Occupational Regulation

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A Program Evaluation Report

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STATE OF MINNESOTA
OFFICE OF THE LEGISLATIVE AUDITOR
JAMES R. NOBLES, LEGISLATIVE AUDITOR

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Members
Legislative Audit Commission

In April 1998, the Legislative Audit Commission directed us to study Minnesota's system of occupational regulation. Legislators were concerned about whether occupational regulation was functioning in the public interest and whether regulation was needed in all cases in which it was proposed.

Minnesota has a complex, multi-faceted system of occupational regulation. Seven state departments and 26 independent boards regulate nearly 200 occupations. At best, it is difficult for the Legislature to monitor the activities of so many independent agencies.

We found that there are some problems with occupational regulation that require legislative attention. Application of the state's policy on occupational regulation is inconsistent and oversight of regulatory agencies needs to be improved. We suggest several alternatives for changing the process and organization of regulation and the process by which regulatory policy is set.

This report was researched and written by Elliot Long (project manager), Craig Helmstetter, Laura Martell, with assistance from Carrie Meyerhoff. We thank the departments of Health and Commerce and the regulatory boards for their assistance.

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Table of Contents

List of Tables and Figures

MINNESOTA OFFICE OF THE LEGISLATIVE AUDITOR

Occupational Regulation

SUMMARY

Many separate state agencies and boards are responsible for occupational regulation.

The statutory purpose of occupational regulation is to protect public health, safety, and welfare. Today there are almost 200 regulated occupations in Minnesota (not counting teachers' licences), but many policy makers in Minnesota and across the country question whether occupational regulation is needed as often as it is used. Many occupations have been newly regulated in Minnesota in the last 25 years. Many separate state agencies and boards are responsible for occupational regulation, and it is difficult for legislators and others to provide necessary oversight to be sure the public interest is being served.

An interim Senate subcommittee held hearings on occupational regulation in the fall of 1997, but no major action was taken during the 1998 session. In April 1998, the Legislative Audit Commission directed the Legislative Auditor to conduct a study of occupational regulation that would look at the effectiveness of the system as a whole. This study addresses the following questions:

- **What is the history of the policy debate on occupational regulation in Minnesota and other states?**

- **What constitutes Minnesota's system of occupational regulation? What occupations and professions are regulated and which state agencies and boards have regulatory authority? How does the system of regulation in Minnesota compare with occupational regulation in other states?**

- **How effective is Minnesota's system of occupational regulation? Is the state's policy on occupational regulation applied consistently? How effective is Legislative oversight of occupational regulation?**

Our overall assessment is that there are some problems with occupational regulation. But, generally, the problems we found are the same problems that have been uncovered and discussed in previous reports by others. Moreover, we do not think Minnesota has a crisis in occupational regulation. In our view, Minnesota today simply has many of the same occupational regulation issues that have persisted here and in most other states for decades.

We suggest ways to improve the administrative structure and procedures of occupational regulation. We do not, however, make recommendations on the core policy issues of "whether to regulate, and if so, how much." Those are policy decisions that must be made by elected officials. And, we think the Legislature already has enacted into law good criteria for making those choices. The "key" is the Legislature's willingness to apply those criteria more rigorously and consistently, both in deliberations on proposals for new or expanded regulation and in retrospective reviews of regulatory authority already enacted.

BACKGROUND

Occupational regulation has been the subject of much criticism.

Occupational regulation is intended to protect the public, but it has been the subject of much criticism, both in concept and execution. Regulating an occupation through the imposition of entry requirements such as education, experience, and examinations necessarily restricts the number of individuals employed in the occupation. A risk of occupational regulation is that it will be used to "fence out" competitors, allowing those in the profession to charge higher prices. Several studies have found that occupational regulation is linked to higher prices, leading researchers to conclude that legislators should carefully weigh the costs and benefits of every proposal to regulate an occupation.[1] Over the years occupational regulation has received other criticism as well. Critics claim that it limits inter-state mobility, excludes marginalized groups from regulated professions, is controlled by the professions it is supposed to regulate, and does not vigorously investigate consumer complaints or discipline practitioners who are guilty of unprofessional conduct.

A principal concern is that occupational regulation will "fence out" competition.

Nationally, occupational regulation has undergone several reforms. Many states have increased the number of public members on their regulatory boards, which some studies show to have a positive impact on the responsiveness of regulatory boards to public interests.[2] In Minnesota, most regulatory boards have at least two public members, but some analysts of occupational regulation continue to call for increased public representation.[3] Another major reform effort has been the centralization or coordination of regulatory activities under umbrella agencies. Advocates of this reform suggest that centralization provides administrative efficiency, reduces the influence of professional organizations, and simplifies the process of legislative oversight of occupational regulation. In Minnesota various commissions, reports, and legislators have proposed forms of regulatory centralization, but no major changes have been enacted.

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1 Carolyn Cox and Susan Foster, *The Costs and Benefits of Occupational Regulation* (Washington, D.C.: Federal Trade Commission, 1990).

2 Elizabeth Graddy and Micheal B. Nichol, "Structural Reforms and Licensing Board Performance," *American Politics Quarterly*, 18 no. 3 (July 1990), 394.

3 Moris M. Kleiner and Mitchell Gordon, "The Growth of Occupational Licensing: Are We Protecting Consumers?" *CURA Reporter* (Minneapolis: December 1996); L. J. Finocchio, C. M. Dower, N. T. Blick, C. M. Gragnola, and the Taskforce on Health Care Workforce Regulation, *Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation* (San Francisco, CA: Pew Health Professions Commission, October 1998).

Across the country, several important legislative reforms have been prompted by concern about occupational regulation.

Two legislative reforms with particular application to occupational regulation are known as "sunrise" and "sunset." In 1976, Minnesota became one of the first states to pass sunrise legislation when it amended Minnesota Statutes Chapter 214 to include criteria for occupational regulation against which any new or increased regulation were to be judged. The regulatory policy articulated by Chapter 214 recognizes the potential danger of occupational fencing and challenges proponents of regulation to demonstrate that regulation serves the public interest.

Sunset legislation mandates periodic reviews of regulatory programs in order for them to continue past a specified date. Sunset has not resulted in the widespread success which it once seemed to promise, and has never been a regular part of occupational regulation in Minnesota, but several authorities continue to call for the implementation of sunset reviews to improve legislative oversight and to eliminate regulatory programs that have become outdated.

The 1976 amendments to Chapter 214 also defined an active role for the Minnesota Department of Health in studying proposals for new regulation of health professions. It established the Human Services Occupations Advisory Council (HSOAC) to advise the Commissioner of Health on regulatory policy. The Council conducted 11 studies between 1976 and 1982, and 13 studies between 1984 and 1990. The 1976 amendments authorized the department to enact "title protection," a form of occupational regulation, through administrative rulemaking; and a number of HSOAC studies recommended title protection to the Commissioner.[4] Other sunrise studies recommended licensure to the Legislature. Still others recommended no regulation.

There have been several executive branch and legislative studies of occupational regulation over the years. In the mid-1970s the Department of Administration conducted a major study and published reports in 1976 and 1977. Among other things, the department recommended replacing all autonomous regulatory boards with advisory boards housed in various state departments. Following the study, a Senate Government Operations Committee task force on occupational regulation was established to follow up on the report's recommendations. The task force did not agree with the suggestion that the independent boards be abolished, although it recommended strengthening the relationship between boards and host departments that provided administrative services. Over the years, however, the relationship between boards and host agencies has become attenuated rather than strengthened, especially for the boards affiliated with the Minnesota Department of Health. Copying and data processing, a major concern in the Department of Administration report, have become less expensive in the last 20 years and the economies available from centralization of these services have greatly diminished or vanished altogether.

In the 1990s, there have been two interim committees of the Legislature, one in the House and one in the Senate, that studied the issue of occupational regulation

4 Title protection restricts the use of a title, such as "athletic trainer," to those who are credentialled by the state, but does not prohibit others from providing the same services if they use a different title. Minnesota law refers to this type of credential as registration, but the nationally used term for title protection is "certification."

and took testimony. However, neither committee proposed legislative reforms that were passed into law.

MINNESOTA'S SYSTEM OF OCCUPATIONAL REGULATION

One of the primary purposes of our study was to assemble a detailed description of Minnesota's system of occupational regulation. We describe the types of regulation, the organization of regulation, and we compare the system of occupational regulation in Minnesota to occupational regulation in other states.

There are various types of occupational regulation, including licensure, certification, and registration.

Occupational regulation can be accomplished in several ways. The most restrictive form of regulation is *licensure* which restricts the right to practice a legally defined occupational scope of practice to license holders.[5] An example is the right to practice medicine or law. A less restrictive form of occupational regulation is *certification* which legally restricts the use of a professional or occupational title, but not the right to provide similar or identical services.[6] For example, no one but certified athletic trainers can use that title. A still less restrictive form of regulation is *registration* where a roster of enrolled practitioners is maintained by state government without any restriction on the right to practice or the right to use a title.[7] Pharmacy drug researchers are registered by this definition of the term.

There are still other forms of occupational regulation used in Minnesota. One model that has been the subject of considerable discussion in recent years is illustrated by the regulation of unlicensed mental health practitioners by the Office of Mental Health Practice in the Minnesota Department of Health.[8] While a number of mental health professions are licensed by regulatory boards (including clinical psychologists, marriage and family therapists, and social workers) others may provide psychotherapy and other mental health services for remuneration without any state license or certification. Minnesota law, nevertheless, specifies prohibited conduct for unlicensed mental health practitioners as well as reporting requirements that they must meet. Failure to meet these statutory requirements can be the basis for disciplinary action.[9]

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5 Scope of practice is defined as the techniques and activities legally reserved for license holders.

6 We are referring here to statutory certification. There are many important private certification programs.

7 These are the predominant national definitions of licensure, certification, and registration, used by the Council of Licensure, Enforcement, and Regulation (CLEAR) and the Pew Health Professions Commission. However, this usage is not generally followed in Minnesota. The term "registration" is often used in Minnesota to mean title protection, for example, and certification is often the term used for practice protection. Chapter 214 defines registration and licensure, but not certification.

8 Established by *Minn. Stat.*§148B.60

9 *Minn. Stat.* §148B.68

In addition, there are common law and statutory causes of civil action as well as criminal prohibitions that can sanction or prevent illegal practices by a wide variety of service providers. Prosecutors and dissatisfied consumers can use these laws to seek punishment and restitution whether or not occupations are regulated. Consumers can also be protected against incompetent practice through business, industrial, or facility regulation. In fact, Chapter 214 specifies the conditions under which occupational regulation is required and calls for the least restrictive form of regulation to be preferred.

Minnesota has a complex multifaceted system of occupational regulation.

Minnesota has a complex, multifaceted system of occupational regulation. Occupations are regulated by 14 health-related licensing boards, 12 non-health-related boards, and 7 departments of state government. Minnesota regulates more occupations than most other states and regulates professions through a variety of organizational arrangements. Our report presents a complete list of regulated occupations, and we have separately published a Directory of Regulated Occupations which provides basic information on each occupation.[10] In general, we found:

- **There are about 188 regulated occupations and professions in Minnesota, not counting many separate teachers' licenses.**

Some of the regulated occupations are familiar: there are about 112,000 teachers, 88,000 nurses, 15,000 physicians, and 21,000 attorneys. On the other hand, some regulated occupations are small and obscure, such as crop hail adjuster or professional karate referee. Weather modifier has been a licensed occupation since 1977 but no licenses have ever been issued.

There are many separate organizational entities with regulatory authority. While most of the small occupations are regulated by state departments, some independent regulatory boards regulate fairly small occupational groups such as the Board of Optometry (801 optometrists), the Board of Podiatry (142 podiatrists), or the Board of Private Detectives and Protective Agents (300 detectives and agents).

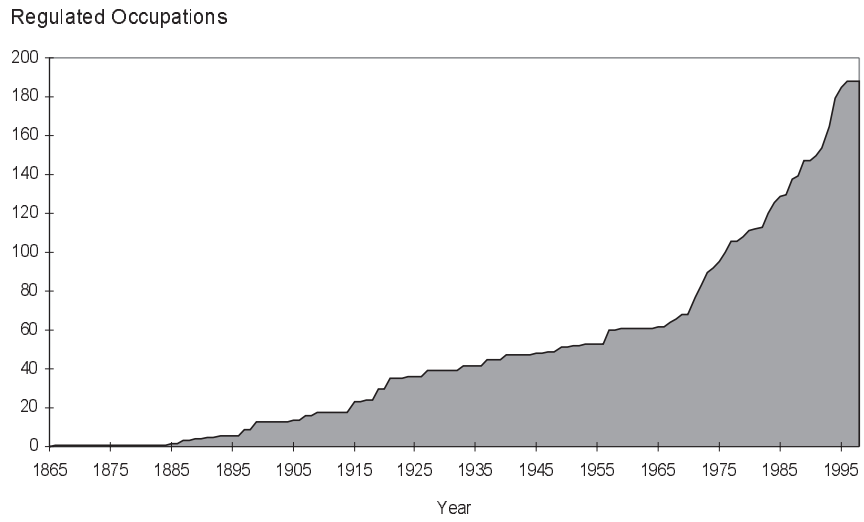
Figure 1 illustrates the explosive growth of regulated occupations in recent decades. During the period 1866-99, there were 13 occupations licensed, including physicians, dentists, attorneys, and barbers. In the period 1900-09, there were five new occupations regulated; in the 1910s there were 12. Between 1920 and 1970, the number regulated each decade was 10 or fewer. But there were 40 newly regulated occupations in the 1970s, 39 in the 1980s, and 41 so far in the 1990s. Indeed, we found that:

- **Despite its sunrise statute, Minnesota regulates more occupations than all but 12 other states, and now regulates about 31 occupations that are regulated by fewer than nine other states.**

10 The Directory is available at http://www.auditor.leg.state.mn.us/pe9905.htm.

The number of regulated occupations has grown rapidly in recent decades.

Figure 1: Cumulative Number of Occupations Regulated in Minnesota by Year



SOURCE: Program Evaluation Division survey.

EFFECTIVENESS OF OCCUPATIONAL REGULATION

Several problems with occupational regulation merit legislative attention. First:

- **The state's policy on occupational regulation articulated in Chapter 214 is not applied consistently or effectively.**

Chapter 214 says that no regulation shall be imposed upon any occupation unless required for the public health, safety, or well-being, and it lays out four criteria for regulation:[11]

- Whether the unregulated practice of an occupation may harm or endanger the health, safety, and welfare of citizens, and whether the potential for harm is recognizable and not remote;

- Whether the practice of an occupation requires specialized skill or training and whether the public needs and will benefit by assurances of initial and continuing occupational ability;

- Whether citizens are or may be effectively protected by other means; and

11 Minn. Stat. §214.001

- Whether the overall cost effectiveness and economic impact would be positive.

If regulation is found to be necessary, Chapter 214 requires the least restrictive mode of regulation to be used. The basic thrust of the statute is that the burden of proof is on the proponents of regulation to make a case for regulation. A threat to public health or safety must be shown to be immediate, not remote.

The state has a policy on occupational regulation, but it is not applied consistently.

There are several reasons why the criteria have not been applied in a rigorous, consistent manner. While Minnesota has a policy governing the regulation of occupations, it does not have a process that might ensure that the policy is applied in a consistent fashion. The application of the Chapter 214 criteria or the collection of data that might make this possible is not the specific responsibility of any state agency or legislative staff office. The Human Services Occupational Advisory Council in the Minnesota Department of Health performed this function on and off between 1976 and 1996 for health occupations. Currently, legislative committees develop some of the information through hearings or staff work, but most of the time occupational regulation issues do not command the time and attention by committees that application of the criteria requires.

Another important factor that interferes with the process is the political influence exercised by occupational groups and their representatives. This was mentioned by many legislators we talked with and ranked high on the list of problems mentioned in a survey we conducted of board and agency managers responsible for occupational regulation. Some larger occupational groups have considerable power, but even small groups with narrow concerns can be influential over time and can interfere with the process by which statutory policy is applied in a given situation. As a recent national report makes clear, this is not a problem that is limited to Minnesota, but is an important national concern related to occupational regulation.[12]

We conclude that there is a need for a mechanism that will control the number of proposals and provide better information bearing on the statutory criteria for regulation. We suggest several options for improving the process by which the Legislature handles proposals for occupational regulation. Some of these are recommendations that have been made before and even tried before, but we think there are compelling reasons to try again. As one option:

- **The Legislature could require a study of whether each major proposal for new or increased regulation meets the Chapter 214 requirements.**

As we mentioned, the Minnesota Department of Health (MDH) used to perform such studies for the health professions, and many in the Legislature and elsewhere believe the studies were useful, even though the recommendations of MDH to the Legislature were not always heeded. We think similar studies should continue to be carried out for every major proposal for new regulation by MDH or other agencies in the case of non-health occupations or professions.

12 Finocchio et al., *Strengthening Consumer Protection*, 21.

Another option worth considering is:

- **Committees hearing bills that propose new occupational regulation could require proponents to submit specific information as a condition for obtaining a hearing.**

Proponents of new occupational regulation should be required to provide specific information.

Proponents could be asked to respond to some of the same questions MDH asked health occupations seeking regulation to address in the HSOAC studies it conducted in the past. Other states have developed questionnaires that cover similar ground, and these could be used as a model. Maine has put a set of questions into its statutes governing occupational regulation. One way or another it would be beneficial for legislative committees to use an expanded and operationalized version of the criteria for occupational regulation contained in Chapter 214.[13]

It can be anticipated that some groups seeking regulation would be unable to provide the required information and analysis. The ability to do so is not irrelevant to the regulatory issue under consideration, however. If an occupation or profession has not reached a certain level of maturity and separate identity, it cannot be regulated effectively. To be regulated, an occupation ought to require knowledge, skills, or abilities that are teachable and testable; the skills should be taught in accredited programs; these programs should be distinguishable from related occupational or professional programs; and the occupation should have its own trade or professional association. It should not be unduly burdensome for an occupation or profession that has reached this level of separate identity to respond to a detailed request for information.

Looking at Minnesota's history and at other states with sunrise laws, we see a number of organizational alternatives that could be used to carry out the studies described above. These include specialized legislative committees, possibly a joint legislative commission, organizational units in the Department of Health or Commerce (depending on the type of regulation under consideration), or a newly created council or organization of some kind. There are arguments in favor and against each of these alternatives. For example, we have observed that sustained focus on applying the policy articulated in Chapter 214 tends to get lost in state agencies with ongoing regulatory programs, and in legislative committees with other, often more compelling issues before them.

Legislative Oversight

Seven departments of state government regulate over 100 occupations. In addition, there are 14 independent boards responsible for regulating 34 health professions and 10 non-health-related boards that regulate 51 other occupations and professions, not counting 2 boards appointed by the Supreme Court that license and regulate lawyers. These boards are independent state agencies in that they are not subject to the authority and control of any state agency. All but a few of the boards are appointed by the Governor. We talked with legislators and state

13 Figure 3.2 of our full report lists some of the specific questions that could be asked.

agency and board staff and reviewed the biennial reports that many boards are required to produce and conclude:

- **Legislative oversight of occupational regulation is inadequate, partly as a consequence of the fact that there are so many separate entities with regulatory responsibilities.**

Legislative oversight of occupational regulation is difficult, but needs to be improved.

One indication of the problem is the use of the biennial reports that Chapter 214 requires 24 boards and the Department of Health to produce. We reviewed the available biennial reports of each of the boards and agencies. We formally requested the reports due in 1996 and reviewed the 1998 reports that were available by November 1998. We found:

- **Several boards or agencies did not submit a report for 1996.**

The Board of Assessors, the Board of Dietetics and Nutrition, the Board of Optometry, and the Office of Mental Health Practice did not submit reports for 1996 as required. In addition, the Minnesota Department of Health is supposed to submit a summary of the health-related reports by December 15 of each even-numbered year, but it has not done this at least since 1990.

In addition,

- **The biennial reports are not widely read, and in many cases they appear to not be read at all.**

The reporting requirements have been changed little since 1976 when Chapter 214 was amended and substantially put into its current form. In our judgment, the Legislature ought to review these requirements and revise them. The reports are required to provide some data that may no longer be of interest. For example the reports must include the hours spent by all board members in meetings and other activities and the locations and dates of examinations. Most of the boards respond quite literally to the statutory specifications, even though the specifications are awkward and the results less than useful. While Chapter 214 invites the boards to include any information which board members believe will be useful, few reports make an effort to provide such information.

Almost all the boards issuing the reports say their readership and use is extremely limited. The reports vary in quality, but, in our judgment, even the best of the reports are not forthcoming and easy to read. There is an absence of needed explanatory notes and considerable expertise is required to understand the reports. The reports have changed little over the years, and without feedback from users there has been little incentive for the boards to improve the usefulness and readability of the reports.

Some of the topics covered by the reports are of significant interest, however, and deserve attention. One example is the statutory requirement to report on the number of complaints against licensed professionals, the nature of the complaints, and the outcome of complaint investigations. Most of the reports provided this data, although it was often not presented completely or clearly, and none of the reports provided historical tables drawn from previous reports which could have

shown how the numbers were changing over time. Most reports did not report the number of open cases at the start and at the end of the biennium, an essential point of information if legislators or the public want to know if the "backlog" is increasing or decreasing over the biennium.

Regulatory boards and state agencies that regulate occupations need to improve their biennial reports.

We conclude that Chapter 214 does not adequately specify the contents of a truly useful report. It requires information that is not necessary or available from other sources, and it does not require important information such as adequate data on complaint investigations and the outcome of investigations. Furthermore, the boards and agencies that are required to report have not designed a useful, readable report on their own. It may not be realistic to expect the boards to put potentially embarrassing information in the reports, so it is important for the Legislature to consider the contents of the reports. We think the most important issue is whether the boards are providing a timely and competent investigation of complaints.

The boards and agencies should meet with interested legislators and staff to revise the reporting requirements. Also, the health boards and MDH should negotiate a way to produce a summary report that would allow the Legislature to oversee the health occupations without reviewing 15 separate reports.

Complaint Investigation

Occupational regulation is supposed to protect the public by establishing occupational entry requirements and by providing a check on the continued competence of practitioners. Clients and other professionals can file a formal complaint against practitioners they feel are not delivering services consistent with professional standards. In some situations, professionals are required to report on other professionals. Effective occupational regulation depends on a timely and competent investigation of complaints. It was beyond the scope of this study to measure the quality of complaint investigations, but it was possible to learn if some boards or agencies had accumulated a significant backlog of pending cases.

We found that the number of complaints filed against regulated professionals varies widely. Many regulatory authorities seldom receive complaints against license holders in the occupations under their authority. But some of the larger professions attracted hundreds of complaints or more per year in recent years. In the two year period ending June 30 1998, there were nearly 2,300 complaints against attorneys, 1,968 against insurance agents, and 1,779 against physicians. We also found:

- **In the case of some regulated occupations, there are many open complaint investigations suggesting that complaints are not always investigated and resolved in a timely fashion.**

A few professions have about as many open investigations as cases filed in a two year period. The Board of Psychology, for example, received 372 complaints in fiscal years 1997-98 and had 432 open cases in August 1998. The Office of Mental Health Practice reported 154 complaints against unlicensed mental health practitioners in fiscal years 1997-98 and had 151 open cases in August 1998. Other professional groups with a significant ratio of open cases to cases filed

include nurses, commercial pesticide applicators, teachers, physicians, and dentists.

We interviewed the executive directors and other staff of five health-related boards with a relatively high volume of complaints to discuss complaint data and to learn more about their case-tracking systems and the availability of data needed for proper management of the caseload and for producing the type of information legislators and the public ought to see. We learned that several of the boards are in the process of developing new information systems, and all recognized to some degree that their reporting of complaint investigations could be made more useful. We also learned that the Board of Dentistry, the Board of Nursing, and the Board of Medical Practice had significantly reduced their backlogs in recent years.

We also reviewed the status of investigations that had been referred to the Attorney General's Office by the boards. The Attorney General investigates about 10 to 15 percent of cases filed with the health boards and is required to be involved in all cases alleging sexual misconduct or an active chemical dependency problem. The purpose of the Attorney General's involvement is to assure public accountability in investigations of licensed professionals by boards dominated by professionals.

A few years ago, the Attorney General's Office was the target of criticism from many of the health boards, because of a backlog of investigative cases and delays in the investigation and resolution of cases. To some extent the boards still complain about the time and money they must spend on legal and investigative services from the Attorney General's Office. We inquired about the current status of the backlog and found:

- **The Attorney General's Office has implemented an effective case tracking system and has made progress in reducing the backlog of investigative cases that existed a few years ago.**

The Attorney General's Office has reduced its backlog of cases in recent years.

There were 246 investigative cases open in the Attorney General's Office at the end of fiscal year 1995. By the end of fiscal year 1998, this number had declined to 170 cases.

Review of Existing Programs

In Chapter 214, Minnesota has an explicit policy governing proposals for new occupational regulation, and statutory statements about the purpose of regulation and the conditions justifying regulation. It is not clear to what extent these principles or criteria should apply to existing regulatory programs, many of which were implemented prior to enactment of the sunrise criteria in 1976. However, there is a need to periodically re-examine the contemporary need for regulatory programs and the Chapter 214 criteria are a useful place to start. Specifically, it is useful to ask if currently regulated occupations would pose a serious threat to the public health or safety if they were not regulated, or if the practice of an occupation requires specialized skill or training. (These are two of the criteria for occupational regulation articulated by Chapter 214.) It is obvious that the application of these criteria requires the exercise of judgment by policy makers aided by relevant data and information.

We have collected some information that is relevant to such a judgment although it is by no means sufficient. The Directory of Regulated Occupations that we are separately publishing shows the education, experience, examination, and continuing education requirements of each regulated occupation in Minnesota. In tabulating this information, we found:

The Legislature should continue to review existing regulated occupations.

- **Out of 188 regulated occupations, 82 have no statutory educational requirements beyond a high school diploma, 69 have no requirements for specialized experience, and 32 have no examination requirements. Twelve occupations have neither specialized education, experience, or examination requirements.**

In addition, 75 occupations of the 188 regulated occupations have no continuing education requirements. We also found that many of the occupations without extensive education or experience requirements have recorded no complaints against license-holders or other regulated workers in a two year period. This may call into question whether these occupations need to be regulated. The issue of whether the state should continue to regulate these or other occupations obviously requires more detailed study, but a review of the Directory we have put together can suggest where to start.

We think a systematic review might show that there are many currently regulated occupations that do not need to be regulated by the state and independent boards that could be consolidated with other boards or state agencies. We discuss a few examples in our full report. For example, we think the regulation of assessors, if necessary, should be carried out by the Department of Revenue rather than the Board of Assessors. Two other independent boards that should be reviewed are the Board of Boxing and the Board of Private Detectives and Protective Agents.

Every regulated occupation can assert a reason why occupational regulation protects the public. The issue for policy makers is whether the threat to public health or safety is real rather than theoretical and whether it exceeds the threat of many unregulated occupations. Do barbers or cosmetologists (regulated) present a greater threat to the public health than waiters or cooks (unregulated)? Do architects (regulated) pose a greater threat than auto mechanics (unregulated)? Are there more direct and effective ways of protecting the public than occupational regulation, such as inspection of facilities?

The Directory of Regulated Occupations we compiled can help focus those reviews.

The organization of occupational regulation also deserves some attention. We think the division of responsibility between the independent health-related boards and the Minnesota Department of Health could be drawn along functional lines. Clinical health occupations could be regulated by the boards and facilities and public health occupations by MDH. Currently, MDH regulates occupational therapists and speech and language pathologists, for example, but the health boards regulate most other clinical practitioners. Previous studies of occupational regulation have focused on the efficiency with which the boards are administered and envisioned that large state agencies could provide administrative services more efficiently than many small boards. The merit of this idea has been called into question by the fact that over the years the health boards have distanced themselves from the Department of Health and set up a joint administrative

services unit, an arrangement that appears to be working well in providing a limited number of services.

There are undoubtedly further opportunities for more collaboration among the boards and improvements in efficiency, but our analysis does not conclude that administrative efficiency is the primary problem with occupational regulation. We think the main issues policy makers should address are applying the policies in Chapter 214 more consistently and improving legislative oversight of regulatory authorities, especially in complaint investigation and enforcement.

Introduction

There are nearly 200 regulated occupations and professions in Minnesota, not counting teachers' licenses. The number of regulated occupations has grown dramatically in recent decades in Minnesota and across the country. Several states including Minnesota have enacted a variety of reforms to try to ensure that occupational regulation works in the public interest.

In April 1998, The Legislative Audit Commission directed the Legislative Auditor to conduct a study of occupational regulation that would look at the effectiveness of the system as a whole. This study addresses the following questions:

- **What is the history of occupational regulation in Minnesota and other states? What are the problems with occupational regulation recognized by policy makers and others, and what solutions to the problems have been suggested or implemented?**

- **What constitutes Minnesota's system of occupational regulation? What occupations and professions are regulated, and which state agencies and boards have regulatory authority? How many people are licensed or otherwise regulated in each occupation? How does the system of regulation in Minnesota compare with occupational regulation in other states?**

- **What proposals for new occupational regulation or significant change in regulation have been introduced in recent years?**

- **How effective is Minnesota's system of occupational regulation? Is the state's policy on occupational regulation applied consistently? How effective is Legislative oversight of occupational regulation?**

To carry out the study we interviewed many board and agency officials involved in occupational regulation, representatives of professional associations, legislators, and others concerned with or knowledgeable about occupational regulation. In order to assemble a complete list of regulated occupations, we surveyed state agencies and occupational licensing boards. We compiled basic descriptive information on each regulated occupation and are separately publishing a Directory of Regulated Occupations.

We compiled a list of regulatory proposals debated by the Legislature in recent years and investigated 13 of these in some detail in order to learn about the

process by which regulatory issues are debated and decided. We reviewed the national literature on occupational regulation and studied occupational regulation in eight states with organizational features of interest.

Chapter 1 of this report provides background information and a history of occupational regulation nationally and in Minnesota. Occupational regulation has been a source of interest and concern for some time and has given rise to several reform strategies that should be considered as Minnesota reforms are discussed.

Chapter 2 is mainly a description of Minnesota's system: which occupations are regulated, which boards and agencies are responsible for regulation, how is occupational regulation financed, and what does it cost? Chapter 2 also compares Minnesota's system to occupational regulation in other states and presents a description of the occupational regulatory agenda before the Legislature in recent years.

Chapter 3 discusses the effectiveness of or system of occupational regulation by analyzing what we believe are the major problems. There are many regulated occupations, however, and it is somewhat difficult to generalize. Our study of effectiveness focuses on the state's general policy on occupational regulation provided in Minnesota Statutes Chapter 214.

Finally, we present two appendices. Appendix A presents a summary of the studies we did of occupational regulation in eight other states. Appendix B presents 13 case studies of recent proposals for new regulation or a change in regulation.

BACKGROUND

CHAPTER 1

Occupational regulation is an issue with a considerable history both nationally and in Minnesota. As the Legislature considers what to do about occupational regulation, it is useful to ask:

- **What is the national history of occupational regulation?**
- **What are the major problems with occupational regulation recognized by policy makers and others?**
- **What are the major national reforms that have influenced the development of occupational regulation?**
- **What is the recent history of the policy debate on occupational regulation in Minnesota?**

Occupational regulation has a long history.

HISTORY

Occupational regulation can be traced back to the imposition of malpractice fees and penalties on surgeons as long ago as 2000 BC.[1] Modern occupational regulation was also foreshadowed in the guild societies of the Middle Ages, and toward the end of that era the first medical practice law was written by Frederick II, Emperor of the Holy Roman Empire.[2] The first licensing laws in the American colonies were passed by Virginia in 1639 and Massachusetts in 1649. Both laws regulated medical services: Virginia's law regulated the fees charged by physicians and the Massachusetts law controlled the quality of medical service provided by midwives, physicians, and surgeons.[3]

Following the colonial era, the licensing of medical doctors was extended across the states. However, during the early nineteenth century Jacksonian populists took issue with occupational regulation because it tended to exclude less privileged

1 Daniel Hogan, *The Regulation of Psychotherapists, Volume I: A Study in the Philosophy and Practice of Professional Regulation* (Cambridge, MA: Ballinger Publishing Co., 1979).

2 Robert L. Hollings and Christal Pike-Nase, *Professional and Occupational Licensure in the United States* (Westport, Connecticut: Greenwood Press, 1997), 1.

3 *Ibid*., xiv.

classes from desirable occupations.[4] By the mid-1800s many occupations, including the practice of medicine and of law, were deregulated in most states.[5] But eventually, concern for public safety, as well as the urging of newly-formed professional associations, led state legislatures to again enact regulations covering various health professions.[6] The American Medical Association, formed in 1847, was influential in persuading Texas to establish an examining board in 1873, and by 1895 nearly every state had passed similar legislation.[7] Since the early 1900s occupational regulation has grown geometrically and today hundreds of occupations are regulated across the United States.

The main purpose of occupational regulation is protection of the public.

The constitutionality of occupational regulation was established in the Supreme Court's 1889 decision, *Dent v. West Virginia*. In *Dent*, the majority held that "the power of the State to provide for the general welfare of its people authorizes it to prescribe all such regulations as in its judgment will secure or tend to secure them against the consequences of ignorance and incapacity as well as of deception and fraud."[8] Thus occupational regulation was established as a legitimate exercise of the inherent police power reserved to the states through the 10th Amendment. However, while protecting some members of the population, occupational regulation also denies some individuals the liberty to practice the occupation of their choice. Therefore, states must exercise care regulating occupations for, "No state shall ... deprive any person of life, liberty, or property without due process of law."[9] The due process clause is also invoked once individual professional licenses are conferred. In *Dent* the Supreme Court held that licenses, and other state-sanctioned credentials, are considered personal property that cannot be revoked without due process.[10]

In sum, the primary public purpose of occupational regulation is protection. The need for public protection stems from the belief that most people do not, or cannot, have the information or expertise to make informed choices concerning the professionals they employ for certain services and, furthermore, that the incompetent practice of these services can result in serious and immediate harm. Further, to most effectively protect the public, states must neither over-regulate occupations nor should they revoke licenses without judicious consideration.

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4 Daniel Hogan, "The Effectiveness of Licensing: History, Evidence, and Recommendations," *Law and Human Behavior* 7, no. 213 (1983): 119.

5 Hollings and Pike-Nase, *Professional and Occupational Licensure*, xiv.

6 Kara Schmitt and Benjamin Shimberg, *Demystifying Occupational and Professional Regulation: Answers to Questions You May Have Been Afraid to Ask* (Lexington, KY: Council on Licensure, Enforcement and Regulation, 1996), 3; and Hogan, "The Effectiveness of Licensing," 119.

7 Hogan, "The Effectiveness of Licensing," 119-120.

8 Dent v. West Virginia, 129 U.S. 114 (1889), quoted in Hollings and Pike-Nase, *Professional and Occupational Licensure*, xiv.

9 *U.S. Const*., amend. XIV, cited in Hollings and Pike-Nase, *Professional and Occupational Licensure*, xiv.

10 Schmitt and Shimberg, *Demystifying Occupational and Professional Regulation*, 46.

CRITICISM OF OCCUPATIONAL REGULATION

Occupational regulation can limit access to regulated occupations and raise prices.

In practice, occupational regulation can have consequences beyond public protection. The most common and widespread criticism of occupational regulation is that it actually protects credentialed workers in regulated occupations, rather than the public at large.[11] "Fencing" is the term used to describe the exclusionary and monopolistic effects of occupational regulation. Occupational regulation is said to "fence out" some potential workers by raising educational requirements, mandating exams, imposing entry fees, and erecting barriers to inter-state mobility.[12] In some cases these barriers may serve to limit the entry of poor, minority, or elderly individuals into a given profession.[13] However, the primary concern associated with occupational fencing is that it limits the number of professionals supplying a given service, which leaves the public vulnerable to increased prices.[14]

It is difficult to assess exactly how much occupational regulation contributes to price increases because of the wide variety of potential influences on pricing. However, a survey of the economic literature on occupational regulation by Cox and Foster, published by the Federal Trade Commission (FTC), concludes that "occupational licensing frequently increases prices and imposes substantial costs on consumers."[15] The FTC study cites three articles on dentistry that found price increases of 4 to 15 percent due to regulation, five articles on optometry that found price increases of 5 to 33 percent due to regulation, and one article on pharmacy and another on law, both finding price increases of at least 5 percent due to occupational regulation.[16]

Similarly, a study done by the American Association of Retired Persons (AARP) reported that regulation often creates undue price burdens on older Americans. For example, AARP estimated that the 500,000 Virginians age 65 or older together lost an estimated $5 to $7.5 million in extra payments per year just for initial visits to dentists "as a result of the restrictive policies of the dental board."[17]

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11 Schmitt and Shimberg, *Demystifying Occupational and Professional Regulation*, 6-9; Carolyn Cox and Susan Foster, *The Costs and Benefits of Occupational Regulation*, (Washington, D. C.: Federal Trade Commission, 1990) 18-20; Hogan, "The Effectiveness of Licensing: History, Evidence, and Recommendations"; Sue A. Blevins, "The Medical Monopoly: Protecting Consumers or Limiting Competition?" *Policy Analysis*, no. 246 (15 December 1995); Eugenia Carpenter, "Licensing and Credentialing in the Health Care Industry," (Washington, DC: AFL-CIO, Department for Professional Employees, September 1996), Publication #96-3; Morris M. Kleiner and Mitchell Gordon, "The Growth of Occupational Licensing: Are We Protecting Consumers?" *CURA Reporter* (Minneapolis: December 1996).

12 Hogan, *The Regulation of Psychotherapists*, 238-9.

13 Stuart Dorsey, "The Occupational Licensing Queue," *The Journal of Human Resources*, 15, no. 3 (1980): 424-434.

14 Cox and Foster, *The Costs and Benefits of Occupational Regulation*; and American Association of Retired Persons (AARP), *Unreasonable Regulation = Unreasonable Prices* (Washington, DC: AARP, Consumer Affairs Section, 1986).

15 Cox and Foster, *The Costs and Benefits of Occupational Regulation*, v.

16 *Ibid*., 31.

17 AARP, *Unreasonable Regulation = Unreasonable Prices*, 27.

Additionally, AARP noted that because of the associated price increases occupational regulation can actually put the public in greater danger than if regulation were not present. For example, in a discussion of the price-effect of regulating optometry AARP commented, "One of the most serious consequences of this combination of factors is that older people who need their vision corrected (and who should have professional eye examinations to detect disease) may neglect to seek vision care at all."[18] Likewise, the FTC report cited a study by Carrol and Gaston (1981) that found a significant association between stricter mandatory entry requirements for electricians and higher numbers of accidental deaths from electrocution: the authors hypothesized that the higher prices associated with stricter regulation pushed a greater number of consumers to attempt their own wiring.[19] Despite this body of evidence, however, the authors of the FTC report state; "we cannot conclude that the costs of licensing always exceed the benefits to consumers. In considering any licensing proposal, it is important to weigh carefully the likely costs against the prospective benefits on a case by case basis."[20]

Most requests for regulation come from occupational associations, not consumer groups.

An indication that occupational regulation can protect professionals is that most requests for occupational regulation originate with professional groups and associations, rather than citizens' organizations or consumer groups. This is not to suggest that such requests are strictly motivated by the desire to reduce professional competition. Occupational groups are motivated to attain state-sanctioned regulation for a variety of reasons. Many professional associations are concerned with maintaining high standards of quality and screening out the individuals who can give the profession bad publicity. According to the Commerce Department an important factor behind some requests for state licensure is the desire to pre-empt local regulatory requirements which often vary from city to city. In the health care professions another concern is the eligibility for third-party reimbursement that often accompanies licensure. However, despite the altruism of various professional groups, they would not likely seek regulation if it were purely a public interest that did not offer the benefits of professional protection to their occupation.

There are several additional criticisms of occupational regulation. Critics often contend that occupational regulation can easily be controlled by the professionals being regulated. Indeed, occupations are often regulated by boards dominated by members of the regulated profession, whose appointments are often based on recommendations of professional associations. Critics suggest that this arrangement limits protection of the public when it comes in conflict with the protection of professionals.

Another criticism has to do with complaint processing and the enforcement of disciplinary actions. Many regulatory boards have been accused of failing to adequately investigate complaints and discipline practitioners. Here again boards

18 AARP, *Unreasonable Regulation = Unreasonable Prices*, 16.

19 Cox and Foster, *The Costs and Benefits of Occupational Regulation*, 29 (S. Carrol and R. Gaston, "Occupational Restrictions and the Quality of Service Received: Some Evidence," *Southern Economic Journal*, 47, no. 4 (1981)).

20 Cox and Foster, *The Costs and Benefits of Occupational Regulation*, v.

Occupational regulation is criticized because it can be controlled by the professions being regulated.

are accused of being protective of their fellow professionals and unwilling to work in the public interest.

A final major area of criticism has to do with assuring continued competence. Critics argue that while entry requirements may be strong enough to guarantee competence when individuals enter regulated professions, existing continuing education requirements do not provide the same safeguards 10 or 20 years later. Although stronger assurances of continued competence, such as periodic retesting, are often resisted by professional associations, the Pew Health Professions Commission recently recommended that states require all regulated health care workers to demonstrate competence in technical and personal skills, knowledge, and judgment throughout their careers.[21] All of these major areas of criticism are related to the inherent tension between maintaining professional expertise on the regulatory bodies on the one hand, and protecting public, as opposed to professional, interests on the other.

NATIONAL REFORMS OF OCCUPATIONAL REGULATION

Because of the concern about occupational fencing and a growing proliferation of requests for regulation, critics began calling for reform of occupational regulation in the 1960s and 1970s.[22] Various state legislatures answered these calls differently, but there were four primary areas of reform: (1) the inclusion of non-professional "public" members on regulating boards, (2) centralization of regulatory activities, (3) the development of "sunrise" legislation to assist with new requests for regulation, and (4) the development of "sunset" legislation to periodically re-evaluate the necessity and performance of specific regulating entities.

Public Membership Requirements

In Minnesota and elsewhere, occupational regulation is often carried out through independent boards, usually appointed directly by the governor. In order to assure that the boards can make competent decisions regarding entry requirements, qualifications of individual practitioners, and the validity of consumer complaints, most board members are practicing professionals. Furthermore, the state laws that define regulatory programs often direct the governor to seek nominations for board appointments from specific professional associations.[23] Thus, it is understandable why some would charge that it is not just the existence of occupational regulation per se, but also the manner in which it is administrated,

21 L.J. Finocchio, C.M. Dower, N.T. Blick, C.M. Gragnola and the Taskforce on Health Care Workforce Regulation. *Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation* (San Francisco, CA: Pew Health Professions Commission) October 1998.

22 Schmitt and Shimberg, *Demystifying Occupational and Professional Regulation*, 6.

23 This is only occassionally the case in Minnesota. For example, see *Minn. Stat.* §§150A.02 (Dentistry), 147.01 (Medical Practice), and 156.01 (Veterinary Medicine).

that results in a regulatory scheme that protects professionals more effectively than it protects the public.

Reforms adopted in Minnesota include requirements for public representation on regulatory boards.

To address these concerns, many states began to incorporate one or two non-professional "public members" into their regulatory boards. In Minnesota, the Legislature began this reform in the early 1970s by placing public members on each of the health boards. Public members are presumed to bring the consumers' interests to the boards, open up a direct line of public involvement to the activities of the board, and guard against overly sympathetic disciplinary actions against professionals found to be at fault. Historically, professionals have argued against the inclusion of many public members on regulatory boards on the grounds that persons not trained in a given field would not have the knowledge and experience necessary to fully understand the technical issues that boards often face.[24] The obvious counter-argument is that the U.S. judicial system makes extensive use of ordinary citizens in jury trials that decide on any number of complex, technical, and scientific matters.[25]

There is some evidence supporting the notion that public members strengthen regulation. One study found a relationship between increased public membership on regulatory boards and the likelihood that state legislatures enact fewer "nonsense" entry requirements for regulated professionals, such as "good moral character," which can only serve as additional fencing mechanisms for professionals.[26] Another study found that "the proportion of public members . . . [has a] positive effect on serious disciplinary actions, suggesting that public members may be effective at improving the disciplinary performance of health occupational licensing boards."[27]

Although the inclusion of one or two public members on regulatory boards is widespread, some feel that the present state of public representation is inadequate. Calls continue to be made for increasing public membership on regulatory boards. For example, the first recommendation made in a recent report by the Arizona Auditor General was: "The Legislature should consider increasing public membership on all health regulatory boards to 50 percent."[28] University of Minnesota professor Morris M. Kleiner calls for a *majority* of public members on regulatory boards.[29] Also, a recent report issued by the Pew Health Commission included the recommendation that "individual professional boards in the states must be more accountable to the public by significantly increasing the representation of public, non-professional members. Public representation should be at least one-third of each professional board."[30]

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24 Schmitt and Shimberg, *Demystifying Occupational and Professional Regulation*, 30.

25 *Ibid*., 30.

26 Elizabeth Graddy, and Michael B. Nichol, "Public Members on Occupational Licensing Boards: Effects on Legislative Regulatory Reforms," *Southern Economic Journal* 55, no. 3 (January 1989): 610-625.

27 Elizabeth Graddy and Michael B. Nichol, "Structural Reforms and Licensing Board Performance," *American Politics Quarterly* 18, no. 3 (July 1990): 394.

28 Arizona Auditor General, "The Heath Regulatory System" (Report #95-13; December 4, 1995), 13.

29 Kleiner and Gordon, "The Growth of Occupational Licensing," 11.

30 Finocchio et al., *Strengthening Consumer Protection*, 16.

Centralization of Regulatory Activities

Another way states have sought to avoid the control of regulatory boards by narrow professional interests was through centralizing regulatory activities under umbrella agencies. For example, although this reform has never been fully implemented, a 1977 report by the Minnesota Department of Administration concluded:

> We believe it is inappropriate for the state to delegate its police power to organizations which have the potential to be controlled by private interests. . . . Therefore we recommend that the authority for occupational licensing be vested in one or more state agencies and that independent licensing boards be abolished and replaced with advisory bodies composed partially of practitioners.[31]

A number of organizational reforms have been tried in other states, including centralization of regulation in umbrella agencies.

In addition to reducing professional control, centralization was thought to carry benefits such as administrative cost savings and increased consistency across professions. Although centralization was not a new idea—in New York the regulation of most occupations was centralized in 1892—the number of states with centralized agencies increased from 16 in 1969 to 33 in 1990.[32]

"Centralization" is actually a concept that exists on a continuum (see Figure 1.1). Only a few states fully administer occupational regulation through centralized agencies (model 3); in others independent regulatory boards have been arranged to obtain services from umbrella agencies or share administrative costs and procedures (model 2). In many states, including Minnesota, occupational regulation is not administered in a consistent manner, but varies from occupation to occupation. In Minnesota some occupations are regulated by fully independent boards (model 1), others are regulated directly by larger agencies (model 3), and still others are regulated through an arrangement that lies somewhere in-between (model 2).[33]

Researchers have identified potential strengths for both centralized occupational regulation and regulation by autonomous boards (see Figure 1.2). Additionally there has been some empirical research on whether centralization actually increases public protection. One quantitative analysis of the disciplinary actions of medical and nursing boards in all states found that *independent* boards actually tend to take more disciplinary actions than boards that are subordinate or advisory to a central agencies. However, the same analysis also found that states with

31 Department of Administration, Management Services Division, *Occupational Licensing Boards and Host Departments in Minnesota*, Part II, (St. Paul, 1977), 127-8. This report is discussed in greater detail below.

32 Schmitt and Shimberg, *Demystifying Occupational and Professional Regulation*, 10.

33 The organization of occupational regulation in Minnesota is discussed at greater length in Chapter 2.

Several organizational models operate across the country, each with certain strengths and weaknesses.

Figure 1.1: Organization of Professional and Occupational Regulation: Three Models

Model 1: Boards are autonomous. They hire their own staff, make decisions about office location, purchasing, and procedures. Each board receives and investigates complaints and disciplines licensees. Each board is responsible for the preparation, conduct, and grading of examinations or the contracting out of these tasks. Each board sets qualifications for licensing and standards for practice. Boards collect fees and maintain financial records. Board staff prepares and mails applications for licensing and renewal, and answers inquiries from licensees and the public.

Model 2: Boards are autonomous and have decision making authority in many areas. The central agency, however, has greater authority over certain functions. Its powers go beyond housekeeping. For example, board budgets, personnel, and records may be subject to some control by the agency. Complaints, investigations, and adjudicatory hearings may be handled by a central staff, even when boards continue to make final decisions with respect to disciplinary actions.

Model 3: The regulatory system is run by an agency director, commission, or council, with or without the assistance of a board. Where boards do exist, they are strictly advisory. The agency director, commission, or council has final decision making authority on all substantive matters. Boards may be delegated such functions as preparing or approving exams, setting pass/fail points, recommending professional standards, and recommending disciplinary sanctions.

SOURCE: Adapted from Benjamin Shimberg and Doug Roederer, with Kara Schmitt, ed., *Questions a Legislator Should Ask*, (Lexington, KY: The Council on Licensure, Enforcement and Regulation, 1989), 20-21. Models 1, 2, and 3 directly correspond to Shimberg and Roederer's models A, C, and E, respectively.

centralized investigative functions tend to take greater disciplinary actions than those where the investigative functions are left to each independent board.[34] Thus, the researchers observe that, "the hypothesized advantages of centralization may apply for some specialized functions."[35]

34 In Minnesota certain investigative functions are centralized in the Attorney General's Office. This is discussed in greater detail in Chapter 3.

35 Elizabeth Graddy and Michael B. Nichol, "Structural Reforms and Licensing Board Performance," (1990): 393-4. They also find that the disciplinary actions of independent boards is strongly and positively related to the number of board-controlled investigators. These findings lead the researchers to the preliminary conclusion that the key to disciplinary action lies less with the institutional arrangement, and more with the amount of resources dedicated to the investigation of complaints.

Figure 1.2: Perceived Benefits of Autonomous Boards and Central Agencies

Autonomous Boards

Professional Expertise
- Assures appropriate peer review of professional practice standards
- Qualified personnel to investigate complaints
- Professional perspective of the public interest

Administrative Efficiency
- Ability to hire staff at the appropriate level and salary
- Less bureaucracy
- Increased decision making capabilities
- Greater visibility to the public and deterrent to potential violators
- Public's perception that there is easier access to the board members
- Greater personal ownership of and responsibility for decisions made

Insulation from Political Interference
- Greater freedom in decision making without political pressure
- Better understanding of licensees' and publics' concerns

Accountability
- Better control by executive and legislative checks and balances
- Greater control over allocation of funds
- Clearer levels of accountability

Central Agencies

Administrative Efficiency
- Consolidation of staff, space, time, and equipment
- Capability to hire more professional staff or consultants to assist the boards

Coordination
- A logical focal point for decisions requiring consideration by executive branch
- Provides a comprehensive forum for review and resolution of jurisdictional disputes
- Provides executive and legislative branches with a single point for interaction
- Better allocation of funds based on overall view of licensing functions
- Enhances the coordination of the executive branch's policies
- Development of standard operating procedures, including training
- Permits a single point of contact for consumer questions and complaints
- Coordinates legislative proposals to identify conflicting positions

Oversight
- Application of uniform criteria to board decisions that yield increased equity
- Serves as an appeal body for board decision**s**

Accountability
- Provides greater accountability to the legislature and public
- Uniformly implemented policies across all boards
- Multi-disciplinary decision making resulting in dispute resolution
- Better recruitment, appointment, and orientation of board members
- Better control of the agency director by the executive branch
- More removal from the pressure of professional lobbyists

SOURCE: Kara Schmitt and Benjamin Shimberg, *Demystifying Occupational and Professional Regulation: Answers to Questions You May Have Been Afraid to Ask*, (Lexington, KY: Council on Licensure, Enforcement and Regulation,1996), 11-12.

Sunrise Legislation

A sunrise law, like Minnesota's, requires a demonstration of the public benefit of regulation prior to enactment.

Given the concerns that were being raised in the 1960s and 1970s about occupational fencing and the fact that many state legislatures were facing an increasing demand to regulate more and more occupations, it is not surprising that several states began looking for a way to screen such requests for validity and true public purpose. One solution was "sunrise" legislation. Sunrise provisions place into statute the idea that "credentialing should be enacted *only* when it is clearly in the public's best interest. Moreover, the level of regulation should be no more restrictive than necessary to protect the public."[36]

In 1971 a set of criteria for regulation was developed by a New Jersey legislative commission. Under what are now referred to as the Bateman criteria, professions should be licensed only when:

1. Their unregulated practice can clearly harm or endanger the health, safety, and welfare of the public and when the potential for such harm is easily recognizable and not remote or dependent upon tenuous argument; and,

2. The public needs, and will benefit by, assurance of initial and continuing professional and occupational ability; and,

3. The public is not effectively protected by other means; and

4. It can be demonstrated that licensing would be the most appropriate form of regulation.[37]

In 1976 Minnesota became one of the first states to enact sunrise legislation when it adopted a slightly modified version of these criteria.[38]

Sunrise is the least widespread of any of the four major reform efforts outlined in this chapter. In addition to Minnesota, sunrise has been adopted in 10 states: Tennessee (1977), Texas and Colorado (1985), Maine, Georgia and Hawaii (1986), Montana and Washington (1987), South Carolina (1988), and Florida (1991).[39] Wisconsin has enacted a sunrise policy through department rules rather than statute. Additionally, several states, including Arizona and Virginia, have more limited sunrise provisions that only apply to health-related occupations. Regardless of the scope of sunrise legislation, some form of the Bateman criteria were used by every state whose statutes we reviewed.[40] An additional criterion that has been added in Minnesota and elsewhere is: "Whether the overall cost

36 Schmitt and Shimberg, *Demystifying Occupational and Professional Regulation*, 17.

37 *Ibid*., 17.

38 The history of Minnesota's sunrise statute, *Minn. Stat.* §214, is discussed in greater detail below.

39 Richard C. Kearney, "Sunset: A Survey and Analysis of the State Experience," *Public Administration Review*, vol. 50 (January-February 1990): 52.

40 Statutes from other states that we reviewed include: Arizona, §32-3103 (applies only to health-related occupations); Florida Ch. 11.62; Maine, Title 32, Ch. 1A (§60-J); Virginia, §54.1100 (applies only to health-related occupations); Revised Code of Washington, Ch. 18.120.010; and Wisconsin, department rules.

effectiveness and economic impact would be positive for the citizens of this state."[41]

In Minnesota, there is currently no state agency or legislative committee responsible for carrying out formal sunrise reviews.

Sunrise is implemented many different ways. In Minnesota there is currently no state agency or committee responsible for carrying out formal sunrise reviews, therefore the extent of Minnesota's sunrise program is the statutory criteria that are to inform the Legislature's decisions concerning occupational regulation.[42] In most other sunrise states a formal review is done either by legislative committees or an executive branch agency. Several states also require that professional groups seeking regulation supply extensive information to the legislature in the form of a completed questionnaire. This information is then used by the reviewing committee or agency to decide whether applicant groups meet the sunrise criteria outlined in statute. For example, Florida's sunrise act requires proponents of legislative proposals for occupational regulation to provide the following information to a substantively-related legislative committee, as well as Florida's Department of Professional and Business Regulation:[43]

- The number of individuals or businesses that would be subject to the regulation.
- The name of each association that represents members of the profession or occupation, and a copy of its codes of ethics or conduct.
- Documentation of the nature and extent of harm to the public caused by the unregulated practice of the profession.
- A list of states that regulate the profession or occupation.
- A list and description of state and federal laws that have been enacted to protect the public with respect to the profession and a statement of the reasons why these laws have not proven adequate to protect the public.
- A copy of any federal legislation mandating regulation.
- An explanation of the reasons why other types of less restrictive regulation would not effectively protect the public.
- The cost of the regulation, including the indirect cost to consumers, and the method proposed to finance the regulation.
- The details of any previous efforts in this state to implement regulation of the profession.

41 *Minn. Stat.* §214.001 subd. 2(d).

42 The implementation of Minnesota's sunrise statute is discussed at greater length in chapter 3. A more formalized sunrise review process for health-related occupations has been promulgated in *Minn. Rules* Chapter 4695, but it is not currently operative. This is discussed in greater detail below.

43 Florida Senate Committee on Professional Regulation, "A Report on the Implementation of the Sunrise Act of 1991," (Tallahassee, January 1993), 15-16.

Although the costs and benefits of sunrise provisions are difficult to measure, many credit sunrise with slowing down the proliferation of occupational regulation. For example, the state of Washington has licensed only one health-related profession since enacting sunrise in 1983 and Florida has not licensed any occupations since passing sunrise in 1991.[44] However, sunrise legislation has not had such an effect in Minnesota, where nearly 50 percent of the occupations now regulated gained state regulation after the enaction of sunrise in 1976.[45]

Sunset laws preschedule regulatory boards for termination.

A common, if constitutionally necessary, frustration with sunrise reviews is that resulting recommendations are not always followed by state legislatures. In some cases this frustration leads those involved to question whether the resources spent on sunrise reviews are worthwhile; for example, the Colorado Legislature recently abolished a joint legislative committee that heard testimony relating to sunrise reviews because of the relative frequency with which its recommendations were ignored by the full body.[46]

Sunset Legislation

Sunset is a method of legislative oversight that schedules termination of regulatory boards and agencies after a designated interval of time unless officially reinstated by the legislature.[47] The sunset process is accompanied by studies and/or legislative hearings that provide an evaluation of the regulatory program under review. Sunset reviews can result in termination or continuation of regulatory programs, but are more likely to result in a series of recommended modifications. Colorado was the first state to enact sunset legislation in 1976 and by 1982 thirty-six states followed by adopting similar provisions.[48] Sunset has not been a routine part of occupational regulation in Minnesota.

Thirty-six states have a sunset law, but only 10 have maintained comprehensive sunset programs.

The results of sunset legislation have not been as dramatic as initially hoped, in part because sunset reviews often function as rallying points for program advocates. As with occupational regulation in general, the issues raised in sunset reviews are of great concern to those directly involved, but are not particularly interesting to the broader public. One observer has commented that sunset "is essentially a no-win situation for legislators. Termination of an obscure regulatory body is unlikely to win votes in the next election, and, in fact, legislators may

44 Telephone interviews with John Welsh, Committee on Health Care Senior Council, Washington House of Representatives (30 July 1998), and Gip Arthur, Committee on Business Regulation and Consumer Affairs, Florida House of Representatives (14 August 1998).

45 The proliferation of occupational regulation in Minnesota in recent years is addressed further in Chapter 3.

46 Colorado State Representative Russel George, "How Sunrise/Sunset Review Can Improve Government Regulation," Eighteenth Annual Conference of the Council on Licensure, Enforcement, and Regulation. Denver, Colorado. September 17, 1998. In Colorado sunrise reviews continue to be conducted by the Department of Regulatory Agencies.

47 Benjamin Shimberg and Doug Roederer with Kara Schmitt ed., *Questions a Legislator Should Ask*, 2nd edition (Lexington, KY: The Council on Licensure, Enforcement and Regulation, 1989), 37.

48 Kearney, "Sunset," 49.

actually damage their re-election chances by terminating an agency or program with an active, supportive constituency."[49]

Although the costs and benefits of sunset are difficult to assess, it does appear to result in some cost savings. During the 1980s three states explicitly compared the costs and benefits of sunset reviews: Connecticut reported costs of $201,500 and savings of $518,000 during 1980-1982; Maryland reported costs of $82,500 and savings of $251,545 in 1983; and in Tennessee $105 million in possible savings from sunset was identified over the ten year period 1978-1988.[50] Additionally, sunset can result in agency improvements simply because it increases legislative oversight and enhances legislators' general understanding of boards and agencies.

Overall, the popularity of sunset has declined since the early 1980s. By 1989 sunset provisions were retained in only 24 of the 36 states that had enacted sunset, and only 10 states maintained comprehensive sunset legislation.[51] Sunset has fallen in favor due to several factors including the costs associated with doing reviews, the intense lobbying it sometimes inspires, and the time commitment it requires of state legislators. Some have also suggested that any unnecessary regulatory programs were eliminated during initial rounds of sunset reviews and that the benefits of continued sunset reviews would likely decline in value—particularly where sunrise has been enacted. However, observers of the regulatory process continue to advocate implementation of sunset and ad hoc sunset-like reviews under the conditions that the reviews are given sufficient resources, and that they are carried out in a more targeted fashion.[52]

National Reforms of Occupational Regulation: Conclusions

Attempts to reform occupational regulation have not ended with the four movements discussed above. However, many of the calls for reform that have continually resurfaced since the 1970s relate to public membership on regulatory boards, administrative organization, and measures to improve legislative oversight such as sunrise and sunset. Other contemporary suggestions relate to the changing nature of health-care delivery. Currently, the most prominent national critique of occupational regulation can be found in the Pew Health Commission's 1995 and 1998 reports, *Reforming Health Care Workforce Regulation* and *Strengthening Consumer Protection*. The recommendations of the 1995 report in particular have pertinence to occupational regulation in general, and are presented

49 Kearney, "Sunset," 52.

50 Kearney, "Sunset," 54.

51 Kearney, "Sunset," 50. The ten states that retained comprehensive review in 1989 were: Alabama, Arizona, Colorado, Delaware, Indiana, Louisiana, Maine, Tennessee, Texas, and Washington. Of these the state that we contacted that is still most actively involved with sunset is Arizona.

52 Schmitt and Shimberg, *Demystifying Occupational and Professional Regulation*, 19; also see L.J. Finocchio et. al., *Reforming Health Care Workforce Regulation* (35-38) and *Strengthening Consumer Protection* (29-33); and Kearney, "Sunset," 56. Kearney notes: "Instead of using Sunrise, some state automatically impose Sunset review requirements on all newly-created agencies. At least seven states that have not enacted a Sunset statute nonetheless have inserted Sunset clauses in statutes establishing selected new programs and agencies" (52).

in Figure 1.3. The 1998 report concentrates on the three areas of (1) regulatory boards and governance structures, (2) professional practice authority, and (3) continuing competence. The 1998 report also includes helpful "legislative implementation templates" on all three issues.

RECENT HISTORY OF OCCUPATIONAL REGULATION IN MINNESOTA

The history of occupational regulation in Minnesota should be considered as the Legislature takes up the issue.

Having presented the national history, criticisms, and major national reforms of occupational regulation, we now review the recent history of occupational regulation in Minnesota. During the last quarter century, occupational regulation has been an important issue in Minnesota as in many other states. Some of the noteworthy historical markers include:

- the adoption of a sunrise law in 1976;
- the establishment of a review process conducted by the Health Department to assess the need for regulation of health occupations in 1976;
- a study of occupational regulation conducted by the Department of Administration in 1976 and 1977;
- recommendations concerning occupational regulation issued by the Commission on Reform and Efficiency (CORE) in 1993; and
- legislative hearings in 1991 and 1997, followed by the introduction of bills in 1992 and 1998 to change the system of occupational regulation.

Sunrise in Minnesota

Requests for occupational regulation proliferated in the 1970s. In Minnesota no more than 12 occupations gained state regulation in a single decade until the 1970s, when *40* occupations gained state regulation. In 1976 Minnesota responded by becoming one of the first states to enact sunrise legislation by amending Minnesota Statutes Chapter 214 to include a policy for the regulation of new occupations.[53]

As discussed earlier in this chapter, sunrise legislation is a means of screening proposals for occupational regulation to ensure they meet criteria for public protection. In Minnesota, three criteria were established in 1976:

- Whether the unregulated practice of an occupation may cause a recognizable, and not remote, harm or danger to citizens of the state;

53 *Minn. Laws* (1976), ch. 222, secs. 1-9.

Figure 1.3: Recommendations from the Pew Health Commission's Taskforce on Health Care Workforce Regulation

1. **Standardizing regulatory terms**: States should use standardized and understandable language for health professions regulation and its functions to clearly describe them for consumers, provider organizations, businesses, and the professions.

2. **Standardizing entry-to-practice requirements**: States should standardize entry-to-practice requirements and limit them to competence assessments for health professions to facilitate the physical and professional mobility of the health professions.

3. **Removing barriers to the full use of competent health professionals**: States should base practice acts on demonstrated initial and continuing competence. This process must allow and expect different professions to share overlapping scopes of practice. States should explore pathways to allow all professionals to provide services to the full extent of their current knowledge, training, experience, and skills.

4. **Redesigning board structure and function**: States should redesign health professional boards and their functions to reflect the interdisciplinary and public accountability demands of the changing health care delivery system.

5. **Informing the public**: Boards should educate consumers to assist them in obtaining the information necessary to make decisions about practitioners and to improve the board's public accountability.

6. **Collecting data on the health professions**: Boards should cooperate with other public and private organizations in collecting data on regulated health professions to support effective workforce planning.

7. **Assuring practitioner competence**: States should require each board to develop, implement, and evaluate continuing competency requirements to assure the continuing competence of regulated health care professionals.

8. **Reforming the professional disciplinary process**: States should maintain a fair, cost-effective, and uniform disciplinary process to exclude incompetent practitioners and to protect and promote the public's health.

9. **Evaluating regulatory effectiveness:** States should develop evaluation tools that assess the objectives, successes, and shortcomings of their regulatory systems and bodies to best protect and promote the public's health.

10. **Understanding the organizational context of health professions regulation**: States should understand the links, overlaps, and conflicts among their health care workforce regulatory systems and other systems which affect the education, regulation, and practice of health care practitioners and work to develop partnerships to streamline regulatory structures and processes.

SOURCE: L. J. Finocchio, C. M. Dower, T. McMahon, C. M. Gragnola, and the Taskforce on Health Care Workforce Regulation, *Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century,* (San Francisco, Ca: Pew Health Professions Commission, 1995).

- Whether the practice of an occupation requires specific skill or training; and
- Whether citizens could be protected by another means.[54]

A fourth criterion was added in 1984:

- Whether the overall cost effectiveness and economic impact would be positive for the citizens of the state.[55]

In addition to establishing criteria for occupational regulation, the 1976 amendments mandated that occupations should be regulated in the least intrusive manner and directed the Legislature to consider a range of options in the following order:

- Creation or extension of common law and statutory causes of civil action and criminal prohibitions;
- Imposition of inspections and the ability to enforce violations by injunctive relief in the courts;
- Implementation of a registration system for the use of a designated title reflecting predetermined qualifications; and
- Implementation of a licensing system which allows practitioners meeting specific criteria to practice and prohibits others from practicing.

A 1976 law established a process in the Minnesota Department of Health for studying proposals for regulating health professions.

The 1976 legislation made other changes as well. It outlined the process of receiving, investigating, and hearing consumer complaints against regulated professionals. It also established a uniform procedure for regulatory bodies to follow for investigations and discipline. Since 1976 the complaint investigation process has been further amended to actively involve representatives from the Office of the Attorney General and allow for hearings before an administrative law judge, rather than before board members regulating the profession. Another change that followed from the 1976 legislation was the establishment of rules concerning health and human service related occupations.

Regulating Health and Human Service Occupations: The Human Services Occupations Advisory Council

Health-related professions account for 34 of the 86 occupations regulated by independent boards in Minnesota. Additionally, the Department of Health regulates 8 clinical health occupations and 17 public and environmental health

54 *Minn. Laws* (1976), ch. 222, sec. 1.

55 *Minn. Laws* (1984), ch 654, art 5, sec. 9.

occupations. Chapter 214 outlines specific guidelines for the Department of Health to use in assessing the need for and making recommendations about regulating new health occupations.

The 1976 amendments to Chapter 214 directed the Department of Health to establish procedures for (1) identifying health occupations not regulated by the state and (2) recommending an appropriate regulatory mode where regulation is deemed necessary.[56] The 1976 legislation also directed the Board of Health (now the Minnesota Department of Health) to establish a Human Services Occupations Advisory Council (HSOAC) to collect and analyze data in order to help the Department formulate policies and rules concerning the regulation of health-related occupations.[57]

Following the 1976 legislation the Board of Health promulgated rules, including a set of "factors for determining the necessity of regulation" based on the sunrise criteria noted above.[58] The "factors" were established to guide HSOAC's study of whether an occupational group applying for regulation should be regulated, and which administrative agency should have regulatory authority. The outcome of HSOAC studies were recommendations made to the Commissioner of Health. The Department of Health was authorized by the 1976 legislation to establish occupational registration through rule making, or to seek licensure through the Legislature.

The studies were carried out by the Human Services Occupational Advisory Council (HSOAC) from 1976 to 1994 with two interruptions.

Between 1976 and 1982, 11 occupational groups underwent the HSOAC process and 2 were eventually regulated.[59] In 1983 the HSOAC process was abolished due to state budget shortfalls.[60] In 1984 the process was reinstated and amended, allowing the Commissioner of Health to appoint temporary voting members to the council.[61] The temporary members were to represent those affected by the proposed regulation. Between 1984 and 1990, 13 proposals went through the HSOAC process, resulting in 6 recommendations for registration. Of these, three occupations were registered through rules promulgated by the Department of Health, the Legislature licensed two occupations, and one occupation was not regulated (see Figure 1.4).

The HSOAC process was once again suspended during 1991 and 1992, until the Legislature reinstated it in 1993. The Department reviewed the registration of speech language pathologists and audiologists in 1994 and the registration of respiratory care practitioners in 1995; these occupations were registered in 1991 and 1992, respectively. These review studies were conducted pursuant to a requirement for the Commissioner of Health to report back to the Legislature three years after registering a health-related occupation.[62] The Department also

56 *Minn. Stat.* §214.13.

57 *Minn. Stat.* §214.14.

58 Minnesota Rules 4695.

59 Environmental health sanitarians were licensed in 1979 and the rules were adopted in 1985 to register physician assistants.

60 *Minn. Laws* (1983), ch. 260, sec. 68.

61 *Minn. Stat.* §214.14

62 *Minn. Stat.* §214.13.

Figure 1.4: Department of Health Reviews of Health-Related Occupations, 1985-90

	Year of Review	Commissioner Recommendation	Current Regulatory Status
Marriage and Family Therapists	1986	Registration	Licensed 1989
Unlicensed Mental Health Providers	1986	Client Protection System	Board abolished 1991. OMHP created in MDH. (Complaint, investigation, and enforcement system)
Social Workers	1986	Registration	Licensed 1989
Acupuncture	1987	Permit, inspection, sterilization course	Licensed 1995
Hearing Instrument Dispenser	1988	Permit, bond, warranty	Certification, exam, continuing education
Speech Language Pathologists/ Audiologists	1988	Registration	Registered 1991 (by rules)
Contact Lens Technicians	1989	Registration	Not Regulated
Occupational Therapists	1989	Registration	Registered 1996 (by rules)
Respiratory Care Practitioners	1989	Registration	Registered 1992 (by rules)
Spectacle Dispensers	1989	No Regulation	Not Regulated
Chemical Dependency Counselors	1990	No Recommendation	Licensure law 1993 Issuance FY 1998
Dietitians/Nutritionists	1990	Licensure (Consumer information)	Licensed 1994
Naturopathic Physicians	1990	No Recommendation	Not Regulated

NOTE: Under Minnesota Rules Chapter 4695 the Commissioner of Health issues recommendations regarding proposed occupational regulation after reviewing the recommendations and reports issued by the Human Services Occupations Advisory Council (HSOAC). The Commissioner has the authority to establish registration through rulemaking. Also note that under *Minn. Stat.* §214.001 licensing is defined as a system of regulation whereby "a practitioner must receive recognition by the state of having met predetermined qualifications, and persons not so licensed are prohibited from practicing," and registration is defined as a system of regulation whereby "the only persons permitted to use a designated title are listed on an official roster after having met predetermined qulifications." This definition of registration departs from the standard definition used in other places throughout this report.

SOURCE: Minnesota Department of Health

produced a study of Health Care Reform and Occupational Regulation in Minnesota in 1995. Since 1996, the HSOAC process has not been funded and studies by the Department of Health are limited to those specifically mandated by the Legislature.

Department of Administration Report

Along with the amendments that established sunrise in Minnesota, the 1976 Legislature directed the Department of Administration to examine the structure of occupational regulation in the state and recommend an effective and economical method for providing staff and administrative services to the independent boards.[63] The department released a two part report in 1976 and 1977 entitled *Occupational Licensing Boards and Host Departments in Minnesota.*

Part I of the report examined the relationships between autonomous boards and the host departments that provided office space and services such as mail, duplication, support staff, and meeting space. It offered recommendations to alleviate problems and inconsistent practices between boards and host departments.

Part II of the report recommended changes to staffing and structure of occupational regulatory boards to improve efficiency and effectiveness. The report discussed various issues facing occupational licensing boards such as ways to measure initial and continuing competence, consistency in disciplinary policies across different boards, and the policy-making role of the boards.

The Department of Administration published reports focusing on provision of administrative services and recommending the abolition of independent licensing boards.

Part II of the report recommended:

- Abolish all licensing boards and incorporate their functions as advisory boards to the health, commerce, education, revenue, and public safety departments which would absorb administrative and regulatory authority. The Attorney General would maintain authority over the investigation and complaint process.

- Create an advisory committee to assist the Legislature in regulating non-health occupations and continue to support the Human Services Occupations Advisory Council.

- Consolidate all licensing board budgets with the department budgets.

Following the release of the Department of Administration (DOA) reports, in 1977 the Senate Governmental Operations Committee created a Task Force on Occupational Licensing to discuss the recommendations of the reports and offer suggestions to the problems associated with occupational regulation. Unlike the DOA report, the Task Force recommended that the boards should remain independent, although they should improve relationships with the host departments. Other recommendations included making a general fund appropriation to the boards to help cover the costs of investigations and disciplinary actions, limiting board participation to policy and discipline matters rather than administrative issues, and eliminating irrelevant licensing criteria.

63 *Minn. Laws* (1976), ch. 222, sec. 207.

The Task Force also made specific recommendations that the Legislature repeal the statutory authority of some boards and expand others. In addition, the Task Force recommended further study for certain issues, including: changing the regulatory status of selected occupations, consolidating smaller boards, and increasing public membership on regulatory boards. Despite the variety of Task Force recommendations none were immediately implemented, and they had minimal impact on occupational regulation in Minnesota.

Commission on Reform and Efficiency Report

Sixteen years after the Department of Administration report, the Minnesota Commission on Reform and Efficiency (CORE) issued *A Minnesota Model - Recommendations for Reorganizing the Executive Branch* in 1993. This wide-ranging report addressed the problems of accountability for small agencies. CORE recommended that boards, commissions, councils, and advisory task forces should be administered by existing departments rather than allowed to exist as fully independent entities. The CORE report saw this as one way of consolidating staffing and support activities and easing procedures for reporting within the executive branch.

Another part of the report offered two recommendations specifically about regulatory boards. It suggested that the Legislature create a central licensing agency to perform administrative functions for the boards while allowing licensing boards to remain independent, and it suggested that all professional licensing boards should go through sunset reviews over a four year period starting in 1994. Neither of these recommendations were implemented.

Subcommittees of the House and Senate studied occupational regulation in the 1990s.

Interim Subcommittees and Legislation

During the 1990s the State Legislature convened two interim committees to study the issue of occupational regulation. In the Fall of 1991 an Occupational Licensing Subcommittee of the House Governmental Operations Committee met to learn about the scope of occupational regulation and the process by which proposed occupational regulation was evaluated. Throughout the Fall, board and agency staff, professional groups, academic researchers, and others provided background information and offered testimony on the effectiveness of the current system of occupations regulated by independent boards and state departments. With this input, subcommittee members traced the history of occupational regulation in Minnesota and discussed inconsistencies in regulatory requirements.

In 1992, following the subcommittee hearings, H.F. 2298 was introduced to establish a legislative commission on occupational regulation. A ten member joint commission was proposed to review proposals for occupational regulation in light of Chapter 214 and recommend whether new regulatory programs should be adopted and which departments should perform the regulatory functions. The commission would also research and analyze trends in occupational regulation and review regulated occupations to assure that they comply with the policies of Chapter 214. The activities of the commission and the staff were to be funded by the licensing fees of occupational groups.

This proposed legislation was designed to limit the growth of occupational licensing boards by making departments responsible for formulating policies and governing occupations. In addition, it proposed to increase public participation on any future advisory boards. It also proposed to eliminate grandfather clauses that allow professionals who are in practice prior to the enactment of new regulation to continue practice without meeting any new credentialing requirements. The bill received hearings in the House Government Structures Division, and the Government Operations Committee of the House and Senate. It was referred to the finance committees in both houses, but ultimately did not pass.

The second interim committee on occupational regulation assembled in the Fall of 1997. This time a Joint Senate Subcommittee on Occupational Licensure met with the goal of improving the Legislature's ability to make short and long term decisions about the increased requests for occupational regulation. The committee questioned whether the focus of occupational regulation is consumer protection and what can be done to improve consumer access. At the subcommittee meetings representatives from departments, boards, the Attorney General's Office, and professional groups spoke about the scope and history of occupational regulation and the complaint and discipline process.

The work of the interim committee culminated in the introduction of S.F. 2380 (1998) to modify Chapter 214. The bill called for the creation of a temporary occupational regulatory oversight council. The oversight council was to consist of two task forces, one relating to health occupations and a second relating to non-health occupations. The bill charged the council to consider how a permanent council could provide oversight of occupational regulation and make recommendations to the Legislature to improve the current regulatory system. The permanent committee responsibilities, as listed in the bill, included actions that would standardize the process for hearing and deciding on occupational regulation requests as well as board and agency activities. The bill was heard in both the Senate and House Governmental Operations Committees and was revised a number of times, but ultimately did not pass out of committee.

Minnesota History: Conclusions

The recent history of occupational regulation in Minnesota reveals that the issues surrounding occupational regulation are not new and that the perceived problems are difficult to resolve. While most legislators agree that the criteria established in Minnesota's sunrise law, Chapter 214, are useful, efforts to operationalize these criteria have resulted in only limited success. The Department of Health's Human Service Occupations Advisory Council is currently in its third and longest phase of inactivity since it was established in 1976. Other reforms, including proposals to administratively centralize regulatory agencies under an umbrella department, or under existing allied departments, have consistently failed to pass each time they were considered.

Organization of Occupational Regulation in Minnesota

CHAPTER 2

In this section we describe how occupational regulation is organized and carried out in Minnesota. We address the following questions:

- **What are the types of occupational regulation used in Minnesota?**
- **Which occupations are regulated in Minnesota?**
- **How is regulation organized and financed in state government?**
- **In general, how does occupational regulation in Minnesota compare with occupational regulation in other states?**
- **What types of regulatory proposals have been before the Legislature in recent years?**

There are several types of occupational regulation, including licensure, certification, and registration.

In order to compile this information we surveyed regulatory boards and state agencies. We reviewed the national literature and interviewed officials from other states. We systematically identified occupational regulation issues before the Legislature in recent years and studied 13 recent proposals for regulation in some detail.

MODES OF OCCUPATIONAL REGULATION

Occupational regulation can be accomplished in several ways. The most restrictive form of regulation is *licensure* which governs the right to practice a legally defined occupational scope of practice. An example is the right to practice medicine or law. A less restrictive form of occupational regulation is *certification* which legally restricts the use of a professional or occupational title, but not the right to provide similar or identical services.[1] For example, no one but certified athletic trainers can use that title. A still less restrictive form of regulation is

1 We are referring here to statutory certification. There are many important private certification programs, for example, certification in medical specialties such as surgery, pediatrics, or psychiatry. In practice, private certification can be virtually as restrictive as licensure.

registration where a roster of enrolled practitioners is maintained by state government without any restriction on the right to practice or the right to use a title.[2] Pharmacy drug researchers are registered by this definition of the term.

There are still other forms of occupational regulation used in Minnesota. One model is illustrated by the regulation of unlicensed mental health practitioners by the Office of Mental Health Practice in the Minnesota Department of Health.[3] While a number of mental health professions are licensed (including clinical psychologists and social workers) others may provide psychotherapy and other mental health services for remuneration without any state license or certification. Minnesota Statutes specify prohibited conduct and reporting requirements that can be the basis for disciplinary action against unlicensed practitioners.[4] This approach is also used to regulate tax preparers who do not have to be licensed as accountants. This model has also been discussed recently as a possible approach for regulating certain complementary and alternative medical professions.

Occupational regulation establishes a legally defined scope of practice and requirements for entry into a profession or occupation.

In addition there are common law and statutory causes of civil action as well as criminal prohibitions that can sanction or prevent illegal practices. Prosecutors and dissatisfied consumers can use these laws to seek punishment and restitution whether or not occupations are regulated. Consumers can also be protected against incompetent practice through business, industrial, or facility regulation. In fact, Minnesota Statutes Chapter 214 specifies the conditions under which occupational regulation is required and calls for the least restrictive form of regulation to be preferred. Thus, a number of approaches can be considered as alternatives to licensure, certification, or registration in situations where some regulation is needed, but a less restrictive approach will serve. Chapter 3 of this report will examine the issue of how effectively the policies articulated in Chapter 214 are being implemented.

Regulatory Functions

Occupational regulation consists of several inter-related functions. The statutes establishing regulation must define a scope of practice (the legally defined techniques and activities of a profession or occupation), and specify licensure or other credentialing requirements including education, experience, or examination requirements necessary for entry into the profession or occupation. In many cases national examinations covering a core of required knowledge have been developed over the years by associations of state regulatory boards. State regulatory agencies administer the examinations and establish passing scores.

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2 These are the predominant national definitions of licensure, certification, and registration, used by the Council of Licensure, Enforcement, and Regulation (CLEAR) and the Pew Health Professions Commission. However, this usage is not generally followed in Minnesota. The term "registration" is often used in Minnesota to mean title protection, for example, and certification is often the term used for practice protection. Chapter 214 defines registration and licensure, but not certification.

3 Established by *Minn. Stat.* §148B.60

4 *Minn. Stat.* §148B.68

A second major function of regulatory boards is enforcement of the laws, rules, and professional standards. Licensing boards or state agencies with regulatory responsibility investigate complaints from the public or other professionals and, depending on the outcome of the investigation, may act to suspend or revoke the license to practice or attach conditions to the right to practice. Short of license discipline a corrective action may be ordered. Usually a voluntary agreement between the parties will be reached, avoiding the need for a formal hearing.

Disciplinary proceedings are not designed to be an effective means for providing restitution to the victims of professional misconduct. While restitution is sometimes involved in negotiated agreements between the board and practitioners, occupational regulation protects the public by preventing future problems through education or counseling in minor cases of misconduct, and through limitation, suspension, or revocation of the right to practice in serious cases.

Regulatory boards enforce standards of competence required for entrance into the profession, but are far less effective in guaranteeing continued competence. Some licenses require continuing education credits for renewal, but many students of occupational regulation are skeptical that continuing education requirements actually assure continued competence.[5]

REGULATED OCCUPATIONS IN MINNESOTA

A major function of regulatory boards and agencies is enforcement of laws, rules, and professional standards.

One of the primary purposes of this study is to assemble and present basic information on regulated occupations in Minnesota, including the number of regulated occupations in Minnesota, the type of regulation (licensure, certification, registration, or other mode) and how many people are licensed or otherwise regulated. To assemble this information, we surveyed occupational licensing boards and state agencies and requested descriptive information on each regulated occupation. We have compiled the data we collected into a separate Directory of Regulated Occupations that can be used as a reference for those with a special interest.[6] For each regulated occupation the Directory presents a brief description of the education, experience, examination, and continuing education requirements required for licensing. In addition, we report data on the number of complaints made against each occupation in recent years and the number of pending investigations. This will be useful to policy makers who wish to get a comparative view of regulated occupations as a whole since information on the requirements of licensure is unavailable from any other recent central source.

Counting each level of licensure within an occupation separately, we calculate that:

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5 Kara Schmitt and Benjamin Shimberg, *Demystifying Occupational and Professional Regulation: Answers to Questions You MayHave Been Afraid to Ask*, (Lexington, KY: Council on Licensure, Enforcement and Regulation, 1996), 49.

6 The directory is available at http://auditor.leg.state.mn.us/pe9905.htm.

- **There are about 188 regulated occupations and professions in Minnesota not counting many separate teachers' licenses.**

This number counts each level within an occupation separately. For example, journeyman plumber and master plumber are counted separately. Some occupations are highly differentiated into multiple levels with separate licenses for each; others, like physicians (while organized into specialties requiring years of training), are governed by a single state license. By our count there are 85 separate occupations and occupational groups that are licensed by the state, if multiple licensing levels within a single occupation are collapsed.

There are nearly 200 regulated occupations in Minnesota plus over 100 separate teacher's licenses.

We treat teachers as a special case, because there are over 100 separate teacher's licenses covering many specialized areas of practice. The large number of licenses reflects, in part, the fine distinctions that are made between similar specialties. For example, there are 27 separate special education teacher licenses. In addition, the number is large because different licensing categories have been used over time, and some discontinued categories are still maintained because there are active teachers licensed within them. While the Minnesota Board of Teaching is currently revising the licensure system in order to consolidate some of the categories, the proposed new system still recognizes about 48 separate licenses.

As the last chapter discussed, the public purpose of occupational regulation is to eliminate or reduce the threat to the health, safety, or well-being of the public that unregulated services would present. Many of the earliest professions to be regulated were the health professions that provide direct care to patients who, arguably, are vulnerable to harm or exploitation because of the complex science behind these services and because of the emotional factors that might cloud a consumer's ability to evaluate health services. Other types of regulated occupations are involved in legal, business, or commercial activities in which the consumer is at risk for economic loss. Other regulated occupations are involved in services aimed at public health or environmental health.

We present several tables describing Minnesota's occupational regulatory system. A series of tables presented below lists the 188 occupations regulated by state government. These are grouped by the licensing board or state agency invested with regulatory authority. In Minnesota, occupations are regulated in various organizational settings including independent health-related licensing boards, independent non-health-related licensing boards, and several state agencies. We will discuss these in turn.

HEALTH-RELATED LICENSING BOARDS

Table 2.1 lists the 14 health-related licensing boards and the health professions they regulate.[7] The health boards are separate state agencies, but they are

7 There are other health professions such as occupational therapists and alcohol and drug abuse counselors that are regulated by the Minnesota Department of Health.

Table 2.1: Occupations Regulated by Health-Related Boards

	Occupation	Mode*	Number Regulated August 1998
Board of Chiropractic Examiners	Chiropractor	L	1,764
Board of Dentistry	Dental Hygienist	L	3,558
	Registered Dental Assistant	R	5,257
	Dentist	L	3,740
	Resident Dentist	L	74
	Faculty Dentist	L	14
Board of Dietetics and Nutrition Practice	Dietitian	L	877
	Nutritionist	L	78
Board of Examiners for Nursing Home Administrators	Nursing Home Administrator	L	935
Board of Marriage and Family Therapy	Marriage and Family Therapist	L	661
Board of Medical Practice	Acupuncturist	L	83
	Athletic Trainer	C	304
	Physical Therapist	C	2,880
	Physician Assistant	C	398
	Physician	L	14,771
	Respiratory Care Practitioner	C	1,159
Board of Nursing	Licensed Practical Nurse	L	22,388
	Public Health Nurse	C	8,713
	Registered Nurse	L	56,731
Board of Optometry	Optometrist	L	801
Board of Pharmacy	Pharmacist	L	5,254
	Pharmacy Drug Researcher	R	81
	Pharmacy Intern	R	525
Board of Podiatric Medicine	Podiatrist	L	142
Board of Psychology	Licensed Psychological Practitioner	L	33
	Licensed Psychologist	L	3,619
Board of Social Work	Licensed Graduate Social Worker	L	1,046
	Licensed Independent Clinical Social Worker	L	2,635
	Licensed Independent Social Worker	L	899
	Licensed Social Worker	L	5,890
Board of Veterinary Medicine	Veterinarian	L	2,654
Emergency Medical Services Regulatory Board	Emergency Medical Technician, Basic	C	9,000
	Emergency Medical Technician, Intermediate	C	450
	Emergency Medical Technician, Paramedic	C	1,700

*NOTE: Mode of regulation. L=Licensure, indicating practice protection. C=Certification, indicating title protection. R=Registration, indicating that the state maintains a roster of practitioners. The use of these terms is not necessarily consistent with statutory language.

SOURCE: Program Evaluation Divisions survey.

co-located, and share some administrative services. The health professions regulated by independent boards contain some of the largest regulated occupational groups as well as some small professions. As Table 2.1 shows, as of mid-1998 there were 14,771 physicians, 56,731 registered nurses, and 22,388 licensed practical nurses. At the other end of the range there were 877 dietitians and 142 podiatrists.

Each board has its own practice act and is governed by a board of directors appointed by the Governor. Each board has two or more public members; otherwise, the composition of the board is predominately composed of members of the professions being regulated.[8] Chapter 214 makes it clear that it is state policy for the boards to be primarily composed of members of the regulated occupations.[9]

The health-related boards are located in the same building, and have a jointly operated administrative services unit.

While the health-related boards are independent agencies, as noted, their offices are all located at the same address, and they jointly operate an administrative services unit that carries out certain administrative functions including personnel, payroll, budgeting, and accounting services. They also collaborate on matters of common concern through several *ad hoc* and standing committees.

Provisions of Chapter 214 contemplated that it would be efficient for departments of state government to provide administrative services to the independent boards. For example, the Minnesota Department of Health (MDH) would provide administrative services to the health boards. In the past, the health-related boards were located in MDH offices, and received various support services, but the boards moved away and MDH provides virtually no administrative services. As the previous chapter discussed, centralization of administrative services has been promoted nationally and in Minnesota as a means to improved efficiency for regulatory boards, but over the last ten years or so Minnesota has moved in the opposite direction. In the next chapter we discuss this issue further.

Table 2.2 provides a summary of health board revenues and expenditures for 1998. In general, occupational licensing and regulation is financed through the fees charged to the professionals being regulated. Together, Minnesota Statutes §214.06 and §16.1285 set a policy that boards should set fees at a level that neither significantly over or under recovers the amount spent on regulation. As Table 2.2 shows, 13 licensing boards took in $11.3 million in fiscal year 1998 and spent $10.9 million. The table excludes revenues and expenditures for the Emergency Medical Services Regulatory Board which began operations in July 1996. In the aggregate, revenues exceeded expenditures by half a million dollars, but five of the 13 boards have a negative difference for the year. The accumulated ending balance for each board was positive, however, and the aggregate balance was about $2.4 million.

8 With the exception of the Emergency Medical Services Board which has one public member.

9 *Minn. Stat.* §214.001

Table 2.2: Health-Related Board Finances (in Thousands), FY1998

Board	FTE[a]	Direct Expenditures	Indirect Expenditures	Total Expenditures	Occupational Licensure Charges	Total Revenue	Current Differences	Accumulated Ending Balance
Chiropractic Examiners	4.75	$ 302	$ 172	$ 474	$ 498	$ 498	$ 24	$ 44
Dentistry	7.0	654	275	929	1,173	1,173	244	537
Dietetics and Nutrition Practice	1.0	77	20	97	130	130	33	228
Examiners for Nursing Home Administrators	2.0	141	30	171	232	232	61	76
Marriage and Family Therapy	1.6	93	17	110	100	100	(10)	32
Medical Practice	23.0	3,431	243	3,674	3,518	3,518	(156)	610
Nursing	29.0	1,603	939	2,542	2,695	2,695	153	472
Optometry	1.0	74	16	90	99	99	9	92
Pharmacy	11.0	790	94	884	876	876	(8)	44
Podiatric Medicine	0.5	33	13	46	42	42	(4)	25
Psychology	7.4	414	262	676	908	914	238	15
Social Work	9.75	674	262	936	745	792	(144)	118
Veterinary Medicine	1.75	173	84	257	301	301	44	87
Emergency Medical Services Regulatory Board[b]	16.0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total (Health Boards)	115.8	$8,459	$2,427	$10,886	$11,317	$11,370	$484	$2,380

NOTE: Financial data are in thousands of dollars. Most figures are estimates.

[a]Number of employees in full-time equivalents.

[b]The Emergency Medical Services Regulatory Board became effective July 1, 1996. Financial data are not yet available.

SOURCE: Health Boards' Administrative Services Unit.

The boards are not directly financed by revenue from licensing or examination fees. They are financed through a biennial appropriation which is based on historic and projected fee revenue. In addition, appropriations are made to the Office of the Attorney General for legal and investigative services for the boards. Each board is billed for services rendered. These amounts are included in the board expenditure amounts presented in Table 2.2 along with all other indirect costs. Indirect costs include the contributions boards made to the Administrative Services Unit, and two programs established by Chapter 214, the HIV and HBV Prevention Program and the Health Professionals Services Program. The HIV/HBV Prevention Program administers mandatory reporting and monitoring requirements for certain regulated professionals infected with the human imunodeficiency virus (HIV) or the hepatitis B virus (HBV). The Health Professional Services Program provides confidential services to health professionals with a chemical dependency or certain other impairments. Nine boards participate in this program.

The first column of Table 2.2 shows the full time staff employed by each board. The number of employees varies from 29 for the Board of Nursing to one for the

boards of Optometry and Dietetics and Nutrition Practice, and one-half a position for the Board of Podiatry.[10] Altogether, there are 115.8 employees in 14 health-related boards, 4.5 positions in the Administrative Services Unit jointly operated by the boards, and 5 positions in the Health Professionals Services Program conducted on behalf of 9 participating boards.

NON-HEALTH-RELATED BOARDS

There are 12 independent non-health-related licensing boards that regulate 52 professions and occupations.[11] These are shown in Table 2.3 along with information on the type of regulation and the number licensed or otherwise regulated as of mid-1998. The Board of Teaching licenses almost 112,000 teachers and other licensed school professionals such as social workers and counselors. In addition, the State Board of Education licenses 5,870 school district administrators. The state licenses about 15,000 peace officers through the Peace Officer Standards and Training Board. The Board of Law Examiners and the Lawyers Professional Responsibility Board licenses and regulates 21,476 lawyers.

Twelve non-health-related boards regulate 52 occupations and professions.

Some non-health boards license small occupational groups. The Board of Assessors licenses less than 1,000 assessors, the Private Detectives and Protective Agents' Services Board licenses 240 detectives and 60 protective agents, and the Board of Boxing licenses 208 boxing and karate participants and officials.

Table 2.4 shows how the boards are appointed, the size of the boards, and the number of public members. The two boards regulating attorneys are appointed by the Supreme Court. The Board of Assessors is appointed by the Commissioner of Revenue, the Private Detectives Board is appointed by the Commissioner of Public Safety, and the remaining boards are appointed by the Governor. All the boards have at least some public members with the exception of the State Board of Education which is not primarily a regulatory or licensing board.

Table 2.5 presents a summary of fee revenues and expenditures for 9 non-health boards for 1998. The Board of Electricity, the Board of Teaching and the State Board of Education are excluded.[12] In total, about $5.7 million in revenue was received in fiscal year 1998 compared to $4.7 million in expenditures. In the aggregate, the boards took in more than they spent, so they ended fiscal year 1998 with a positive balance of $1 million. The accumulated balance of the boards is

10 These two boards actually share an executive director and clerical worker.

11 The category "Non-health-related licensing board" appears in *Minn. Stat.* §214.01. These boards are subject to some of the same Ch. 214 requirements as the health-related boards.

12 The Departmental Earnings Report published by the Department of Finance does not separately present data for the boards of teaching and eduction. Their fee revenues and expenditures are combined with the Department of Children Families and Learning. The Board of Electricity is excluded because most of its financial activity relates to electrical inspections rather than occupational regulation.

Table 2.3: Occupations Regulated by Non-Health-Related Boards

	Occupation	Mode*	Number Regulated August 1998
Board of Accountancy	Certified Public Accountant	L	6,115
	Certified Public Accountant (Inactive)	C	4,634
	Licensed Public Accountant	L	363
Board of Architecture, Engineering, Land Surveying, Landscape Architecture, Geoscience, and Interior Design	Architect	L	3,396
	Certified Interior Designer	C	1,148
	Professional Engineer	L	10,250
	Engineer in Training	C	7,800
	Professional Geologist	L	140
	Geologist in Training	C	3
	Land Surveyor	L	478
	Land Surveyor in Training	C	100
	Landscape Architect	L	342
	Professional Soil Scientist	L	26
	Soil Scientist in Training	C	1
Board of Assessors	Accredited Minnesota Assessor	L	53
	Certified Minnesota Assessor	L	754
	Certified Minnesota Assessor Specialist	L	119
	Senior Accredited Minnesota Assessor	L	244
Board of Barber Examiners	Apprentice Barber	L	146
	Barber Instructor	L	12
	Registered Barber	L	2,667
Board of Boxing	Amateur Boxing Referee	L	24
	Amateur Boxing Second/Coach	L	42
	Amateur Karate Referee	L	0
	Amateur Karate Second/Coach	L	6
	Professional Boxer	L	49
	Professional Boxing Manager	L	1
	Professional Boxing Referee	L	5
	Professional Boxing Second/Coach	L	70
	Professional Karate Contestant	L	6
	Professional Karate Referee	L	1
	Professional Karate Second/Coach	L	4
Board of Education	School Administrator/Supervisory Personnel	L	5,870
Board of Electricity	Class A Electrical Installer	L	4
	Class A Journeyman Electrician	L	8,741
	Class A Master Electrician	L	5,301
	Class B Electrical Installer	L	15
	Lineman	L	118
	Maintenance Electrician	L	477
	Elevator Constructor	L	327
	Master Elevator Constructor	L	54
Board of Law Examiners / Lawyer's Professional Responsibility Board	Attorney	L	21,476
Board of Teaching	Educational Speech/Language Pathologist	L	2,696
	School Counselors, Elementary	L	2,683
	School Nurse	L	674
	School Psychologist	L	836
	School Social Worker	L	1,156
	Teacher	L	111,995
Peace Officers Standards and Training Board	Part Time Peace Officer	L	1,547
	Peace Officer	L	13,759
Private Detectives and Protective Agent Services Board	Private Detective	L	240
	Protective Agent	L	60

*NOTE: Mode of regulation. L=Licensure, indicating practice protection. C=Certification, indicating title protection. The use of these terms is not necessarily consistent with statutory language.

SOURCE: Program Evaluation Division survey.

Table 2.4: Non-Health-Related Board Composition

	Appointing Authority	Number of Positions on Board	Number of Public Members
Board of Accountancy	Governor	9	2
Board of Architecture, Engineering, Land Surveying, Landscape Architecture, Geoscience, and Interior Design	Governor	21	5
Board of Assessors	Commissioner of Revenue	9	3
Board of Barber Examiners	Governor	4	1
Board of Boxing	Governor	7	2
Board of Education	Governor	9	0
Board of Electricity	Governor	11	2
Board of Law Examiners	Minnesota Supreme Court	9	2
Board of Teaching	Governor	11	3
Lawyer's Professional Responsibility Board	Minnesota Supreme Court	23	9
Peace Officers Standards and Training Board	Governor	15	2
Private Detectives and Protective Agent Services Board	Commissioner of Public Safety	5	2

SOURCE: Program Evaluation Division survey.

Table 2.5: Non-Health-Related Board Finances (in Thousands), FY1998

Board	FTE[a]	Total Expenditures	Occupational Licensure Charges	Other Revenue	Total Revenue	Current Differences	Accumulated Ending Balance
Accountancy	5.0	$ 657	$ 390	$ 237	$ 627	$ (30)	$ (13)
Architecture, Engineering, Land Surveying, Landscape Architecture, Geoscience, and Interior Design	8.5	801	875	138	1,013	212	380
Assessors	1.0	45	45	0	45	0	0
Barber Examiners	2.0	139	129	3	132	(7)	(2)
Boxing	1.5	91	3	0	3	(88)	(256)
Law Examiners	7.1	746	860	936	1,796	1,051	1,051
Lawyer's Professional Responsibility Board	22.0	1,698	1,822	94	1,916	218	873
Peace Officers Standards and Training Board	6.0	405	56	41	97	(308)	(835)
Private Detectives and Protective Agent Services	1.0	138	102	(6)	96	(42)	(93)
Total (Non-Health Boards)	54.1	$4,720	$4,282	$1,443	$5,725	$1,006	$1,105

NOTE: Financial data are in thousands of dollars. Figures are estimates.

NOTE: Financial data for the boards of Education and Teaching are not included because their budgets are integrated with the agency budget for the Department of Children, Families & Learning. Data for the Board of Electricity are not included because most of this board's financial activity relates to electrical inspection. The board reported $810 thousand in occupational licensure charges in FY1998.

[a]Number of employees in full-time equivalents.

SOURCE: Minnesota Department of Finance, 1998-99 Departmental Earnings Report.

$1.1 million, but the Board of Boxing and the Peace Officers Standards and Training Board each have sizable negative balances[13]

The first column of Table 2.5 shows the full time equivalent (FTE) staff positions for each board. The smallest boards are staffed with one position. The boards generally receive certain administrative services from larger state agencies. The Department of Public Safety provides administrative support for the Peace Officers Standards and Training (POST) Board and the Private Detectives Board. The latter board is housed in the Department of Public Safety. The Department of Revenue houses the Board of Assessors and provides services. The Department of Administration, provides services to the Board of Electricity; the Department of Children, Families & Learning houses and provides services to the Board of Teaching and the State Board of Education; and the Department of Commerce provides services to the boards of Accountancy, Architecture, Barbers, and Boxing. The boards pay indirect costs for these services (included in the totals presented in Table 2.5) based on past and projected expenditures.

OCCUPATIONS REGULATED BY STATE DEPARTMENTS

The Minnesota departments of Health and Commerce are the state agencies with the broadest responsibility for occupational regulation.

Seven state departments (not counting the Supreme Court) regulate occupations. In some cases an advisory board is involved in the process, but it is the department that holds regulatory authority. The Minnesota Department of Health (MDH) and the Department of Commerce have the broadest responsibility for occupational regulation. There are five additional departments with some occupational regulatory responsibilities.

Minnesota Department of Health

The Department of Health regulates various professions and occupations, including some that provide clinical services to patients such as occupational therapists, audiologists, and alcohol and drug counselors and some that provide services that relate to public health such as environmental health specialists or asbestos abatement workers. Table 2.6 lists the occupations regulated by MDH. Those that deal with clinical services are organized in the Division of Health Policy and Systems Compliance. Those that relate to public or environmental health are in the Division of Environmental Health. Table 2.6 shows the number licensed or otherwise regulated as of mid-1998.

Department of Commerce

The Department of Commerce has several types of regulatory programs. Table 2.7 shows the occupations licensed by the department. In mid-1998 the

13 As noted earlier, the boards are expected to set fees so they recover their costs. The Board of Boxing has a statutory exemption from this requirement because it is too small to be self sufficient.

Table 2.6: Occupations Regulated by the Department of Health

	Occupation	Mode*	Number Regulated August 1998
Division of Health Policy and Systems Compliance	Alcohol and Drug Counselor	L	65
	Audiologist	C	240
	Hearing Instrument Dispenser	L	300
	Mortuary Science Professional	L	1,650
	Occupational Therapist	C	1,862
	Occupational Therapist Assistant	C	809
	Speech Language Pathologist	C	763
	Unlicensed Mental Health Practitioner	O	NA
Division of Environmental Health	Asbestos Inspector	L	479
	Asbestos Management Planner	L	151
	Asbestos Project Designer	L	116
	Asbestos Site Supervisor	L	935
	Asbestos Worker	L	716
	Environmental Health Specialist/Sanitarian	L	327
	Lead Contractor/Supervisor	L	200
	Lead Inspector	L	89
	Lead Training Course Provider	O	6
	Lead Worker	L	28
	Plumber's Apprentice	R	1,019
	Journeyman Plumber	L	2,646
	Master Plumber	L	2,493
	Water Conditioning Contractor	L	177
	Water Conditioning Installer	L	186
	Water Supply Systems Operator	C	2,450
	X-ray Operator	R	2,200

*NOTE: Mode of regulation. L=Licensure, indicating practice protection. C=Certification, indicating title protection. R=Registration, indicating that the state maintains a roster of practitioners. O=Other, indicating an alternate form of regulation. The use of these terms is not necessarily consistent with statutory language.

SOURCE: Program Evaluation Division survey.

department licensed over 96,000 notaries, over 49,000 insurance agents, over 20,000 cosmetologists, over 20,000 real estate brokers and agents, as well as a number of smaller occupations. In addition to occupational regulation the department regulates businesses and financial and insurance products. The department views occupational, industrial, and product regulation as three strategies to accomplish the objective of protecting the public. In fact, some of its occupational regulatory program is integrated with these other regulatory responsibilities making it difficult to sort out how much staff and money is devoted to occupational regulation.

Occupations Regulated by Other State Departments

Five other state departments are responsible for licensing or otherwise regulating various occupations: Administration, Agriculture, Labor and Industry, Public Safety, and the Pollution Control Agency. These are shown in Table 2.8. As we noted earlier additional information on each of the regulated occupations is provided in the Directory of Regulated Occupations that we are publishing separately.

Table 2.7: Occupations Regulated by the Department of Commerce

	Mode*	Number Regulated August 1998
Abstractor	L	361
Certified General Property Appraiser	L	871
Certified Real Property Appraiser	L	740
Licensed Real Property Appraiser	L	57
Registered Real Property Appraiser	L	692
Crop Hail Adjuster	L	219
Independent Adjuster	L	949
Public Adjuster	L	33
Public Adjuster Solicitor	L	4
Insurance Agent	L	49,550
Notary Publics	L	96,323
Real Estate Broker	L	6,074
Real Estate Limited Broker	L	1,659
Real Estate Closer	L	39
Real Estate Salesperson	L	14,156
Cosmetologist	L	9,441
Cosmetology Instructor	L	331
Cosmetology Manager	L	12,834
Esthetician	L	469
Manicurist	L	1,619

*NOTE: Mode of regulation. L=Licensure, indicating practice protection. The use of this term is not necessarily consistent with statutory language.

SOURCE: Program Evaluation Division survey.

Financing Occupational Regulation in State Departments

Roughly $42 million was collected in occupational licensing charges in 1998.

The independent licensing boards discussed earlier in this chapter are independent agencies dedicated to occupational regulation in one form or another. They collect fees for licensure, examinations, and other user services and spend money for the operating and administrative expenses connected with their regulation and enforcement activities. Earlier we reported on their revenues and expenditures. It is more difficult to provide a clear picture of the costs of occupational regulation in state agencies because the regulatory programs do not formally account for all the administrative services they receive from the department of which they are a part, and because their occupational regulatory activities are often integrated with business regulation or product regulation responsibilities.

In addition, fee income is classified differently for different departments in the Departmental Earnings Report which the Department of Finance issues every two years. Departments do not report how licensure fees are spent; they report only

Table 2.8: Occupations Regulated by Other Departments

	Occupation	Mode*	Number Regulated August 1998
Department of Administration			
Building Codes and Standards Division	Accessibility Specialist	L	38
	Certified Building Official	L	598
	Certified Building Official, Class 1	C	36
	Certified Building Official, Limited	L	110
	Grandfathered Building Official	L	5
Department of Agriculture			
Agronomy and Plant Protection Services Division	Journeyman Structural Pesticide Applicator	L	343
	Master Structural Pesticide Applicator	L	97
	Pesticide Applicator, Non-Commercial	L	2,853
	Pesticide Applicator, Commercial	L	4,923
	Pesticide Applicator, Private	L	25,276
	Journeyman Aquatic Pest Controller	L	21
	Master Aquatic Pest Controller	L	33
	Tree Inspector	C	811
Agriculture Marketing and Development	Weather Modifier	L	0
Dairy and Food Inspection Division	Babcock Milk Hauler	L	4
	Bulk Hauler Milk Tester	L	1,164
Laboratory Services	Certified Industry Supervisor (Dairy Inspection)	C	164
	Certified Lab Analyst (Dairy Inspection)	C	89
Department of Labor and Industry			
Code Administration and Inspection Services	1st Class Boiler Engineer, Grade A	L	1,674
	1st Class Boiler Engineer, Grade B	L	1,294
	1st Class Boiler Engineer, Grade C	L	3,259
	2nd Class Boiler Engineer, Grade A	L	1,323
	2nd Class Boiler Engineer, Grade B	L	2,037
	2nd Boiler Engineer, Grade C	L	3,259
	Chief Boiler Engineer, Grade A	L	1,984
	Chief Boiler Engineer, Grade B	L	864
	Chief Boiler Engineer, Grade C	L	2,082
	Special Boiler Engineer	L	15,255
	Boat Pilot	L	473
	Apprentice Steamfitter	R	NA
	Contractor Steamfitter	L	306
	Journeyman Steamfitter	L	2,191
Labor Standards Division	Employment Counselor	L	24
	Employment Manager	L	30
Rehabilitation and Medical Affairs Section	Qualified Rehabilitation Consultant Intern	R	56
	Qualified Rehabilitation Consultant	R	345
Pollution Control Agency			
Ground Water and Solid Waste	Demolition or Industrial Waste Landfill Inspector	L	5
	Demolition or Industrial Waste Landfill Operator	L	710
	Municipal Solid Waste Landfill Operator	L	220
	Municipal Solid Waste Landfill Inspector	L	85
Hazardous Waste Division	Underground Storage Tank Supervisor	L	517
Water Quality Division	Individual Sewage Treatment System, Designer II	L	558
	Individual Sewage Treatment System, Inspector	L	24
	Individual Sewage Treatment System, Installers	L	1,243
	Individual Sewage Treatment System, Pumper	L	354
	Waste Disposal Inspector	C	25
	Waste Disposal Operator	C	530
	Waste Water Facility Operator	C	2,350

Table 2.8: Occupations Regulated by Other Departments, Continued

	Occupation	Mode*	Number Regulated August 1998
Department of Public Safety			
Division of Driver and Vehicle Services	Commercial Driver Training Instructor, Auto	L	102
	Commercial Driver Training Instructor, Motorcycle	L	372
	Commercial Vehicle Operator	L	169,696
Fire Marshall Division			
	Journeyman Sprinkler Fitter	C	480
	Journeyman Sprinkler Fitter, Conditional	C	0
	Journeyman Sprinkler Fitter, Limited	C	50
	Design Contractor	L	4
	Managing Employee Certification	C	65
	Fireworks Operator	L	344

*NOTE: Mode of regulation. L=Licensure, indicating practice protection. C=Certification, indicating title protection. R=Registration, indicating that the state maintains a roster of practitioners. The use of these terms is not necessarily consistent with statutory language.

SOURCE: Program Evaluation Division survey.

the total direct and indirect expenditures of their fee income including fees relating to business regulation and, in some cases, user fees. Some departments such as Administration and the Pollution Control Agency did not report any revenue from licensure charges in 1998 even though they regulate some occupations. Other departments such as Children, Families & Learning did not report any user fees. Because of variation in the way departments account for occupational regulatory fees, we do not present any detailed information on occupational regulatory costs in state departments.

However, as a broad indicator, it is useful to note that statewide, $41.3 million is identified as occupational licensing charges in 1997 and $42.0 million in 1998 in the Departmental Earnings Report published by the Department of Finance. This total is for all state agencies including the independent boards.

ROLE OF THE ATTORNEY GENERAL

The Office of the Attorney General provides some special services to the independent regulatory boards in addition to the legal services it provides to all state agencies. Chapter 214 specifies a role for the Attorney General in the investigation of complaints against licensed professionals, because of concern that the public interest would not otherwise be adequately represented in an investigative process conducted by boards whose membership is largely composed of the members of the professions being regulated. In addition, public accountability is impeded by the fact that investigations are highly confidential under Minnesota's data privacy laws.[14] In its investigative role, the Attorney General functions as an independent investigator, but it can subsequently represent

14 Minn. Stat. §214.1

the board in a contested case hearing if a voluntary settlement cannot be negotiated.

Chapter 214 imposes some special requirements on the health-related boards. The Attorney General's Office has a Licensing Investigations Division with expertise in the health professions to which the boards refer serious charges. The Attorney General's Office must be involved in complaints that lead to licensing discipline. And cases of sexual misconduct and chemical dependency must also be referred to the Attorney General for investigation. About 10 to 15 percent of complaints made to the health boards are referred to the AGO for investigation and all cases involving license discipline are reviewed by the Attorney General's legal staff assigned to each board. Chapter 3 examines the status of complaint investigation at the Attorney General's Office in additional detail.

COMPARISON WITH OTHER STATES

Minnesota regulates more occupations than all but 12 states.

We sought to learn which occupations are regulated in most states and which occupations regulated in Minnesota are regulated in few other states. We found:

- **According to the available national data, Minnesota regulates somewhat more occupations and professions than most other states.**

Figure 2.1 compares the occupations regulated in each state. According to data tabulated from a directory of occupational regulation published by the Council on Licensing, Enforcement, and Regulation (CLEAR), Minnesota ranks 13th highest among the 50 states in the number of occupations regulated.[15] According to the CLEAR directory, Minnesota licenses 99 occupations, certifies 11 and registers 32 for a total of 142 regulated occupations. The national average is 96.5 licensed, 5.7 certified, 21.4 registered for a total of 124 regulated occupations.[16]

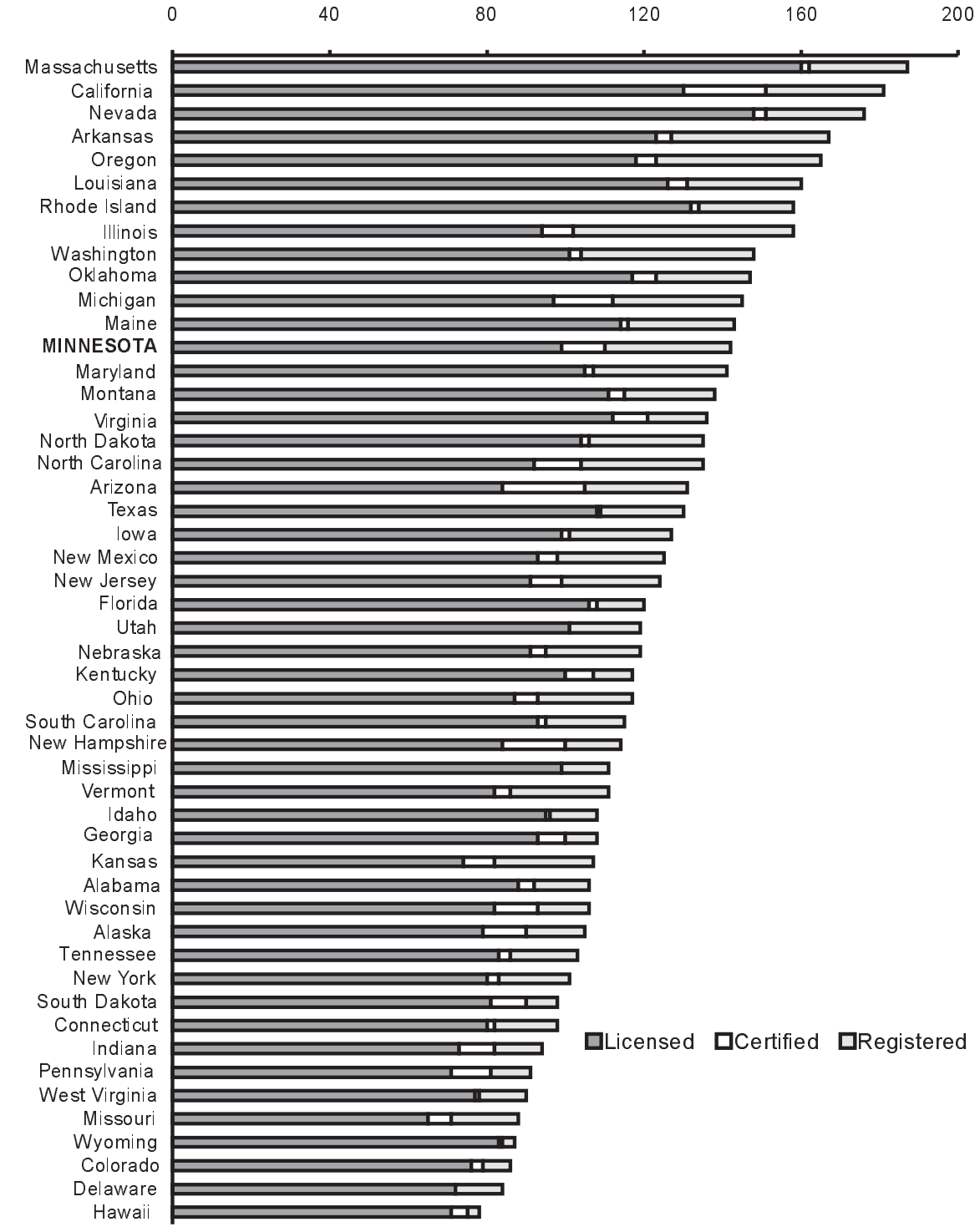
Analysis of the CLEAR data also shows that some occupations are regulated in virtually every state. Table 2.9 shows the 40 most commonly regulated occupations. Among the occupations and professions licensed in every state are attorneys, dentists, nurses, physicians, and veterinarians. Cosmetologists and barbers are also licensed in nearly all states.

We also sought to learn which occupations are regulated in Minnesota but relatively few other states. Table 2.10 shows some of these. Because of variations in names of occupations and professions across the states, it is difficult to be sure this table is completely accurate, but there appear to be at least a dozen or more occupations licensed by Minnesota state government that are not licensed

15 Lise Smith-Peters, ed., *The Directory of Professional and Occupational Regulation in the United States*, (Lexington, KY: The Council on Licensure, Enforcement and Regulation, 1994).

16 The number of regulated occupations in Minnesota from the CLEAR study does not correspond exactly with the number we have calculated for mid-1998, however most of the discrepancies are due to the fact that somewhat different definitions were used in the two studies and because the studies were carried out five years apart.

Figure 2.1: Number of Regulated Occupations by State



SOURCE: Data compiled from Lise Smith-Peters, ed., *The Directory of Occupational Regulation in the United States* (Lexington, KY: The Council on Licensure, Enforcement and Regulation, 1994).

Table 2.9: The Most Commonly Regulated Occupations

Some occupations are regulated in all or nearly all states.

		Number of States Regulating			
	Mode*	License	Certify	Register	Total
Architect	L	50	0	0	50
Attorney	L	50	0	0	50
Chiropractor	L	50	0	0	50
Dentist	L	50	0	0	50
Insurance Agent	L	50	0	0	50
Nurse, Registered	L	50	0	0	50
Optometrist	L	50	0	0	50
Osteopath	L	50	0	0	50
Paramedic	L	50	0	0	50
Pharmacist	L	50	0	0	50
Physician	L	50	0	0	50
Podiatrist	L	50	0	0	50
Real Estate Broker	L	50	0	0	50
Real Estate Sales Person	L	50	0	0	50
Veterinarian	L	50	0	0	50
Cosmetologist	L	49	0	1	50
Dental Hygienist	L	49	0	1	50
Land Surveyor	L	49	1	0	50
Physical Therapist	C	48	2	0	50
Psychologist	L	47	2	1	50
Nurse, Licensed Practical	L	49	0	0	49
Accountant, Certified Public	C	42	6	1	49
Physician Assistant	C	37	11	1	49
Nursing Home Administrator	L	48	0	0	48
School Teacher, Elementary	L	48	0	0	48
School Teacher, **S**econdary	L	48	0	0	48
Barber	L	47	0	1	48
Funeral Director	L	46	0	0	46
Emergency Medical Technician	L	45	0	0	45
Hearing Aid Dealer/Fitter	L	45	0	0	45
Cosmetology: Manicurist	L	43	0	0	43
Landscape Architect	L	34	8	1	43
Audiologist	C	41	1	0	42
Engineer, Professional	L	41	0	0	41
School Teacher, Special Education	L	41	0	0	41
Speech Pathologist	C	40	1	0	41
Occupational Therapist	C	36	4	0	40
School Teacher, Vocational	L	36	2	0	38
Wastewater Treatment Operator	L	21	17	0	38
Pesticide Applicator	L	36	1	0	37

*NOTE: Mode of regulation in Minnesota. L=Licensure, indicating practice protection. C=Certification, indicating title protection. The use of these terms is not necessarily consistent with statutory language.

SOURCE: Data compiled from Lise Smith-Peters, ed., *The Directory of Professional and Occupational Regulation in the United States* (Lexington, KY: The Council on Licensure, Enforcement and Regulations, 1994).

Table 2.10: Occupations Regulated by Few States Other Than Minnesota

	Number of States Regulating
Aquatic Pest Controller, Journeyman*	1
Aquatic Pest Controller, Master*	1
Elevator Constructor	1
Nurse, Public Health	1
Psychologist, Consulting	1
Waste Disposal Inspector	1
Waste Disposal Operator	1
Weather Modifier*	1
Contractor, Lead Abatement[a]	2
Contractor, Pipefitter	2
Electrician, lineman	2
Electrician, Specialty	2
Lead Abatement Training Provider[a]	2
Rehabilitation Counselor	2
Soil Scientist	2
Soil Scientist in Training	2
Water Conditioning Installer	2
Boiler Engineer	3
Lead Abatement Worker[a]	3
Pipefitter, Journeyman	3
Assessor	5
Public Appraiser/Adjuster	5
Water Conditioning Contractor	5
Respiratory Care Technician	5
Septic Tank Pumper	5
Abstractor	6
School Social Worker	6
Building Code Official	7
Fireworks Handler	7
Nutritionist	7
Arborist/Tree Inspector	8

NOTE: "Regulation" includes licensure, certification, and registration.

[a]Environmental Protection Agency requirements have resulted in increased numbers of states regulating lead abatement workers. According to the Minnesota Department of Health, 15 states currently regulate lead abatement workers.

SOURCE: Data compiled from Lise Smith-Peters, ed., *The Directory of Professional and Occupational Regulation in the United States* (Lexington, KY: The Council on Licensure, Enforcement and Regulations, 1994). Except starred (*) occupations, which are not in the directory but are regulated in Minnesota.

Some occupations regulated in Minnesota are regulated in only a few other states.

by more than six other states. Some of these may be licensed by local government in other states. Nevertheless, the fact that most other states do not license various occupations may suggest a need to re-examine the utility of licensing the occupations in Minnesota.

Case Studies

To learn more about how occupational regulation is handled in other states we selected a group of states that illustrate a variety of organizational models for further study. These are listed in Figure 2.2. Our research suggests that the issues currently facing Minnesota are very similar to the issues facing other states. Furthermore, while occupational regulation is organized and implemented differently in other states, the states we studied still struggle with the same kinds of problems we observe in Minnesota (and discuss in the next chapter). We present a summary of the case studies in Appendix A. Many of the ideas for reform that have been discussed in Minnesota have been tried elsewhere.

Figure 2.2: Case Studies of Other States

	Organizational feature of interest
Arizona	- Comprehensive sunset provision - Sunrise provision for health-related occupations
Florida	- Recent reorganization of occupational regulation - Enactment of sunrise legislation - Privatization of Board of Professional Engineers' staff
Maine	- Regulatory centralization - Recent revisions to strengthen sunrise provision
Oregon	- Recent history of reform and counter-reform
Texas	- Health Professions Council - Sunset provision
Virginia	- Regulatory centralization - Board of Health Professions
Washington	- Sunrise provision for health professions - Uniform Disciplinary Act for health professions - Centralization of health-related boards
Wisconsin	- Regulatory centralization under the Department of Regulation and Licensing

MINNESOTA'S OCCUPATIONAL REGULATORY AGENDA

In addition to describing our current system of occupational regulation, we sought to learn what types of proposals for occupational regulation have been brought

We studied several proposals for new regulation or changes in occupational regulation in order to understand the process by which such proposals are considered in the Legislature.

before the legislature in recent years. In order to identify the issues we searched topical indexes of bills in the House and Senate as well as the Revisor's system.[17]

This process, while not a fool-proof method of identifying all important issues, yielded a list of 38 bills (not counting companion bills) relating to 44 proposals for new regulation or changes to existing regulation. All in all, we think the list is reasonably representative of the regulatory proposals that have been introduced as bills in recent years. This list is presented in Figure 2.3. These bills propose regulatory changes affecting various occupations. Some seek new regulation, for example, licensing of naturopathic physicians. Some propose a change in the level of regulation, for example, licensure instead of registration of dental assistants and physical therapists. Some propose to increase entry requirements, for example requiring a fifth year of higher education in order to become a certified public accountant. Some proposals sought to extend the scope of practice, for example to allow physician assistants the right to render emergency care without a supervising physician. Some proposals changed continuing education requirements. Only one proposal proposed a fundamental reduction in state occupational regulation: there was a proposal to abolish the Board of Architecture, Engineering, Land Surveying, Landscape Architecture, Geoscience, and Interior Design. Some proposals to change occupational regulation in Minnesota are a reflection of changes in federal requirements, other states' requirements, and the pattern of local government regulation.

We selected 13 of the issues for more detailed study. These are listed in Figure 2.4. We selected a set of proposals that was deliberately varied, including some bills that received a hearing and some that did not; some of the proposals were enacted into law, others had been around for a few years without success. We chose a mix of occupations including clinical health occupations, public health occupations, and non-health professions and occupations. We listened to any available tapes of the legislative committee deliberations on the bills. We talked to some of the legislators involved, and relevant agency and licensing board staff, professional association representatives, lobbyists, and others.

A brief description of each of the case studies is provided in Appendix B. These case studies provided some of the information we use in the next chapter to reach conclusions about the effectiveness of our system of occupational regulation including the effectiveness of the process by which agencies and the legislature decide whether regulation is needed.

17 Specifically, we reviewed the House of Representatives Topical Index of bills for 1997 and looked under topics that related to regulation. We noted which bills looked like occupational regulation proposals from the short description provided not including minor housekeeping bills. We then cross referenced the list with the Senate Topical Index of bills for 1997. Next, we searched the Revisor's system and used the 1997 topic headings to search for 1998 bills. Finally, we edited out bills not having to do with the subject and added bills identified from other sources.

Figure 2.3: Recent Legislative Proposals

	Year	House File	Senate File	Bill Focus
Accountants	1997	301	239	Increasing entry requirements
	1998	2308	2014	Granting more discipline power to board
Asbestos Workers	1997	--	937	New regulation
Board of Architects, etc.	1998	2827	--	Abolishing the board
Commercial Waste Technicians	1998	2799	3353	New regulation
Dental Assistants	1998	--	3408	Increasing level of regulation to licensure
Emergency Medical Technicians	1997	257	510	Registering first responders
Hearing Instrument Dispensers	1997	2086	--	Increasing scope of practice
Heating and Ventilating Installers	1997	1533	1251	New regulation
Individual Sewage Treatment System Professionals	1997	--	1730	Exempting professional engineers from regulation requirements
Industrial Hygienists	1997	668	668	New regulation
Insurance Agents	1997	740	349	Increasing categories of regulation Increasing entry requirements Specifying continuing education requirements
Interpreter-Transliterator	1997	1297	1164	New regulation
Lead Workers	1998	2334	2108	Changing requirements to meet federal standards
Massage & Oriental Bodywork Therapists	1997	1135	1011	New regulation
Mortuary Science Professionals	1997	367	199	Updating entry requirements
Naturopathic Doctors	1997	780	561	New regulation
	1997	396	523	New regulation
Nurse Anesthetists	1997	1238	131	Establishing title protection
Nurses	1997	1117	898	Increasing scope of practice
Opticians	1997	886	851	New regulation
Physical Therapists	1997	885	301	Establishing independent board
Physician Assistants	1997	491	352	Increasing scope of practice
	1997	490	639	Creating advisory council
Plumbers	1997	1795	1597	Regulating in all cities
Private Detectives and Protective Agents	1998	2533	2199	Granting more discipline power to board New regulation for bail bondsmen and bounty hunters
Psychologists	1997	861	662	Reducing internship requirements
Real Estate Appraisers	1997	1032	501	Specifying continuing education requirements Decreasing experience requirements
Respiratory Care Providers	1997	1702	741	Writing statues rather than rules
Sign Contractors	1997	1115	975	New regulation
Social Workers	1997	864	457	Background checks on applicants
	1998	3639	--	Clarifying education requirements
	1998	2762	2102	Changing experience requirements
Speech Language Pathologists	1997	826	835	Exemptions of hearing instrument dispenser requirements
Unlicensed Mental Health Practitioners	1997	669	927	Licensing “professional counselors”
	1995	66	891	Licensing “professional counselors”
Vertical Heat Contractors	1997	1534	1332	New regulation
Water Conditioning Professionals	1998	3244	2857	Mandating continuing education for contractors Regulating contractors in all cities Changing supervision requirements for installers

SOURCE: Office of the Revisor of Statutes.

Figure 2.4: Legislative Issue Case Studies

	Year	House File	Senate File	Outcome	Bill Focus
Accountants	1997	301	239	Did not pass	Increasing entry requirements
	1998	2308	2014	Passed	Granting more discipline power to board
Board of Architects, etc.	1998	2827	--	Did not pass	Abolishing the board
Dental Assistants	1998	--	3408	Did not pass	Increasing level of regulation to licensure
Lead Workers	1998	2334	2108	Passed	Changing requirements to meet federal standards
Mortuary Science Professionals	1997	367	199	Passed	Updating entry requirements
Naturopathic Doctors	1997	780	561	Did not pass	New regulation
	1997	396	523*	Did not pass*	New regulation*
Nurse	1997	1238	131	Did not pass	Establishing title protection for nurse anesthetists
Opticians	1997	886	851	Did not pass	New regulation
Physical Therapists	1997	885	301	Did not pass	Establishing independent board
Plumbers and Water	1997	1795	1597	Did not pass	Regulating plumbers in all cities
Conditioning Professionals	1998	3244	2857	Did not pass	Mandating continuing education for water conditioning contractors Regulating water conditioning contractors in all cities Changing supervision requirements for water conditioning installers
Private Detectives and Protective Agents	1998	2533	2199	Did not pass	Granting more discipline power to board New regulation for bail bondsmen and bounty hunters
Real Estate Appraisers	1997	1032	501	Passed	Specifying continuing education requirements Decreasing experience requirements
Unlicensed Mental Health	1995	66	891	Did not pass (vetoed)	Licensing “professional counselors”
Practitioners	1997	669	927	Did not pass	Licensing “professional counselors”

*S.F. 523 eventually became a proposal for a study of complementary and alternative medicine. This study was passed as an amendment to the 1997 omnibus health and human services appropriations bill (S.F. 1908).

SOURCE: Office of the Revisor of Statutes.

SUMMARY

Minnesota regulates more occupations than most other states and has a complex, multifaceted organizational structure for regulating occupations composed of free-standing independent boards whose members are appointed by the Governor, other boards whose members are appointed by department heads, and occupations that are regulated by various state agencies.

The Minnesota Legislature has seen a proliferation of proposals for occupational regulation in recent years that has challenged its ability to deal effectively with occupational regulation. The next chapter presents our findings and conclusions about the effectiveness of Minnesota’s system and our recommendations for improving both the structure and process of occupational regulation.

Effectiveness of Occupational Regulation

CHAPTER 3

This chapter presents our findings on the effectiveness of Minnesota's system of occupational regulation. The question of effectiveness is difficult to answer because there are many regulated occupations and many agencies of government with regulatory authority. It goes without saying that some regulatory programs are working well and others are not. This chapter focuses on the system as a whole and asks:

- **Is Minnesota's policy on occupational regulation applied consistently?**
- **Does occupational regulation receive adequate oversight from the Legislature?**
- **Are complaints against license holders investigated and resolved in a timely fashion?**
- **Is occupational regulation needed as often as it is used? Are there problems in the way occupational regulation is organized and financed?**

There are problems with occupational regulation that require legislative attention.

In discussing these issues we offer a few recommendations for the Legislature and agency and board managers to consider, but we do not recommend sweeping reforms of the sort that have been proposed by some studies of occupational regulation in the past. Such recommendations have been largely ignored in Minnesota in the past, and our interviews with policy makers suggests that the climate for major organizational changes is probably less receptive now.

In general, we find that there are problems with occupational regulation in Minnesota that require attention. The kinds of problems we see in Minnesota are discussed at length in the national literature and have been the subject of reform efforts around the country and in Minnesota on several occasions in the past. See Chapter 1 for a review of the history of occupational regulation in Minnesota and other states. Many of the problems are chronic and reflect the conflict between opposing interests that occupational regulation attempts to reconcile. Many people we talked with recognize the imperfections in the system but are pessimistic about reform.

We suggest ways to improve the administrative structure and procedures of occupational regulation. We do not, however, make recommendations on the core policy issues of "whether to regulate, and if so, how much." Those are policy

decisions that must be made by elected officials. And, we think the Legislature already has enacted into law good criteria for making those choices. The "key" is the Legislature's willingness to apply those criteria more rigorously and consistently, both in deliberations on proposals for new or expanded regulation and in retrospective reviews of regulatory authority already enacted.

MINNESOTA POLICY

Minnesota's occupational regulatory policy is set out in Minnesota Statutes Chapter 214, and elsewhere in statutes and rules. All proposals for new regulation are supposed to be evaluated against the criteria presented in Chapter 214. On the basis of interviews and 13 case studies of recent proposals for regulation, we have concluded:[1]

- **The state's policy on occupational regulation articulated in Chapter 214 is not applied consistently or effectively.**

Minnesota law outlines criteria for occupational regulation.

Chapter 214 says that no regulation shall be imposed upon any occupation unless required for safety and well-being and lays out four criteria for regulation:[2]

- Whether the unregulated practice of an occupation may harm or endanger the health, safety, and welfare of citizens, and whether the potential for harm is recognizable and not remote.
- Whether the practice of an occupation requires specialized skill or training and whether the public needs and will benefit by assurances of initial and continuing occupational ability;
- Whether citizens are or may be effectively protected by other means; and
- Whether the overall cost effectiveness and economic impact would be positive.

If regulation is found to be necessary, the statutes require the least restrictive mode of regulation to be used. In ascending order, these are:

- Creation or extension of common law or statutory causes of civil action and the creation or extension of criminal prohibitions;
- Imposition of inspection requirements and the ability to enforce violations by injunctive relief in the courts;
- Implementation of a system of registration (defined in Minnesota as title protection);

1 A brief description of the case studies is presented in Appendix B.

2 *Minn. Stat.* §214.001

- Implementation of a system of licensing (practice protection).

There are several reasons why it has been difficult to apply the policy in a consistent manner:

- **There has been a proliferation of proposals for occupational regulation in recent years.**

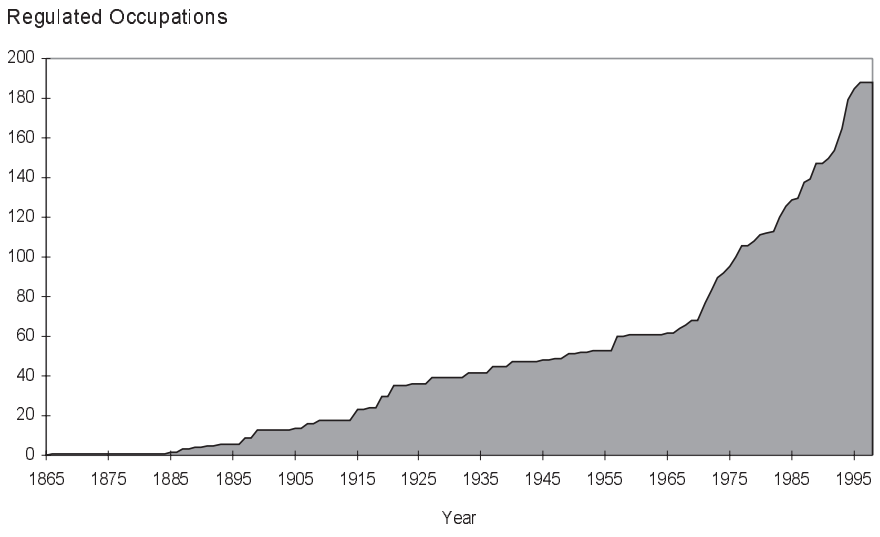
- **Legislative committees often have not had time to consider regulatory proposals in light of the criteria and hear testimony that might provide needed information.**

- **Committees often do not have staff or agency reports and recommendations that could provide needed information.**

Legislators and others have observed that there has been a proliferation of requests for licensure in recent years. Figure 3.1 shows the explosive growth of regulated occupations in recent decades in Minnesota. Table 3.1 shows the number of occupations or professions first licensed in various time periods. During the period 1866-99 there were 13 occupations licensed including physicians, dentists, attorneys, and barbers. In the period 1900-09 there were 5 new occupations regulated, in the 1910s there were 12. As the table shows, between 1920 and 1970, the number regulated each decade was 10 or fewer. But there were 40 newly regulated occupations in the 1970s, 39 in the 1980s, and 41 so far in the 1990s.

While Minnesota has a policy governing the regulation of occupations, it does not have a process by which the policy is applied in a consistent fashion. The

Figure 3.1: Cumulative Number of Occupations Regulated in Minnesota by Year



SOURCE: Program Evaluation Division survey.

Table 3.1: Number of Occupations Regulated in Minnesota by Period of Time

	Number of Occupations Gaining State Regulation	Cumulative Number of Regulated Occupations
1865-99	13	13
1900-09	5	18
1910-19	12	30
1920-29	9	39
1930-39	6	45
1940-49	6	51
1950-59	10	61
1960-69	7	68
1970-79	40	108
1980-89	39	147
1990-98	41	188

SOURCE: Program Evaluation Division survey.

Minnesota has a policy governing occupational regulation but no process to apply the policy effectively.

application of the Chapter 214 criteria or the collection of data that might make this possible is not the specific responsibility of any state agency or legislative staff office. Legislative committees can develop some of the information through hearings or staff work, but most of the time occupational regulation issues do not command the time and attention by committees that this would require. Several legislators who we interviewed mentioned that they are faced with making decisions about regulation without enough time or information.

There is another important factor that interferes with the process: political influence by occupational groups and their representatives. This was mentioned by many legislators we talked with and ranked high on the list of problems mentioned in a survey we conducted of board and agency managers responsible for occupational regulation. Whether motivated by a desire to become eligible for third-party reimbursement, protect the right to practice, or pre-empt varying local regulatory requirements, occupational associations are active in the political and legislative process. Some larger occupational groups have considerable power, but even small groups with narrow concerns can be influential over time and can interfere with the process by which statutory policy is applied in a given situation. As the 1998 Pew Commission Report points out, this is an important national concern related to occupational regulation.[3]

We conclude that there is a need for a mechanism that will help control the number of proposals and provide for better information bearing on the statutory criteria for regulation. We suggest several options for improving the process by which the Legislature handles proposals for occupational regulation. Some of

3 L. J. Finocchio, C. M. Dower, N. T. Blick, C. M. Gragnola, and the Taskforce on Health Care Workforce Regulation, *Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation* (San Francisco, CA: Pew Health Professions Commission, 1998), 21.

these are recommendations which have been made before and even tried before but we think there are compelling reasons to try again. Our interviews detected no widespread sense of urgency, however, even among legislators and others who think there is a real problem, so our options include incremental steps that can be taken without any major organizational changes. As one option:

Better information is needed on how regulatory proposals meet state policy objectives. We suggest several options for carrying out studies of regulatory proposals.

- **The Legislature could require a study of how each major proposal for new regulation or significant increase in regulation meets the Chapter 214 criteria.**

There are several alternatives for conducting the studies. They could be carried out by state agencies, by specialized legislative staff, or by existing committees. As we discussed in Chapter 1, the Minnesota Department of Health (MDH) Human Services Occupational Advisory Council (HSOAC) used to perform such studies for the health-related occupations, and many in the Legislature and elsewhere believe the studies were useful even though the recommendations of MDH were not always heeded.

The following option could be tried without implementing any major organizational changes:

- **Committees hearing bills proposing new occupational regulation could require proponents to submit specific information as a condition for obtaining a hearing.**

The virtue of this idea would be to focus debate on issues relating to the Chapter 214 criteria. The criteria would have to be operationalized in a specific set of questions, however. The questions asked by the Health Department in carrying out the HSOAC studies could serve as a model. Additional models are provided by other states that have institutionalized a sunrise process. For example, the Florida House of Representatives Committee on Business and Professional Regulation uses a "Sunrise Questionnaire" that poses 62 questions that proponents of regulation must address. Florida's sunrise law is similar to that of Minnesota and other states with such legislation in that the regulatory decision hinges on the extent to which the unregulated practice of the occupation will endanger the public health, safety, or welfare. Maine has put a set of questions into its statute governing occupational regulation.

We think legislative committees could use a relatively simple version of these questionnaires in the first stage of the process by which regulatory proposals are considered, and require a more detailed study for those ideas that make the first cut. Figure 3.2 lists some illustrative questions proponents for occupational regulation could be required to address.

A secondary benefit of requiring specific information would be that some groups seeking regulation would be unable to mount the organized effort to produce a reasonable proposal. The ability to do so is not irrelevant to the issue under consideration because if an occupation or profession has not reached a certain level of maturity and separate identity, it cannot be regulated effectively by enacting a practice act, issuing credentials that have a specific meaning, and enforcing standards of practice. As a practical matter, to be regulated an

Proponents of occupational regulation should be asked to provide more specific information.

Figure 3.2: Illustrative Questions for Proponents of Occupational Regulation

- Identify the associations, organizations, and other groups representing the occupations seeking regulation and estimate the number of members in each.
- Describe the functions typically performed by members of this occupational group. Indicate the functions performed by this occupational group which are similar to those performed by other occupational groups. Indicate the difference between related occupational groups.
- Describe the various levels of practitioner specialization and the qualifications of each. Describe the minimum qualifications for entry into the occupation. Is there a state or national examination currently used for entry? Is the occupation affiliated with an association which enacts and enforces standards? Explain enforcement mechanisms in instances of practitioner noncompliance with established standards.
- Describe and document the physical, emotional, social, or financial consequences to the consumer resulting from erroneous or incompetent care or omission of appropriate care.
- Describe how the public would be protected by regulation of this occupational group.
- What functions performed by the occupational group are unsupervised? What are typical work settings? Is there state or local business, facility, product, or industry regulation that can protect consumers or clients?
- What is the expected impact of the proposed regulation on the existing supply of practitioners? What percentage of current practitioners will be able to meet the proposed eligibility criteria?

SOURCE: Adapted from Minnesota Department of Health Human Services Occupational Advisory Council (HSOAC) questionnaire.

occupation should require knowledge, skills, or abilities that are teachable and testable, the skills should be taught in accredited programs, these programs should be distinguishable from related occupational or professional programs, and the profession should have its own professional association. It should not be unduly burdensome for an occupation or profession that has reached this level of separate organizational identity to respond to a detailed request for information.

The question remains: how should a requirement for information be administered, and should an agency separate from the legislative committees now charged with implementing Chapter 214 be involved in the process? One option is to continue

to have several committees responsible for hearing bills on occupational regulation. Alternatively,

- **The Legislature could create committees or subcommittees specializing on occupational and professional regulation.**

Analysis of proposed regulation could be carried out by existing legislative committees, new committees, or executive branch agencies.

Minnesota has, in the past, organized interim subcommittees to look at occupational regulation, most recently in 1997 and earlier in 1991. In addition, last year a subcommittee on Licensing and Scope of Practice of the House Health and Human Services Committee was organized to hear testimony on alternative and complementary medical professions, but this has not been a permanent subcommittee. The advantage of a specialized committee is that it can become more knowledgeable about Chapter 214 and occupational regulation in general, and it could be assisted by a staff that develops expertise and a focus on occupational regulation that is now lacking. Currently, legislative staff provide an orientation to Chapter 214 periodically, but we have learned from interviews and from listening to tapes of committee hearings that the policies contained in Chapter 214 do not necessarily govern the discussion of regulatory proposals.

As another option:

- **The Legislature could establish a joint legislative commission on occupational regulation to which all proposals for new or increased regulation would be referred.**

As we described in Chapter 1, the legislative task force that looked at occupational regulation in 1991 recommended creation of a joint legislative commission. The Minnesota Legislative Commission on Pensions and Retirement provides a model for this approach. Virtually all bills relating to pensions go through this commission, so it is possible to maintain consistency in policy decisions. This arrangement also facilitates the development of staff expertise.

Arizona and Maine also provide models of a joint committee approach to occupational regulation. Maine has a joint Business and Economic Development Committee that hears bills on occupational regulation (all of Maine's committees are joint committees), however, in practice, bills can be heard in other committees (at least upon occasion) if that suits the bill's sponsors. Arizona also convenes a joint committee to conduct sunrise reviews of regulatory proposals affecting health-related professions. A brief summary of our research into the organization of occupational regulation in eight states is presented in Appendix A.

Alternatively, the studies could be by executive branch agencies with recommendations to the Legislature. Two possibilities are:

- **The Legislature could establish organizational units in the departments of health and commerce for the purpose of carrying out studies of occupational regulatory policy and making recommendations, or**

- **Create a new agency or council in the executive branch independent of the state departments and boards with regulatory responsibilities.**

Some managers in the Health and Commerce departments and elsewhere have pointed out that the functions of enforcement of existing occupational regulations and policy analysis of new regulatory proposals are incompatible activities. A department might lack objectivity in studying proposals that would affect an ongoing program or might be accused of self-interest if it seeks to expand regulatory authority. Despite the potential conflict of interest, one legislator we interviewed suggested that evaluations of regulatory proposals should be done in executive branch departments, since, compared to legislative committees, the departments are less vulnerable to political manipulation. The departments also have a level of professional expertise in various professional areas without the biases often associated with regulatory boards or advisory councils dominated by professionals.

Analysis of regulatory policy should be kept organization-ally separate from on-going regulatory programs.

The Legislature could take some specific action to encourage or direct the boards or agencies with regulatory responsibility to take a more active role in policy studies. The departments of Health and Commerce (the two state departments with, by far, the greatest occupational regulatory responsibility) are both reluctant to take the lead in policy studies, at least judging by the interviews we have had, mainly with middle management. MDH has had an occupational policy analysis program at various times between 1976 and 1995. The program was interrupted in part because of reduced funding, but the activity has started and stopped several times over the years and it is clear that MDH has attached a low priority to this activity. Our interviews with middle and upper management at the Commerce Department also suggest that they feel policy studies should be done by another agency. Both departments express a degree of frustration with the fact that their previous recommendations have not been heeded.

We believe that neither Commerce nor Health will be able to contribute much to solving the problem unless a separate organizational unit is created within the agencies, free of ongoing regulatory responsibilities so that a measure of objectivity can be assured and so that occupational policy analysis is the central focus of the unit's work. MDH is currently empowered to establish title protection through the rule-making process and this authority could be extended to the Department of Commerce as well.[4] Under this arrangement, departmental studies or recommendations for occupational licensure would be made to the appropriate legislative committees.

Over the years there have been proposals to create a new executive branch organization or council to study proposals for occupational regulation and make recommendations. Last year a bill proposed the creation of an interagency task force that would in turn develop a detailed proposal for a permanent council (The Occupational Regulatory Coordinating Council) whose members would be appointed by the commissioners of Health and Commerce.[5] One of the principal

4 Title protection means the use of a title like "athletic trainer" is reserved to credentialled workers, but others can provide the same services as long as they use another job title.

5 S. F. 2380.

responsibilities of the council would have been to develop a method of reviewing and evaluating requests for new occupational regulation and to review the structure and organization of the regulatory system. It was also intended that the council would review the application of the Minnesota Data Practices Act to occupational regulation.

Neither this bill nor scaled back versions of it were enacted in the 1998 session, but the options discussed above and similar recommendations over the years are based on a finding that bears repeating here:

- **Application of Minnesota's occupational regulatory policies is haphazard, and there is a need to improve the process by which the Legislature carries out this responsibility.**

OVERSIGHT OF OCCUPATIONAL REGULATION

A large share of state responsibility for occupational regulation is assigned to the 14 independent boards responsible for regulating 34 health professions and the 10 non-health-related boards that regulate 51 other occupations and professions.[6] These boards are independent state agencies, all but a few of which are appointed by the Governor. As independent agencies, they require oversight by legislative committees, but oversight is difficult to accomplish consistently since the boards are both numerous and small in comparison to other state agencies. This situation has led some states, including Virginia, Florida, and Colorado, to establish departments of occupational regulation that deal with the Legislature and in some cases represent the interests of independent boards.[7]

Twenty-four boards and agencies are required to report on their regulatory activities every two years.

The two primary opportunities for legislative oversight of occupational regulation in Minnesota are the appropriations process and biennial reports that are required from 24 boards and agencies prior to each budget session.[8] Figure 3.3 lists the boards and agency offices that are required to submit reports. Chapter 214 specifies the content of the report in some detail and includes requirements to report on board meetings, participation of board members, the number of license holders, and licensing and examination activity. The reports must also include data on the number of complaints that allege a violation of the statutes the board is empowered to enforce as well as the nature of the complaints and the disposition of complaints by type.

We reviewed the available biennial reports of each of the independent boards. We formally requested the biennial report due in 1996 from each board, and we also examined the 1998 reports that were available by November 1998.

6 Not counting the two boards appointed by the Supreme Court that regulate the legal profession.

7 While many have urged abolishing independent boards, including a study by the Minnesota Department of Administration in 1977, independent boards survive in all but three states.

8 *Minn. Stat.* §214.07

Well-prepared biennial reports from the boards could be useful to the Governor and the Legislature.

Figure 3.3: Regulatory Boards and Offices Required to Issue Biennial Reports

Health-Related	Non-Health-Related
Board of Chiropractic Examiners	Board of Accountancy
Board of Dentistry	Board of Architecture, Engineering, Land Surveying, Landscape Architecture, Geoscience, and Interior Design
Board of Dietetics and Nutrition Practice	Board of Assessors
Board of Examiners of Nursing Home Administrators	Board of Barber Examiners
Board of Marriage and Family Therapy	Board of Boxing
Board of Medical Practice	Board of Electricity
Board of Nursing	Board of Teaching
Board of Optometry	Peace Officer Standards and Training Board
Board of Pharmacy	Private Detective and Protective Agent Licensing Board
Board of Podiatric Medicine	
Board of Psychology	
Board of Social Work	
Board of Veterinary Medicine	
Alcohol and Drug Counselors' Licensing Advisory Council	
Office of Mental Health Practice	

SOURCE: *Minn. Stat.* §214.

We found:

- **Several boards or agencies did not submit a report for 1996.**

The Board of Assessors, the Board of Dietetics and Nutrition, the Board of Optometry, and the Office of Mental Health Practice, did not submit reports for 1996 as required.[9] In addition, the Minnesota Department of Health is supposed to submit a summary of the health-related reports by December 15 of each even-numbered year, but it has not done this in at least the last several bienniums. The Health Department argues that it does not receive funding to prepare the summary called for in statute. The Department of Administration used to be required to publish a similar summary report for the non-health-related boards, but this requirement was repealed in 1990.

These biennial reports could be a useful to the Governor and the Legislature in carrying out their oversight responsibilities and could be useful to the public, but we found:

9 These agencies did submit reports for 1998, however.

- **The biennial reports are not widely read and in many cases they appear to not be read at all. The board staff we interviewed were unable to recall a conversation with legislators or legislative staff about the reports or their contents. The 1996 reports were not used in legislative oversight hearings or hearings on the subject matter they covered.**

The reporting requirements have been little changed since 1976 when Chapter 214 was amended and substantially put into its current form. In our judgment, the Legislature ought to review these requirements and revise them. The reports are required to provide some data that may no longer be of interest, for example, the hours spent by all board members in meetings and other activities, or the locations and dates of examinations. Most of the boards respond quite literally to the statutory specifications, even though the specifications are awkward and the results are less than useful. While the boards are invited to include any information which board members believe will be useful, few reports make an effort to provide such information. Our review of the reports suggests:

The biennial reports have not been widely read, but they cover some topics, like complaint investigation and disciplinary action that legislators need to monitor.

- **The quality of the reports needs to be improved.**

The reports vary in quality, but even the best of the reports are not forthcoming and easy to read. There is an absence of needed explanatory notes and considerable expertise is required to understand what the reports are saying. The reports have changed little over the years, and without feedback from users, there has been little incentive for the boards to improve the usefulness and readability of the reports.

There are some topics covered by the report that are of significant interest, however, so our criticism of the reports involves what they do not include as well as what they do include. One example is the statutory requirement to report on the number of complaints against licensed professionals, the nature of the complaints, and the outcome of complaint investigations. We examined the biennial reports to see if they provided information on the volume of complaints, the type of complaints, the outcome of complaint investigations, and the number of open cases. A couple of the reports provided this data, although it was often not presented completely or clearly, and none of the reports provided historical tables drawn from previous reports which would show how the numbers are changing over time. Many reports did not present the number of open cases at the start and at the end of the biennium, essential information if legislators or the public want to know if the “backlog” is increasing or decreasing over the biennium. Another common problem was classifying complaints into catch-all categories such as “unprofessional conduct,” which provided an inadequate breakdown of what the substance of the complaint was really about.

As we have suggested, the unsatisfactory state of affairs we have just described is not solely the responsibility of the boards.

- **Chapter 214 does not require a useful report of complaints, investigations, and outcomes.**

Minnesota Statutes §214.07 specifies that some important information be provided such as the number and type of complaints and the disposition of the complaints, but it does not require information on the number of open cases, including those carried over from previous years, and it does not require information on how long it took to investigate and resolve the cases that were closed, or the age of cases that are still open. The boards could and should, in our view, provide a more useful report whether or not the law requires it. They should be encouraged to go beyond what is narrowly required as many government agencies and private companies do in their annual reports. We recommend:

- **The Legislature should create a task force to reconsider the reporting requirements in Chapter 214, and revise them in order to make the biennial reports more useful.**

The task force should include representatives from the boards subject to the reporting requirements in Chapter 214, plus Department of Health and Department of Commerce representatives and legislative staff. Many of the health boards are required to submit additional information over that required of the non-health boards, and it may be that a separate task force will be needed to handle issues raised by these requirements.[10]

The content of the reports should be reviewed and the format improved.

Finally, the Board of Medical Practice and the Board of Nursing are required to provide "specific information regarding complaints and communications involving obstetrics, gynecology, prenatal care, and delivery, and the boards' responses or dispositions."[11] The reports of the Board of Nursing and the Board of Medical Practice for 1998 make note of several complaints involving obstetrics, gynecology, prenatal care, and delivery, but do not provide any real information, nor do board representatives understand what type of information is required. This point, of no real significance by itself, serves as an example of the nearly total absence of useful communication between the boards and policy makers.

We also think oversight will be easier if the reports adopt common reporting formats to the extent possible where they are providing information required by law. This does not mean that the type of complaints about psychologists will be the same as those as those against pharmacists. Standardization can only go so far, but informative categories can be developed in either case and defined for the reader in a way that is helpful. Whether or not a broader task force is established to work on the problem, we recommend:

- **The health-related boards should establish a committee or use an existing committee to improve the reports.**

10 All the health boards except Veterinary Medicine are required to forward all complaints involving sexual contact with a patient to the Attorney General, and each board is required to include summaries of each individual case involving sexual contact.

11 *Minn. Stat.* §214.07 Subd. 1a. This was added by *Minn. Laws* (1990), ch. 568, art. 3, secs. 6 and 7.

We also suggest they work to establish common reporting formats and consider publishing a health boards summary report.

The health-related boards or the Health Department ought to produce a summary report.

MDH does not regard its responsibility to publish a summary report as a high priority. In fairness, over time, its responsibilities relating to the health professions regulated by the boards have diminished. As the state agencies with primary responsibility for the clinical health professions, the boards are more likely to put energy into improving the required reports. The Minnesota Department of Health regulates two professions, unlicensed mental health practitioners and alcohol and drug counselors, for which reports are required similar to those required from the independent health boards. If a single report were compiled, it would be desirable to have data on all the health professions covered by the Chapter 214 reporting requirements including these. It might also be desirable to expand the reporting requirement to include the other occupations regulated by MDH's Division of Health Policy and Systems Compliance, including audiologists, speech pathologists, hearing instrument dispensers, and occupational therapists.

The non-health-related boards are affiliated with several agencies. The Department of Commerce provides administrative services to most of them and could consider producing or coordinating a summary report of complaints received by the non-health boards.

The purpose of an improved summary report is to help revitalize communication between the independent boards and the Legislature on one function that has been a source of legislative concern in the past, the handling of complaints against licensed professionals. The 1997 Legislature reduced the mandatory distribution of the reports by eliminating a requirement that the reports be distributed to the Legislature in accordance with Minnesota law (*Minn. Stat.* §3.195) which requires that copies be sent to the Legislative Reference Library.[12] Our recommendation is to move in the opposite direction.

- **We think the reports should be available through the Legislative Reference Library.**

COMPLAINT INVESTIGATION

Occupational regulation is designed to protect the public in two ways: (1) by establishing a level of competence for those entering a regulated occupation, and (2) by providing a check on the continued competence of practitioners. Although most analysts agree that states do a better job accomplishing the first of these functions, the issue of assuring continued competence is still important. The primary means of enforcing standards on a continuing basis is through the investigation of complaints and imposition of license discipline or other corrective action as appropriate.[13]

12 *Minn. Stat.* §214.07 Subd. 1.

13 As we discussed in Chapter 1, continuing education requirements generally are not viewed as an effective method of assuring continued competence.

There are 188 regulated occupations in Minnesota. The number of license holders or otherwise regulated practitioners varies widely across these professions, and the rate at which complaints are made also varies widely. In order to gain a broad perspective on the effectiveness of complaint investigation we sought to find out:

- **In recent years, which professions have had a high volume of complaints and a high rate of complaints?**
- **How many complaint investigations were open at the time of the survey (August 1998) and how many occupations had a high number of open cases in relation to the number filed annually?**
- **Has the Attorney General's Office kept abreast of the investigative caseload referred to it by the regulatory boards?**

Some occupations attract a relatively high volume of complaints.

Table 3.2 shows the number of complaints made in 1997 and 1998 for the 30 occupations with the highest number of complaints.[14] Table 3.2 also shows the number regulated in each occupation. Attorneys, physicians, nurses, dentists, and psychologists are near the top of the list partly because they are large professions. A few much smaller occupations are on the list: commercial driving training instructor, qualified rehabilitation consultants, building officials, and hearing instrument dispensers.

Table 3.3 presents the top 35 occupations ranked by the number of complaints per 1,000 regulated practitioners. This table contains a diverse set of professions and occupations. Some professions attract complaints for reasons that seem obvious because of the type of services provided and the sensitive nature of the relationship between the provider and purchaser of services. This group includes physicians, attorneys, psychologists, and other mental health service providers.

Our concern is whether complaints are given a timely and competent investigation. One way of looking at this issue is to see how many complaint investigations are currently open in relation to the number of complaints filed annually.[15] If the number open equals or exceeds the number filed each year, it is very likely that there are too many cases to manage properly. Table 3.4 presents data on the number of complaints filed in a two year period and the number of cases open in August 1998 for the 20 regulated occupations with the largest number of open cases. Physicians, attorneys, and psychologists are at the top of this list (ranked by number of open complaints).

14 We were unable to compile data on complaint investigations for 49 of the 188 regulated occupations since some departments and boards do not track complaint investigations separately for each of the occupations they regulate.

15 A better way to quickly look at the question is to observe whether the number of open cases is increasing or decreasing over time. We reviewed the biennial reports of the licensing boards and found that only a few reported this information for the biennial period. None reported longer historical trends.

Table 3.2: Regulated Occupations with the Highest Number of Complaints, FY1997-98

	Complaints FY1997	Complaints FY1998	Total Complaints FY1997-98	Number Regulated August 1998
Attorney	1,314	973	2,287	21,476
Insurance Agent*	1,139	829	1,968	49,550
Physician	904	875	1,779	14,771
Registered Nurse	494	462	956	56,731
Real Estate Salesperson*	493	359	852	14,156
Licensed Practical Nurse	368	280	648	22,388
Dentist	208	172	380	3,740
Licensed Psychologist	178	194	372	3,619
Teacher	124	220	344	111,995
Chiropractor	147	179	326	1,764
Pesticide Applicator, Commercial	0	190	190	4,923
Professional Engineer	127	60	187	10,250
Commercial Driving Training Instructor, Auto	80	100	180	372
Cosmetologist*	85	79	164	9,441
Peace Officer	88	67	155	13,759
Unlicensed Mental Health Practitioner	69	85	154	**
Pharmacist	70	68	138	5,254
Cosmetology Manager*	75	55	130	12,834
Qualified Rehabilitation Consultant	78	48	126	345
Certified Public Accountant	72	33	105	6,115
Licensed Social Worker	31	66	97	5,890
Licensed Independent Clinical Social Worker	48	49	97	2,635
Registered Barber	70	26	96	2,667
Notary Public*	46	39	85	96,323
Veterinarian	34	47	81	2,654
Certified Building Official	40	40	80	598
Nursing Home Administrator	33	40	73	935
Pesticide Applicator, Private Certification	30	30	60	25,276
Mortuary Science Professional	30	30	60	1,650
Hearing Instrument Dispenser	36	18	54	300

NOTE: Complaint data unavailable for 49 occupations.

*These occupations are regulated by the Commerce Department. The department reports complaints based on cases closed, whereas other agencies report complaints filed.

**Not available. Unlicensed Mental Health Practitioners are not mandated to register with the state. The Department of Health's Office of Mental Health receives and investigates complaints against mental health practioners who are not regulated through other agencies such as the Board of Psychology, the Board of Social Work, or the Board of Marriage and Family Therapy.

SOURCE: Program Evaluation Division survey.

Table 3.3: Regulated Occupations with the Highest Annual Rate of Complaints, FY1997-98

	Number Regulated August 1998	Annualized Number of Complaints per 1,000 Regulated Professionals
Commercial Driving Training Instructor, Auto	372	241.94
Qualified Rehabilitation Consultant	345	182.61
Chiropractor	1,764	92.41
Hearing Instrument Dispenser	300	90.00
Private Detective	240	83.34
Certified Building Official	598	66.89
Physician	14,771	60.22
Attorney	21,476	53.25
Licensed Psychologist	3,619	51.40
Journeyman Pesticide Applicator, Structural	343	51.02
Dentist	3,740	50.80
Podiatrist	142	45.78
Land Surveyor	478	42.89
Nursing Home Administrator	935	39.04
Real Estate Salesperson*	14,156	30.10
Physician Assistant	398	28.90
Insurance Agent*	49,550	19.86
Pesticide Applicator, Commercial	4,923	19.30
Marriage and Family Therapist	661	18.91
Licensed Independent Clinical Social Worker	2,635	18.41
Mortuary Science Professional	1,650	18.18
Registered Barber	2,667	18.00
Veterinarian	2,654	15.26
Licensed Practical Nurse	22,388	14.47
Licensed Graduate Social Worker	1,046	14.34
Licensed Public Accountant	363	13.78
Pharmacist	5,254	13.14
Tree Inspector	811	12.33
Optometrist	801	11.24
Professional Engineer	10,250	9.12
Cosmetologist*	9,441	8.69
Certified Public Accountant	6,115	8.59
Registered Nurse	56,731	8.43
Abstractor*	361	8.31
Licensed Social Worker	5,890	8.24

NOTE: Complaint data unavailable for 49 occupations. Five occupations with fewer than 65 credential holders were excluded. The annual rate was calculated by dividing the average number of complaints for FY1997 and FY1998 (multiplied by 1000) by the number of regulated professionals in August 1998.

*These occupations are regulated by the Commerce Department. The department reports complaints based on cases closed, whereas other agencies report complaints filed.

SOURCE: Program Evaluation Division survey.

Table 3.4: Regulated Occupations with the Highest Number of Cases Open, August 1998

	Number Regulated August 1998	Total Complaints FY1997-98	Cases Open August 1998
Physician	14,771	1,779	607
Attorney	21,476	2,287	462
Licensed Psychologist	3,619	372	432
Registered Nurse	56,731	956	334
Licensed Practical Nurse	22,388	648	178
Unlicensed Mental Health Practitioner	**	154	151
Pesticide Applicator, Commercial	4,923	190	150
Teacher	111,995	344	112
Dentist	3,740	380	104
Chiropractor	1,764	326	63
Professional Engineer	10,250	187	61
Qualified Rehabilitation Consultant	345	126	52
Licensed Social Worker	5,890	97	44
Pharmacist	5,254	138	37
Peace Officer	13,759	155	30
Hearing Instrument Dispenser	300	54	26
Physical Therapist	2,880	31	26
Certified Public Accountant	6,115	105	25
Architect	3,396	46	19
Licensed Graduate Social Worker	1,046	30	17

**Not Available. Unlicensed Mental Health Practitioners are not mandated to register with the state. The Department of Health's Office of Mental Health receives and investigates complaints against mental health practitioners who are not regulated through other agencies such as the Board of Psychology, the Board of Social Work, or the Board of Marriage and Family Therapy.

NOTE: Complaint data unavailable for 49 occupations.

SOURCE: Program Evaluation Division survey.

It is important to note:

- **A few occupations have a significant number of open cases. Several have more than a year's worth of complaints under investigation. One profession has more than two years worth of complaints under investigation and another nearly this many.**

Some occupations have a high number of cases open in relation to complaints filed, indicating that complaints do not receive a timely investigation.

Table 3.4 shows that psychologists, unlicensed mental health practitioners, social workers, and certain other occupations had a fairly large number of complaints open in relation to the number received in a two year period ending June 30, 1998. The Board of Psychology reported more open complaints as of August 1998 than the total number received in fiscal years 1997 and 1998.[16] The Office of Mental Health Practice also reported nearly as many open cases as complaints filed in a two year period.

We talked with the executive directors and other staff of five health-related boards with a relatively high volume of complaints to discuss complaint data and to learn a little more about their case-tracking systems. We also inquired about the availability of data needed, in our judgment, for proper management of the investigative caseload and for producing the type of information legislators and the public ought to see. We learned that several of the boards are in the process of developing new information systems, and all recognize to some degree that their reporting of complaint investigations could be made more useful. We also learned that the boards of Dentistry, Nursing, and Medical Practice had significantly reduced their backlogs in recent years.

The number of cases open at a particular point in time is not as important as whether complaints are receiving a timely and competent investigation. As we discuss elsewhere, the boards should report trends in the number of open cases. If the number of open cases is large and growing, additional staff may need to be assigned to complaint investigations because there is almost certainly a problem in conducting timely and thorough investigations.

We also reviewed the status of investigations that had been referred to the Attorney General's Office. The Licensing Investigations Division of the Attorney General's Office provides investigative services. A separate division of the Attorney General's Office provides legal services to the boards, reviews all dispositions involving license discipline, and represents the boards in negotiations or litigation subsequent to the investigation of a complaint. The Licensing Investigations Division currently consists of about 15 investigators. In addition to generalists, the division employs nurses and people with expertise in pharmacy, social work, dentistry, psychology, and certain other disciplines regulated by the health boards, because many complaints involve technical issues which require specialized expertise. The Attorney General's Office investigates about 10 to 15 percent of cases filed with the health boards and is required to be involved in all cases alleging sexual misconduct or an active chemical dependency problem. The purpose of the Attorney General's involvement is to assure public accountability in investigations of licensed professionals by boards dominated by professionals

16 The Board of Psychology did not know if the number of open complaints was growing or shrinking over time and could only put this data together manually through a hand tabulation.

where the substance of the investigations is not available to the public. The Attorney General's Office is not as frequently involved with investigation of cases for the non-health boards, but performs a similar role for several of these boards.

A few years ago, the Attorney General's Office was the target of criticism from many of the boards, because of a backlog of investigative cases and delays in the investigation and resolution of cases. To some extent the boards still complain about the time and money they must spend on legal and investigative services from the Attorney General's Office. We inquired about the current status of the backlog and found:

- **The Attorney General's Office has reduced the backlog of investigative cases that existed a few years ago and has implemented an effective case tracking system.**

The Attorney General's Office has a case tracking system that provides useful reports to management and to the boards so that the status and age of the caseload can be monitored regularly. A summary of the status of investigations referred to the Attorney General from the regulatory boards is shown in Table 3.5. The table shows that there were 170 cases open at the end of fiscal year 1998, down from

Table 3.5: Complaints Investigated by the Attorney General's Office, FY1995-98

Fiscal Year	Cases Opened	Cases Closed	Cases Open at End of Year
1995	241	136	246
1996	352	334	240
1997	444	478	185
1998	336	335	170

SOURCE: Office of the Attorney General.

246 cases open at the end of fiscal year 1995. The number of cases opened has generally increased since 1995, but the number of cases closed has increased even more so that the inventory of open investigations, while still quite high, has declined. The regulatory boards need a case tracking system with similar capabilities, because only 10 to 15 percent of investigations are carried out by the Attorney General, and the boards need to keep track of the rest of the caseload.

REVIEW OF EXISTING PROGRAMS

Since 1976 Minnesota has had an explicit policy governing proposals for new occupational regulation. It is not clear to what extent these principles or criteria should apply to existing regulatory programs, many of which were implemented prior to enactment of the sunrise provisions of Chapter 214. However, we believe

there is a need to periodically re-examine the contemporary relevance of regulatory programs, and the Chapter 214 criteria are a useful place to start.

Recognizing the possibility that some programs are out of date, some other states have enacted sunset laws that require periodic reviews of regulatory programs. However, as we discussed in Chapter 1, in many cases sunset laws have not rewarded the promise that led to their enactment. While sunset requirements have been repealed or scaled back in some states, they are still credited with some modest successes. National analysts of occupational regulation still call for some form of sunset reviews, and many of the people we talked with believe there is a need to take a fresh look at occupational regulation to see if regulatory requirements are still needed in all cases.[17]

We recommend a review of existing regulatory programs.

Minnesota has more regulated occupations than most states, and Minnesota regulates some occupations that are regulated in few other states. Minnesota also has some very small occupations regulated by independent boards. While it is beyond the scope of this study to provide definitive answers, this section addresses the following questions:

- **Are there occupations that do not have significant initial or continuing education, experience, or examination requirements and thus may not need to be regulated?**
- **Are some regulatory requirements inconsistent or out of date in terms of coverage? Is there a consistent use of terminology in regulation of different occupations? Are there small or outdated regulatory boards that could be eliminated or consolidated?**
- **Is there a way of reorganizing occupational regulation so that related occupations are located in the same agencies or otherwise affiliated with other similar professions or occupations.**

Education, Experience, and Examination Requirements

The Directory of Regulated Occupations we compiled can help focus this review.

A comprehensive review of the 188 regulated occupations is well beyond the scope of this study. However, we have compiled a Directory of Regulated Occupations (published separately) that presents descriptive information on regulated occupations including data on the education, experience, and examination requirements for each occupation, the number of regulated professionals, and the number and type of complaints filed against license holders. Analysis of this database could be a starting point for a review, or oversight hearings relating to occupational regulation.

17 Kara Schmitt and Benjamin Shimberg, *Demystifying Occupational and Professional Regulation: Answers to Questions You My Have Been Afraid to Ask* (Lexington, KY: Council on Licensure, Enforcement and Regulation, 1996), 19; Richard C. Kearney, "Sunset: A Survey and Analysis of the State Experience," *Public Administration Review*, vol. 50 (January-February 1990), 56; and Finocchio et. al., *Strengthening Consumer Protection*, 29-3.

One criterion defining the need to regulate in Chapter 214 is whether the practice of an occupation requires specialized skills or training, and whether the public needs and will benefit from assurances of initial and continuing occupational ability.[18] We reviewed regulated occupations in Minnesota to see how many lacked significant statutory requirements for education, experience, examination, and continuing education.

We found:

- **Out of 188 regulated occupations, 82 have no statutory educational requirements beyond a high school diploma, 69 have no requirements for specialized experience, and 32 have no examination requirements. Twelve occupations have neither specialized education, experience, or examination requirements.**

In addition, 75 occupations of the 188 regulated occupations have no continuing education requirements.

Some regulated occupations have no specialized education, experience, or examination requirements.

The issue of whether the state should continue to regulate these or other occupations obviously requires more detailed study, but a review of the database and Directory we have put together can suggest where to start. Table 3.6 lists the regulated occupations with the most limited statutory requirements. Several of these occupations have no educational requirements beyond a high school diploma, no experience requirements, no examination requirements, and no requirements for continuing education. The remainder have requirements in only one of these categories. In addition, many of these occupations are among the 67 reporting occupations that indicated receiving no formal complaints over a two year period, calling into question whether regulation of these occupations is necessary.

A number of the people we interviewed note that the statutes governing occupational regulation are often out of date and in need of revision. We did not attempt to measure the extent of these problems although it is fairly easy to find examples that appear to contradict the basic policy articulated by Chapter 214. For example, the licensure of plumbers is required only in cities over 5,000 population.[19] If licensure is required because of a threat to health or safety (the primary criterion of Chapter 214), it should be required everywhere. In fact, the Minnesota Department of Health has made this argument, so far without success, because it is opposed by representatives of licensed plumbers. If plumbers present a threat to public health that is no greater than that presented by other building trades most of which are not regulated, or if it is judged that other types of regulation such as enforcement of building standards is sufficient, then state licensure of plumbers could be eliminated statewide.[20]

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18 *Minn. Stat.* §214.001.

19 The justification for licensing plumbers is based on the potential public health threat conveyed through municipal water and sewer systems. Licensure is not required for plumbers working on houses or businesses served by individual wells or on-site waste disposal systems.

20 See Appendix B for more discussion of this issue.

Table 3.6: Regulated Occupations with Limited Statutory Requirements

	Statutory Requirements				
	Education	Experience	Examination	Continuing Education	Complaints FY1997-98
Amateur Boxing Referee	No	Yes	No	No	0
Amateur Boxing Second/Coach	No	Yes	No	No	0
Amateur Karate Referee	No	Yes	No	No	0
Amateur Karate Second/Coach	No	Yes	No	No	0
Apprentice Steamfitter	No	No	No	No	0
Babcock Milk Hauler	No	No	Yes	No	0
Building Inspector, Class 1	No	No	No	Yes	0
Certified Industry Supervisor (Dairy)	No	No	Yes	No	0
Certified Lab Analyst (Dairy)	No	No	Yes	No	0
Commercial Vehicle Operator	No	No	Yes	No	0
Conditional Journeyman Sprinkler Fitter	No	Yes	No	No	0
Crop Hail Adjuster	No	No	No	No	N/A
Lead Training Course Provider	No	Yes	No	No	0
Notary Public	No	No	No	No	85
Part Time Peace Officer	No	No	Yes	No	0
Pharmacy Drug Researcher	No	No	No	No	0
Pharmacy Intern	Yes	No	No	No	0
Plumber's Apprentice	No	No	No	No	N/A
Professional Boxer	No	Yes	No	No	0
Professional Boxing Manager	No	No	No	No	N/A
Professional Boxing Referee	No	Yes	No	No	0
Professional Boxing Second/Coach	No	Yes	No	No	0
Professional Karate Contestant	No	No	No	No	N/A
Professional Karate Referee	No	Yes	No	No	0
Professional Karate Second/Coach	No	No	No	No	N/A
Public Adjuster Solicitor	No	No	No	No	N/A
Real Estate Limited Broker	No	No	No	No	N/A
Unlicensed Mental Health Practitioner	No	No	No	No	154
X-ray Operator	No	No	Yes	No	0

NOTE: N/A indicates "Not Available."

SOURCE: Program Evaluation Division survey.

Based on these findings, we recommend that:

- **The Legislature should conduct a review of regulated occupations in order to eliminate the unnecessary and outdated regulation of certain occupations.**

Terminology

As we have noted earlier, the terminology relating to occupational regulation is sometimes confusing. Registered nurses are actually licensed. Certified public accountants are usually licensed, but some are not. In reviewing statutes governing occupational regulation and occupational titles in common use we found:

- **There is an inconsistent use of terminology relating to occupational regulation in Minnesota law, and Minnesota's terminology differs from definitions in national use.**

We recommend that Minnesota adopt nationally-used definitions of licensure, certification and registration.

Nationally, the term *licensure* is usually defined to mean that the right to practice a legally defined scope of practice is limited to license holders; *certification* is defined to mean that the use of a title is restricted to those who are certified; and *registration* means that a roster of practitioners is maintained by the state without any restrictions on the right to practice or the right to use a title. In contrast, Chapter 214 defines registration as "title protection," so Minnesota departs from recommended national definitions. As a consequence speech language pathologist, audiologist, physical therapist, and athletic trainer, for example, are protected titles, although they are defined as registered in law.

Some professions with "certified" in the title are actually licensed and even if this is not confusing in the case of well-known professions such as certified public accountant, it is confusing in the case of some less well-known professions such as certified building official or certified real property appraiser.

Small Independent Boards

In reviewing the independent regulatory boards we have concluded that a good case can be made that:

- **Some small boards should be eliminated or absorbed by another state agency because they are too small to be effectively overseen as independent entities or because they must charge high fees to relatively small numbers of license holders.**

Although some boards are housed in state departments and use the same administrative support services as organizational divisions of the department, independent boards are essentially separate state agencies.[21] A critical difference between the board staff and departmental employees concerns who is in charge. The board staff's activities are governed by the appointed board members. In most cases the boards prepare a separate budget on the basis of which they receive an appropriation, and the boards are also required to submit a biennial report under the terms of Chapter 214 as we have already discussed.

Small independent boards buried in the offices of state departments can lose their identity as separate agencies, yet they are not subject to the same administrative and managerial controls as subordinate organizational units within a department. Of course, any decision to eliminate or consolidate boards would have to balance the claims made by proponents and opponents in a judicious fashion, so while we suspect some boards should be eliminated or consolidated, here we are only making the case, on the basis of our work, that a review might be fruitful and should be undertaken at the direction of the Legislature.

Some small independent boards can be abolished or subsumed by a state agency.

One example is the Board of Assessors, created in 1971. The Legislature and the Department of Revenue were concerned about the professional qualifications of assessors working for counties and other local units of government, and the board was created to establish and enforce professional standards in the form of licensing requirements. In its early years the board came under criticism from Department of Revenue officials who were concerned with excessive travel by board members to out-of-state conferences. While this problem was solved by subjecting the board to department policies, the department had to exercise this control indirectly through its power to appoint or reappoint board members. Over the years, there have been other problems where the Department of Revenue and the Board of Assessors had a different view of proper conduct by board members and licensed assessors.

By law, the Board of Assessors is appointed by the Commissioner of Revenue, and its board must include two Revenue Department employees. Currently there is no staff director, one of the Revenue employees on the board serves as executive secretary of the board and supervises a single clerical employee of the board. The board did not submit a biennial report in 1996, and its staff was very vague in conversations with us about this responsibility.[22] Revenue department officials with whom we spoke did not oppose the idea of eliminating the independent authority of the board, although they would probably want to retain licensing authority in the department. On the basis of our brief review, therefore, it appears that the Board of Assessors may be one independent board that should be considered for elimination.

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21 The Board of Assessors, The Board of Private Detectives and Protective Agents, and the Board of Teaching are housed in department offices, and the first two are appointed by department heads. See Table 2.4 on page 34 for additional details.

22 Presumably as a result of the conversation, the Board completed a report for the biennium ending in fiscal year 1998.

Two other small independent non-health boards should be examined as candidates for elimination or consolidation with the departments they already are part of: the Board of Boxing and the Board of Private Detectives and Protective Agents. The Board of Boxing issues very few licenses for boxing and karate participants and officials. The Board is exempt from the general state requirement that it be financed through licensure and other fees. Presumably when the Legislature granted this exemption in 1989 it considered whether the board met a contemporary need and decided to continue it. But every other professional or amateur sport regulates participation and competition through private organizations without state occupational licensure.

The Board of Private Detectives and Protective Agents is housed in the Department of Public Safety, and appointed by the Commissioner of Public Safety. The Department of Public Safety provides administrative services to the board and provided additional services when a board clerical position was vacant. Because it only licenses 300 people it must charge license fees of $415 to $515 every two years.[23] High fees are not a problem for a large firm which only needs one license, but can be a problem for sole proprietors who need the same license. Security personnel working for private companies do not have to be licensed. Enforcing the law against unlicensed practice is a problem, and board staff say it is difficult to expand the board's activities into needed areas because of resistance to raising fees. Other states have a larger regulated community and collect more revenue by both licensing agencies and charging a registration fee for employees.

There are further opportunities for joint administrative services to the health-related boards.

Most other states do not have an independent licensing board for Private Detectives, but house the function in the Public Safety Department, State Police, or Attorney General's Office. This might be a better arrangement in Minnesota if the regulatory program is to be expanded to cover additional security industry workers.

There are several health-related boards that employ two or fewer staff and regulate fewer than 1000 professionals that could be consolidated for administrative purposes. The Board of Dietetics and Nutrition and the Board of Optometry use the same staff, but fewer staff in the aggregate could probably serve the needs of several other small boards such as the boards of podiatric Medicine, Nursing Home Administrators, and Marriage and Family Therapy. The health boards' administrative services unit provides some services to the boards, and some health board representatives feel its role could be expanded. As we said earlier, the Legislature should encourage the boards to consolidate administrative functions where possible and cooperate in communicating with the Legislature and the public.

Organization

As noted in Chapter 1, previous Minnesota studies of occupational regulation have recommended sweeping centralization of occupational regulation and elimination of the independent boards. Other states have placed independent boards in departments of occupational regulation or departments of regulated health

23 Partnership licenses are $815 and $865 and corporate licenses are $915 and $965.

professions. We do not reach such a conclusion because Minnesota's health boards are already co-located and share some administrative services through a jointly financed administrative services unit, and because the other boards are either located in state agencies or receive some administrative services from state agencies.

However, as we have discussed, we think the number of independent entities involved in occupational regulation makes it very difficult for the Legislature to provide the oversight which is needed. Elsewhere we have recommended that the health boards and Minnesota Department of Health work out a better way of reporting important information (some of which is required by law) to the Legislature. Beyond this, we have concluded:

- **The Legislature should take a further look at how occupational regulation is organized in state government.**

We suggest that regulation of occupations be organized more along functional lines. For example, there is no obvious reason why audiologists, speech pathologists, occupational therapists, alcohol and drug counselors, and unlicensed mental health practitioners are regulated by the Health Department and all other health-related professions dealing with clients or patients are regulated by one or another of the health boards. It might make sense to regulate all occupations with client-patient relationships through the health boards and allow MDH to regulate public and environmental health professions. In the process it might be possible to consolidate boards so there is no increase or even a decrease in the number of small boards.

FINANCING

The method of financing occupational regulation creates some problems.

In Minnesota, as in many other states, occupational regulation is generally financed through credentialing fees including examination, licensing, and renewal fees.[24] This arrangement holds some advantages for the regulated occupations and the public. The professions can argue that even if regulation benefits those regulated, the cost of regulation is also borne by those who are regulated. However, the research literature makes it clear that a significant share of the cost of regulation is shifted to consumers of services provided by regulated occupations.

Here we ask:

- **Does the method by which occupational regulation is financed result in adequate funding of regulatory programs?**

- **How do licensure fees vary across regulated occupations?**

24 Minn. Stat. §16A.1285, sub. 2 says: "Unless otherwise provided by law, specific charges ... must be set at a level that neither significantly over recovers nor under recovers costs, including overhead costs, involved in providing the services."

While we raise these issues, we do not have definitive answers, but we think there is some evidence to question whether our policy on financing is working well in all cases.

Our survey of 48 agency and board managers responsible for occupational regulation found seven managers' top complaint was about inadequate staffing or inadequate financial resources. There were other complaints about the high cost of investigations and five managers complained about unlicensed practitioners. Several people we talked with thought that regulatory fees alone should not be expected to finance enforcement of laws against unlicensed practitioners, since licensed practitioners were in a sense penalized for the behavior of unlicensed practitioners.

We found two indications that financing regulation through user fees causes problems. First, licensing fees vary greatly in large measure because regulatory financing must be substantially borne by those regulated. Table 3.7 presents a list of the 40 highest licensing fees and the number regulated in each case. Small occupations like hearing instrument dispenser, private detective, and podiatrist are at the top of the list, and most of the 40 listed occupations represent occupational groups of less than 1,000 people. Attorneys and physicians and dentists and other health-related professions also have relatively high fees. There were over 21,000 licensed attorneys in mid 1998, for example, and they paid an annual fee of $207. Table 3.7 shows, many lower paid professions pay as much or more in annual fees even though they finance regulatory programs that are quite modest.

It is difficult to learn the cost of occupational regulation in state agencies.

Second, when regulation is administered by a state department, it is difficult to know whether the cost of regulation is recovered by fees, because departments vary in how they categorize and report fee income and expenditures. Departments in which occupational regulation is a relatively small part of department operations do not account for regulatory revenues and expenditures in a way that permits a reader of financial reports to understand the cost of regulatory programs and whether the regulatory fees are reasonably close to regulatory expenditures as required by Minnesota law. We reviewed data on fee income in the Departmental Earnings Report published by the Department of Finance, but found it to be inadequate as a source of data on the cost of occupational regulation. Because many independent boards are essentially dedicated to occupational regulation, it is easy to calculate the cost of their programs from regularly published tables, however it is difficult to tell the degree to which fees finance regulatory programs in state agencies, since the expenditure of fee income is not accounted for separately and since there are administrative services that departments provide that are not subject to any formal financial transaction.

ADMINISTRATIVE CONSOLIDATION

As noted in Chapter 2, Minnesota has a relatively large number of regulated occupations and a large number of boards and agencies with regulatory responsibility. Previous analysts have been concerned about the effect of this type of organizational structure on administrative efficiency. For instance, the Department of Administration report in the late 1970s summarized in Chapter 1 recommended that the independent boards be abolished and re-established as

Table 3.7: Regulated Occupations with the Highest Yearly Fees

	Yearly Fee	Number Regulated August 1998
Hearing Instrument Dispenser	$330.00	300
Private Detective	257.50	240
Podiatrist	250.00	142
Contractor Steamfitter	220.00	306
Protective Agent	207.50	60
Attorney	207.00	21,476
Chiropractor	200.00	1,764
Nursing Home Administrator	200.00	935
Licensed Psychologist	187.50	3,619
Dentist	168.00	3,740
Faculty Dentist	168.00	14
Physician	168.00	14,771
Acupuncturist	150.00	83
Alcohol and Drug Counselor	147.50	65
Licensed Psychological Practitioner	125.00	33
Occupational Therapist	121.00	1,862
Master Plumber	120.00	2,493
Licensed Independent Clinical Social Worker	115.00	2,635
Marriage and Family Therapist	115.00	661
Physician Assistant	115.00	398
Licensed Independent Social Worker	105.00	899
Optometrist	105.00	801
Asbestos Inspector	100.00	479
Asbestos Management Planner	100.00	151
Asbestos Project Designer	100.00	116
Athletic Trainer	100.00	304
Dietitian	100.00	877
Individual Sewage Treatment System Designer II	100.00	558
Individual Sewage Treatment System Inspector	100.00	24
Individual Sewage Treatment System Installer	100.00	1,243
Individual Sewage Treatment System Pumper	100.00	354
Mortuary Science Professional	100.00	1,650
Nutritionist	100.00	78
Qualified Rehabilitation Consultant	100.00	345
Qualified Rehabilitation Consultant Intern	100.00	56
Veterinarian	100.00	2,654
Weather Modifier	100.00	0
Pharmacist	95.00	5,254
Audiologist	80.00	240
Speech Language Pathologist	80.00	763

SOURCE: Program Evaluation Division survey.

Some boards impose high annual license fees.

advisory boards in host agencies that would provide administrative services. The CORE study in the early 1990s also seemed motivated by concern with administrative efficiency when it recommended the creation of a central licensing agency to perform administrative functions for the boards that would remain independent.

Administrative consolidation was the focus of earlier studies, but we conclude that other problems are more urgent now.

The Department of Administration made its recommendations after a detailed and lengthy study. However, in some ways its focus now seems quite out of date because the problem driving the recommendation to consolidate the regulatory boards into state agencies was the cost of typing, copying, and similar support services. The availability of less expensive computers and copiers have changed the economics of clerical services in the years since the report was written. Since the late 1970s the health boards have moved in a direction opposite to that envisaged by the Department of Administration report so that now they receive virtually no administrative services from the Minnesota Department of Health whereas in the past they were located in department offices and received various support services from the department. We think the major problem caused by so many independent entities is not administrative inefficiency. Rather it is application of the state's occupational regulatory policy articulated in Chapter 214 and legislative and executive branch oversight. These are serious problems. Organizing the independent boards in some kind of umbrella agency as some other states such as Florida, Virginia, and Wisconsin have done could make it easier for the Legislature and the Governor to oversee the degree to which occupational regulation is achieving its intended purposes. However, as we discussed in Chapter 1, this idea has been proposed in the past and was strongly resisted. In the case of the health boards, there is an evolutionary process that might lead to the same end, without a fight if the administrative services unit is expanded and the boards otherwise cooperate in communicating with the Legislature.

It is an open question whether the health boards will succeed in establishing the type of collaborative process and structure that will achieve greater administrative efficiency, collaboration on common challenges, and improved relations with the Legislature and the public, but since some progress has been made it may be reasonable to continue down the same path.

SUMMARY

We conclude that there are problems with Minnesota's system of occupational regulation that need attention from the Legislature and executive branch agencies. While the problems are not intractable, the Legislature has not usually treated occupational regulation as a major issue, so it has proved difficult in the past to enact reforms and to carry out the work required to make the changes that are needed even in the absence of major legislation.

The most serious problems we found are, first, the Legislature is not applying its occupational regulatory policy (Chapter 214) in a consistent or effective fashion. This is partly because there is a proliferation of proposals for regulation and partly because there is no legislative or executive branch office established to carry out the needed studies. Second, oversight of the boards and agencies responsible for

occupational regulation is inadequate, partly because of the large number of small agencies and programs.

Our recommendations are to establish a more formal approach to carrying out "sunrise" studies of proposals for new or increased occupational regulation. These could be done by the committees now responsible for hearing bills proposing occupational regulation, by specialized legislative committees or a joint commission, or by state departments such as the Minnesota Department of Health or the Department of Commerce. If the studies are done in state agencies with regulatory programs, we suggest that they be carried out by units within these departments not engaged in operating current regulatory programs.

We also believe oversight of regulatory boards and agencies can be improved. We recommend that the biennial reports required by Chapter 214 be improved by reviewing and revising what the law now requires, and by a vigorous effort by the independent boards and agencies involved to produce reports that are meaningful and command public attention. The boards and departments should find a way to produce summary reports so that the Legislature does not have to review numerous separate reports to get an overview of the situation.

Finally, our review of existing programs leads us to conclude that continued state regulation of certain occupations may not be justified by the criteria for occupational regulation contained in Chapter 214. We think a review of the current system, using the Directory of Occupational Regulation we have produced during this study as a starting point, will enable elimination and consolidation of some programs.

Occupational Regulation in Other States

APPENDIX A

This appendix summarizes what we learned about occupational regulation through case studies of eight other states. We address the following questions:

- **What is the legislative process for occupational regulation in other states?**
- **What are the unique characteristics of occupational regulation in other states?**
- **What are the recent developments in occupational regulation?**

To find out how occupational regulation is handled in other states we selected a group of states that illustrate a variety of organizational models (see Chapter 2, Figure 2.2). We also selected states that had recently issued reports dealing with occupational regulation, indicating that the issue was under study and debate. After reviewing any available reports, we conducted telephone interviews with legislative staff and departmental officials in each state. We gathered additional information at the annual conference of the Council on Licensure, Enforcement, and Regulation (CLEAR).[1]

Briefly, our research suggests that the issues currently facing Minnesota are very similar to the occupational regulation issues facing other states. Furthermore, while occupational regulation is organized and implemented differently in other states, no state has effectively "solved the problem." This appendix provides a brief sketch of the legislative process, distinguishing characteristics, and recent developments for each of the eight states that we contacted.

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1 "Charting a Course for 21st Century Regulation," Eighteenth Annual Conference, Council on Licensure, Enforcement, and Regulation. Denver, Colorado. September 16-19, 1998. According to the organizations' website: CLEAR is an international association of state and provincial officials involved with occupational and professional licensing and regulation issues. . . . CLEAR's mission is to improve the quality and understanding of professional and occupational regulation to enhance public protection. CLEAR's purpose is to bring together government officials, agencies and others to encourage and provide for the exchange of information and ideas (http:\\www.clearhq.org; November 30, 1998).

ARIZONA

Arizona has a comprehensive sunset provision and a sunrise law covering health professions.

Arizona is relatively pro-active in the area of occupational regulation. A defining feature of Arizona state government is its level of involvement with sunset legislation. Arizona has comprehensive sunset legislation, meaning *all* state programs are subject to periodic review. Sunset is widely accepted in Arizona and works well according to legislative staff.[2]

Arizona also performs sunrise reviews, but only for health-related occupations. In Arizona, sunrise reviews apply to scope of practice issues as well as the regulation of previously unregulated occupations. Each year applicant groups are required to submit a completed questionnaire to the Joint Legislative Audit Committee (JLAC) by September 1st. The JLAC then refers the issue to a relevant Committee of Reference, which is a joint committee convened specifically for the sunrise review. The Committee of Reference holds hearings and issues recommendations to the Legislature by December 1st. The process can be circumvented by applicant groups who are successful in finding legislators willing to sponsor proposals outside of the process. However, Arizona legislative staff suggested that it is typically not in the applicant group's best interest to circumvent the sunrise process since doing so is likely to become part of the legislative debate. The sunrise process in Arizona is somewhat contentious and politicized, with occupational groups fiercely debating issues during the Committee of Reference hearings.

FLORIDA

Florida has recently reorganized its administration of occupational regulation.

Prior to the 1970s, occupational regulation in Florida was administered through several autonomous, independent boards appointed by the Governor. In the late 1970s, all occupational regulation was centralized in Florida's Department of Professional Regulation (DPR). However, substantial departmental reorganization in recent years moved oversight of health professions from DPR to the newly created Department of Health. In addition, the Department of Business Regulation was consolidated with the Department of Professional Regulation. Currently, eighteen regulatory boards are organized under the Department of Business and Professional Regulation's Division of Professions. The division is funded by license fees and provides administrative services. Investigations of consumer complaints are handled by the department's Division of Regulation.

In 1991 Florida discontinued its formerly active involvement with sunset reviews in favor of sunrise legislation. Florida's sunrise act is triggered by proposals to regulate previously unregulated occupations, but does not necessarily cover proposals to expand or enhance the scope of practice of occupations already regulated by the state. Florida's sunrise reviews require the collection of information from two primary sources: (1) a questionnaire filled out by the occupational group seeking regulation and (2) the Department of Business

2 Ms. Liana Martin, Research Analyst with Arizona House Health Committee, Telephone interview, Phoenix, Arizona, August 14, 1998.

Regulation's Division of Professions. The department provides information concerning the resources that would be needed to implement the new regulation, how the proposed legislation compares to existing regulation, and how regulation might be attained through less restrictive or more cost-effective alternatives. Staff of a relevant legislative committee compiles this information and reports back to the committee with its recommendations. Committee members then sponsor legislation relating to the proposal as they see fit. It should be noted that the implementation of Florida's sunrise law is dependent on the will of committee chairpersons who may choose to hear a bill proposing new occupational regulation before the completion of a formal sunrise review.

Overall, Florida's sunrise provision has been successful in limiting licensure; no groups have been licensed since it was initiated in 1991. Furthermore, according to legislative staff, the sunrise process is less politicized than was the sunset process, largely because the latter dealt with established regulatory bodies and professional associations invested in retaining state regulation.[3]

Another development regarding occupational regulation in Florida is the privatization of the Board of Professional Engineers' staff through the creation of the Florida Engineers Management Corporation (FEMC), operational as of July 1998. The FEMC does not in any way replace the Governor-appointed Board of Professional Engineers but rather supplies the staff services previously performed by Department of Business and Professional Regulation personnel. The FEMC was originally proposed by the Florida Engineer's Society, which had concerns that the previously-existing departmental staffing did not develop the desired level of long-term dedication to and expertise about engineering. Some state officials have concerns about the legality of the FEMC, primarily related to the granting of police-power to a private organization and the degree to which staff privatization might bolster the monopolistic tendencies of board regulation.

MAINE

Maine has a central Office of Licensing and Regulation.

In Maine occupational licensing activities are overseen by the Office of Licensing and Regulation in the Department of Professional and Financial Regulation. The office is responsible for 42 boards, commissions, and registrations. There are also six independent and autonomous health boards.

Hearings for initial or expanded occupational regulation are usually held by the Business and Economic Development Committee, a joint House/Senate committee.[4] Occasionally bills are heard by more than one joint committee, and occasionally professional groups are able to circumvent the Business and Economic Development Committee by having proposals introduced in different committees. If the bill passes the joint committee it returns to the floor of the legislative body that introduced the bill. At any time the Legislature may ask the

3 Mr. Gip Arthur, Florida House Committee on Business Regulation and Consumer Affairs, Telephone interview, Tallahassee, Florida, August 14, 1998.

4 All legislative committees in Maine are joint committees.

Department of Professional and Financial Regulation to study the issue and make recommendations for regulation.

In 1995, Maine passed amended sunrise legislation to help limit the growth of new regulated occupations. The legislation replaced a 1986 sunrise statute that was essentially ignored by legislators and groups seeking regulation. The new statute mandates groups seeking new or substantial expansion of regulation to answer questions pertaining to thirteen criteria stated in law. The law also provides any group opposed to the legislation the opportunity to present arguments to the legislative committee hearing the issue. The committee is instructed to analyze the answers provided by the group seeking regulation, as well as comments from any group opposing the proposed regulation, before making a decision. This new law was designed to help legislators assess the need for occupational regulation in terms of public health, safety, and welfare, and also address issues of costs and benefits, means of voluntary regulation, specialized skill, and minimal competence.

OREGON

Oregon has a recent history of reform and counter-reform.

The series of reforms and counter reforms that Oregon has experienced in recent years illustrates the trends and frustrations associated with occupational regulation in many states. In the 1960s non-health-related boards were administratively consolidated under the Department of Commerce. In 1971 the same was done for health-related boards under the Department of Human Resources' Health Division. By 1975, the health boards were given a more autonomous semi-independent status, and by 1987 the boards of Nursing, Medical Examiners, and Chiropractic Examiners were made fully autonomous. In 1987 the Commerce Department was abolished and the several boards it administered were dispersed to different agencies or became independent. A bill introduced in 1993 would have placed all boards in a semi-independent status, and a budgetary note in 1995 required the Department of Administrative Services to examine the feasibility of consolidating occupational regulation.[5] Neither of these reforms were passed, although six boards were granted semi-independent status during the 1998 legislative session.

Oregon also enacted sunset legislation in 1977, but it was repealed in 1993 due to funding shortages. Additionally, the Oregon legislature used to have a sunrise committee, but it was discontinued due to lack of interest. Since Oregon does not have active sunrise or sunset provisions it is not surprising that occupational regulation has proliferated in Oregon.[6]

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5 Oregon Department of Administrative Services, Budget, and Management Division, *Regulated Professional Occupations*, (Salem, January 1997).

6 According to *The Directory of Professional and Occupational Regulation in the United States* (CLEAR, 1994), Oregon regulates 165 occupations, compared to a national state average of 124. Only four states regulate more occupations than Oregon (Massachusetts, California, Nevada, and Arkansas). As noted in Chapter 2, *The Directory of Professional and Occupational Regulation in the United States* indicates that Minnesota regulates 142 occupations and ranks 13th highest among all states (see Figure 2.1, page 41).

TEXAS

Texas has a Health Professions Council.

In Texas occupational regulation is organized under three entities: (1) the Department of Licensing and Regulation has jurisdiction over several non-health-related occupations, (2) the Department of Health oversees the regulation of some health professions, and (3) the Health Professions Council coordinates the efforts of the independent health boards. The Health Professions Council is a unique and frequently cited aspect of occupational regulation in Texas. The Council, whose membership includes the executive directors of the health boards, was created as a result of a sunset review in the early 1990s. In an effort to encourage cost savings, the sunset review commission recommended that the health boards share administrative services such as photocopying and processing consumer complaints. The Health Professions Council also reviews policy issues, although it is not a policy-making body.

In Texas the Sunset Advisory Commission reviews each agency every twelve years. The commission also provides the legislature with basic information regarding proposed legislation upon request. Texas does not have a formal sunrise provision, although sunrise for health professions was proposed during the 1998 session. The legislation would have given the Health Professions Council responsibility for conducting sunrise reviews, but the proposal did not pass partly because of concerns relating to whether the executive directors of enforcing agencies should create policy and then enforce laws.

VIRGINIA

Virginia has two departments that oversee occupational regulation.

Virginia has two departments that oversee occupational regulation, the Department of Health Professions and the Department of Professional and Occupational Regulation. The departments provide administrative support for the health and non-health boards, respectively. Additionally, the Department of Professional and Occupational Regulation directly regulates some occupations. The departments are also responsible for conducting studies and soliciting public comment about occupations seeking regulation. Health boards wishing to introduce new legislation must submit the proposals to the Department of Professional and Occupational Regulation before they are presented to the Assembly. New occupations seeking legislation may submit bills to the Assembly or approach the department for assistance.

In addition to the Department of Health Professions, the regulation of health professions is also overseen by the Board of Health Professions. The Board of Health Professions, made up of representatives from all twelve health boards and five public members, approves all health board budgets. The Board of Health Professions also coordinates policy from each of the regulatory boards, reviews all board-sponsored legislative proposals, and advises the governor and assembly.

WASHINGTON

Washington has enacted a sunrise law and a uniform disciplinary act for health professions. It also has centralized the administration of the health boards.

The most interesting aspects of occupational regulation in Washington relate to the health care professions. Washington passed three major reforms in the regulation of health care professions during the 1980s. First, in 1983, Washington passed a sunrise act that applies to scope of practice proposals as well as proposals for regulating previously unregulated professions. Similar to Minnesota's sunrise statute, Washington's sunrise act stipulates that when regulation is deemed necessary, the legislature should enact the least restrictive form of regulation; however, Washington's act explicitly provides the three options of registration, certification, and licensing.[7] The act has been successful in limiting the number of new occupations regulated in Washington; since it was passed only one health profession has become licensed. Two problems were noted with Washington's statute. One was that the act mandates sunrise reviews by both the Health Board and the Department of Health. This two review system has been somewhat problematic since the two agencies receive different information and sometimes offer different recommendations. The other problem is that the statute mandates the reviews to be narrowly tailored to the specific proposals at hand. This is problematic because the proposals can undergo substantial change in the time between the beginning of the reviews and the time at which the reviews are presented to the legislature.

The second major reform was in 1986 when Washington passed a Uniform Disciplinary Act (UDA) for health professions. As its name suggests, the UDA requires boards to take similar disciplinary actions for similar violations. The UDA also broadened the range of disciplinary actions available to the boards. Prior to the passage of the UDA board disciplinary action was largely limited to the harsh measure of license revocation. Finally, the UDA also requires the boards to report to the Legislature periodically on disciplinary actions. Currently, the Washington State Department of Licensing is drafting a proposal for a similar UDA which would cover all non-health professions. The proposed legislation would add to the existing practice acts which govern each profession by creating a uniform system of sanctions and remedies covering all regulated professions.[8]

A third reform came in 1989 with the creation of the Department of Health. At that time the administrative, staffing, and budgetary decisions of the health-related boards were moved from the Department of Licensing to the Department of Health. The boards retain full rule-making authority.

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7 *Revised Code of Washington* §18.120.010. Minnesota's sunrise act, *Minn. Stat.* §214.001, explicitly provides only two levels of occupational regulation: licensing and registration (the latter defined in Minnesota statute as title protection).

8 The proposed Uniform Disciplinary Act for Non-Health Professions will not be presented until legislative session year 2000. Another mechanism for attaining regulatory uniformity in Washington is found in the "uniform administrative provisions" (RCW §18.122), which provides groups seeking occupational regulation a template for legislative proposals. Among the reported advantages of the template is that the consistency in format makes it easier to analyze proposal content.

WISCONSIN

Wisconsin has a Department of Regulation and Licensing responsible for both health and non-health occupations.

In Wisconsin occupational regulation is overseen by the Department of Regulation and Licensing, which was created in 1976. The Secretary of the department is appointed by the Governor. This department handles both health and non-health occupations. Many of the professions have regulatory boards which maintain responsibility for policy development and disciplinary actions, but other occupations are directly regulated by the department. In recent years the state has shifted towards using less restrictive forms of regulation. Thus, most newly-regulated occupations are overseen by the department rather than a board. The department handles the complaint and investigation process, although the Attorney General's Office may assist in a very limited number of cases.

Legislative proposals relating to occupational regulation are heard in various committees of the Assembly and Senate. Wisconsin does not have a sunrise provision, but the Department of Regulation and Licensing does apply sunrise-like criteria when it studies regulation requests. Frequently the Legislature will direct new groups seeking regulation to the department so the department can apply the sunrise criteria and issue a recommendation commensurate with the administration's political agenda. In addition to studying new regulation requests, the department is responsible for assisting regulatory boards in the preparation and presentation of any proposed regulatory changes. In these situations, the department will apply the sunrise criteria and issue a recommendation about the proposed legislation. Occasionally the department may oppose the boards' position on legislation or rules. Should the Legislature decide to regulate an occupation or business entity contrary to the department's recommendation, the legislature will ask the department to work with the group to ensure that the regulation can be implemented effectively.

SUMMARY

In conclusion, we found that all of the states that we contacted were struggling with the questions similar to those that gave rise to this report, including: What is the best way to inform legislative decision making concerning occupational regulation? What is the most efficient way to organize occupational regulation? How can regulatory entities best address consumer complaints? Several people we talked to in other states echoed concerns raised in Minnesota about the degree to which occupational regulation actually protects the public and the relative political strength of professional organizations.

In general, states that have formal sunrise provisions, complete with questionnaires for applicant groups and summary reports generated by either executive branch departments or legislative staff, give the impression of a better-informed legislative process. However, even states with such complete sunrise provisions experience frustrations with professional groups that are able to circumvent the process. Generally, states with sunset provisions give the impression that they do a better job of providing continued legislative oversight.

Centralization of regulatory activities leaves a more ambiguous impression; while many states have centralized, many have also backed away from centralization. While centralization may create some efficiencies, it also creates additional layers of bureaucracy. Several states appear to have at least temporarily settled this issue through the creation of a sort of middle ground that retains at least some independent regulatory boards but segregates health and non-health professions under different umbrella departments. One benefit of at least some degree of centralization is that it provides a focal point for the legislative oversight that is more easily lost in a system made of several small independent boards.

In sum, despite the flexibility that our federal system allows, no state we studied appears to have solved the subtle yet chronic problems that accompany occupational regulation. While our research into occupational regulation in other states left us with some impressionistic conclusions about the costs and benefits of certain organizational features, we found no convincing evidence that any particular organizational arrangement or process provides an assured solution to any given problem associated with occupational regulation.

Case Studies of Occupational Regulation

LEGISLATIVE PROPOSALS IN 1997 AND 1998

APPENDIX B

We sought to gain a better understanding of the issues concerning occupational regulation that have been before the Legislature in recent years. We first compiled a list of all bills presented to the Legislature relating to occupational regulation in 1997 and 1998. Some proposed creating new regulatory programs, one proposed abolishing an established regulatory board, and others proposed broadening an established profession's scope of practice.[1] In Chapter 2, Figure 2.3 presents a list of these bills. From this list we chose to closely examine 13 case studies listed in Figure 2.4 (Chapter 2).

We conducted 13 case studies of occupational regulatory proposals before the Legislature in 1997 and 1998.

The 13 case studies, while not statistically representative of all occupational regulation issues facing the Legislature, were chosen to illustrate a wide range of issues affecting health and non-health professions. They include proposals that passed and those that did not, occupations regulated by departments as well as those regulated by independent boards (or seeking to be regulated by independent boards). Our research included reviewing the proposed legislation, listening to tapes of legislative hearings, and interviewing people on all sides of the issues including legislators, representatives of professional associations, lobbyists, and board and department staff.

ACCOUNTING

Accountants have long been licensed in many states. Licensure of accountants dates back to the Depression, when it was deemed necessary for some outside agent to certify the legitimacy of the bookkeeping procedures of businesses. Currently, certified public accountants are licensed in 42 states and otherwise regulated in 7 others.[2] In Minnesota there are three types of regulated accountants: certified public accountants, licensed public accountants, and unlicensed or inactive certified public accountants. Illustrating the confusion that often surrounds occupational regulation, certified public accountants (CPAs) are actually *licensed* to do public accounting. Licensed public accountants (LPAs), accountants who practiced public accounting prior to 1979, are also licensed to do public accounting. Unlicensed or inactive CPAs are those who have passed the

1 Scope of practice is defined as the techniques and activities legally reserved for license holders.

2 Lise Smith-Peters, ed., *The Directory of Professional and Occupational Regulation in the United States* (Louisville, KY: The Council on Licensure, Enforcement and Regulation, 1994).

CPA exam, but have not gained the experience necessary to become a licensed CPA, or those who have been licensed CPAs but have allowed their license to lapse. Unlicensed CPAs can use the title CPA, but cannot independently practice public accounting—thus the level of regulation for unlicensed CPAs is certification, as the term is used nationally. In general, accountants are not required to be licensed, certified, or registered with the board and can practice any type of accounting that does not include public accounting, or performing independent audits which result in professional opinions concerning the fairness of a company's financial statement.

A 1997 bill proposed to increase the educational requirement for CPAs.

There have been two notable legislative proposals involving the regulation of accountants in recent years. The first coincides with a national campaign by both the American Institute of Certified Public Accountants (AICPA) and the National Association of State Boards of Accountancy (NASBA). It proposes to increase the educational requirements for a CPA from a high school diploma to 150 undergraduate credit hours, which is five years of post secondary education. Forty-four states have implemented the 150 hour requirement. Although the campaign began in the early 1990s and has the support of both the Minnesota Society of Certified Public Accountants and the state Board of Accountancy, this change has not yet won approval from the Minnesota Legislature. The proposal has faced opposition from several groups including state community colleges offering two-year degrees in accounting. The two-year programs fear that the 150 hour requirement would divert students from their programs to colleges and universities offering the full program. They also argue that the added expenses associated with attending a five-year program would unnecessarily exclude poor and minority students from the profession. In recent hearings legislators have tested the proposal against a Chapter 214 criterion by asking whether the proposed changes would actually protect the public. While sponsors of the proposal argue that the 150 hour rule would improve public protection against certain risks, most of their arguments have to do with bringing the standards for public accounting in Minnesota in line with the standards in other states. In 1997, H.F. 301 and S.F. 239 were passed out of the Commerce Committee of both chambers and then referred to the respective education committees, where the bills were stalled.

The second notable legislative development occurred in 1998 when the legislature passed H.F. 2308/S.F. 2014, a bill that broadens the disciplinary capabilities of the Board of Accountancy. The board is now able to discipline accountants who are not licensed or certified as CPAs or LPAs. It is too early to measure the extent to which this will affect the practice of accountancy. In Minnesota this model of regulation has been used to regulate unlicensed mental health practitioners since 1996, with some success.

In sum, the title *certified* public accountant is a good example of the confusing terminology that can be found in occupational regulation. Since this title is used nationally it is unlikely to change. Legislators are likely to face ongoing pressure to raise the educational requirements for a CPA to 150 credit hours as the AICPA and NASBA continue to press nationally for this and other aspects of their model Uniform Accountancy Act. The Minnesota Legislature's resistance to this campaign can be seen as a successful application of Chapter 214, which requires consideration of "[w]hether the unregulated practice of an occupation may harm or endanger the health, safety, and welfare of citizens of the state and whether the potential for harm is recognizable and not remote." However, it may be that

Chapter 214 ought to include additional potentially important criteria, such as the effect of regulatory decisions on inter-state mobility. Finally, the power now vested in the Board of Accountancy to discipline unlicensed and uncertified accountants represents an innovative form of regulation that deserves continued attention as a potential less restrictive form of regulation.

ARCHITECTURE, ENGINEERING, AND ALLIED PROFESSIONS

In Minnesota architects, engineers, land surveyors, landscape architects, geoscientists (geologists and soil scientists), and interior designers are regulated by a single board. Architects, engineers, land surveyors, and landscape architects are licensed in well over half of the states, while geoscientists and interior designers are regulated in fewer states (see Table B.1).

Table B.1: Number of States Licensing Architecture, Engineering, and Allied Professions, 1994

	Number of States Licensing
Architect	50
Land Surveyor	49
Professional Engineer	41
Landscape Architect	34
Geologist	13
Soil Scientist[a]	0
Interior Designer[b]	4

[a]In 1994 Soil Scientist were certified in 2 states.
[b]In 1994 Interior Designers were certified in 7 states, including Minnesota.

SOURCE: Lise Smith-Peters, ed. *The Directory of Professional and Occupational Regulation in the United States* (Lexington, KY: The Council on Licensure, Enforcement and Regulation, 1994).

A 1998 bill proposed abolishing the Board of Architecture.

A 1998 legislative proposal, H.F. 2827, would have abolished the Board of Architecture, Engineering, Land Surveying, Landscape Architecture, Geoscience and Interior Design (AELSLAGID). The proposal was inspired by a professional engineer who is also a former AELSLAGID board member. This individual has filed several hundred complaints with the board, typically alleging that certain construction projects do not follow the statutory mandate to include a licensed engineer. The complaints have resulted in only a limited number of disciplinary actions. Thus, H.F. 2827 is based on the premise that the board does not protect the public as a whole, but rather protects certain construction companies by allowing them to break the law. The bill failed to attract any co-authors in the House and it did not receive any hearings.

Given the lack of support for this bill in either the House or Senate, it is likely that the bill was intended as more of a warning to the board than an actual attempt to abolish the board. Overall, the primary point that this case seems to make is that

board performance could be better monitored through increased oversight. With increased oversight, whether through sunset reviews, improved biennial reporting, or by some other means, the Legislature and the public could have more confidence that regulatory boards are truly working in the public's interest.

REGISTERED DENTAL ASSISTANTS

Legislation in 1998 sought licensure for registered dental assistants.

Registered dental assistants have been regulated by the Board of Dentistry since 1977. In 1994 they were registered in 4 states and regulated in 11 states.[3] (Unregulated dental assistants are employed in Minnesota but do not perform any intra-oral functions.) In 1998, S.F. 3408 was introduced. The proposed legislation sought licensure for registered dental assistants. The bill did not change the activities defining the scope of practice for dental assistants, and it would have given registered dental assistants the same level of credentialing as dental hygienists. The Minnesota Dental Assistants Association (MDAA), which represents about 20 to 30 percent of Minnesota dental assistants, supported the bill. The board did not oppose S.F. 3408 because registered dental assistants are required to meet education, exam, and continuing education requirements as do dental hygienists. The bill was introduced late and received no hearings.

The case study of dental assistants provides an example of an attempt to change the inconsistent use of the words certify, register, and license in Minnesota. Since registered dental assistants have a defined scope of practice, education, exam, and continuing education requirements, it is logical that they be licensed. The fact that they are currently referred to as registered dental assistants, yet they have title protection and practice protection illustrates the need for a review and standardization of terminology as we recommend in Chapter 3.

LEAD WORKERS

In 1998, legislation was enacted bringing Minnesota law into line with EPA requirements for licensing lead workers.

Lead workers were regulated in Minnesota in 1993 by the Department of Health's Division of Environmental Health. Only workers doing intentional lead removal are required to be licensed. If an individual or contractor removes lead incidental to a remodeling project, no license is required. Furthermore, these rules only apply to work done on buildings that have the potential to be homes or places frequented by children.

The impetus for regulating this occupational group was the 1992 Federal Housing Act, which mandated regulation of lead removal, and the 1996 Environmental Protection Agency (EPA) requirements that followed. In 1998 H.F. 2334 and S.F. 2108 were introduced to bring Minnesota statutes in line with the EPA standards relating to lead removal. Recognizing the need to update Minnesota's standards, and desiring to avoid the alternative of direct regulation by the EPA, the bills were backed by the Minnesota Department of Health. There were no groups opposed to the changes and the bills were passed with minimal discussion.

3 Ibid.

In this case the state proposal for a change in occupational regulation originated from a federal requirement. Prior to this federal initiative only two states regulated lead workers.[4] It is debatable whether the licensing of lead workers meets the criteria for regulation established in Chapter 214, especially since licensure is only required for specific lead removal projects. However, this case provides an example of how states must sometimes adjust regulatory policies in order to pre-empt federal regulation.

Another issued raised in this case relates to the financing of occupational regulation. The fees generated by licensing lead workers do not cover the costs of regulation. The program receives some support from federal grants, but even with federal funds the licensing program is not self-supporting. This is a problem in light of Minnesota Statutes §16A.1285, which requires occupational regulation to be self supporting.

MORTUARY SCIENCE PROFESSIONALS

In 1994, 35 states regulated embalmers and 46 states regulated funeral directors.[5] Mortuary science professionals are currently regulated in Minnesota by the Mortuary Science section of the Department of Health.

In 1998, the Health Department succeeeded in changing licensure requirements for morticians after trying to get a bill passed for three years.

In 1997, H.F. 367/S.F. 199 was passed, changing the current licensing program. The legislation for morticians and embalmers included changing age and education requirements for licensees, and limiting the number of interns per license holder. This is the first major change to the statute since the 1950s, and it brings Minnesota in line with other states. It also accommodates people who are entering the field as a second career by giving more flexibility to education requirements. Although there was no opposition to the bill, it was presented to the Legislature for three consecutive years before it passed. Health Department staff involved in supporting the bill say the hardest part of the process was managing the bill in the Legislature.

This case study illustrates how difficult and time consuming it can be to pass legislation regarding occupational regulation. The legislative process for the mortuary science profession took at least three years, even without any opposition. We have heard that the Legislature is more likely to pass bills that have consensus among the participants, but that did not happen the first two years mortuary science bills were introduced.

Although the new statute appears to have more stringent education requirements, the department says the requirements in Minnesota mirror standards from other states and make it easier for people to enter the field if they already have some education. Adjusting the requirements to match those of other states indicates a growing awareness of professional mobility among those involved with mortuary sciences, a trend that is also affecting other occupations.

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4 Ibid.

5 Ibid.

NATUROPATHIC DOCTORS

Naturopathic doctors (NDs or naturopaths) are defined as "trained specialists in a separate and distinct healing art which uses non-invasive natural medicine."[6] Naturopathic doctors are currently licensed in nine states,[7] but they are not regulated in Minnesota. Efforts of naturopaths to secure licensure in Minnesota can be traced back to an unsuccessful proposal in 1909. However, after the passage of the Basic Sciences Act in 1927, naturopaths who passed the Basic Sciences Examination were entitled to registration. In 1974 much of the Basic Sciences Act was repealed, including the registration of naturopathic doctors.[8]

Naturopathic physicians have sought licensure in recent years.

Naturopaths have again sought licensure in recent years. In 1987 the Minnesota Association of Naturopathic Physicians (MANP) submitted a proposal for licensure under an independent board of Naturopathic Physician Examiners to the then-operative Human Services Occupations Advisory Council (HSOAC).[9] The HSOAC's final report declined to recommend state regulation, although a tie vote by the council narrowly defeated a recommendation for the registration of naturopathic doctors. According to the HSOAC report, the proposal failed primarily on the cost effectiveness criterion in Chapter 214, since it would have been difficult for the five naturopaths in Minnesota who would have qualified for regulation at that time to provide the fee revenue necessary to support an independent board.

Another proposal for licensing naturopaths was presented to the Legislature in 1997.[10] The proposal was modeled after the acupuncturists' practice act and proposed regulation through an advisory board to the Board of Medical Practices. This proposal was partially motivated by disciplinary actions brought by the Board of Medical Practices against a practicing ND. This particular ND acknowledged that she was performing activities reserved by statute for medical doctors, but correctly pointed out that the practice act for physicians is extremely broad. She argued that as a graduate of a four-year post-graduate program in naturopathy her training was rigorous and adequately prepared her to provide the services that she had provided. Indeed, the extensive training required by the National Council on Naturopathic Education serves as the basic justification

6 Wendell W. Whitman, N.D., M.Di., "What is a Naturopath," WWW document, URL http://www.cnra.org/what.is.a.naturopath.html, December 8, 1998. Mr. Whitman is an associate of the Council on Naturopathic Registration and Accreditation, based in Washington D.C. His definition of Naturopathic Doctors continues: "... Naturopathic doctors are conventionally trained in subjects such as anatomy, physiology, counseling, dietary evaluations, nutrition, herbology, acupressure, muscle relaxation and structural normalization, homeopathy, iridology, exercise therapy, hydrotherapy, oxygen therapy and thermal therapy. Some practitioners are also trained in additional specialties such as acupuncture or natural childbirth."

7 Smith-Peters, *The Directory of Professional and Occupational Regulation in the United States*.

8 *Complementary Medicine: A Report to the Legislature*, (St. Paul, MN: Minnesota Department of Health, Health Economics Program, January 15, 1998).

9 *Human Services Occupations Advisory Council Recommendations on the Regulation of Naturopathic Physicians,* (St. Paul, MN: Minnesota Department of Health, October 27, 1988). The Staff Recommendation and Commissioner's Determination that normally accompanied HSOAC reports were not made in this case since funding for the study was stopped prior to completion.

10 H.F. 396/S.F. 523 and H.F. 780/S.F. 561.

offered by proponents of licensure. Ironically, the educational requirements also served as the greatest impediment to the 1997 proposal. Among the most forceful opposition to the bill was a diverse group of alternative medical practitioners, many who use the title "naturopath." Most if not all naturopaths who actively opposed the proposal would not have met the educational requirements, and feared possible restrictions on their practices if the proposal passed. Ultimately, the 1997 proposal received hearings but did not win approval. However, it did provide impetus for a report on Complimentary and Alternative Medicine by the Minnesota Department of Health, which concluded that there is not presently enough information to justify government regulation of naturopaths or other alternative medical providers.[11]

The case of naturopathic doctors reveals some of the difficulty that smaller professional groups face in attempting to gain state regulation. Given that the most vocal opposition to the bill came from other practitioners of naturopathy, the proposal to license "qualified" naturopathic doctors also illustrates the way occupational regulation can be used to "fence out" potential competitors. However, the same could be said of the long-established regulation of medical doctors: the medical doctors' practice act effectively prevents naturopathic physicians from exercising the full scope of practice in which they have been trained.

The case of naturopaths also provides an example of the Legislature using a report to inform its decisions regarding occupational regulation. In some ways this demonstrates the ability of the Legislature to implement studies on an "as needed" basis, which would seem to negate the need to establish a more institutionalized sunrise review process, as we recommend in Chapter 3. However, the report casted a broad net and concluded with a blanket recommendation against regulating any of the professions providing complementary and alternative medical services. While the report does represent a laudable attempt to bring more objective reasoning to bear on the issue, it was not focused on the particular proposal at hand, as was the more useful HSOAC report issued in response to the 1987 proposal.

NURSING

Nursing is one of the oldest regulated professions in Minnesota. The profession was first licensed in 1907 and is currently one of the largest regulated professions in the state. The Board of Nursing licenses about 80,000 registered nurses and licensed practical nurses. Like the entire health care system, the nursing profession has undergone many changes in recent years. The advent of new technology and new health service organizations has increased the role of nurses, and less trained health workers are now performing some of the duties previously reserved for nurses. These changes were the impetus for two bills presented to the Legislature in 1997.

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11 Complementary Medicine: A Report to the Legislature. The study was mandated through an amendment to the 1997 Omnibus Health and Human Services Appropriations Act - *Minn. Laws* (1997) ch. 203, sec. 3, subd. 2.

The first bill, H.F. 1117/S.F. 898, would have increased the scope of practice for nurses. It would have allowed nurses to pronounce death in a situation when working under anyone currently authorized to pronounce death, and it would allow nurses to implement medical protocols as delegated by a licensed physician. The bill also would have increased the board's ability to revoke temporary permits, and increase the situations warranting automatic suspension of nurses. The bill received no hearings.

The second bill, H.F. 1238/S.F. 131, requested title protection for certified nurse anesthetists. It received no hearings. This bill was part of an ongoing dispute between nurse anesthetists and anesthesiologists over billing practices and the role nurses play in administering anesthesia. This is an example of the scope of practice disputes that are often brought before the Legislature.

Changes in health care delivery have led to legislative proposals affecting the licensure of nurses.

This case study serves as an excellent example of several recurring themes revealed in our study. The first issue is consensus. The bill that would have increased regulated activities for registered nurses and licensed practical nurses was supported by the board, but opposed by the Minnesota Nursing Association. The association was leery of giving licensed practical nurses more responsibility, thus jeopardizing patient care and the jobs of registered nurses. Both groups, the board and the association, say it is difficult to pass legislation without agreement among the participants.

A second issue for nurses is the changing scope of medical actions nurses perform and professional competency. As mentioned earlier, the nursing profession is changing to reflect expanding technology and medical standards as well as the way medicine is practiced in health maintenance organizations. This leads to changes in the duties nurses perform. Questions then arise about what actions nurses can perform without harming a patient. If licensure assures minimal competency, are nurses still competent to protect the public as their roles change? The continual technological evolution in the field of nursing and health care in general lend support to the calls for enacting a more effective means of assessing continued professional competency.

A third legislative issue affecting nurses also relates to other health care professions. There has been an increase in complimentary and alternative medicine groups requesting occupational regulation, and these groups have practices that mirror those of nurses. There is a concern that licensing new groups will prevent nurses from performing some duties, thus raising the cost of health care as consumers seek other professionals to perform specific services. Since there is no longer a HSOAC process review, and the questions of the sunrise provisions of Chapter 214 are often ignored, most groups are not required to answer questions about harm, training, and alternative means of regulation or private credentialing.

OPTICIANS

Opticians dispense eyeglasses and contact lenses.[12] Opticians are currently licensed in 21 states, but have never been regulated in Minnesota.[13] The Minnesota Opticians Society (MOS) has been trying to gain some form of regulation for opticians for a number of years without success. The 1997 proposal for licensure, H.F. 886/S.F. 851, received no hearings in either the House or the Senate.

Opticians have sought regulation in recent years.

Opticians see a need for licensure because, like pharmacists, they are involved with dispensing prescriptions. The MOS argues that improper dispensation of eye glasses and especially contact lenses can be harmful to the eye and cause accidental injuries. Opticians also express a need to upgrade the services provided to the public as well as their professional image.[14] The MOS also points out that opticians require specialized skills and that an exam to assess the necessary skills is already available: the American Board of Opticianry (ABO) offers an examination leading to private certification of opticians and Anoka-Ramsey Community College offers a two-year program in preparation for the ABO exam.

Opposition to regulating opticians comes from many quarters. Large optical stores oppose regulation because of the added labor costs involved with hiring a regulated work force. Ophthalmologists and optometrists are also generally opposed, partially because of the perceived encroachment on their practices. Some ophthalmologists and optometrists dispense contacts and eyeglasses as one part of their business operations and would, therefore, be hostile to regulation which might threaten the viability of their in-house operations.

A similar proposal was submitted to the Department of Health's Human Services Occupations Advisory Council (HSOAC) in 1989.[15] The HSOAC broke opticians into two professional groups: spectacle dispensers and contact lens dispensers. The HSOAC did not recommend any form of regulation for spectacle dispensers, but did recommend voluntary registration for contact lens dispensers. On January 18, 1989 the Commissioner of Health issued a determination that concurred with HSOAC recommendations, setting in motion a system of certification for contact lens dispensers.[16] The MOS appealed this decision, which was subsequently

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12 To avoid confusion *opticians* should be differentiated from *opthalmologists*, who are licensed medical doctors specializing in eye-care and eye surgery, and *optometrists* who are licensed to examine eyes and prescribe glasses, contacts and therapeutic drugs.

13 Smith-Peters, *The Directory of Professional and Occupational Regulation in the United States*.

14 One optician cited a recent 20/20 program which suggested that half of all eyeglasses are made improperly.

15 As discussed in greater detail in chapter 1, the Human Services Occupations Advisory Council is not currently operative.

16 The HSOAC and the Commissioner's use of the term "registration" is consistent with a system of certification, as used in our report. The Commissioner's summary of findings, conclusions and recommendations (January 1, 1989) states: "...contact lens fitters will be placed on a roster maintained by the state after meeting predetermined qualifications and will be permitted to use a specific occupational title(s). The protected title will be "contact lens technician" and close variations of this title."

re-affirmed by the Commissioner. However, during rule making Health Department staff found that there were too few contact lens dispensers in the state to make a certification program financially viable, and the process was dropped.

An optician involved in the HSOAC process indicated that hearings directly before the Legislature would be preferable, but opticians involved with the most recent proposal indicated their frustration with the lack of structure and direction under the current arrangement. Opticians involved with the most recent proposal also indicated frustration with the amount of resources that they needed to spend in order to familiarize themselves with the particulars of getting their proposal introduced. They eventually hired a lobbyist who was successful in finding authors, but unsuccessful in securing a hearing.

Opticianry is not a profession where decisions regarding regulation are clear cut. While many of the materials that are used by opticians do constitute a potential immediate danger to the consuming public, there are some safeguards already in place. For example, contact lens materials and solutions are regulated at the federal level by the Food and Drug Administration. Additionally, consumers who have been wronged by incorrectly filled prescriptions could seek legal remedy through other means, such as small claims court and the better business bureau. Furthermore, consumers can seek out ABO certified opticians if some level of quality assurance is desired. However, if it is true that half of all glasses prescriptions are filled incorrectly, the costs to the public—in terms of blurred vision, headaches, and accidents—may be quite large. Given the countervailing issues involved and the added complications associated with powerful professional groups, the case of opticians provides an example of a proposal that could benefit from the added measure of objectivity that would accompany a more formal review of the proposal. Although a similar proposal received such a review in 1989, the Legislature would have to decide whether the current proposal deserved another review, based on factors including changes to the proposal and changes in the affected profession, such as technological advances.

PHYSICAL THERAPISTS

Physical therapists have asked the Legislature to create a Board of Physicial Therapy.

Physical therapists are regulated in all 50 states and physical therapy assistants are regulated in 36.[17] Minnesota is one of two states that regulates physical therapists through *certification* rather than licensure.[18] Physical therapists have been regulated under the Board of Medical Practices since 1951 and there are currently 2,880 certified physical therapists in Minnesota.

17 Smith-Peters, *The Directory of Professional and Occupational Regulation in the United States*.

18 Minnesota statute provides title protection, but not practice protection, to Physical Therapists; that is, anyone may provide services that are equivalent to those provided by a Physical Therapist, but they may not use the title "Physical Therapist," or anything that resembles it, unless they have been certified by the board (*Minn. Stat.* §148.71). Consistent with *Minn. Stat.* §214.001 this level of regulation is referred to as "registration," which is equivalent to "certification" as used in our report.

A 1997 legislative proposal, H.F. 885/S.F. 303, backed by the Minnesota Chapter of the American Physical Therapy Association (APTA), would have placed the regulation of physical therapists under the auspices of an independent Board of Physical Therapy.[19] The proposal was eventually incorporated into the Health and Human Services omnibus bill that passed through the House of Representatives. However, in conference committee the proposal was replaced by a study. The Health Department is currently convening "a workgroup to study the feasibility and need of creating a separate Board of Rehabilitation Therapy Occupations, including physical therapists, occupational therapists, speech language pathologists, audiologists, hearing instrument dispensers, and any other related occupation group that the commissioner determines should be included."[20] The Minnesota APTA is frustrated with this development since it perceives the study as unnecessarily delaying the creation of an independent Board of Physical Therapy.

PLUMBERS AND WATER CONDITIONING PROFESSIONALS

Plumbers are licensed by the Department of Health, but only need a license to work in cities of 5,000 people or more.

Plumbers are regulated because of the health and safety issues that surround municipal water and sewer systems. Journeymen plumbers are licensed in 29 states and water conditioning installers, involved in the installation of water softeners, are licensed in only two states: Minnesota and North Dakota.[21] In Minnesota, plumbers and water conditioning professionals are licensed by the Environmental Health Services Division of the Minnesota Department of Health, but only required to have a state license when working in cities of 5,000 or more.[22] The distinction between small and larger cities is not related to any public purpose, but has remained in statute since 1933 largely because of the vested interests of various plumbing and water conditioning businesses, unions, and professional organizations.

Recent legislative proposals, H.F. 1795/S.F. 1597 for plumbers and H.F. 3244/S.F. 2857 for water conditioning contractors, would have required state wide licensure of both plumbers and water conditioning contractors. Neither received hearings. These proposals were not put forward by the Department of Health, but the department has supported state wide licensing of plumbers since at least the early 1990s when it was involved with a working group on plumbing and water safety issues. In 1991 this working group forwarded a proposal for state wide licensure

19 The proposal also included a language change which would replace the term "certificate of registration" with "license." This language change could have caused some confusion; although under *Minn. Stat.* §214 licensure is a level of regulation reserved for practice protection, the proposal would not have actually changed the current level of regulation, only the terminology.

20 *Minn. Laws* (1998), ch. 407, art. 2, sec. 108.

21 Master plumbers are licensed in 23 states and apprentices are licensed in 8, registered in 9. Smith-Peters, *The Directory of Professional and Occupational Regulation in the United States*.

22 "Plumbers" includes master plumbers, journeyman plumbers, and apprentices. Apprentices are not licensed but registered. Water conditioning installers include both installers and contractors. In cities of 5,000 or more water conditioning installers are limited to working on one- or two-family dwellings.

of plumbers, partially based on the fact that most code violations investigated by the Health Department result from work done by unlicensed plumbers. The department has reservations about proposals for state wide licensure of water conditioning contractors, because as a group water conditioning professionals have a questionable record in terms of code compliance. In either case the department has not recently been engaged by the Legislature in discussions concerning these issues.

Based on national comparisons, the need for licensure in the case of plumbers and certainly water conditioning contractors is open to debate. However, the Legislature certainly would have a hard time justifying, in terms of the guidelines of Chapter 214, the distinction between cities of more and less than 5,000 inhabitants. Concerns over public health, safety, and welfare take an obvious backseat to the professional turf created by the enduring population distinction. This case illustrates power of professional interests within the Legislature relative to the limited influence of the regulatory bodies themselves.

PRIVATE DETECTIVES AND PROTECTIVE AGENTS

The Board of Private Detectives and Protective Agents regulates about 300 people. Since so few people are regulated by the board, the biennial license fees are among the highest in Minnesota: $415 to $515 for individuals and $815 to $965 for business licenses. If someone practicing as a private detective or protective agent works for another licensed entity, an individual license is not necessary. The professional activities for these occupations are expanding as private detectives and protective agents assume responsibilities previously left to law enforcement personnel.

In 1998, two bills relating to the regulation of private detectives were introduced.

In the last legislative session two bills concerning the board were introduced. The first, H.F. 1552/S.F. 1395, received hearings in the House in 1997. It would have granted the board authority to issue cease and desist orders and impose penalties on unlicensed people. Similar powers have been granted to the Board of Accountancy and the Office of Mental Health Practitioners.

In 1998 the second proposal, H.F. 2533/S.F. 2199, received hearings in the Senate but did not pass. This bill would have explicitly required licenses for people acting as bail bondsmen and bounty hunters. Because the board believes bail bondsmen and bounty hunters require licensure under existing law the board considered the proposal to be a simple clarification of language. However, industry representatives fought the bill, claiming licensure would be a financial hardship.

The 1998 initiative illustrates the confusion of existing legislation. The board and the regulated occupations have different opinions of what activities require a board license. When the board supported legislation to clarify this issue, the bill was defeated largely because of the opposition of the organized industry representatives. Furthermore, the board staff feels there is a misunderstanding of

the board's role because professionals expect the board to lobby for the profession rather than protect the public.

REAL ESTATE APPRAISERS

During the 1997 legislative session the Department of Commerce Omnibus Bill, H.F. 1032/S.F. 501, included a provision to change the licensing requirement of real estate appraisers by increasing the training requirements for two classes of licensees and reducing the requirement for the entry level appraiser.

In 1997, legislation was enacted that brought Minnesota into conformity with national practice in regulation of real estate appraisers.

The Minnesota Association of Professional Appraisers (MAPA) asked Commerce to sponsor this provision because the change was being made across the country in response to a recommendation by the national organization that sets professional credentials and standards for practice. The need for national standards dates from the 1970s when mortgages started to be traded in the secondary market and a need was defined for uniform appraisal standards. The Minnesota legislation was the culmination of a long process nationally and locally.

Once the Commerce Department agreed with the Minnesota Association of Professional Appraisers that a change in licensing and continuing education requirements was needed in order to bring Minnesota into conformity with national standards, the legislative proposal was not controversial. Commerce did not agree with MAPA's request to establish increased requirements for entry level appraisers because it restricted access to the occupation. MAPA was willing to drop that part of the proposal because it was not part of the national compact. Commerce argued against the proposal. MAPA chose to work through the Department of Commerce and get its approval rather than approaching the Legislature directly. This case is an example of the system working reasonably well in that policy issues were studied by Commerce, a satisfactory compromise was reached, and a needed change was made to licensure requirements.

UNLICENSED MENTAL HEALTH PRACTITIONERS

In Minnesota, a diverse group of practitioners offer mental health services including unlicensed mental health practitioners. Unlike adjacent professions such as clinical psychology, social work, and marriage and family counseling, unlicensed mental health practitioners are not licensed, registered, or certified, but they are disciplined by the Office of Mental Health Practitioners (OMHP) in the Department of Health if consumers or other professionals file complaints. The investigation and disciplinary process is funded by general fund allocations. This is different than most other occupations which receive special fund allocations based on expected fee income. One of the potential benefits of this model is that it allows the department to collect statistics about complaints which could indicate whether the group needs a stronger form of regulation.

During the last two sessions, bills were introduced to license professional counsellors.

In the last two legislative sessions bills were introduced to license some mental health practitioners under the title professional counselors and establish education and practice criteria. Professional counselors are licensed in 46 states.[23] The 1995 bill, H.F. 66/S.F. 891, requested licensure for professional counselors but made provisions for people who do not meet the entry requirements to continue practicing as unlicensed mental health practitioners as long as the title professional counselor is not used. Proponents of the bill said that registration is not enough to protect the public. Although the Department of Health did not study the issue and stayed neutral during the hearings, the bill was passed. It was vetoed by the Governor, who commented, "The state should tread lightly when it comes to occupational regulation. If there is a need for regulation, the state should impose the minimum amount of regulation necessary to protect the public." He further commented that this bill would regulate a myriad of professions but exempt other professionals who practice similar services. A similar proposal, H.F. 669/S.F. 925, was introduced in 1997, but received no hearings.

The recent legislation requesting licensure of professional counselors shows the confusion currently surrounding regulation terminology. Although the proposal requested licensure for professional counselors it actually only offered title protection, equivalent to certification under the national terminology. It makes a good case for standardizing language as we recommend in Chapter 3.

SUMMARY

The 13 case studies described above illustrate the variety of occupational regulation legislation presented to the Legislature each year. The case studies represent occupations seeking new regulation such as the naturopaths, and those wishing to expand their scope of practice such as nurses. The issues also represent changes in board authority as when the Legislature granted the Board of Accountancy authority to discipline unregulated professionals. In addition, the case studies show that there can be confusion over terminology and inconsistencies in the proposed regulations. For example, registered dental assistants argue that licensure more accurately reflects the practice protection they have as well as the education, exam, and continuing education requirements needed to practice. Sometimes inconsistencies in regulation become entrenched in statute, as is the case with plumbers only needing licensure in cities of 5,000 or more. Lastly, the issues represent tenacity of the parties supporting occupational regulation proposals. Many of these bills have been brought before the Legislature multiple times. For instance, the mortuary science bill was introduced for three consecutive years before it was passed, despite having no active opposition. The bill to regulate unlicensed mental health practitioners was vetoed in 1996, yet it was re-introduced in 1997. These issues demonstrate the breadth and complexity of occupational regulation proposals facing legislators in recent years.

23 American Counseling Association, 5999 Stevenson Avenue, Alexandria, VA 22304.

Health Licensing Boards

Chiropractic ~ Dentistry ~ Dietetics & Nutrition Practice ~ Marriage & Family Therapy ~ Medical Practice ~ Nursing ~
Nursing Home Administrators ~ Optometry ~ Pharmacy ~ Podiatric Medicine ~ Psychology ~ Social Work ~ Veterinary Medicine

January 22, 1999

Roger Brooks, Deputy Legislative Auditor
Office of the Legislative Auditor
1st Floor South, Centennial Building
658 Cedar Street
St Paul MN 55155

Dear Mr. Brooks:

I am writing on behalf of the Executive Directors of the 13 health-related licensing boards to commend you on your report on *Occupational Regulation.* The boards are always interested in obtaining new information and perspectives to improve our efforts to fulfill our primary mission of public protection, and we believe that your report offers constructive comments and suggestions to help us do so.

We fully endorse the great majority of the observations and recommendations you make. We want to particularly highlight our support for the following conclusions.

- The state's policy on occupational regulation articulated in Chapter 214 is not applied consistently or effectively.

- The legislature should improve the process by which it handles proposals for occupational regulation. One way to do so, the report suggests, would be for committees hearing bills proposing new occupational regulation to require proponents to submit specific information as a condition for obtaining a hearing. Your itemization in Figure 3.2 of the kind of information needed is excellent.

- Communication between the boards and the legislature should be improved. One way to do so would be for the boards' biennial reports to contain information more useful to the legislature.

While we consider your report to be objective and balanced, we have concerns about the following items.

- The report suggests administratively consolidating small boards. Three of the boards specifically mentioned—Marriage & Family Therapy, Nursing Home Administrators, and Podiatric Medicine—are already cooperating among themselves and with the boards' Administrative Services Unit to save costs and provide better staffing. We

believe that the best approach is to strengthen the boards' cooperative efforts to identify and address specific problems.

- The report recommends using consistent terminology, so that terms such as "licensure" and "registration" have the same meanings for all regulated occupations in Minnesota. We agree that consistency is important, but we think that the use of terms within the report is confusing, because the meanings used are not consistent with the meanings commonly used in Minnesota. We are particularly troubled by your use of the term "certification" to mean what we commonly refer to as "registration" in Minnesota. The misunderstanding this can lead to is illustrated in Table 2.1, where, for example, athletic trainers, physical therapists, physician assistants, and respiratory care practitioners are described as being "certified," whereas in fact, under Minnesota law, they are registered. We support the Pew Health Professions Commission's recommendation that "states should decline to use the term 'certification,' leaving it to the exclusive use of private sector credentialing bodies." (*Reforming Health Care Workforce Regulation*, December 1995, page 4)

We are heartened by the report's endorsement of the cooperative steps the boards have already begun. We believe that our continuing efforts to strengthen our collaborative process and structure will "achieve greater administrative efficiency, collaboration on common challenges, and improved relations with the Legislature and the public." (p 77)

We appreciate your efforts to discuss with us your findings and to give us the opportunity to comment on your report. We look forward to working with you and with the Legislature to continue to strengthen what is already an effective system of occupational regulation.

Sincerely,

Joyce M. Schowalter

Joyce M. Schowalter
Executive Director, Board of Nursing
Chair, Executive Directors Forum

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