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.

---

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]

---

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.

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

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

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 Work-force 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]

---

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:

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

> 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]

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 decisions

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.

Sunset laws preschedule regulatory boards for termination.

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]

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

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

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.

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.

Part II of the report recommended:

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

- 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.