STATE OF MINNESOTA

BOARD OF CHIROPRACTIC EXAMINERS

Proposed Permanent Rules Relating to Prepay Plans

STATEMENT OF NEED AND REASONABLENESS (AMENDED)

1. ALTERNATIVE FORMAT

Upon request, this Statement of Need and Reasonableness (Hereinafter "Statement") can be made available in an alternative format, such as large print, Braille, or Cassette tape. To make a request, contact the Board at:

Minnesota Board of Chiropractic Examiners
2829 University Ave. SE, Suite 300
Minneapolis, MN 55414-3220
Phone: 651-201-2850
Fax: 651-201-2851
TTY: 1-800-627-3529

2. INTRODUCTION

The Minnesota Board of Chiropractic Examiners (hereinafter "Board") is the regulatory agency empowered with the responsibility of regulating doctors of chiropractic in the State of Minnesota. The Board was codified originally in 1919, but the general rule making authority by which rules are promulgated originates in the 1983 legislative session. Pursuant to Minn. Stat. §14.23 (2008) the Board hereby affirmatively presents the facts establishing the need for, and reasonableness of the establishment of rules related to the establishment and implementation of pre-pay plans.

In order to adopt the proposed rules or amendments to the rules, the Board must demonstrate that it has complied with all procedural and substantive requirements for rulemaking. Those requirements are as follows: 1) there is statutory authority to adopt or amend the rules; 2) the rules or amendments are needed and are reasonable; 3) all necessary procedural steps have been taken; and 4) any additional requirements imposed by law have been satisfied. This Statement demonstrates that the Board has met these requirements.

3. STATUTORY AUTHORITY

The general statutory authority of the Board to adopt or amend rules is codified in Minn. Stat. § 148.08 (2008) which authorizes the Board to "promulgate rules necessary to administer sections 148.01 to 148.105 to protect the health, safety, and welfare of the public, including rules governing the practice of chiropractic, and defining any terms, whether or not used in sections 148.01 to 148.105, if the definitions are not inconsistent with the provisions of 148.01 to 148.105." Research indicates that this authority was originally established in Session Laws Chapter 346, section 4 (Subd. 3) amending 1982 Statutes, Section 148.08. To date, this authority has not expired.

4. STATEMENT OF NEED AND REASONABLENESS

General Discussion

On both a local and national level, there has been utilization of what can generically be described as "pre-pay" plans, utilized ostensibly for the benefit of both doctor and patient. In short, the benefit to the doctor is reported as an improved revenue stream with less administrative overhead and improved communication with the patients regarding financial obligations.[1] Typically, the benefit to the patient may include reduced overall cost for care. While other benefits may be claimed by participants, these are the most common. However, it has become clear that the

[1] This presumes the proper and correct use of such plans, with full and understandable disclosure of all contractual elements, particularly the impact of early termination of the plan, along with the doctors timely and proper compliance with such termination.

implementation and administration of such programs result in considerable misunderstanding and are even potentially ripe for significant abuse.

More recently, these plans have now been coupled with the use of health care "credit cards," an inherently legitimate solution for those with limited funds to acquire ongoing health care, but which is also available for potential significant misuse. In fact, such misuse has very recently provoked the Minnesota Attorney General's office to file two separate civil complaints against licensee's alleged to have engaged in such improper use.[1] For the reader to understand the elements of the rule, an explanation of how these programs work, separately and in juxtaposition is necessary.

General Discussion - Pre-Pay Plans

While there are various permutations, the general frame of pre-pay plans is fairly consistent. Typically a patient enters a chiropractic clinic for an assessment as to the need for care. The chiropractor takes a history on the patient, and then provides an assessment via appropriate general physical, orthopedic, neurological, postural, chiropractic, and radiological exams. Based upon the results of these assessments, the chiropractor comes to a conclusion as to what it will take to resolve the patients problems. Typically, this is expressed in a certain number of visits within a prescribed period of time. For example, the chiropractor may conclude that the patient should engage in somewhere between 50-80 visits, over a years period of time.[2] Certainly, the reader can appreciate the notion that this (much like the orthodontic analogy) may result in a significant cost. This then leads to the second step in the pre-pay arrangement.

Let's assume that the chiropractor typically charges $50 for a chiropractic adjustment.[3] Should the chiropractor then be recommending 80 visits, simple math can illustrate that the total cost of such

---

1 The Board has been a co-complainant in both of these actions. Please see RE: State of Minnesota and Minnesota Board of Chiropractic Examiners vs Erik Okeson, D.C., individually and d/b/a/ Okeson Optimal Chiropractic; Court File No. 19HA-CV-09-7091. See also State of Minnesota and Minnesota Board of Chiropractic Examiners vs. Express Health, P.A. and Cory D. Couillard, DC. Court File No. 19HA-CV-09-5050 .

2 While this may be difficult to understand, the chiropractor will provide an analogy to orthodontic care, where the orthodontists training and experience tells him/her that so many visits over a set period of time will be necessary to resolve the patients dentition.

3 This example is purely for discussion purposes only, and should not be construed as a standard charge in the chiropractic field. The Board makes no assertions herein as to the average charge for a chiropractic adjustment.

care would then be $4000. This is a significant amount and may be a challenge for patients to pay. However, the chiropractor may then offer the patient a program, in which if the total cost of services is rendered at the beginning of care, the chiropractor would be willing to provide a significant discount as an inducement. Again, by way of example, perhaps the chiropractor offers a 30% discount if the patient "pre-pays" the account...that is pays it all up front in a lump sum, or in a very short pre-determined period of time. In this scenario, the patient would have saved $1200. (80 x $50 x .30 = 1200.) So in this example, the patient would pay $2800 ($4000 - $1200).[1] Such a "savings" could induce the patient to find a way to make such a payment up front in order to benefit from the savings.

Thus far in the explanation, there seems to be little problem with the program per se. The problem most commonly seems to occur when the patient elects to terminate the program early. It is at this point when the professional atmosphere often becomes "charged" as the patient now expects proper reimbursement of the unused portion of the funds. Moreover, and quite commonly, the doctor has not properly managed or disbursed these funds. This may result in a hardship for the doctor to extend the reimbursement, and those doctors who have poorly managed the program, may find themselves improperly restricting or reducing the legitimate reimbursement to the patient. For example the most common scenario seen by the Board, is for the doctor to recalculate the used portion based on the original retail charge and either reimburse the patient the significantly reduced difference or, depending on where the patient is in the treatment regimen, may conclude that the entire amount has been "earned" and no reimbursement is available. This results in a disparity between the patients expectations, and the actual reimbursement...a common recipe for a complaint.

---

1 Another way to view this is from the discounted charge. A $50 dollar charge at a 30% reduction equals a net charge of $35.

The following shows an example in the difference in reimbursement for a patient using the above numbers, but who elects to terminate the program after 50 visits.

	Doctors Expectations	**Patient's Expectations**
Amount Paid	$2800.00	$2800.00
Used (50 visits)	2500.00§	1750.00‡
Reimbursement	$300.00	$1050.00

§ Reimbursement based on retail charges: 50 visits x $50 = $2500

‡ Reimbursement based on Discounted charges: 50 visits x $35 = $1050

This example shows that the patient is going to receive $750 less than anticipated. It is highly likely this will result in a complaint. However, let us now add the new variable which has been juxtaposed with the "pre-pay" plans over approximately the last two years. Enter, the health care "credit-card."

General Discussion - Health Care Credit Cards

There are companies who produce and distribute credit cards which are designed primarily for use in paying for health care charges which the patient cannot pay in a lump sum. An excellent example (as previously used) is orthodontia. It is not uncommon that an orthodontic plan may cost $5000-$7000...difficult for most people's pocketbook. However the health care credit card allows for full payment, with the consumer allowed to pay the credit card over time. In fact, the more commonly used company allows for no interest, provided that all charges are paid within a year, and all bills are paid on time.[1]

Ostensibly, the patient must understand that this is a credit card and that they are responsible for payment of the charges. Moreover, they must authorize the application of such charges, usually accomplished by the filling out of an application and the provision of credit information. Finally, in order to generate an actual charge there is typically a charge slip which must be signed by the

[1] It is of significant concern that failing to pay on time, or complete payment within a year may result in interest rates as high as nearly 30%, but this is beyond the scope of this discussion.

patient. However, the credit card company allows for online input via a computer terminal in the doctors office. As a result, the company relies on the veracity of the doctor, who is providing the information on the patient's behalf.[1] This creates conditions which are exploitable and abusable. In effect, these conditions place the doctor in control of the patients money, by allowing the doctor to establish a credit line for the patient, and then charge the credit line without authorization.

Finally, the juxtaposition of these two events creates conditions which when exploited result in a significant harmful outcome to the patient. The Board has encountered situations in which the combined use of these two elements have resulted in severe credit damage to patients, including in at least one case, the denial of a mortgage for the purchase of a home. As stated earlier, the situation has become so egregious that the Minnesota Attorney General has intervened with regard to a couple of such cases.

2500.7000 Prepay Plans

Subpart 1. Description. This section defines the components that make up a prepay plan and requires a written description of what is included in the plan.

Subpart 2. Escrow Account. This section requires that any payments made in advance of services rendered be separately identified and accounted for, and placed into a different account to prevent commingling of such funds with the doctors operating funds. This section also requires that funds may only be transferred as money is earned by the provision of services, or for the purposes of reimbursement for a plan which is terminated early. In this manner the doctor avoids both being paid for services not rendered, and maintains a fund for reimbursement for those cases which terminate early. This section also provides for the distribution of interest to the patient in the event the account is an interest bearing account. Finally, this section provides for regular reconciliation of the account in order to maintain its integrity.

Subpart 3. Written Plans. This section provides that all plans be in writing and signed by both doctor and patient. It also provides for a detailed description of what services are and are not covered by the plan. As a result of this section, the patient may receive an accounting of the status of their funds on a timely basis. Additionally, this section provides for a clear explanation of what

---

[1] This may also apply to the licensee's staff who is/are operating under the direction of the doctor.

reimbursement policies and formulae will be utilized should the patient or doctor elect to terminate the program early. This would include any policies which may result from intervening events such as a worker's compensation or other personal injury, which may require a modification of the treatment regimen. Finally, this section concludes with a requirement that the doctor notify the patient when any pre-paid funds have been exhausted.

Subpart 4. Limitation on number of service treatment dates per plan. This provision limits the number of treatments which can be calculated on a per plan basis. In so doing, there is a limitation on the potential loss by the patient. However, the patient is free to enter into a follow up plan with the doctor if more treatment is recommended by the doctor and acceptable to the patient. In this manner there is no limitation on the total number of treatments, but merely a stop-gap measure to give the patient the opportunity to affirmatively decide to continue such care.

Subpart 5. Billing to 3rd party payors. If a doctor establishes or agrees to a discounted fee, then s/he may not bill a 3rd party payor for a fee different than that which is charged. To do so, runs the risk that the doctor is actually paid a fee in excess of what is actually charged. This section requires the doctor to bill for actual charges, rather than to bill for the retail charge.

Subpart 6. Right of Cancellation. When a patient has entered a doctors office in pain or discomfort, they are in a vulnerable state. Further, it is a well established understanding that doctors have considerable power and influence over patients. Some doctors using such plans as described herein, have become adept at exercising this influence and exploiting this pain or discomfort to entice the patient to enter into such a plan. Commonly these interactions take place in the doctors office with all the trappings of the doctors authority, including licenses and certificates on walls, X-ray view boxes with X-rays on them, therapy equipment strewn about, etc. Patients in this state of mind are vulnerable to such inducements, and need an opportunity to exercise sound judgement separate from such influence, in order to make well considered decisions about the long term impact of their health care. For this reason, the Board seeks to provide a 3 day right of recision for the patient who may develop second thoughts about the choice they made in the office.

As a practical matter, if the contract is a good one, and the patient truly believes this is the best health care choice for them with all things carefully considered, then the contract will stand. However, should the patient come to a different conclusion, there should be no penalty for doing so.

This provision offers the patient an opportunity to have this time and be able to come to a different conclusion absent any undue influence. Should the patient's care be indemnified by a 3rd party, then the doctor is prohibited from submitting the charges until after the 3rd day has passed. Finally, this provision provides for full disclosure to the patient of this right of recision and also provides for a timely reimbursement of any monies paid should the patient exercise this option to rescind.

As a result of comments received, the Board has revised the language of the proposed prepay plan rule. The comments received seemed to fall into three categories:

1. Belief that a limitation of 50 visits in a plan would unfairly hamper a chiropractor who needed to provide more visits to a patient;
2. A belief that requiring an escrow account for those pre-pay plans which utilized smaller dollar amounts was overly burdensome; and
3. A belief that persons can enter into any type of contract with any conditions, and the contract would prevail above all else, including law.

To begin with, number 3 fails on it's face. Certainly, persons cannot establish contractual conditions which violate state law or Administrative Rules. If this were the case, then any two persons could simply conspire to create a contract which holds them exempt from any rule (or statute) with which they disagree. Accordingly, there was no additional effort applied to this request.

With regard to number 1, the Board was not planning a full limitation on the number of visits, and this position reflects a misreading/misunderstanding of the provision which was being considered. The Board was considering a limitation on the number of visits *per plan* (See line 3.9) which would help prevent the patients from overextending themselves. However, the proposed rule also allowed for the renewal of a plan, should the 50 visits be reached, and the patient and doctor feel that additional visits would be of benefit. (Please see Line 3.10-11)

Finally, the Board considered the impact of such a rule on very low level plans, which by their nature are typically short term, and if/when there is a dispute over termination of the plan, the dollar amounts under dispute are typically marginal. Accordingly, the Board has reconsidered this and set a threshold of $1000 for such plans, before this rule will apply. (See lines 1.4-1.9)

For the Reasons stated above, the Board believes these rules to be needed and reasonable.

5. COMPLIANCE WITH PROCEDURAL RULEMAKING REQUIREMENTS

Pursuant to Minn. Stat. §14.23, (2008) and in accordance with the requirements established in Minn. Stat. §14.131 (2008), the Board has prepared this Statement of Need and Reasonableness which is available to the public.

The Board will publish a Dual Notice of Intent to Amend or Adopt the Rules With or Without a Public Hearing in the **State Register** and mail copies of the Notice and proposed amendment(s) to persons registered with the Minnesota Board of Chiropractic Examiners pursuant to Minn. Stat. § 14.22, subdivision 1, and §14.14, subdivision 1a. As required by Minn. Stat. §14.22, and M. R. 2010.0300, the notice will include the following information: 1) that the public has 30 days in which to submit comments in support of, or in opposition to, the proposed rule(s) and that comment is encouraged; 2) that each comment should identify the portion of the proposed rule addressed, the reason for the comment, and any change proposed; 3) that if 25 or more persons submit a written request for a public hearing within the 30-day comment period, a public hearing will be held; 4) the manner in which persons shall request a public hearing on the proposed rule; 5) the requirements contained in section 14.25 relating to a written request required for a public hearing, and that the requester is encouraged to propose any change desired; 6) that the proposed rule(s) may be modified if modifications are supported by the data and views submitted; and 7) that if a hearing is not required, notice of the date of submission of the proposed rule to the Chief Administrative Law Judge for review will be mailed to any person requesting to receive the notice; 8) that if a hearing is required, the time, date and location of the hearing. Further, in connection with clauses (1) and (3) above, the notice will also include the dates on which the comment period ends.

The Board will then submit the proposed amendment and notice as published, the amendment as proposed for adoption, any written comments which have been received, and this Statement of Need and Reasonableness to the Administrative Law Judge for approval of the proposed rules or amendments as to their legality and form.

These rules will become effective five working days after publication of a Notice of Adoption in the **State Register.**

6. RULE DEVELOPMENT PROCESS

The development of rules follows action by the full Board in which an authorizing resolution is adopted. The proposed rule is then submitted to the rules committee for language development, and the Request for Comments is published. The rules committee consists of three Board members, (at least one of which is a public member) and the executive director. At this point, the rules follow the rest of the statutory requirements established in the Administrative Procedures Act.

7. DESCRIPTION OF CLASSES OF PERSONS PROBABLY AFFECTED BY RULE

Minnesota Statute §14.131 (1) (2008) requires that the SONAR include a description of the classes of persons who probably will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule. It is the Board's position that the class(es) of persons that will be affected by the rule(s) will be doctors of chiropractic who may wish to utilize pre-payment plans, and/or health care credit cards as well as the patients who may wish to participate in such plans, or who may wish to use the health care credit cards to pay for care.

8. PROBABLE COSTS TO AGENCY(IES) OF IMPLEMENTATION AND ENFORCEMENT

Minnesota Statute §14.131 (2) (2008) requires that the agency promulgating the rule include any information ascertained regarding the probable costs to the agency and to any other agency of the implementation and enforcement of the proposed rule(s) and any anticipated effect on state revenues. The Board has an annual budget of $160,000 to be used for Attorney General's costs, utilized in its efforts at enforcement. Therefore, costs for enforcement would be unable to exceed that amount plus any amounts required of staff time. However, the nature of the rule(s) proposed are such, that it is expected that the costs required to enforce these requirements would be minimal. There are no other state agencies responsible for implementing or enforcing the Board's rules.

Therefore the Board does not believe other state agencies will incur any costs if these rules are adopted. In fact, there is room to argue that this will reduce costs to the Board by establishing clear criteria under which doctors of chiropractic may implement these plans, providing clear disclosure to the patients, and providing a reasonable time in which the patient can make reasonable decisions. Accordingly, the Board believes this would result in reduced complaints in this area. These proposed rules will have no impact on the State's general fund, since the Board's entire budget is administered through the Special Revenue Fund, rather than the General Fund.

9. DETERMINATION OF LESS COSTLY/INTRUSIVE METHODS FOR ACHIEVING PURPOSE

Minnesota Statute §14.131 (3) (2008) requires that the agency promulgating the rule include any information ascertained as to whether there are less costly or less intrusive methods for achieving the purpose of the proposed rule(s). The Board submitted the rules to the scrutiny of the "Request for Comments", as well as publishing information in the Board newsletter. Furthermore, the professional association representing the professional interests of the licensees receives all rules promulgation mailings. To date, no information has been presented which suggests less costly or intrusive methods for accomplishing the purposes of the proposed rule. Additionally, there will be a Notice of Intent to Adopt published in the State Register as part of the normal process of promulgation. This will allow another opportunity for interested parties to make such comments which will become part of the record, and which will be reviewed by the full Board before final adoption. The Board will have the opportunity to submit the proposed rule(s) to additional changes if comments suggest less costly or intrusive methods to accomplish the task. Finally, the Board will consider final adoption at a public Board meeting, allowing a third opportunity for comment and modification if necessary. Nevertheless, the Board does not believe there are any less costly or intrusive methods for achieving this purpose.

10. DESCRIPTION OF ALTERNATIVE METHODS CONSIDERED

Minnesota Statute §14.131 (4) (2008) requires that the agency promulgating the rule include any information ascertained regarding a description of any alternative methods for achieving the purpose of the proposed rule that were considered by the agency, and why they were rejected in favor of the proposed rule. There were no other methods considered for achieving the purpose of the proposed rule(s). This stems from the fact that the Administrative Procedures act imposes limitations on State Agencies establishing enforceable policies by any method other than rule. While the objectives of some of the rules may be achieved by education to the profession, experience has shown that the outcomes of these attempts to educate the profession through such vehicles as the Board newsletter, are not consistent, and cannot be relied upon. Moreover, efforts such as this are costly, and do not have the force and effect of law. Therefore, there is no motivation for the licensees to comply even if they do become aware of the policy(ies). In order for the Board to establish standards by which the public can feel protected, and by which the licensees can measure their behavior, such policies must be the subject of rule or statute. Administrative Rules promulgation is the vehicle granted by the legislature to the agency to establish such policy(ies). The only other vehicle currently available to the Board to achieve these goals, is to utilize the Boards Rules Waiver authority. However, the Board uses this authority sparingly and not, typically, for an ongoing experience. The variance rule is typically utilized to address unanticipated situations. Accordingly, the Board believes rule making is the most appropriate vehicle to accomplish its goal.

11. PROBABLE COST OF COMPLIANCE WITH RULE

Minnesota Statute §14.131 (5) (2008) requires that the agency promulgating the rule include any information ascertained regarding the probable costs of complying with the proposed rule(s), as well as "including the portion of the total costs that will be borne by identifiable categories of affected parties, such as separate classes of governmental units, businesses, or individuals." Additionally, Minnesota Statute §14.127 (Session Laws 2008) requires that an agency must determine if the cost

of complying with a proposed rule in the first year after the rule takes effect will exceed $25,000 for: (1) any one business that has less than 50 full time employees; or (2) any statutory or home rule charter city that has less than ten full time employees. The Board anticipates minimal costs will be associated in complying with this rule amendment to any affected party and certainly no costs would meet those thresholds.

12. PROBABLE COST OF NOT ADOPTING PROPOSED RULES

Minnesota Statute §14.131 (6) (2008) requires that the agency promulgating the rule include any information describing the probable costs or consequences of not adopting the proposed rule, including those costs or consequences borne by identifiable categories of affected parties, such as separate classes of government units, businesses, or individuals. This is difficult to ascertain at this time. However, the Board has faced numerous such complaints with a significant increase in such complaints in just the last two years. Moreover, the Board has become a party to 2 separate civil actions in cooperation with the Office Of The Attorney General, for allegations of significant and egregious conduct employing these 2 very issues. Given that these actions are pending the total cost cannot be measured at this time. However, the Board hereby asserts that these costs will be substantial, and will largely be borne by the Board.

13. EVALUATION BY COMMISSIONER OF FINANCE

Minnesota Statute §14.131 (6) (2008) requires that the agency promulgating the rule must consult with the Commissioner of Finance to help evaluate the fiscal impact and fiscal benefits of the proposed rule on units of local government. Pursuant to a memorandum from the Minnesota Office of Management and Budget, Jim King, Executive Budget Officer, has concluded "there is no fiscal impact on local units of government." (See Attached.)

14. ASSESSMENT OF CONFLICT WITH FEDERAL REGULATIONS

Minnesota Statute §14.131 (7) (2008) requires that the agency promulgating the rule include any information ascertained regarding an assessment of any differences between the proposed rule and existing federal regulations and a specific analysis of the need for and reasonableness of each difference. Since the federal government is not involved in the licensure of doctors of chiropractic, it is believed that the rule(s) herein proposed offer no conflict with federal regulations.

15. DESCRIPTION OF ADDITIONAL EFFORTS TO NOTIFY

Minnesota Statute §14.131 (2008) requires that the agency promulgating the rule(s) include any information ascertained regarding additional notification to persons or classes of persons who may be affected by the proposed rule or must explain why these efforts were not made. The Board provides a newsletter mailed at no charge to all licensees as well as other persons, organizations, or agencies indicating interest in acquiring the newsletter. Notices regarding rule subject matter and invitations to acquire information on rules being promulgated are a standard part of the newsletter. Additionally, the Board maintains a current list of all persons or organizations indicating an interest in the Board's rules promulgation activity. The Board mails separate notification to all persons or organizations on this list. It is known that the professional association which represents the interests of the profession at large is a recipient of the newsletter, and is also maintained on the active rules notification list. Finally, beginning in October of 1998, the Board established a web site (www.mn-chiroboard.state.mn.us). Since that date, all statutorily required postings also appear on the Board's web site. The Board diligently attempts to make the profession and the public aware of the Board's web site. Beyond this, the primary affected parties to this rule are doctors of chiropractic who may wish to perform animal chiropractic. To that end, the Board submitted for consideration, an additional notice plan. This Plan was approved by the Honorable Eric L. Lipman, Administrative Law Judge on April 19, 2010 is attached and incorporated by reference herein.

16. STATE REGULATORY POLICY

Minnesota Statute §14.131 (2008) requires that this Statement describe how the agency, in developing the rules, considered and implemented the legislative policy supporting performance-based regulatory systems set forth in section 14.002 (2008). Minnesota Statute §14.002 states that

whenever feasible, state agencies must develop rules and regulatory programs that emphasize superior achievement in meeting the agency's regulatory objectives and maximum flexibility for the regulated party and the agency in meeting those goals. Clearly, this rule sets some restrictions on a doctor of chiropractor's conduct with relation to the implementation and utilization of those procedures described herein. However, previous inaction provided for no resolution of the problem, and in fact it appears to be increasing significantly. Therefore, the Board believes that this proposed amendment certainly meets the goal of superior achievement but seeks to do so with the least level of INflexibility which will meet the obligation of the Board to protect the public.

17. EFFECT ON LOCAL GOVERNMENTS

Minnesota Statutes §14.128 (2009 Minn. Laws. Ch. 152, s.1) requires that an agency must determine if a local government will be required to adopt or amend an ordinance or other regulation to comply with a proposed agency rule. Promulgation of this rule appears to have no such effect on any division of local government, which would require the adoption or amendment of an ordinance or other regulation.

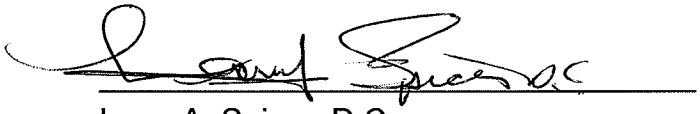
18. CONCLUSION

Based on the information contained herein, the Board has demonstrated that these proposed rules are both needed and reasonable to enable the Board to fulfill its regulatory and enforcement duties in accordance with current statutes and rules, and provide necessary and important services to applicants and former licensees. Accordingly, the Board hereby respectfully submits this Statement of Need and Reasonableness.

Dated: December 12, 2010

STATE OF MINNESOTA

BOARD OF CHIROPRACTIC EXAMINERS



Larry A. Spicer, D.C.
Executive Director

Attachments: Memorandum; Minnesota Office of Management and Budget (August 3, 2010)
Additional Notice Plan, Approved April 19, 2010