence does not support the view that Certificate of Need regulation reduces the costs of providing healthcare services...consumers would most likely be better served if CON regulations were removed."[14] As one study reports, "in researching the scholarly journals, one cannot find a single article that asserts that CON laws succeed in lowering healthcare costs."[15]

CON as a Hidden Health Care Tax

While the discussion to this point has focused on the economics of CON, it should be pointed out that there are other fallback arguments for these regulations that relate to the provision of care to the indigent. Oddly enough, the arguments from this perspective actually contradict the "cost saving" case for CON. The argument is that entry restrictions, and the higher prices and profits that go along with them, are necessary to induce providers to provide free indigent

care. As summarized in a study by Campbell and Fournier, "CON policies have...been pursued with the implicit aim of 'cross subsidization,' that is, regulators have used their power to issue licenses and restrict competition in order to create an incentive to hospitals to provide high levels of care to the indigent population."[16]

What this means is that CON laws are used to create a hidden tax. The cost of health care and the profits to health care providers are purposely kept high by granting monopoly privileges. It is then expected that these excess profits will be used to provide free health care to the indigent. Health care customers are forced to pay a premium created by CON laws and the proceeds from this premium are used to pay for indigent care. If nothing else, this is dishonest. If a social and political goal is to see to it that those who cannot afford health care have their needs taken care of, then the costs of that policy should be up front and explicit. This is the only way the electorate can make informed decisions regarding public policy. If it is deemed that those who are paying for health care services should bear the burden of also paying for care given to the indigent, then an explicit excise tax should be placed as a line item on all health care invoices, and CON laws should be abolished. If CON laws are being used to hide this tax from the electorate, then not only are they inconsistent with sound economics, they are also inconsistent with an open and democratic political process.

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Another way in which CON imposes a hidden tax on the health care system relates to the resources hospitals and other health care entrepreneurs must devote to obtaining the certificate. The process of obtaining a CON is not only time consuming but expensive. As

noted previously, in the case involving the group of neurologists from Garner seeking a CON for MRI equipment, over $250,000 was spent on what was ultimately a futile effort. This is not money that was spent on equipment or improving neurological services to patients. It was money spent to gain permission from the state to offer services to patients. Like any other tax, it is an additional cost of doing business that ultimately raises health care expenses across the board. This $250,000 is just one instance from many battles to gain CON "licenses" that are continuously being fought across North Carolina. As also mentioned previously, it has been reported that the effort by Good Hope Hospital in Harnett County has cost in the millions.[17]

Health Care Policy: Breaking the Consumption/Payment Link

Is health care over-priced? In many, if not most cases, the answer is yes. But this is not a problem that CON regulations can address. In fact, as argued previously, such laws are likely to contribute to the problem. The reason why health care may be overpriced is that, in most cases, what economists call "the consumption/payment link" is broken.

Because of government entitlement programs and the nature of modern health insurance, most people do not directly pay their own health care expenses. In 2002 over 84 percent of all personal health care expenditures were made by someone other than the person receiving the care.[18] Unlike the market for other goods and services, health care is consumed by the patient and, minus a co-pay or deductible, paid for by state and local government or by an insurance company operating a health care plan. Hence, the "consumption/payment link" that is typical of the clothing market, the computer market, or most other buyer/seller arrangements, is broken in the health care market.

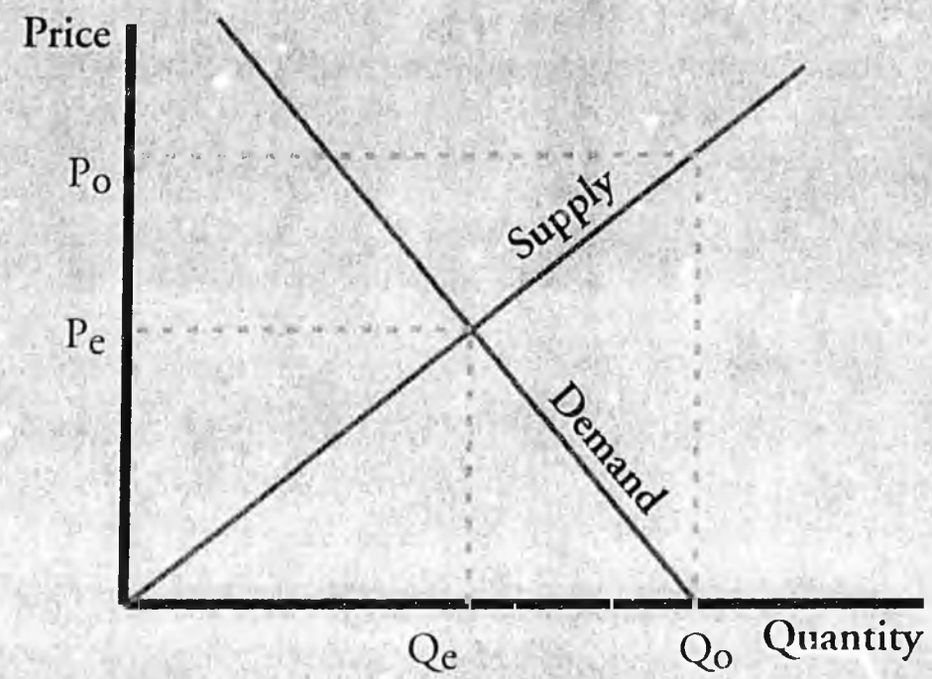
How is Health Care Like an All-You-Can-Eat Buffet or a Free Shopping Spree?

This arrangement causes health care to be over-priced because it leads to health care being over-consumed. People will generally consume more of any product when the amount paid is unrelated to the amount consumed. Furthermore, they will consume relatively more of what would otherwise be the highest-priced or higher-valued options. This is why people tend to "over-eat" at all-you-can-eat buffets. It also explains why, if there are crab legs or sirloin steaks on this buffet, people will tend to consume relatively more of those items than the hot dogs or beans.

Imagine if a grocery store operated like health care. Instead of walking up and down the aisles seeing different prices for different food items and making tradeoffs between prices and different kinds of products, we were all on an employer-paid-for "food insurance" plan. Whenever we needed groceries, we drove to the local supermarket and paid a fixed co-pay at the door. Once inside, we could simply take all the food products "we needed." As a food consumer, how might we behave? Would we take only "what we needed" or all that we could carry out? Would we go directly to the hot dogs and canned beans or would we find ourselves eating significantly more filet mignon and lobster? Clearly, the "purchase" of food overall and the proportion of lobster and high-priced cuts of meat relative to hot dogs and beans would increase. This would send the overall price of food and the "food insurance" premiums and co-pays through the roof. This is exactly what has been happening for decades in the health care market. [For a simple diagrammatical explanation of the economics involved in this phenomena see Diagram 1 on next page.]

DIAGRAM 1:

Breaking the Consumption/Payment Link



The graph shows the extreme case when the product is consumed by one person and the payment is made entirely by a third party. In a typical market, price would settle at P_e and the amount consumed would be Q_e. This is "market equilibrium" where quantity and price offered by the supplier is equal to the quantity and price that is acceptable to the demander. This is not typical of health care markets. The graph also shows the result when the price to the consumer is zero. At zero price, the consumer will want to purchase not Q_e but Q_o. But the supplier will only be willing to bring forth this greater supply of health care services at a higher price. In the graph above P_o shows the amount the supplier would need to receive in order to bring forth this greater quantity of services. In health care markets, depending on how much deductibles and co-pays are, the quantity consumed will be somewhere between Q_e and Q_o and the price will lie somewhere between P_e and P_o.

The Problem of Low Deductibles

The fact that many plans have low deductibles with routine health care problems being paid by insurance, rather than only high-cost operations and catastrophic conditions, also fuels the costs of health care. In the 1940s, '50s, and '60s, most people referred to health care insurance as "hospitalization insurance." This is because insurance mostly covered high-cost health problems that required operations and stays in the hospital. The effect of what is now called "first dollar coverage" or near first dollar coverage, i.e., plans with very low deductibles, can be seen if we imagine the effects of auto insurance that not only covered damage from accidents, but oil changes and tune-ups as well. If people showed up for an oil change and showed the mechanic an insurance card, the service shop would clearly be less concerned about keeping the price competitive, and the car owner would be less concerned about getting the best deal. The prices of oil changes, tune-ups, etc., would be much higher than they are today.

Isn't the Free Market Failing?

The current consumption and payment arrangements are not the result of a free market for health care, but a failed set of government policies. As noted, most people do not pay direcly for their own health care, but it goes beyond that. They don't even pay directly for, or even own their own health insurance policy, like they would with auto or homeowners insurance. Taxpayer-funded programs like Medicare and Medicaid pay nearly 45 percent of all health care bills.[19] The rest is mostly paid for by group health insurance policies that are owned by employers. For most types of insurance, such as auto, homeowners, and life, premiums are associated with the risks posed by the owners of the policy, i.e., those who are covered by the policy. The problem of over-consumption is tempered by the policy owner's desire to keep his or her premiums low. This market check is

not in place for health insurance. Those who are insured are not paying individual premiums for their insurance, and the amount being paid in premiums is not related to the risk associated with insuring individual policyholders. As noted, with few exceptions, there *are* no individual policyholders.

All the usual checks that would occur in a free market are missing. There are a number of reasons for this but the most important is related to the way health insurance is treated for income tax purposes. The tax code penalizes the individual ownership of health insurance policies and encourages the ownership of group policies by employers. Since WWII, health insurance provided by employers is considered a tax-free benefit to the employee, while personally owned health insurance plans must be paid for with after-tax income.[20] This has led to very generous and expensive low- or no-deductible plans offered by employers. In many cases a tax-free dollar offered in the form of a low- or no-deductible health insurance benefit is more valuable to an employee than a taxable dollar offered in the form of wages. So we end up in a situation where public policy has led to both an over-use of health insurance and health care services.

The current consumption and payment arrangements are not the result of a free market for health care, but a failed set of government policies.

The public policy answer to this problem is arriving, albeit tentatively and slowly, in the form of "health savings accounts" (HSAs), which were made legal as part of the Medicare Reform Act passed in 2003. The entire point of these accounts is to reconnect the consumption/payment link. These plans allow employers to offer high-deductible insurance plans to their employees, which have lower premiums. The employer then deposits a fixed amount each year into an individual HSA that is owned by the employee and where both the

amount deposited and any interest earned is tax exempt. The money in this account can be used to pay for expenses up to the deductible as well as other health care costs. In addition, any amount left in an HSA can be willed to the owner's heirs, who are not required to use this money for health care expenses. The important point is that any amount from this account that is not spent remains the property of the employee, to be used for either future health care problems, retirement income, or to make their children and grandchildren better off.

This approach reconnects consumption and payment for most routine health care related costs. A dollar spent on health care services now is a dollar that cannot be used later. As in other areas of income allocation, people will consider tradeoffs. By in part reconnecting the consumption/payment link, HSAs provide people with an incentive to be smarter and more cost-conscious health care consumers. In addition, this approach returns insurance to its original purpose: to manage risk of catastrophic medical expenses as opposed to being a form of "pre-payment" for routine medical services.

CON AND THE IMPOSSIBILITY OF CENTRAL PLANNING

As has been noted at several points throughout this paper, CON regulations are an attempt at complete central planning of investment in health care related facilities. The underlying premise is twofold. First is that individuals and companies acting in a free market will misallocate health care resources. As stated directly in North Carolina's CON law, 'if left to the market place to allocate health service facilities and health care services, geographical maldistribution of these facilities and services would occur..." and "the proliferation of unnecessary healthcare facilities [will] result in costly duplication."[21]

The second premise behind the law, implied by all that the law empowers the state to do, is that the state, through centralized

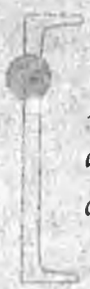
bureaucratic allocation of health care investment, can improve on market results, and better serve the public's health care needs. The point here is that even if the first premise, as tenuous as it is, is accepted, there is no reason to assume that a large-scale intervention, such as authorized by CON laws, can do anything to improve the situation.

This second assumption ignores all that the economics profession has learned over the last 50 years regarding command-and-control methods of resource allocation and the central planning of both economies in general and specific markets within economic systems. All of the reasons economists typically give regarding why economic central planning fails, apply to CON regulations.

In a free market, resource allocation is driven by entrepreneurs who try to predict what consumer demand is and will be for the future. Before a physicians group invests in MRI equipment, for example, they would want to be sure the community of patients they serve would bring forth enough business to eventually make that investment pay off. They have powerful market incentives to get it right. If their market analysis is wrong, they lose money and their entire practice suffers. In other words, the best judges as to whether the service will be "needed" are the entrepreneurs and investors themselves. It is the profit-and-loss system that works to efficiently allocate investment and to provide the information necessary for making wise investments. In the absence of CON, these medical entrepreneurs would be operating in all aspects of the health care market. Hospitals will continuously re-evaluate their circumstances to determine if new birthing rooms are needed, or an expanded emergency room is nec-

In a free market, resource allocation is driven by entrepreneurs who try to predict what consumer demand is and will be for the future.

essary, or if a new helicopter evacuation unit would be worthwhile. The key is that, in each of these cases, they have a strong incentive to accurately assess the market and the community's "needs." If they can't, they lose money and must divert revenues and resources from other, more worthwhile parts of their operations.



A good entrepreneurial decision is one that accurately assesses health care consumers' needs and survives the competitive pressures of the marketplace.

CON laws substitute bureaucratic decision-making for the market's entrepreneurial assessments. The problem is that the government decision-makers have no basis for gathering accurate market information and, furthermore, they have no incentive to make sure investments get made in the right places, at the right times, and in the right amounts. Unlike the case with private entrepreneurs, if their decisions prove to be wrong, there are no personal consequences borne by the planners responsible. In fact, there is no real way of determining after the fact whether or not a proper decision has been made. Whether or not a market decision makes economic sense is determined as part of the competitive economic process itself. A good entrepreneurial decision is one that accurately assesses health care consumers' needs and survives the competitive pressures of the marketplace. That is, it is a decision that satisfies consumer needs at least as well as, if not better than, existing and potential competitors.

For those who are granted membership in the CON-sponsored cartel, the real tests of the marketplace are foregone. In other words, the market forces that would ultimately determine whether a particular investment by a hospital, clinic, physician's practice, etc. truly served the needs of the community, are blocked. The bureaucrats that decide on CON do not, indeed cannot, actually determine whether

there is a need that will best be filled by a particular applicant because they are outside the market process that actually generates that information.

Economist Friedrich Hayek in his Nobel Laureate lecture, "The Pretense of Knowledge," argued that central planners, like those charged with determining who should and should not get to provide medical services, can only "pretend" to have the information necessary to make the kinds of decisions they claim to be making. At best, any determination of "need" by such planners will be arbitrary and will not reflect actual market conditions. At worst, these planners can become witting or unwitting tools of entrenched interests who wish to keep competition out of the market. As University of Pennsylvania analyst Mark Pauly noted, CON programs "tended to be 'captured' or dominated by the hospitals they were intended to regulate, and that those hospitals used regulation to keep out competition."[22]

The bureaucrats that decide on CON *do not, indeed cannot, actually determine whether there is a need that will best be filled by a particular applicant because they are outside the market process that actually generates that information.*

CONCLUSION

Certificate-of-Need Laws in North Carolina and other states should be repealed. State governments should not be aiding and abetting monopolies or their formation, or acting as a cartel enforcement mechanism for established health care interests. This is especially true in health care markets, where competition, which is widely recognized by economists as **the** most effective tool for driving costs down, is sorely needed. It is competition that provides the incentives to discover new technologies and new efficiencies for delivering those technologies to patients.

The idea that in the area of health care services, free market competition can't work as a means of cost control, is not grounded in either economic theory or empirical evidence. Indeed, in areas where competition is allowed to flourish, such as optometry, the customer is well served with plenty of options and competitive pricing. Furthermore, believing also that CON laws and the bureaucrats that administer them can do a better job than the competitive market process, is not only wishful thinking, it is the economic equivalent of believing the Earth is flat. Somehow, legislators have convinced themselves we can have the results of open competition by creating monopolies – as Orwell said, love is hate and war is peace.

Health care provision around the world is controlled by varying degrees of government central planning. Consequently, all systems tend to be dominated by different forms of health care market malfunctions. In countries like Canada and Great Britain, there are long queues and bottlenecks for vital services and treatments. In the United States, there are problems associated with high costs and affordability. None of these countries allow free markets and open competition. Government command-and-control has failed; it is time to let the free market work.

End Notes

(1) "North Carolina Division of Facility Services, Certificate of Need Section, Overview of CON Process," found at http://facility-services.state.nc.us/conpage.htm

(2) North Carolina General Statute. 131E, Article 9, §175-190, found at http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/ByArticle/Chapter_131E/Article_9.html

(3) Lee Weisbecker, "Doctor claims state's CON rules favor hospitals," *Triangle Business Journal*, April 29, 2005.

(4) Christopher J.Conover and Frank Sloan, "Does Removing Certificate of Need Regulations Lead to a Surge in Healthcare Spending?" *Journal of Health Politics, Policy and Law*, Vol. 23, No.3, June 1998.

(5) Charles Gerena, "Putting on the Brakes," *Region Focus*, Spring 2004, Federal Reserve Bank of Richmond. Found at www.richmondfed.org/publications/economic_research/region_focus/spring_2004/feature1.cfm

(6) Ellen S. Campbell and Gary Fournier, "Certificate-of-Need Deregulation and Indigent Hospital Care,"*Journal of Health Politics, Policy and Law*, Vol. 18, No. 4, 1993, p. 906.

(7) Ellen Jane Schneiter, et. al. "Rising Healthcare Costs: State Health Cost Containment Approaches," National Academy for State Health Policy, June 2002, p. 4.

(8) See "The Federal Trade Commission and Certificate of Need Regulations: An AHP Critique, January 2005, http://www.ahpanet.org/Con_issues.html and "Improving Healthcare: A Dose of Competition," a report by the Federal Trade Commission and the Department of Justice, 2004, www.ftc.gov. It should be pointed out that among economists "Marxist" and socialist economics is considered to be the most prominent of the non-orthodox or "heterodox" approaches to economic analysis. It will be argued below that CON are indeed grounded in fundamental principles of what is called "market socialism."

(9) Article 9, Certificate of Need, p.1. As will be discussed at length below, health care services are over-utilized, but not as a result of "the open market" but interventions that distort the market.

(10) In the section below titled "The Impossibility of Central Planning" this will be referred to as "a pretense of knowledge" which is a term coined by Nobel Prize-winning economist Friedrich Hayek.

(11) Op. cit. at note 6.

(12) Joyce A. Lanning and Michael Morrisey and Robert Ohsfeldt, "Endogenous Hospital Regulation and its Effects on Hospital and Non-Hospital Expenditures," *Journal of Regulatory Economics*, Vol, 3, No. 2, 1991 as cited in Ibid.

(13) "Improving Healthcare: A Dose of Competition," a report by the Federal Trade Commission and the Department of Justice, July, 2004, http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf

(14) From FTC press release found at http://www.ftc.gov/opa/predawn/F89/nc-con.txt.

(15) Patrick John McGinley, "Beyond Healthcare Reform: Reconsidering Certificate-of-Need Laws in a Managed Competition System," *Florida State University Law Review*, Vol. 23, No. 1, 1995.

(16) Campbell ES, Fournier GM, "Certificate-of-need Deregulation and Indigent Hospital Care," *Journal of Health Politics, Policy and Law*, Vol. 18, No. 4, 1993. Abstract found at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=8120351&dopt=Abstract

(17) From conversations with reporters covering the story for *The Daily Record* of Dunn, N.C.

(18) See http://www.census.gov/prod/2004pubs/04statab/health.pdf, table no. 120. "Personal Healthcare Expenditures by Object and Source of Payment: 2002"

(19) Ibid.

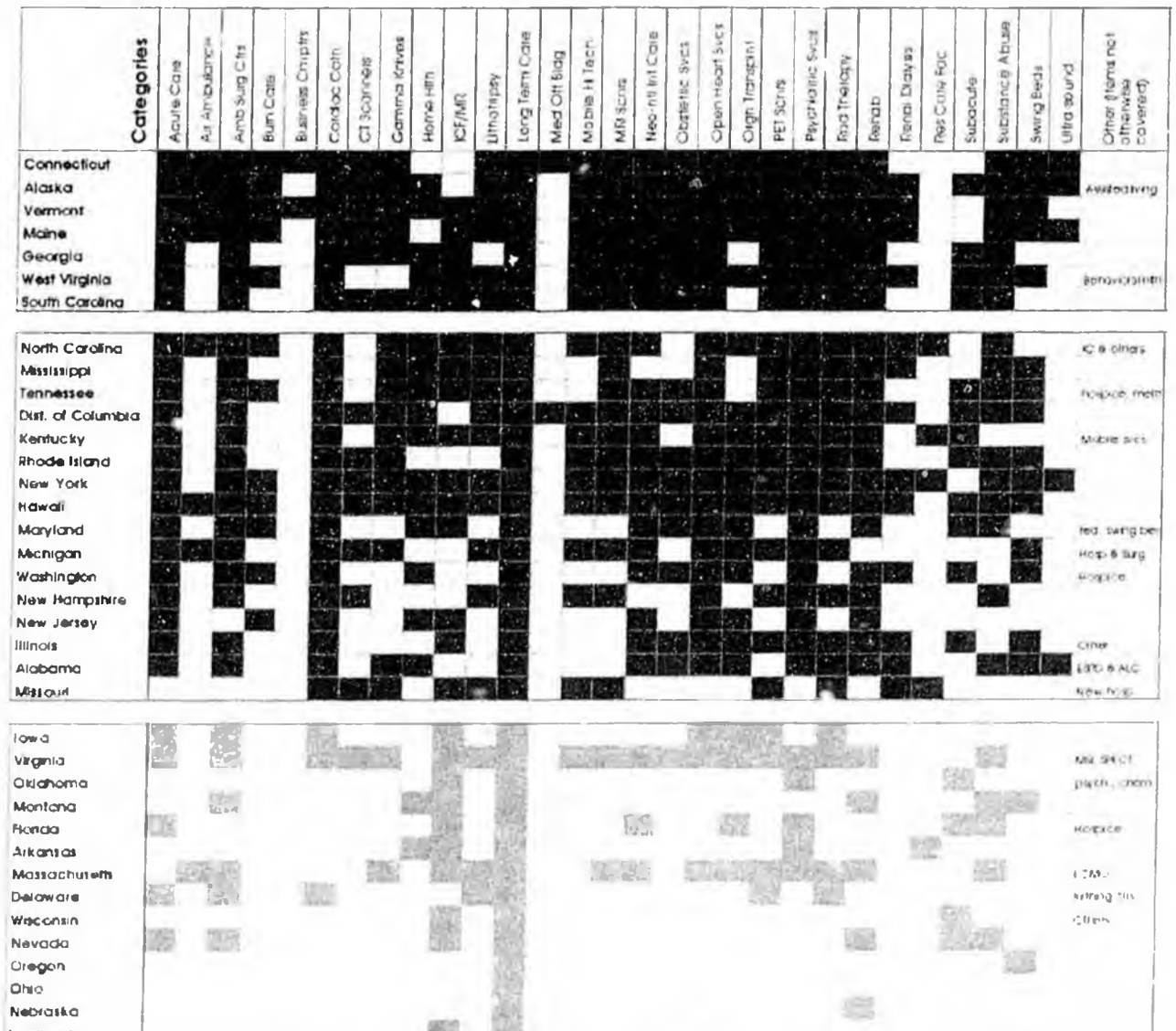
(20) This policy was implemented during WWII in order to get around strict controls on money wages. Tax-free benefits were then used as a way of attracting better employees.

(21) Op. cit. at note 2.

(22) As quoted by Terree Wasley, "Certificate of Need: Poor Healthcare Policy," Mackinac Center for Public Policy, June 17, 1993.

CON Regulated Services by State

(this information is summarized from the 2004 National Directory of Health Planning, Policy and Regulatory Agencies, the fifteenth edition published by the American Health Planning Association)



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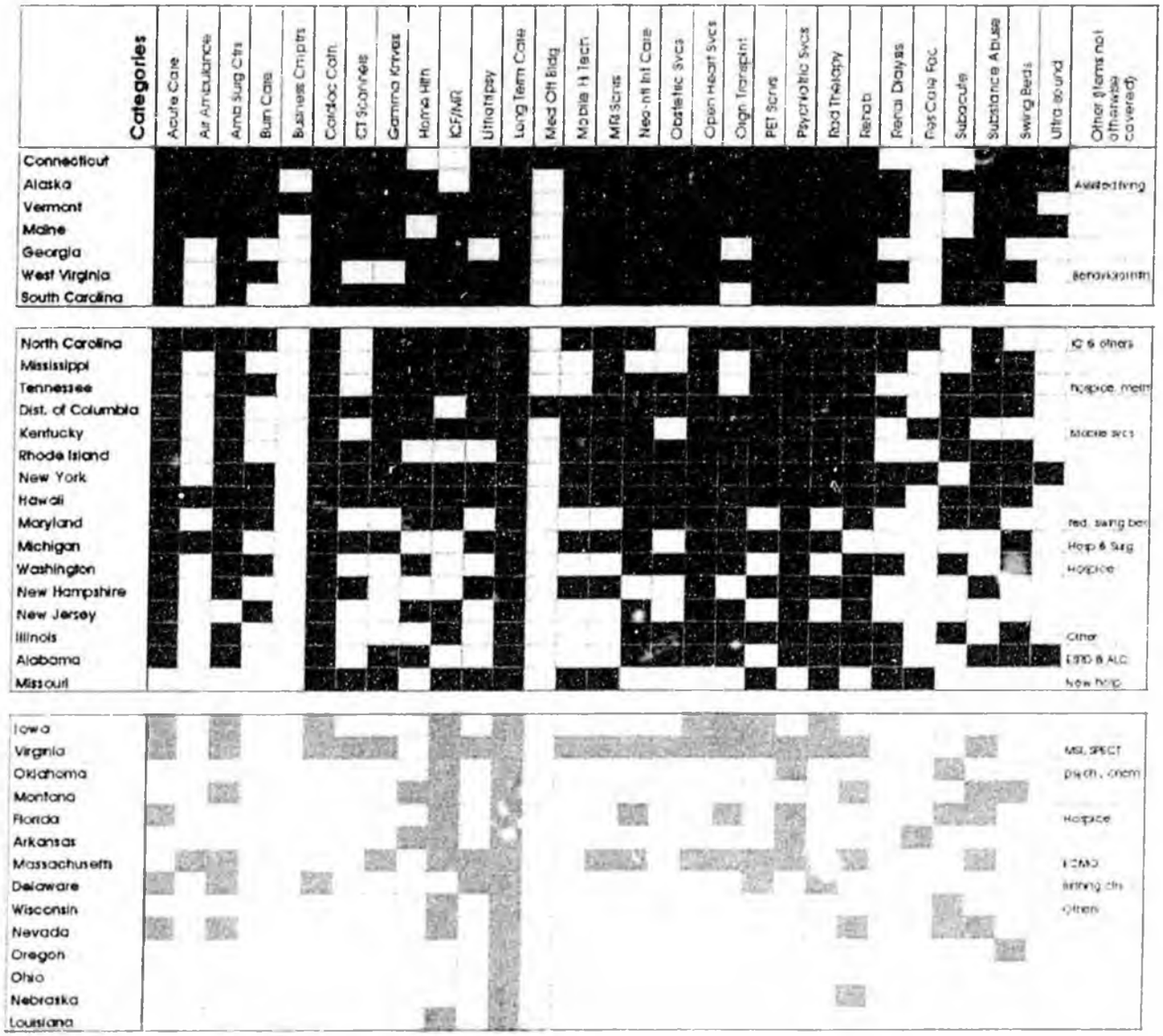


About the Author

Roy Cordato is Vice President for Research and Resident Scholar at the John Locke Foundation. He is also Visiting Faculty at the Economics Department at North Carolina State University where he is advisor to a student club and teaches "Political Economy of the Market Process," a course that he designed. From 1993-2000 he served as the Lundy Professor of Business Philosophy at Campbell University in Buies Creek, NC. From 1987 to 1993 he was Senior Economist at the Institute for Research on the Economics of Taxation (IRET) in Washington, D.C. He has served as full-time economics faculty at the University of Hartford and at Auburn University, and as adjunct faculty at Johns Hopkins University.

Cordato's publications include a 1992 book, *Welfare Economics and Externalities in an Open Ended Universe* (Kluwer Academic Publishers). His articles have appeared in a number of economics journals and law reviews in addition to *The Christian Science Monitor, The Washington Times, Investor's Business Daily, The Journal of Commerce, The Congressional Record, The Orange County Register, The Freeman, Human Events*, and many other newspapers and magazines. In 2000 he received the Freedoms Foundation's Leavey Award in Free Enterprise Education. He is also a member of the Mont Pelerin Society and former executive board member of The Association of Private Enterprise Education. Cordato holds an M.A. in urban and regional economics from the University of Hartford and a Ph.D. in economics from George Mason University. He also holds a Bachelors of Music Education from the Hartt School of Music.

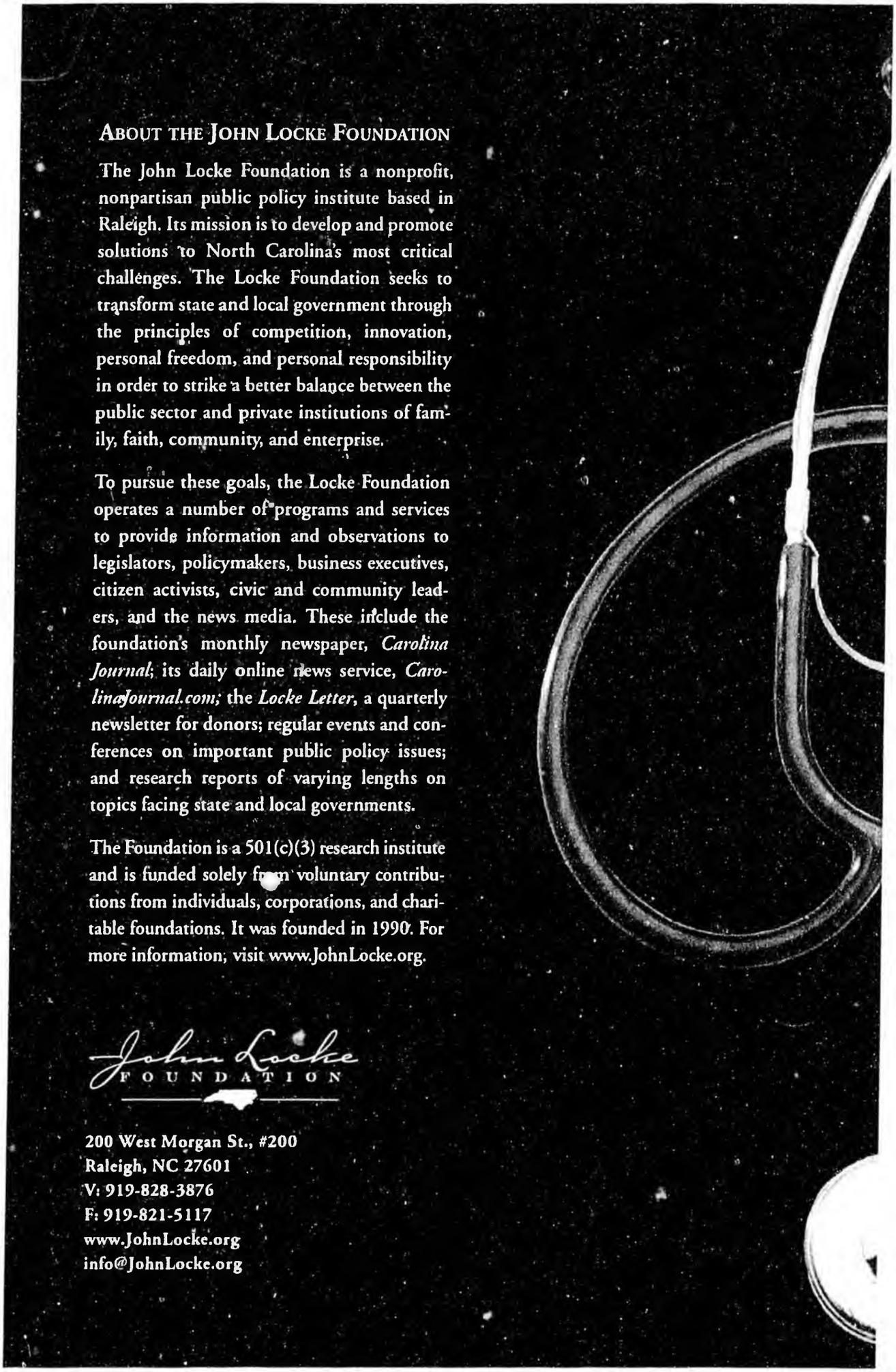
The author would like to thank John Locke Foundation intern Travis Fisher for his valuable assistance on this paper.

About the John Locke Foundation

The John Locke Foundation is a nonprofit, nonpartisan public policy institute based in Raleigh. Its mission is to develop and promote solutions to North Carolina's most critical challenges. The Locke Foundation seeks to transform state and local government through the principles of competition, innovation, personal freedom, and personal responsibility in order to strike a better balance between the public sector and private institutions of family, faith, community, and enterprise.

To pursue these goals, the Locke Foundation operates a number of programs and services to provide information and observations to legislators, policymakers, business executives, citizen activists, civic and community leaders, and the news media. These include the foundation's monthly newspaper, *Carolina Journal*; its daily online news service, *CarolinaJournal.com;* the *Locke Letter*, a quarterly newsletter for donors; regular events and conferences on important public policy issues; and research reports of varying lengths on topics facing state and local governments.

The Foundation is a 501(c)(3) research institute and is funded solely from voluntary contributions from individuals, corporations, and charitable foundations. It was founded in 1990. For more information, visit www.JohnLocke.org.



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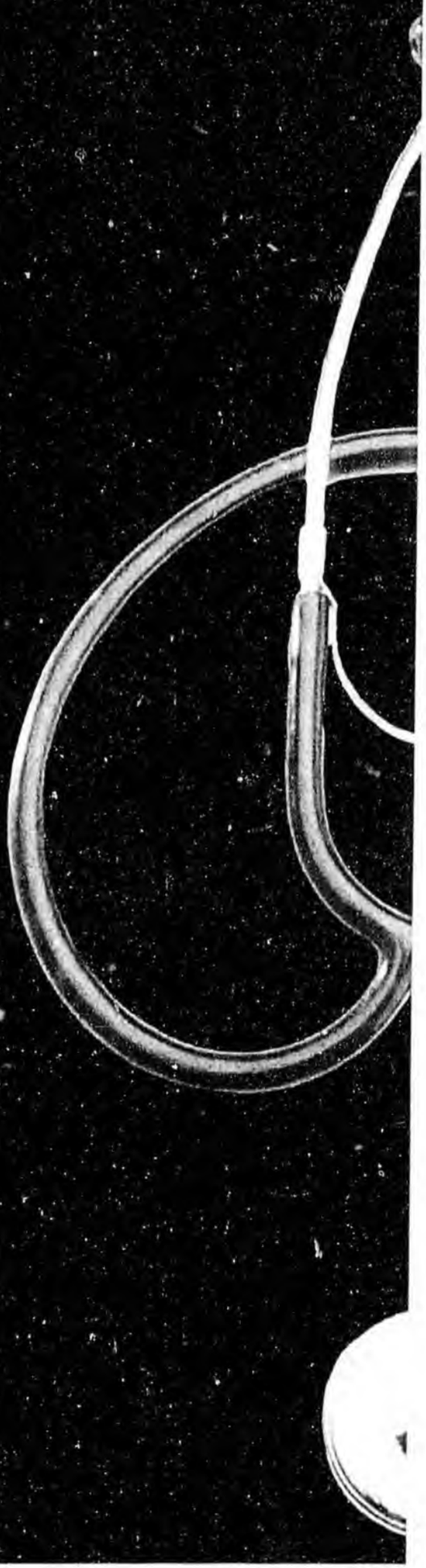

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HB

18

REPRESENTATIVE KEVIN MEYER

HOUSE DISTRICT 30

MEMORANDUM

DATE: January 30, 2006

TO: Representative Meyer

FROM: Mike Pawlowski

RE: Changes to HB 18 in Blank CS HB 18 (25-LS0131\M)

The Blank CS for HB 18 (25-LS0131\M) represents a merging of HB 18 (Rep. Meyer) and HB 55 (Rep. Kelly) with clarifying language suggested by the Alaska Commission on Post-Secondary Education.

Changes:

Section 1: Replaced section one of HB 18 with section 1 of HB 55 and inserted clarifying language on line 9 that specifies the program should admit **at least** 20 participants each year.

Section 2: Replaced **one-third** on page 2 line 7 with **50 percent** (new page 2 line 6) to bring the base obligation a program participant accrues in line with existing statute.

Replaced "student" with "program participant" throughout section 2 to better reflect the status of person under the WWAMI program since a person serving their residency is still under the program but not technically a student.

Email: Representative_Kevin_Meyer@legis.state.ak.us • **Toll Free:** (866) 465-4945
Session: State Capitol, Juneau, Alaska 99801-1182 • Phone: (907) 465-4945 Fax: (907) 465-3476
Interim: 716 W. 4th Ave., Anchorage, Alaska 99501-2133 • Phone: (907) 269-0199 Fax: (907) 269-0197

REPRESENTATIVE KEVIN MEYER

HOUSE DISTRICT 30

Sponsor Statement for House Bill 18

"An Act amending the functions and powers of the Alaska Commission on Postsecondary Education; and relating to the repayment provisions for medical education and postsecondary degree program participants."

Alaska currently has a shortage of physicians and the shortage is projected to get progressively worse over the next 20 years as Alaska's practicing physicians begin to retire. A physician shortage has serious implications for Alaskans access to quality medical care and can lead to increased costs for that care.

Alaska is one of five northwestern states that participate in a regional medical school referred to as WWAMI. WWAMI is an acronym for the participating states: Washington, Wyoming, Alaska, Montana and Idaho. Alaska currently places ten students per year at the University of Washington School of Medicine and these students become part of a class of 180 from the five participating states. To be eligible, students must have resided in Alaska for the previous two years and must spend their first year at the University of Alaska Anchorage before moving on to attend the University of Washington School of Medicine.

Under the WWAMI agreement, students pay in-state tuition at the University of Washington and the State of Alaska pays the difference. Students who enter the program must return to Alaska to practice or pay back the State's subsidy. House Bill 18 removes the limit on the number of students currently set in statute, decreases the amount a person is required to pay back if they don't return to Alaska and allows a person to defer their return to Alaska during their military or other specified public service.

Over its history, the WWAMI program has been effective at attracting physicians to practice in Alaska and has been ranked as the #1 Primary Care Medical School by U.S. News and World report for the past 12 years. Expanding the WWAMI program will help ease the pending physician shortage and provide better access to medical care throughout Alaska.

(Updated: 1/16/2007)

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REPRESENTATIVE KEVIN MEYER

HOUSE DISTRICT 30

MEMORANDUM

DATE: **January 16, 2007**

TO: **Representative Kevin Meyer**

FROM: **Mike Pawlowski**

RE: **Sectional Analysis for HB 18**
(Version No. 25 – LS0131\C)

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Allows the Alaska Commission on Postsecondary Education to enter into agreements to expand the number of Alaska residents eligible to participate in the WWAMI medical education program.

Section 2. Expands the requirement in 14.43.510(b) that requires a person to return to Alaska to practice in the specialty they received their medical degree in by inserting a more generic allowance that a person "actively engage in professional medical practice." decreases the amount a person who does not return to Alaska is required to pay backa to one-third of the state's subsidy. Allows a student to serve their residency, fellowship training or service with the military, U.S. Public Health Service or Indian Health Service before interest begins to accrue.

Section 3. Includes resident fellowship training or service with the military, U.S. Public Health Service or Indian Health Service in the activities that a person can perform before returning to Alaska to enter professional medical practice.

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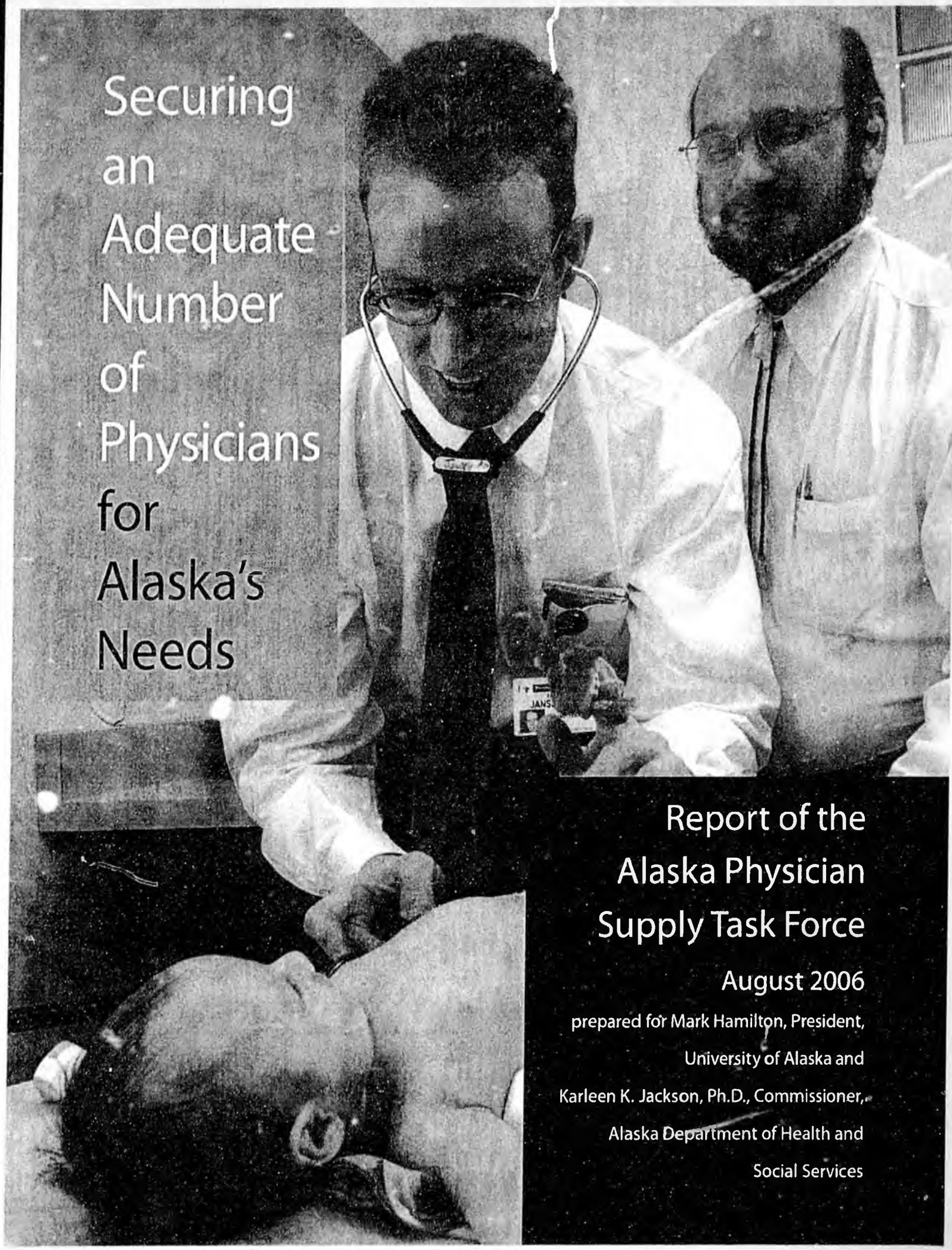
Securing an Adequate Number of Physicians for Alaska's Needs



Report of the Alaska Physician Supply Task Force

August 2006

prepared for Mark Hamilton, President, University of Alaska and Karleen K. Jackson, Ph.D., Commissioner, Alaska Department of Health and Social Services

Acknowledgements

The Alaska Physician Supply Task Force wishes to thank the staff for their time, diligence, and expertise provided throughout this project. We also thank all those who contributed their knowledge and expertise in providing information and comments on our report.

Task Force Members

Richard Mandsager, MD, State of Alaska Director of Public Health (Co-Chair)

Harold Johnston, MD, Director, Alaska Family Medicine Residency (Co-Chair)

Rod Betit, President, Alaska State Hospital and Nursing Home Association

Jan Gehler, Ph. D., Interim Provost, University of Alaska Anchorage

David Head, MD, Medical Director, Norton Sound Health Corporation, and Chair, Alaska State Medical Board, representing Alaska Native Tribal Health Consortium

Jim Jordan, Executive Director, Alaska State Medical Association

Karen Perdue, Associate Vice President for Health Affairs, University of Alaska

Dennis Valenzeno, Ph. D., Director, Alaska WWAMI Biomedical Program

Staff

Patricia Carr, Alice Rarig, Joyce Hughes, Stephanie Zidek-Chandler, and Jean Findley, from Health Planning and Systems Development Unit, Alaska Department of Health and Social Services, staffed the Task Force and coordinated production of the report.

Project Funding and Support

Funding to support the Alaska Physician Supply Task Force was provided by the University of Alaska Statewide, Office of the Associate Vice President for Health through federal grants from the Health Resources and Services Administration, Office of Rural Health Policy, Special Projects (#D1ARH00052) and Centers for Disease Control (#H75/CCH024673-01). Additional funding for staff time was provided through the Department of Health and Social Services: Health Planning and Systems Development's Alaska Office of Rural Health (HRSA #H95RH00135), State Planning Grant (HRSA #PO9HSO5505), Primary Care Cooperative Agreement (HRSA #U68CSO0157), and Rural Hospital Flexibility Program (HRSA #H54RH00014).

The Task Force members acknowledge the resources that were provided by our own organizations. Our organizations have supported our time, travel and related in-kind resources for the project.

Cover photo: Foreground, Andrew Janssen, M.D., a 2005 graduate of the Alaska Family Medicine Residency Program, examines 6-month-old Cooper Baines at the Providence Family Medicine Center in Anchorage, Alaska. Paul W. Davis, M.D., is shown in background. Photo by Greg Martin, 2005, courtesy of Providence Family Medicine Center.

Securing an Adequate Number of Physicians for Alaska's Needs

Report of the
Alaska Physician Supply Task Force

Prepared for
Mark Hamilton, President, University of Alaska and
Karleen Jackson, Ph.D., Commissioner, Alaska Department of Health & Social Services

August 2006

Table of Contents

List of Figures

Executive Summary

The Alaska Physician Supply Task Force was commissioned in January 2006 by the President of the University of Alaska and the Commissioner of the Department of Health and Social Services to address two questions:

1. What is the current and future need for physicians in Alaska?
2. What strategies have been used and could be used in meeting the need for physicians in Alaska? Strategies of interest are:

    - programs to attract and prepare students for health careers;
    - medical school opportunities;
    - graduate medical education; and
    - recruitment and retention of physicians.

The Task Force has met regularly and drawn on a wide variety of sources of information, including public participation. The consensus of the Task Force is that this report represents the best answer possible to these questions, within the constraints of time and budget, and the inherent uncertainties of available data and predictions. The major conclusions and reasoning of the group are summarized here, and detailed in the body of the report.

Alaska has a shortage of physicians.[1] Although not at crisis levels, the shortage is affecting access to care throughout the state, and increasing cost to hospitals and health care organizations. Up to 16% of rural physician positions in Alaska were vacant in 2004. Patients with Medicare are having difficulty finding a primary care physician. Several important specialties are in serious shortage in Alaska.

The shortage is very likely to worsen over the next 20 years as the state's population increases and ages. Physician supply nationwide is entering a period of shortage, according to the best current predictions. Physicians in Alaska are aging and one-third may be retiring in the next 10-15 years. The new generation of physicians wants a more balanced life, meaning fewer hours on duty and more predictable schedules. These trends mean that more physicians will be required to serve the same population. Technology and scientific advances have increased the amount of medical care available, adding to the need for physicians, as the patients expect more care than previously.

As the national supply of physicians shrinks, recruitment will become more competitive. Alaska's traditional system of recruiting physicians from federal assignment in the military and Indian Health Service is much less effective with changes in these systems. Although Alaska has two very successful programs to produce its own physicians, the Alaska WWAMI medical school program and the Alaska Family Medicine Residency,

[1] Unless otherwise specified, "physician" in this report means medical doctor as well as doctor of osteopathy.

Alaska is far behind the other states in production capacity. These two programs, even if expanded, cannot meet the need.

The current trend in physician growth in Alaska is inadequate to keep up with basic population growth and to correct the current deficit. Unless changes are made in the systems used to increase physician numbers, the deficit will worsen, with significant consequences for access and quality of care for Alaskans, as well as increased cost for health care delivery systems.

The time frames to increase physician supply are long; it takes from seven to 13 years from entry into medical school to entry into practice. The time it takes to develop new or expanded programs adds to this delay. It is important to act quickly to begin the programs that will yield more physicians in the next two decades. Delay will only add to the cost and worsen the deficit to recoup.

Responses to this problem involve preparing and attracting Alaskan youth so they can enter medical careers, improving recruitment of physicians to practice in Alaska, and retaining the physicians who currently practice here. The Task Force recommends specific strategies and action steps to achieve four goals related to assuring an adequate supply of physicians to meet Alaska's need.

Goals:

1. Increase the in-state production of physicians by increasing the number and viability of medical school and residency positions in Alaska and for Alaskans.
2. Increase the recruitment of physicians to Alaska by assessing needs and coordinating recruitment efforts.
3. Expand and support programs that prepare Alaskans for medical careers.
4. Increase retention of physicians by improving the practice environment in Alaska.

The following sections summarize the findings of the Alaska Physician Supply Task Force supporting these goals. The body of the report contains the full discussion of the goals, strategy recommendations, and the rationale behind the recommendations.

Assessment of need. The Task Force estimates that Alaska has a shortage of 375 physicians, based on the conclusion that Alaska should have 110% of the current national average physician-to-population ratio. In order to correct the deficit and reach an adequate supply of physicians by 2025, Alaska needs to add a net of 59 physicians per year, starting immediately. Alaska currently gains 78 physicians per year but loses 40 physicians yearly for various reasons. In order to improve its doctor to population ratio, and assure having an adequate supply in 20 years, the current net gain of 38 physicians per year will need to increase to 59 per year, more than a 50% increase. If the loss each year is greater than the recent average of 40 per year, Alaska will need more than 90 physicians to enter practice in Alaska each year.

These conclusions are supported by the following findings.

Finding 1. The ratio of physicians to population in Alaska is below the national average at 2.05 MDs per 1000 population vs. 2.38 MDs per 1000 population in the US.

Finding 2. Alaska should have 10% more physicians per population than the national average because Alaska's rural nature, great distances and severe weather result in structural inefficiencies of the health care system. Alaskan physicians' administrative and supervisory responsibilities in addition to patient care contribute to the need for more physicians to provide patient care services.

Finding 3. Competition for physicians will intensify since the entire nation is expected to experience a shortage of physicians, associated with the aging of the population and an inadequate production of physicians.

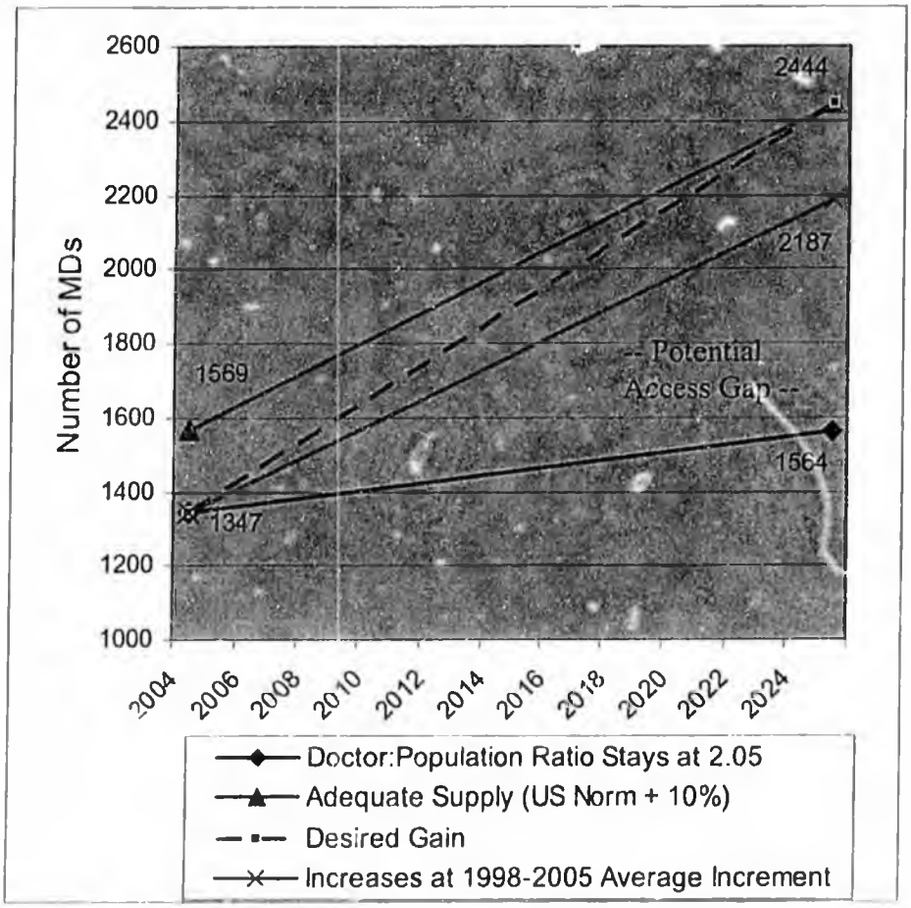
Finding 4. Retirement and practice reductions of aging physicians in Alaska and elsewhere, as well as changing preferences of physicians for more limited work hours, add to the need for more physicians.

Finding 5. Alaska has and should maintain a higher ratio of mid-level providers (advanced nurse practitioners and physician assistants) to physicians than the national average, in order to make it feasible to provide high quality and timely care to the population. Without these providers the need for physicians would be even higher.

Finding 6. Shortages are most apparent in internal medicine, medical subspecialties and psychiatry. It is important to evaluate the need for specialty types and distribution throughout Alaska, in order to plan for physician recruitment.

Over the next twenty years, nearly twice as many "physicians in practice" will be needed – about 1100 more than the current 1347 MDs in patient care – to meet expected demand as the state's elderly population triples and as medical practice patterns change. This projection assumes that doctors of osteopathy, advanced nurse practitioners and physician assistants will continue to increase proportionately over time.

Figure A. Gain in Alaskan Physicians: Static Doctor to Population Ratio vs. Desired Growth Scenario



Source: Based on HPSD analysis (AMA Master File 2006)

Basis for strategies for meeting the need for physicians for Alaska's health care system. After investigating the supply and need for physicians and reaching Findings 1- 6, the Task Force shifted its focus to investigating strategies for meeting the need. The Task Force drew on the knowledge of in-state professionals and educators, and of national experts, to identify lessons and information that form the basis for recommendations for action, as well as for further investigation and monitoring. The Task Force's selection of strategies is based on the following findings.

Finding 7. Alaska is one of six states without an independent in-state medical school. Alaska funds ten state-supported "seats" at the regional WWAMI medical school, administratively centered at the University of Washington School of Medicine. This number (10 seats) represents fewer seats per capita than all but five of the 50 states.

Finding 8. Residency programs are one of the most effective ways to produce physicians for a state or community. Alaska has only one in-state residency, the AFMR, which places 70% of its graduates in Alaska.

Maintaining and expanding residency opportunities will be critical in augmenting Alaska's physician numbers.

Finding 9. Over the last ten years, an increasing number of Alaskan students have applied to medical schools; the average number of applicants has been 65. In 2005, 29 of 73 applicants were admitted into medical school. Ten per year attend WWAMI and the remainder attends medical schools without state support from Alaska. Since 1996, only WWAMI has had Alaska-supported seats. Prior to 1996, Alaska supported programs for medical and osteopathic students through the WICHE program and student loans.

Finding 10. Recruitment for physicians is facilitated by the availability of loan repayment programs such as the IHS and NHSC loan repayment programs. Service obligations related to student loans have historically accounted for some recruitment and should be explored.

Finding 11. There are several initiatives to increase interest in medical careers among Alaskans, including efforts by the tribal health care system, hospitals, the University of Alaska's newly funded Area Health Education Center (AHEC) and the UA Scholars Awards, school system initiatives for improvement of math and science programs, and programs that encourage students to go into health careers. Collectively, these initiatives generate qualified applicants to medical schools, but too few applicants matriculate to replenish Alaska's shortage, and there is inadequate diversity.

Finding 12. Medical practice environments in Alaska have positive and negative aspects that affect the recruitment and retention of physicians.

Finding 13. Surveys of providers (physicians and mid-levels) by the AMA and many states have provided data on practice characteristics, preferences, and retirement plans.

Finding 14. Workforce development activities exist in multiple locations including the tribally managed system, private sector, and various state and federal agencies. However existing programs are not monitoring or analyzing specialty distribution or needs, changing roles of mid-level providers, or potential impact of electronic health records on all providers. Coordination of the efforts, and research and analysis of relevant trends, should inform policy.

In view of these findings, the relevant literature, and the experience of other states, the Task Force developed the following goals and strategies to respond to the physician shortage. The strategies are chosen because of their likely effectiveness, cost-to-benefit advantages, and achievability. Each strategy is discussed with respect to the time frame in which it will be effective, and the average expected cost to the state to produce each practicing physician, where such information is reasonably accessible. The listing below

gives a brief identification of each goal and strategy. Full discussion of the strategies is included in the body of the report.

Goals and Strategies for Securing an Adequate Physician Supply for Alaska's Needs

Major Goal	Strategy	Timeline for Impact	Estimated Cost
1. Increase the in-state production of physicians by increasing the number and viability of medical school and residency positions in Alaska and for Alaskans.	A. Increase the number of state-subsidized medical school positions (WWAMI) from 10 to 30 per year	Medium	$250,000 per practicing physician
	B. Ensure financial viability of the AFMR through state support including Medicaid support	Short	$60,000 per practicing physician
	C. Increase the number of residency positions in Alaska, both in family medicine and appropriate additional specialties	Short	$100,000 per year plus $30,000 for planning in year 1 & 2
	D. Assist Alaskan students to attend medical school by: i) reactivating and funding the use of the WICHE Professional Student Exchange Program with a service obligation attached, and ii) evaluating the possibility of seats for Alaskans in the planned osteopathic school at the Pacific Northwest University of the Health Science	Medium	i) $550,000 per practicing physician for WICHE; ii) cost unknown at time of PSTF report
	E. Investigate mechanisms for increasing Alaska-based experiences and education for WWAMI Students	Medium	Unknown at time of PSTF Report
	F. Maximize Medicare payments to teaching hospitals in Alaska	Short	Zero cost to the state

	G. Empanel a group to assess medical education in Alaska, including the viability of establishing an Alaska-based medical school	Long	Undetermined at time of PSTF Report
2. Increase the recruitment of physicians to Alaska by assessing needs and coordinating recruitment efforts.	A. Create a Medical Provider Workforce Assessment Office to monitor physician supply and facilitate physician recruitment efforts	Short	$250,000 per year
	B. Research and test a physician re-location incentive payment program	Short	$65,000 per physician
	C. Expand loan repayment assistance programs and funding for physicians practicing in Alaska	Short	Undetermined – need to consult with other states
3. Expand and support programs that prepare Alaskans for medical careers	A. Expand and coordinate programs that prepare Alaskans for careers in medicine	Medium	Up to $1,000,000 per year
4. Increase retention of physicians by improving the practice environment in Alaska.	A. Develop a physician practice environment index for Alaska	Short	$100,000 to develop index; $20,000 annually to update
	B. Develop tools that promote community-based approaches to physician recruitment and retention	Short	$50,000 per year
	C. Support federal tax credit legislation Initiative for physicians that meet frontier practice requirements	Short	Zero cost to the state

Adoption of these strategies will depend on further analysis of resources and a balancing of effectiveness and achievability. Strategies to recruit and retain physicians promise the earliest positive results, but probably have a relatively low benefit ceiling, in that the maximum number of physicians achievable by those strategies will soon be reached. The

strategies likely to produce significant numbers of doctors over time are those designed to train physicians in Alaska, i.e. medical school and residency programs, but the time to realize the benefit in most cases is longer.

Implementation strategy – next steps for key policy makers. The shortage of physicians and other health care providers creates one of Alaska's most challenging public health and higher education issues. To ensure the work of the Task Force is carried forward, it is recommended that the President and Commissioner establish permanent structures to implement these recommendations. One component of this action would be creation of a Medical Provider Workforce Assessment Office (Strategy 2A).

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

January 17, 2007

Honorable Kevin Meyer
State of Alaska State Medical Association
House of Representatives
State Capitol, Room 515
Juneau, AK 99801-1182

Re: HB 18 – WWAMI Program Expansion

Dear Representative Meyer:

The Alaska State Medical Association (ASMA) represents physicians statewide and is primarily concerned with the health of all Alaskans.

ASMA is writing this letter to urge you to support HB18. HB18 provides a vital step in addressing the chronic and, most recently, acute shortage of physicians in Alaska.

ASMA participated in the process commissioned by University of Alaska President, Mark Hamilton and Alaska Department of Health and Social Services Commissioner Karleen Jackson to quantify the seriousness of the physician shortage in Alaska and to develop recommendations to address the shortage. Indeed, the seriousness of the shortage now and twenty years into the future was validated in this exhaustive study. HB18 is the embodiment of one recommendation that was made – expand the WWAMI class size.

ASMA, for more than 20 years, has been in support of an increase in the WWAMI class size to address the chronic shortage of physicians in Alaska, and it again has class expansion as one of its primary advocacy initiatives for 2007 In recent years, Alaska has many more qualified applicants than the current 10 seat class size.

HB18 is a critical step in beginning to face Alaska's chronic shortage of physicians. ASMA recognizes that this will not help the current acute shortage and will advocate that other measures are necessary in the short term.

ASMA strongly urges the passage of HB18 early this year so that the WWAMI class size can be increased from 10 to 20 medical students starting this Fall.

Sincerely,

By: Roland Gower, MD President
For: The Alaska State Medical Association

Providence | Health System

3200 Providence Drive
P.O. Box 196604
Anchorage, Alaska
99519-6604

Tel 907.562.2211

January 17, 2007

The Honorable Kevin Meyer
Alaska State House of Representatives
State Capitol – Room 515
Juneau, AK 99801-1182

Dear ~~Representative~~ KEVIN Meyer:

I write today in support of the bill you introduced, House Bill 18, to increase the number of medical students in the WWAMI program along with a requirement for payback of financial assistance if the student does not return to Alaska to practice medicine. Passage of this important legislation is a major priority for Providence, Alaskans for Access to Health Care, the Alaska State Hospital and Nursing Home Association, and other health care organizations.

While certainly not viewed as the total solution, passage of this bill will be an important step in helping to solve the physician shortage faced in Alaska. All of us at Providence stand ready to assist in any way possible to ensure passage of this legislation.

If you have any questions or if I may be of assistance in any way, please let me know.

Sincerely,

E. Al Parrish
VP/CE Alaska Region
Providence Health System

Alaska Physicians & Surgeons, Inc.
4120 Laurel Street, Suite 206
Anchorage, Alaska 99508
Phone: 907-561-7705 Fax: 907-561-7704
Website: www.apsdoctors.org

January 16, 2007

Honorable Kevin Meyer
State of Alaska
House of Representatives
State Capitol
Juneau, AK 99801-1182

Dear Representative Meyer,

Alaska Physicians & Surgeons (APS) is writing you this letter in support of HB18.

Alaska Physicians & Surgeons along with many other Healthcare organizations strongly supports HB18, and we have set as one of our major initiatives for 2007, to support legislation to fund an expansion of the WWAMI medical school program for Alaskan's from 10 seats to 20 starting next fall.

While HB18 will not solve the chronic physician shortage in the short term, it is a vital step in helping Alaska catch up with the rest of the lower 48. Our physician per capita population is among the lowest in the country. It has been almost 30 years since the inception of WWAMI and it is high time for Alaska to get an additional 10 seats.

APS endorses the WWAMI legislation and encourages the bills passage during this session.

Sincerely,

Michael Haugen, JD, MBA
Executive Director

ASHNHA
Alaska State Hospital and Nursing Home Association
426 Main St • Juneau, AK • 99801

January 16, 2007

Honorable Kevin Meyer
State of Alaska
House of Representatives
State Capitol
Juneau, AK 99801-1182

Dear Representative Meyer:

The Alaska State Hospital and Nursing Home Association (ASHNHA) is submitting this letter of support for HB18, an Act that gives the Alaska Commission on Postsecondary Education authority to increase the number of medical students placed in the WWHAMI program, and adding a requirement for payback of financial assistance if the student does not return to Alaska to practice medicine.

ASHNHA participated in a process commissioned by President Hamilton of the University of Alaska and Commissioner Karleen Jackson of the Alaska Department of Health and Social Services to review the seriousness of physician shortages in Alaska, and to develop recommendations for addressing this shortage. The conclusions of that exhaustive review substantiated that the physician shortage in Alaska is already very serious in some communities, and will become even more acute over the next 5 to 10 years if steps are not taken to address this issue. This is perhaps the most pressing public health issue facing the State of Alaska at this time.

Expanding the present WWHAMI program from 10 medical students to 20 students is one of the most prudent steps the State can take to address this shortage of physicians. The WWHAMI program has proven to be a cost-effective investment for training physicians that will return to Alaska to practice. Adding the measure that will require repayment of student financial assistance will strengthen WWHAMI even further and increase the likelihood that students will select Alaska as their home and place of practice.

ASHNHA's Board of Directors has identified expansion of the WWHAMI program as one of its top three legislative priorities for 2007 and therefore strongly supports HB18 and the measures it contains.

Sincerely,

Rod Betit

Rod L. Betit
President/CEO

WWAMI Program Expansion

- WWAMI (Washington, Wyoming, Alaska, Montana, and Idaho) is Alaska's medical school
  - Collaborative medical education: 5 states, 6 institutions
  - 35 year history – Alaska was the 1st partner with Washington

- Need to *increase the net gain* of physicians by 21 per year
  - Actual (current) – gain 78, lose 40 for NET GAIN = 38
  - Needed (current) – gain 100, lose 40 for NET GAIN = 60
  - Future years – need will increase as aging physician population retires

- WWAMI doubling is a critical part of the overall strategy
  - No single strategy can achieve the needed increase (others: recruitment, retention, residency)
  - Class size same as 1971 when program started, 10 seats per year

- Why now?
  - Current physician shortage in Alaska
  - Nationwide shortage, worsening over next decade
  - Other states recruiting physicians aggressively

- Why WWAMI?
  - Cost
    - WWAMI is 2/3 the cost of WICHE *per Alaska physician produced*
    - Cost per medical student below national average (per AAMC)
    - Low in-state student tuition
  - Return on Alaska's investment
    - 7 - 8 WWAMI graduates start practice in Alaska each year
    - 3 years of 4-year medical school available *in Alaska*
  - Excellence in medical education
    - #1 Primary Care, 13 consecutive years (*US News & World Report, 2006)*
    - #1 Rural Health, 15 consecutive years (*US News & World Report, 2006)*
    - #1 Family Medicine, 15 consecutive years (*US News & World Report, 2006)*
    - Alaska WWAMI students excel among WWAMI peers

- How does WWAMI (medical education) work?
  - Undergraduate – can attend any undergraduate school
  - Application
    - Evaluation based on:
      - GPA (grade point average)
      - MCAT (medical college aptitude test)
      - Interview – ~50 percent of applicants
    - Excellent applicant pool in Alaska/Highly Competitive
      - 78 in 2005-06 for 10 positions
      - 35 to 40 qualified
      - top 30 – indistinguishable GPAs and MCATs
  - Year 1 at UAA – 10 Alaskans / year
  - Year 2 at UW – students from all 5 WWAMI states, 182 students / year
  - Year 3 Clerkships
    - Clinical experiences, ~ 6 weeks each
    - All 3rd year clerkships offered in Alaska
  - Year 4 Clerkships
    - Clinical experiences, ~ 4 to 6 weeks each
    - Most 4th year clerkships available in Alaska
  - Practicing Physicians
    - Participate in WWAMI education – clerkships, R/UOP, WRITE, etc.
    - Are supported by WWAMI MedCon, free phone consultation service

Note: A Physician Supply Task Force report issued in August 2006 is available at www.alaska.edu/health

Summary Projected Costs and Revenue for Doubling Class Size, WWAMI FY08

Investments in University of Alaska, University of Alaska Anchorage

Projected Operating Budget	Total	Projected Revenue	Total
Personnel (2 new faculty in clinical and microbiology areas; associated support staff)	$250,000	Legislative Appropriation	$280,000
Travel, Contractuals, Commodities	$80,000	Tuition Revenue	$50,000
Total	**$330,000**	**Total**	**$330,000**

Projected One-Time Capital Costs	Total	Projected One-Time Revenue	Total
Classroom furniture/renovations	$55,000	Legislative Appropriation FY07	$475,000
Renovation – Office space, research labs, study space	$595,000	Legislative Appropriation FY08	$475,000
Laboratory upgrade/renovations	$100,000		
Faculty start-up research packages	$200,000		
Total	**$950,000**	**Total**	**$950,000**

Added Payments to University of Washington for Years, 2, 3, and 4 of Program

	FY08	FY09	FY10	FY11	FY12-ongoing*
Additional 10 students 2nd Year		$505,558	$505,558	$505,558	$505,558
Additional 10 students 3rd Year			$520,371	$520,371	$520,371
Additional 10 students 4th Year				$321,939	$321,939
Total		**$505,558**	**$1,025,929**	**$1,347,868**	**$1,347,868**

* The cost increments annually based on inflation – not included for FY12.
More than half (~59%) of all WWAMI income, from years 1 through 4 is spent in Alaska.

Total Investments

FY 07 $ 475,000 in one-time capital (already allocated)
FY 08 $ 475,000 in one-time capital (requested this year)
FY 08 $ 280,000 in base support at UAA (requested this year)
FY 09 $ 505,558 in base for payments to UW
FY 10 $1,025,929 in base for payments to UW
FY 11 $1,347,868 in base for payments to UW

AARP Alaska

January 29, 2007

The Honorable Peggy Wilson, Chair
House Health, Education and Social Services Committee
Alaska State Capitol, Room 403
Juneau, AK 99801-1182

RE: HB 55 (Kelly)--Support

Dear Chair Wilson:

On behalf of the members of AARP in Alaska, we strongly encourage you and your colleagues on the House Health, Education and Social Services Committee to support HB 55, introduced by Representative Mike Kelly.

It is no secret that Alaska has a shortage of physicians which is expected to get worse over the next few years. AARP members in many Alaska communities already tell us that they are unable to find a physician who will accept them as Medicare beneficiaries. The current situation is so bad that United States Senator Lisa Murkowski is scheduling a Senate hearing on the issue in Anchorage on February 20.

The one bright spot in this shortage is the WWAMI program which has provided ten slots for family practice physicians to spend their residency in Alaska. Upon completion of their medical education, most of these physicians have chosen to stay here and practice in our cities as well as in our remote communities.

You and your House Committee colleagues have seen the Alaska Physician Supply Task Force report produced jointly by the University of Alaska and the Department of Health and Social Services. This excellent report should serve us as a roadmap for our future directions in physician training.

The former exodus of Alaska retirees has been reversed over the past few years. Because of our improved health services and provider community, older Alaskans have determined that they can remain here after retirement, close to their friends and families.

If older Alaskans are unable to find a physician willing to see them, we will be back with the situation of retirees leaving the state so they can be assured of access to health professionals.

HB 55 offers us the first real meaningful opportunity to begin to meet this need. Doubling the number of family practice residents from ten to twenty won't solve our problem but it is an excellent first step.

Our AARP members, your constituents, want to stay here after retirement. An affirmative vote on HB 55 will help accomplish that.

We urge an "AYE" vote on HB 55.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Vice-Chair Bob Roses
Representative Anna Fairclough
Representative Mark Neuman
Representative Paul Seaton
Representative Berta Gardner
Representative Sharon Cissna
Representative Mike Kelly

ASHNHA Position on HB 18
Prepared by: Rod Betit, President/CEO
January 29, 2007

WHO ASHNHA REPRESENTS: The *Alaska State Hospital and Nursing Home Association* represents 24 acute care hospitals, 2 behavioral health facilities, 6 assisted living facilities (Alaska Pioneer Homes), and 5 free-standing nursing facilities. Nine of our 24 acute care hospitals also provide nursing home services. We believe ASHNHA's rich composition of private, federal, state, and tribal health care facilities provides a balanced viewpoint on important health care policy matters. ASHNHA's membership evaluates health care legislation weekly and authorizes the position expressed in this testimony.

ASHNHA's POSITION ON HB 18: ASHNHA's membership **'strongly supports'** passage of HB18 for the reasons noted below. ASHNHA does not offer any amendments to HB 18 as we believe the bill is excellent as written.

SUPPORTING TESTIMONY:

➲ As determined by the Alaska Physician Supply Taskforce in 2006, Alaska is presently facing a shortage of 300 physicians and this gap is expected to grow dramatically in the years ahead.

➲ Many states are reporting a physician shortage in large part due to physician retirements and an inadequate number of physicians completing training to replace them. This is further exacerbated by U.S. population growth that exceeds the rate of increase in new medical school slots.

➲ Alaska must be proactive to address this situation. While adding additional slots to the WWHAMI program will not solve the entire physician shortage problem, it is a key initial step to take. ASHNHA also supports those provisions of HB 18 that would strengthen the pay back provisions for any WWHAMI participant who does not return to Alaska to practice.

➲ **ASHNHA urges your support of HB 18. Thank you for this opportunity to testify.**

This Testimony is on Behalf of the Following Alaska Health Care Facilities

Alaska Regional Hospital, Alaska Native Medical Center, Alaska Pioneer Home System, Bartlett Regional Hospital, Bassett Army Community Hospital, Central Peninsula General Hospital, Cordova Community Medical Center, Denali Center Nursing Home, Fairbanks Memorial Hospital, Heritage Place Nursing Home, Kanakanak General Hospital, Ketchikan General Hospital, Maniilaq Health Center, Mary Conrad Center, Mat-Su Regional Hospital, Mt. Edgecumbe Hospital SEARHC, Norton Sound Regional Hospital, Petersburg Medical Center, Providence Alaska Medical Center, Providence Extended Care Center, Providence Kodiak Island Medical Center, Providence Seward Medical & Care Center, Providence Valdez Medical Center, Sitka Community Hospital, South Peninsula Hospital, St. Elias Specialty Hospital, USAF 3rd Medical Group- Elmendorf, Wrangell Medical Center, Yukon Kuskokwim Delta Regional Hospital, Alaska Psychiatric Institute, North Star Behavioral Health System, Wildflower Court Nursing Home.

Alaska State Hospital & Nursing Home Association, 426 Main St., Juneau, AK 99801 (907) 586-1790

Summary Projected Costs and Revenue for Doubling Class Size, WWAMI FY08

Investments in University of Alaska, University of Alaska Anchorage

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FY 11 $1,347,868 in base for payments to UW

HB

29

ALASKA STATE LEGISLATURE

SESSION ADDRESS
Alaska State Capitol
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112 Mill Bay Road
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Representative Gabrielle LeDoux

Sponsor Statement for House Bill No. 29
Safe Haven for Infants Act

This is a bill that will allow parents to safely surrender infants shortly after birth without fear of being criminally prosecuted. The parent may, without expressing an intent to return for the infant, leave the infant in the physical custody of a person who the parent reasonably believes to be a peace officer, a physician or hospital employee in a hospital or hospital emergency room, or a volunteer with or employee of a fire station or emergency medical service who is performing activities within the scope of the volunteer's or employee's fire services or emergency medical services duties.

There are similar laws in 47 other states. This is a way of encouraging people to avoid abandoning infants in a way that could lead to injury or death. A record regarding the surrender of an infant is confidential and is not subject to public inspection.

Representative_Gabrielle_LeDoux@legis.state.ak.us

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: HB029-LAW-HSCP-2-6-0
Bill Version: HB 29
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Law
Title: An Act relating to safe haven for infants
RDU: Civil
Component: Human Services Child Protection
Sponsor: Representative LeDoux
Requester: House Health, Education & Social Services
Component No.

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2007) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2008 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

The bill prohibits prosecution of a parent who safely surrenders an otherwise uninjured infant in the physical custody of a person who the parent reasonably believes is a peace officer, a physician or hospital employee in a hospital or hospital emergency room, or a volunteer with or employee of a fire station or emergency medical service who is performing activities within the scope of the volunteer's or employee's fire services or emergency medical services duties. The department does not anticipate any significant fiscal impact.

Prepared by: Robert Meiners, Acting Director
Phone: 465-5427
Division: Administrative Services Division
Date/Time: 2/6/07 7:20 AM
Approved by: Robert Meiners for Talis Colberg, Attorney General
Date: 2/6/2007
Agency: Department of Law

Legislative Research Services

Alaska State Legislature
Legislative Affairs Agency
Division of Legal and Research Services

State Capitol, Juneau, AK 99801
Phone: 907-465-3991
Fax: 907-465-3908

January 27, 2006

Memorandum

TO: Representative Gabrielle LeDoux
FROM: Becky Taylor
Legislative Analyst
RE: Safe Haven Laws in Other States
LRS Report 06.118

You asked for an overview of safe haven laws. Specifically, you were interested in which states have such laws, when these laws were enacted, where and up until what age infants can be dropped off in different states, and how these laws address the issue of parental rights.

Safe Haven laws are intended to reduce infant abandonment and abuse by providing mothers in crisis with designated locations where they can leave an infant and know that the child will be safe and cared for. Hospitals, police and fire stations, and emergency medical service agencies are often used as safe haven locations. Age limits of 72 hours or 30 days are most common, although North Dakota's safe havens will accept children up to a year old. A few states require a check of the putative father registry, and include provisions to contact the putative father, but most do not require notification of fathers who may not be aware of the child's birth.

At least forty-six states have enacted safe haven laws. According to the Child Welfare League of America, forty-one of these states passed safe haven legislation between 1999 and August 2002. Currently, Alaska, Hawaii, Nebraska, and Vermont appear to be the only states that do not have safe haven laws. Massachusetts was the most recent state to enact this type of legislation with the 2004 Safe Haven Act of Massachusetts. A number of organizations have compiled information about these laws. We have attached the following publications that address your specific questions in more detail:

- "Infant Safe Haven Laws," *State Statute Series 2004*, National Adoption Information Clearinghouse, U.S. Department of Health and Human Services, current through November 2004.
- "Update: Safe Havens for Abandoned Infants," National Conference of State Legislatures, October 21, 2003.
- Williams-Mbengue, Nina, "Safe Havens for Abandoned Infants," *NCSL State Legislative Report*, Volume 26, Number 8, National Conference of State Legislatures, September 2001.
- "Baby Abandonment Project," Child Welfare League of America, August 2002. As you will see, this document provides brief summaries of the various laws current as of 2002, including information, in many cases, specific to your questions. The on-line version of this compilation of state laws includes links to the text of each state's bill, and is available at *http://www.cwla.org/programs/pregprev/flocrittsafehaven.htm*.

I hope you find this information to be useful. Please do not hesitate to contact us if you have questions or need additional information.

National Clearinghouse on Child Abuse and Neglect Information
National Adoption Information Clearinghouse

Gateways to Information: Protecting Children and Strengthening Families

State Statutes Series 2004

Infant Safe Haven Laws

State legislatures have felt the need to address infant abandonment and infanticide in response to a reported increase in the abandonment of infants.

Beginning in Texas in 1999, "Baby Moses laws" or infant safe haven legislation has been enacted as an incentive for mothers in crisis to safely relinquish their babies to a safe haven where the baby will be protected and provided with medical care until a permanent home can be found. Safe haven laws generally allow the parent, or an agent of the parent, to remain anonymous and to be shielded from prosecution for abandonment or neglect in exchange for safely surrendering the baby to a safe haven.

To date, approximately[1] 46[2] States have enacted safe haven legislation to provide a vehicle for the safe relinquishment of unwanted newborns.

Who May Leave a Baby at a Safe Haven

In most States with safe haven laws, a parent may surrender the baby to a safe haven. In four States (Georgia, Maryland, Minnesota, and Tennessee),[3] only the mother may relinquish the infant, while Idaho specifies that only a custodial parent may surrender the infant. Other States allow either parent of the baby, an agent of the parent (someone who has the parent's approval),[4] or another person having custody of the child[5] to take the baby to a safe haven. Five States[6] do not specify the person who may relinquish an infant.

Safe Haven Providers

Safe haven providers include hospitals, emergency medical services, police stations, and fire stations. Generally, anyone on staff at these institutions can receive an infant, and the provider is authorized to provide any care and treatment the infant may require.

---

[1] The word *approximately* is used to stress the fact that the States frequently amend their laws, so this information is current only through November 2004.

[2] Alaska, Hawaii, Nebraska, Vermont, the District of Columbia, and the territories of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands have not yet addressed the issue of abandoned newborns in legislation.

[3] Maryland and Minnesota do allow the mother to approve another person to deliver the infant on her behalf.

[4] In 10 States: Arizona, Arkansas, Connecticut, Iowa, Missouri, North Dakota, Rhode Island, South Carolina, Utah, and Wyoming.

[5] In California and Kansas.

[6] Delaware, Maine, New Jersey, New Mexico, and New York.

National Adoption Information Clearinghouse
330 C St., SW
Washington, DC 20447
(888) 251-0075 or (703) 352-3488
naic@caliber.com
http://naic.acf.hhs.gov

U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Children's Bureau

In many States, the provider is required to ask the parent for family and medical history information. In some States, the provider is required to attempt to give the parent or parents information about the legal effects of leaving the infant and information about referral services. In all cases, the relinquishing parent may not be compelled either to provide personal information or to accept the information offered.

The focus of these laws is protecting newborns, and in approximately 16 States,[7] infants who are 72 hours old or younger may be relinquished to a designated safe haven. Many other States accept infants up to 1 month old,[8] while North Dakota's safe havens will accept a child as old as 1 year.[9]

Immunity From Liability

Safe haven providers are given protection from liability for anything that might happen to the infant while in their care unless there is evidence of major negligence on the part of the safe haven.

Protections for the Parents

Anonymity for the parent or agent of the parent may be expressly guaranteed in statute,[10] or the statute may state that the safe haven cannot compel the parent or agent of the parent to provide identifying information.[11] Some States provide an assurance of confidentiality for any information that is provided.[12]

In addition to the guarantee of anonymity, many States limit prosecution[13] or provide that safe relinquishment of the infant is an affirmative defense[14] in any prosecution[15] of the parent or his/her agent for any crime against the child, such as abandonment, neglect, or child endangerment.

The privileges of anonymity and immunity will be forfeited in most States if there is evidence of abuse or neglect of the child.

---

[7] Alabama, Arizona, California, Colorado, Florida, Illinois, Kentucky, Maryland, Michigan, Minnesota, Mississippi, Ohio, Tennessee, Utah, Washington and Wisconsin

[8] In 14 States: Arkansas, Connecticut, Idaho, Louisiana, Maine, Missouri, Montana, Nevada, New Jersey, Oregon, Pennsylvania, Rhode Island, South Carolina, and West Virginia

[9] Other States specify varying age limits in their statutes: 5 days (New York), 7 days (Georgia, Massachusetts, New Hampshire, North Carolina, and Oklahoma), 14 days (Delaware, Iowa, Virginia, and Wyoming), 45 days (Indiana and Kansas); 60 days (South Dakota and Texas), and 90 days (New Mexico).

[10] In approximately 13 States: Arizona, Delaware, Florida, Illinois, Kentucky, Ohio, Oklahoma, Texas, Utah, Washington, West Virginia, Wisconsin, and Wyoming

[11] In 26 States: Arizona, California, Connecticut, Delaware, Idaho, Indiana, Iowa, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, West Virginia, and Wyoming

[12] In 12 States: Connecticut, Delaware, Idaho, Iowa, Kentucky, Maine, Michigan, Montana, New Mexico, Rhode Island, South Carolina, and Tennessee

[13] In approximately 7 States (Arizona, Connecticut, Illinois, Louisiana, Nevada, Pennsylvania, and South Dakota), the statutes state that a safe relinquishment is not considered a violation of the law. In 21 States, the relinquishing parent is provided immunity from prosecution: California, Florida, Georgia, Idaho, Iowa, Kansas, Kentucky, Maryland, Minnesota, Missouri (if the child is 5 days old or younger), Montana, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, Tennessee, Wisconsin, and Washington.

[14] In a State with an affirmative defense provision, a parent or agent of the parent can be charged and prosecuted, but the act of leaving the baby safely at a safe haven can be a defense to an accusation of abandonment, abuse, neglect, or child endangerment.

[15] In 17 States: Alabama, Arkansas, Colorado, Delaware, Indiana, Maine, Michigan, Mississippi, Missouri (if the child is 6 days old or older, but less than 30 days old), New Jersey, New York, Oregon, Texas, Utah, Virginia, West Virginia, and Wyoming

Consequences of Relinquishment

In most States with safe haven laws, custody of the infant who has been relinquished will be transferred to the department that handles child protective or child welfare cases.

The department has responsibility for placing the child, usually in a pre-adoptive home, and for petitioning the court for termination of the birth parent's parental rights. Several States have procedures in place for a parent to reclaim the infant,[16] usually within a specified time period and before any petition to terminate parental rights has been granted. A few States[17] also have provisions for a nonrelinquishing father to petition for custody of the child.

This publication is a product of the State Statutes Series prepared by the National Adoption Information Clearinghouse (NAIC). While every attempt has been made to be as complete as possible, additional information on these topics may be in other sections of a State's code as well as agency regulations, case law, and informal practices and procedures.

Electronic copies of this publication may be downloaded from the Clearinghouse website at http://naic.acf.hhs.gov/general/legal/statutes/safehaven.cfm.

- To find statute information for a particular State, go to http://naic.acf.hhs.gov/general/legal/statutes/search and select the specific State and topic.
- To find information on all of the States and territories, view the complete PDF at http://naic.acf.hhs.gov/general/legal/statutes/safehavenall.pdf or call the Clearinghouse at (888) 251-0075 or (703) 352-3488 to order a copy.

[16] Approximately 16 States have provisions for the relinquishing parent to petition to reclaim the child: California, Connecticut, Delaware, Florida, Idaho, Illinois, Iowa, Kentucky, Louisiana, Michigan, Missouri, Montana, New Mexico, Rhode Island, Tennessee, and Wyoming.
[17] In approximately 4 States: Louisiana, South Dakota, Tennessee, and Utah.

C l Welfare Project

UPDATE: SAFE HAVENS FOR ABANDONED INFANTS
October 21, 2003

Forty-five states now have some type of safe haven legislation. (The following states do not have safe haven legislation: AK, HI (Vetoed 7/2/03), MA, NE and VT.) Most of the laws designate hospitals, emergency medical services, fire stations and police stations as safe locations. One exception is New York, which stipulates that the baby may be left with a suitable person or may be left in a suitable location so long as an appropriate person is promptly notified. Immunity is granted generally to employees who are required to accept and care for relinquished infants. About half of the states will not prosecute parents who relinquish unharmed infants. The remainder allows an affirmative defense to prosecution. State laws vary on the age of infants who may be relinquished. The ages range from 72 hours old or younger up to 5 days old or younger. The most common ages found in the statues are 72 hours and 30 days.

How Effective are the Laws?

The laws continue to have a limited effect. A number of states have begun to report on infants abandoned after the passage of the safe haven legislation. As of September 2001, approximately 33 babies had been legally relinquished including five each in Texas, Michigan and Alabama, six in New Jersey, four in California, two in Connecticut, Minnesota and Ohio and one each in Kansas and South Carolina. The numbers are approximate because officials in several states reported that they are not officially tracking the numbers of infants or that they had unofficial media counts of infants. Officials in New York, West Virginia and Florida reported that they were not sure that any infants had been relinquished because their laws do not require reporting or tracking that information. As of September 2002, state agency officials in California report that they have had 20 infants abandoned through the law since their legislation went into effect. New Jersey reported 10 safe haven infants, a 63% reduction in infant abandonment, since the passage of their law in 2000 (compared to 8 abandonments prior to the passage of the law). Illinois reported 2 safe haven abandonments since their law was enacted in 2001.

Unlawful abandonment continues to be a problem. As of September 2001, Texas reported at least 12 infants had been abandoned illegally since the passage of its law, but the abandonments occurred before the start of a public awareness campaign. None have been abandoned outside safe havens since this publicity. Louisiana reported that five infants had been abandoned illegally since passage of its law. Three babies died, and the parents were prosecuted. At least five babies were illegally abandoned in California; two more of the... were found dead. In Connecticut, one baby was discarded near a highway. Three babies had been abandoned illegally in Colorado. In one case, the mother attempted to regain custody. Michigan reported nine attempts including one in which a judge ruled that the case was not a safe haven surrender because the parents had not been given enough information on their legal rights. As of September 2002, California reported 21 illegal abandonments and 17 infants abandoned found deceased. Illinois reported four infants illegally abandoned and found deceased. Illinois averaged 25 illegal abandonments over the previous four-year period.

Areas of Concerns for Policymakers

Child welfare experts, state agency officials and state lawmakers continue to examine a number of critical issues related to infant safe haven legislation:

Need for Examination of Statewide Services for Women at Risk

Many child welfare experts state that, although safe haven legislation may be a good idea, it needs to be part of a larger effort to examine services for women who are at risk of abandoning their infants. Experts from the fields of child welfare, mental health, youth services, the medical establishment and teen pregnancy will want to work with young parents to examine the existing system of services. Such an examination might provide some answers about why this population of parents is unable -or unwilling- to use these services.

Lack of a Comprehensive Strategy for the Prevention of Infant Abandonment

Critics are concerned that states are not viewing safe haven programs as an integral part of child abuse prevention. Has infant abandonment been considered in the state's child abuse prevention efforts? Does the strategy target young women at risk of abandonment? These are just a few questions policymakers may want to ask as they work with public health, child protection, child abuse prevention, mental health, families and others to develop a comprehensive strategy to prevent infant abandonment.

Anonymity and Termination of Parental Rights

Child welfare experts are apprehensive that the anonymity provided to parents in the safe haven laws conflicts with biological parents' due process rights in termination of parental rights proceedings. As previously mentioned, states have attempted to address this critical issue by providing some type of notice or search for the biological parents of the abandoned infant in an effort to include them in judicial proceedings related to the adoption of the infant. States will want to carefully examine their termination of parental rights statutes to avoid conflicts with safe haven laws.

Relationship to Existing Child Welfare Statutes

Likewise, states may want to examine all their existing statutes related to adoption, paternity, custody and all judicial proceedings associated with child abandonment. It also is important that states clarify their definitions of infant abandonment. For example, several states with new laws exempt safe haven abandonment from the statutory definition of abandonment, child abuse or child neglect. Other states add safe haven abandonment to their existing definition of abandonment.

Father's Rights

All states require a check of the putative father registry and include provisions to contact the putative father, but most do not contain provisions to address notification of fathers who may not be aware of the child's birth. Critics contend that denying notification unfairly presumes that these fathers do not want to care for their children. Utah's legislation addresses this concern by requiring a search of the confidential registry for unmarried biological parents and requiring that notice be sent to each potential father identified in the registry. The termination of parental rights hearing must be scheduled as soon as possible if no one has identified himself as the father (or if the mother has not identified herself) within two weeks after notice is complete. If a non-relinquishing parent is not identified, the surrender of the newborn shall be considered grounds for termination of parental rights of both parents.

Adoption

Adoption advocates are particularly concerned about the lack of medical and family history. They note that a lack of information about their backgrounds is often troublesome for adopted children and worry about the stability of the child and his or her adopted family later in life. They fear that the lack could be a setback to the trend in adoption policy to provide the adoptee with information about the birth family. Adoption and other child welfare experts also point out that the legislation may not be necessary because most states will not prosecute women who give birth and relinquish their newborns in the hospital. Additionally, every state allows women to voluntarily relinquish their infants for adoption.

Parental Irresponsibility

Many policymakers are concerned that these laws may only encourage parental irresponsibility. Since so little is known about the women who abandon their babies, there is no proof that the legislation will discourage mothers from leaving their infants in unsafe places. For women who might otherwise seek help from family, friends and social service agencies, the enactment of safe haven laws might encourage them to anonymously abandon their newborns rather than take advantage of their traditional network of support.

Denver Office: Tel: 303-364-7700 | Fax: 303-364-7800 | 7700 East First Place | Denver, CO 80230 | Map
Washington Office: Tel: 202-624-5400 | Fax: 202-737-1069 | 444 North Capitol Street, N.W., Suite 515 | Washington, D.C. 20001

STATE BY STATE COMPARISON OF 'SAFE HAVEN' LAWS

	A	B	C	D	E	F
1	**STATE**	**Days to surrender**	**Who can surrender**	**Focus of Law**	**Anonymity for parent or agent of parent may be expressly guaranteed in statute**	**Statute states that the safe haven cannot compel parent or agent of parent to provide identifying info**
2	Alabama	3 days		Protecting newborns		
3	Arizona	3 days	a parent or a parents agent	Protecting newborns	Yes	Yes
4	Arkansas	30 days	a parent or a parents agent			
5	California	3 days	a parent or a parents agent or another person having custody of the child	Protecting newborns		Yes
6	Colorado	3 days		Protecting newborns		
7	Connecticut	30 days	a parent or a parents agent			Yes
8	Delaware	14 days	not specified		Yes	Yes
9	Florida	3 days		Protecting newborns	Yes	
10	Georgia	Less than 1 week	Mother only			
11	Idaho	30 days	Custodial parent			Yes
12	Illinois	3 days		Protecting newborns	Yes	
13	Indiana	45 days				Yes
14	Iowa	14 days	a parent or a parents agent			Yes
15	Kansas	45 days	a parent or a parents agent or another person having custody of the child			
16	Kentucky	14 days		Protecting newborns	Yes	
17	Louisiana	30 days				Yes
18	Maine	31 days	not specified			Yes
19	Massachusetts	Less than 1 week				Yes
20	Maryland	Less than 3 days	Mother only/or another person approved by the mother to deliver infant on her behalf	rotecting newborns		

SOURCE: CHILD WELFARE LEAGUE OF AMERICA

STATE BY STATE COMPARISON OF 'SAFE HAVEN' LAWS

	A	B	C	D	E	F
21	Michigan	3 days		Protecting newborns		Yes
22	Minnesota	3 days	Mother only/or another person approved by the mother to deliver infant on her behalf	Protecting newborns		Yes
23	Mississippi			Protecting newborns		
24	Missouri	Less than 30 days	a parent or a parents agent			
25	Montana	30 days				Yes
26	Nevada	30 days				Yes
27	New Hampshire					Yes
28	New Jersey	30 days	not specified			Yes
29	New Mexico	90 days	not specified			Yes
30	New York	5 days	not specified			
31	North Carolina	7 days				Yes
32	North Dakota	1 year	a parent or a parents agent			Yes
33	Ohio	3 days		Protecting newborns	Yes	
34	Oklahoma	7 days			Yes	Yes
35	Oregon	30 days				Yes
36	Rhode Island	30 days	a parent or a parents agent			
37	South Carolina	30 days	a parent or a parents agent			Yes
38	South Dakota	60 days				Yes
39	Tennessee	3 days	Mother only	Protecting newborns		Yes
40	Texas	60 days			Yes	
41	Utah	3 days	a parent or a parents agent	Protecting newborns	Yes	
42	Washington	3 days		Protecting newborns	Yes	
43	West Virginia	30 days			Yes	Yes
44	Wisconsin	3 days		Protecting newborns	Yes	
45	Wyoming		a parent or a parents agent		Yes	Yes

SOURCE: CHILD WELFARE LEAGUE OF AMERICA

From: infoweb@newsbank.com
Sent: Wednesday, October 19, 2005 1:28 PM

Subject: Requested NewsBank Article

Paper: Anchorage Daily News (AK)
Title: INFANT FOUND AT UAA
Author: TRACY BARBOURDaily News reporterStaff
Date: June 13, 1995
Section: Metro
Page: B1

A newborn boy abandoned on the sidewalk in front of a University of Alaska Anchorage building Monday morning was in serious condition by the end of the day.A campus employee found ''Baby Doe'' about 7

a.m. at the University Lake Building, which houses support services, said Nancy Killoran, a university spokeswoman.

Baby Doe, who appears to be white and a couple days old, was left wrapped in a blanket and with a shoestring tied around his umbilical chord, she said.

The university employee called campus security, who alerted the Anchorage Police Department.

Police found the newborn suffering from hypothermia. Otherwise, he appeared to be fine, Anchorage police Sgt. Gary Apperson said.

But by 7 p.m Monday, Baby Doe was listed in serious condition at Providence hospital, a spital spokeswoman said. She refused to say what the child was suffering from.

Police said they have no idea who deserted the baby and that there was no note or other clues to the identity of the boy's parents.

Whoever abandoned the child faces charges of child abandonment and neglect, police said.

Author: TRACY BARBOURDaily News reporterStaff
Section: Metro
Page: B1

From: infoweb@newsbank.com
Sent: Wednesday, October 19, 2005 1:59 PM

Subject: Requested NewsBank Article

Paper: Anchorage Daily News (AK)
Title: NEWBORN GIRL FOUND IN BATHROOM STALL AT HOSPITAL
Author: PETER S. GOODMANDaily News reporterStaff
Date: December 1, 1994
Section: Nation
Page: A1

A newborn girl was found wrapped in a blanket in a bathroom stall at Alaska Regional Hospital on Wednesday morning.A hospital employee found the infant when she went into the first-floor women's restroom to get a cup of water about 7:30 a.m., police said. A note of explanation was found nearby, but investigators would not reveal what it said. Several people later told investigators they had heard the baby crying as they passed by the bathroom. Hospital staff rushed the newborn to the emergency room, said Mary Hofbauer, a nursing supervisor. Doctors pronounced her in satisfactory shape.

State child welfare authorities took formal custody of the child, who remained at the hospital late Wednesday.

Police spent much of the day trying to locate the baby's mother. Detective Terry Games said witnesses spotted a white woman with long brown hair near where the baby was found. She was described as being in her mid-to-late teens, 5-feet-6 to 5-feet-7-inches tall and wearing a long brown coat. Police "strongly believe" she is the baby's mother, Games said.

Hofbauer said the infant is a "pretty little baby" who appeared to be about 12 hours old at the time she was found. She had apparently been born full term. Police said she weighed nearly 7 pounds and measured about 19 inches long.

The state will likely place the baby in a foster home after doctors clear her to be released from the hospital, said Faye Moore, regional administrator at the Division of Youth and Family Services in Anchorage. What happens after that is uncertain.

Moore wouldn't discuss the particulars of the case, but she predicted there is less than an even chance the mother will be found. If the mother never enters the picture, the state would likely try to get court approval to put the baby up for adoption, she said.

Bob Newell, an intake officer with the youth services agency, said it would be several months before the baby can be adopted because the state is obligated to give the mother a chance to come forward and claim her child.

If the mother does turn up and shows an interest in taking the baby, the state would assess whether she's fit to be a parent, Moore said. She "would have the burden of demonstrating to us (she) can take care of the child."

According to Newell, the state typically does whatever it takes to help mothers become suitable parents. They may undergo drug or alcohol counseling, welfare assistance or job placement, Newell said.

According to Joyce Johnson at the Child Welfare League of America in Washington, D.C., women who abandon babies tend to be young, poor and isolated. They don't know how to cope with being pregnant and they lack the sophistication to get help, she said.

"Maybe they haven't located the father or they haven't told their family that they're pregnant," Johnson said. "It's a trauma. They're not thinking coherently. And there's fear. How are they going to take care of the child? Maybe they don't have any money."

Johnson said there are places for such women to go: social service organizations that counsel women on their options, provide shelter and find them medical care.

Elaine Stoneburner, the adoption coordinator at Catholic Social Services in Anchorage, has a list of two dozen couples waiting to adopt babies. They are likely to wait anywhere from 10 months to three and a half years for a child, she said. For those would-be parents, news of a newborn being left in a bathroom stings, she said.

ohnson said that abandoned children are usually left in public places where the mothers hope they'll be found and cared for. But not always. On New Year's Eve, police found a newborn girl outside a used-clothing store in Peters Creek. She was rushed to Providence Hospital and treated for hypothermia. She was eventually adopted.

If the mother of the hospital baby is found, she could face criminal charges for abandoning her child, police said. Assistant District Attorney Steve Branchflower said the mother's intentions would be weighed in any decision to prosecute.

"Is the baby in a Dumpster or in a hospital?" Branchflower asked. "That says something about a person's intent."

Joan Teel, a private adoption consultant and former state social worker, said that's an important detail.

"There should be no judgment passed," she said. "Let's applaud (the mother) for putting the baby somewhere safe and warm."

Author: PETER S. GOODMANDaily News reporterStaff
Section: Nation
Page: A1

From: infoweb@newsbank.com
Sent: Wednesday, October 19, 2005 2:00 PM

Subject: Requested NewsBank Article

Paper: Anchorage Daily News (AK)
Title: ABANDONED BABY GETS A NEW YEAR'S EVE CHANCE DAY-OLD GIRL LEFT OUTSIDE
Author: S.J. KOMARNITSKYDaily News reporterStaff
Date: January 1, 1994
Section: Nation
Page: A1

It was a shocking discovery: a baby girl wrapped only in a blanket outside a used clothing store in Peters Creek in the freezing cold, her umbilical cord still attached and tied off with a piece of twine. The pudgy newborn would have faced a night outdoors in freezing temperatures if not for a woman's anonymous call to police and a quick search by two nurses from a nearby senior center.Instead, she was rushed to Providence Hospital, where she was listed in serious condition with hypothermia late New Year's Eve. A police investigator estimated she was about a day old.

Officers first heard about the baby just before 3 p.m. when a woman called from a pay phone at the Peters Creek Trading Post with an anonymous tip. The woman said there was a cold baby in a container at The Garret, a used-clothing store about a mile from the convenience store. The woman didn't make herself clear and hung up before dispatchers could get her name or ask her any questions.

But they made out enough to know there might be a baby somewhere around the clothing store. Dispatchers were still deciphering the message when they called the Chugiak Senior Center where Sharon Cloud, 44, and Charlene Beckwith, 50, work as nurse's assistants. The center is just downhill from the store.

Beckwith said they were told a child had been dropped off in a container and were asked to take a look around.

So, she and Cloud started working their way up the hill toward the store, looking in Dumpsters along the way. Nothing. Then they started searching around the store, which was closed. Still nothing.

In the meantime, Officer Robert Dutton headed to The Garret to check things out. Dispatchers still weren't sure exactly what the woman had told them and sent Dutton without lights or sirens, he said. But another officer, hearing there might be a baby involved, told Dutton to speed up.

It was just after Dutton arrived that Cloud found the girl.

Beckwith said she and Cloud had already made one search around the building when Dutton showed up. They were about to go back, thinking it was a prank call. That's when Cloud started looking through a pile of donated clothes in plastic bags left on a walkway not in a container in front of the store and found the girl under a lampshade.

"I had just been going through the clothes and I had just seen a doll," Cloud said. "I thought it was another doll. But then she moved."

Dutton told the two women to get the baby into his car, where it was warm. He later said the temperature outside was about 21 degrees.

Beckwith said the girl never cried and it was hard to tell if she was suffering from hypothermia.

"She had that newborn baby look, kind of bluish-purple," she said.

But, once the two women got in the patrol car, Beckwith could see that the girl's toes and

fingers were "really blue." The baby acted like one of her feet was numb, Beckwith said.

Dutton drove Beckwith back to the senior center and headed for Providence Hospital with Cloud cradling the child in her arms in the back seat.

rriving at Providence just before 4 p.m., the girl was rushed to an intensive care unit nd immediately put under heat lamps.

Beckwith said she's glad they found the baby in time. The clothing store was closed for the day.

"She probably would not have made it through the night," she said.

Temperatures in Anchorage were forecast to be about 20 degrees Friday night.

So far, there are few clues to the mother's identity.

Dianne Hagerty, who works at the Trading Post, said nobody noticed a woman making a call from the store's pay phone around 3 p.m. The phone is around the corner, and the store gets a lot of traffic, she said.

"Usually you don't pay attention to who is on the phone anyway," she said.

Beckwith said a woman was dropping off clothes at The Garret when she and Cloud first came up the hill. But the woman looked to be in her 50s and she said she had just arrived, Beckwith said.

The woman was putting her donation right next to where the baby was. She said she never heard a peep, Beckwith said.

Police investigators are asking for the public's help in locating a woman who was in late pregnancy and now isn't, and who doesn't have a baby to show for it.

Lt. Bill Gaither said the woman could face a number of charges for abandoning the girl, cluding child abuse, child neglect, reckless endangerment and endangering the welfare of minor.

That is if the child survives, he said. If she dies, the mother could face murder charges, he said.

Beckwith said that there's already a waiting list of staffers at the center and even one elderly resident who say they'd be happy to adopt the baby.

"She's a very cute little female, kind of pudgy infant," Beckwith said.

Beckwith said the image that stayed in her mind was what Cloud told her later, that, on the ride to the hospital, the girl clung to her finger the whole time.

"We couldn't believe anyone would do such an atrocity," Beckwith said. "It was just such a pathetic thing to see. The fact that she was so naked and outside was kind of devastating."

Author: S.J. KOMARNITSKYDaily News reporterStaff
Section: Nation
Page: A1

From: infoweb@newsbank.com
Sent: Wednesday, October 19, 2005 1:27 PM
Subject: Requested NewsBank Article

Paper: Anchorage Daily News (AK)
Title: INFANT FOUND IN BIN
Author: DON HUNTERDaily News reporterStaff
Date: September 6, 1986
Section: Metro
Page: 1

A newborn baby boy abandoned in a box in a Muldoon alley Thursday night was in good condition Friday at Humana Hospital.The infant was wrapped in a towel and hidden in a cardboard box left on the ground beside a Salvation Army collection bin. He was found by two teen-age boys who heard him crying as they rode by on their bicycles.

"It was crying, real loud," 15-year-old Christian Chain said. Chain was interviewed Friday while walking his dog, Duke, in the neighorhood.

"The box was closed," he said. "There was no lid, but the sides were folded up on top of the baby. We opened it up and, you know, there was a baby . . .

"It was wrapped in a towel, a tan towel," he said.

"It was real young, not that old at all."

Only minutes before Chain and Lamont Williams, 14, found the baby, an anonymous caller told an Anchorage Police dispatcher a baby had been left at the bin.

the time officers arrived, the boys had picked up the box, climbed back on their bikes, and taken the baby to the Chain home, where they called police.

The boys discovered the baby shortly after 9 p.m., according to police. Officers took him to Humana Hospital about 9:30 p.m. Police Spokesman Joe Young said the infant was "a few hours old, at most."

Salvation Army dispatcher Alice Phillips said donations left at the bin are picked up about 11 a.m. every day The bin is directly behind a Salvation Army thrift shop at 101 Muldoon Road.

Lynn Whitley, a hospital spokeswoman, said the baby weighed seven pounds, one ounce and was in satisfactory condition in the Humana nursery late Friday afternoon. He was stable, with vital signs within normal limits, she said.

The infant is now in the custody of the state division of family and youth services. Dolly Coke, a social worker supervisor, said in cases where the state assumes custody of children, they are placed in a foster home until a permanent placement is arranged.

Authorities have named the baby John Doe.

Storekeepers and residents of a trailer park across the street from the thrift shop said they had seen no unusual activity Thursday night. But a delivery man for a sandwich shop directly across Muldoon Road said he saw a young couple acting a little strangely.

"I was fixing to go out and make some deliveries, and I was sitting in my car adjusting packages and something caught my eye just across the street at the Goodwill box," said Chuck Argo.

.ere was a couple in a late model, foreign pickup, sort of rummaging around in the boxes there. I thought it was unusual to see people with a truck like that looking in the bin . . .

"Then they had a bundle, looked like a bundle of clothes, and just kind of laid it over there in the boxes and took off. I didn't think anything of it until I got back (from making deliveries) and my supervisor said" police had been there.

'It didn't dawn on me it could have been a child," he said.

Young, the police spokesman, said another person called police late Thursday night after seeing reports of the abandonment on television. The caller said he had seen "a very pregnant woman in the area of the bin an hour or two before," Young said.

"That's not very much to go on," he said.

Coke, the social worker, said state law prevents her from discussing Baby Doe's specific case. She did describe procedures used in similar cases, however.

"It's very rare" for a newborn infant to be abandoned, she said. "I've been here five years, and I don't know of another infant I can remember who was abandoned . . .

"Whenever a child is abandoned you can usually assume the mother was under a great deal of stress, and may have assumed she could not provide for the child," she said.

"In these cases, it's my experience the parent will eventually surface," Coke said. "Sometimes, someone who has been pregnant suddenly isn't, and there's no baby, and someone who knows her will call. Or sometimes they have a second thought and the parent will come forth."

If the parent or parents do appear, social workers will counsel them and try to decide the best solution for the child, Coke said.

Author: DON HUNTERDaily News reporterStaff
Section: Metro
Page: 1

Alaska Conference of Catholic Bishops

415 Sixth Street, Suite 300
Juneau, Alaska 99801
Ph (907) 586-2404 / Fax (907) 586-2405
E-mail citw@alaska.net

The Honorable Gabrielle LeDoux
House of Representatives
Alaska State Capitol
Juneau, Alaska 99801-1182

February 5, 2007

Re: HB 29: Safe Haven Bill

Dear Representative LeDoux:

Thank-you for sponsoring House Bill 29, an Act relating to infants who are safely surrendered by a parent shortly after birth. The Alaska Conference of Catholic Bishops (ACCB) supports passage of this legislation.

The intent of the bill is not to circumvent the statutory adoption process a responsible parent would utilize in relinquishing a child. Rather, the intent of the bill is to provide an alternative to a parent who might otherwise abandon his or her child in an unsafe place. We support the bill because it might save the life of a child.

We find it truly sad that our society needs a "safe haven" bill at all. Unfortunately, the weak and vulnerable in society from conception to natural death are often treated as objects or things to be used, abused or discarded instead of being treated with dignity as very human life deserves. We also find it sad that a person with a newborn child feels so isolated and alone that abandoning his or her child in an unsafe place seems to be the only alternative available. The bill does not address these larger issues and is not a long term solution but even if only one life is saved, the legislation is worthy of passage.

We, therefore, urge support for HB 29. We further support the Office of Children's Services developing a public information campaign about the legislation should it pass to increase the bill's effectiveness.

Sincerely:

Chip Wagoner
Executive Director
Alaska Conference of Catholic Bishops

ALASKA WOMEN'S LOBBY

AWL Mission: To defend and advance the rights and needs of Women, Children and Families in Alaska

P.O. Box 20891
Juneau, Alaska 99802-0891
www.akwomenslobby.org

Position Paper

HB 322, SAFE SURRENDER OF BABIES
April 2006

The Alaska Women's Lobby supports HB 322. The bill is an important safety measure to increase the likelihood that troubled parents will turn over their newborns to medical or other emergency personnel instead of leaving them in potentially dangerous situations.

Beginning in Texas in 1999, "Baby Moses laws" or infant safe haven legislation has been enacted as an incentive for mothers in crisis to safely relinquish their babies to a safe haven where the baby will be protected and provided with medical care until a permanent home can be found. Safe haven laws generally allow the parent, or an agent of the parent, to remain anonymous and to be shielded from prosecution for abandonment or neglect in exchange for safely surrendering the baby to a safe haven. According to a report of the Alan Gattmacher Institute, as of June 2005, these laws exist in 45 states. It is time for Alaska to join these other states.

Variations by state include limits on the infant's age at time of relinquishment (72 hours to 1 year) and the people and places authorized to accept the infants (e.g., Emergency Medical Services, hospitals, fire stations, and police stations). Most state policies adopt a "no questions asked" approach, but some states require that a person accepting the infant ask for a medical history. We support the one year time length this bill suggests.

One important issue to consider as the bill moves through the committee process is public education about the bill when it becomes law. In 2003, 15 states had mandated public information campaigns to increase public awareness of safe haven legislation. Several common elements of such campaigns include toll-free hotlines, pamphlets and written material, and public service messages. Funding should be provided so that once the service is available, those who are eligible to receive the infants can be trained and the public can be made aware of the service throughout the state.

Thank you for hearing this piece of legislation. Creating avenues for parents to relinquish newborns in a way that protects both the parents and the newborns should lessen the odds of finding babies abandoned in dumpsters or empty parking lots.

Planned Parenthood of Alaska

Testimony
House Bill 322

Planned Parenthood of Alaska applauds Representatives LeDoux and Representative Gruenberg for introducing the "Safe Surrender" bill. House Bill 322 allows a parent to surrender a newborn at a designated safe place where someone can attend to the infant's needs. Any parent who relinquishes an unharmed infant under this bill will have total anonymity. Sixteen states have already passed similar laws. President Bush signed the first Safe Surrender bill into law while he was governor of Texas.

The decriminalization of infant abandonment is an important step to help young women deal with an unwanted pregnancy. Alaska's open adoption law, while securing adoptee rights, may deter women from adoption and push them toward abortion. Many of these women do not want their families to know about their pregnancy. There is no guarantee of privacy in open adoption; furthermore, adoption is a complicated and intrusive process. It requires permission from the father, questioning, paper work, etc. Safe Surrender is an offer of assistance to women who might otherwise abandon a newborn. Under existing law the police track down a woman who abandons an infant. Illegal abandonment can lead to a baby's death and the mother's prosecution.

This is a first step. Safe Surrender does not address the societal ills that lead to unintended pregnancy and the drastic acts of infanticide and abandonment. Teens need to know if they make a mistake their family and society will treat them compassionately. Young people need to have honest and medically accurate sex education. We need enhanced out-reach and support for at-risk parents. Greater access to birth control, including insurance coverage of all FDA approved contraception, should be made available.

Therefore, Planned Parenthood of Alaska supports this bill.

Sincerely,

Clover Simon, MSW
Planned Parenthood of Alaska
4001 Lake Otis Pkwy
Anchorage, AK 99503
907.770.9705

FRANK H. MURKOWSKI, GOVERNOR

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

OFFICE OF CHILDREN'S SERVICES

P.O. BOX 110630
JUNEAU, ALASKA 99811-0630
PHONE: (907) 465-3191

April 24, 2006

Honorable Representative Gabrielle LeDoux
Alaska State Legislature
State Capitol, Room 412
Juneau, AK 99801-1182

Dear Representative LeDoux:

Thank you for your work this legislative session on House Bill 322. Passage of this bill may prevent harm to some infants as it allows a parent to safely surrender their child without fear of criminal prosecution.

The Office of Children's Services supports HB 322 and is interested in collaborating with you on new state law that would provide an infant who may otherwise be abused or neglected with the opportunity for a stable and loving home.

Thank you for your commitment to Alaska's children and their families.

Sincerely,

Tammy Sandoval
Deputy Commissioner

AMERICAN COLLEGE
of NURSE-MIDWIVES
With women for a lifetime

Alaska Chapter-ACNM
P.O. Box 243091, Anchorage, Alaska 99524-3091
907-566-3775, Fax 907-561-1429
www.alaskamidwives.org

February 12, 2007

RE: In support of HB 29 "Safe Surrender of Infants Act"

I am writing on behalf of the Alaska Chapter of the American College of Nurse-Midwives (AK-ACNM) to express our support for HB 29.

We believe that providing parents who are overwhelmed, or otherwise incapable of caring for their infant, an avenue for safe surrender will save lives and protect these fragile, vulnerable children from harm.

We respectfully request that funding for training those eligible to receive infants and a public awareness/education campaign be addressed during the hearing process.

Thank you very much for taking our opinion into consideration during your deliberation on this important matter.

Sincerely,

Laura Sarcone ann

Laura L. Sarcone, ANP, CNM
Legislative Liaison
AK-ACNM

ALASKA'S WOMEN'S LOBBY
AWL Mission: To defend and advance the rights and needs of Women, Children and Families in Alaska

P.O. Box 20891
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Support for HB 29, Safe Havens
February 2007

The Alaska Women's Lobby supports HB 29. The bill is an important safety measure to increase the likelihood that troubled parents will turn over their newborns to medical or other emergency personnel instead of leaving them in potentially dangerous situations.

Beginning in Texas in 1999, "Baby Moses laws" or infant safe haven legislation has been enacted as an incentive for mothers in crisis to safely relinquish their babies to a safe haven where the baby will be protected and provided with medical care until a permanent home can be found. Safe haven laws generally allow the parent, or an agent of the parent, to remain anonymous and to be shielded from prosecution for abandonment or neglect in exchange for safely surrendering the baby to a safe haven. According to the latest statistics these laws exist in 47 states. It is time for Alaska to join these other states. *We appreciate the sponsor's 21 day limit on the infant's age but would encourage committee discussion on what would be the best limit for Alaska.*

One important issue to consider as the bill moves through the committee process is public education about the bill when it becomes law. In 2003, 15 states had mandated public information campaigns to increase public awareness of safe haven legislation. Several common elements of such campaigns include toll-free hotlines, pamphlets and written material, and public service messages. Funding should be provided so that once the service is available, those who are eligible to receive the infants can be trained and the public can be made aware of the service throughout the state.

Thank you for hearing this piece of legislation. Creating avenues for parents to relinquish newborns in a way that protects both the parents and the newborns should lessen the odds of finding babies abandoned in dumpsters or empty parking lots.