11-0901-21263-1

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE BOARD OF CHIROPRACTIC EXAMINERS

In the Matter of the Proposed Rules Relating to Chiropractic Prepay Plans, Minnesota Rules Part 2500.7000

REPORT OF THE ADMINISTRATIVE LAW JUDGE

Administrative Law Judge Barbara L. Neilson conducted a hearing in this rulemaking proceeding commencing at 9:00 a.m. on February 16, 2011, at the Minnesota Board of Chiropractic Examiners, Conference Room A, University Park Plaza, 2829 University Avenue Southeast, Minneapolis, Minnesota. The hearing continued until everyone present had an opportunity to be heard concerning the proposed rules.

The hearing and this Report are part of a rulemaking process governed by the Minnesota Administrative Procedure Act.[1] The legislature has designed the rulemaking process to ensure that state agencies have met all the requirements that Minnesota law specifies for adopting rules. Those requirements include assurances that the proposed rules are necessary and reasonable and that any modifications that the agency made after the proposed rules were initially published do not result in the rules being substantially different from what the agency originally proposed. The rulemaking process also includes a hearing when a sufficient number of persons request one. The hearing is intended to allow the agency and the Administrative Law Judge reviewing the proposed rules to hear public comment regarding the impact of the proposed rules and what changes might be appropriate.

Careen H. Martin, Assistant Attorney General, represented the Board of Chiropractic Examiners (the Board) at the hearing. The members of the Board's hearing panel were Larry A. Spicer, D.C., Executive Director of the Board; Howard Fidler, D.C., Board member; Michelle "Micki" King, Health Program Representative; and Ann Braam, Office Administrative Specialist. Forty-two people signed the hearing register.

The Board and the Administrative Law Judge received written comments on the proposed rules prior to the hearing. After the hearing, the Administrative Law Judge kept the administrative record open for an additional twenty calendar days, until Tuesday, March 8, 2011, to allow interested persons and the Board to submit written comments. Thereafter, the record remained open for an additional five business days,

[1] Minn. Stat. §§ 14.131 through 14.20. Unless otherwise specified, all references to Minnesota Statutes are to the 2010 version.

until Tuesday, March 15, 2011, to allow interested persons and the Board to file a written response to any comments received during the initial comment period.[2] Numerous comments were received during the rulemaking process, and all of the comments received were read and considered.[3] To aid the public in participating in this matter, comments were posted on the Office of Administrative Hearings' website shortly after they were received. The hearing record closed for all purposes on March 15, 2011.

NOTICE

The Board must make this Report available for review by anyone who wishes to review it for at least five working days before the Board takes any further action to adopt final rules or to modify or withdraw the proposed rules. If the Board makes changes in the rules other than those recommended in this report, it must submit the rules, along with the complete hearing record, to the Chief Administrative Law Judge for a review of those changes before it may adopt the rules in final form.

Because the Administrative Law Judge has determined that the proposed rules are defective in certain respects, state law requires that this Report be submitted to the Chief Administrative Law Judge for his approval. If the Chief Administrative Law Judge approves the adverse findings contained in this Report, he will advise the Board of actions that will correct the defects, and the Board may not adopt the rules until the Chief Administrative Law Judge determines that the defects have been corrected. However, if the Chief Administrative Law Judge identifies defects that relate to the issues of need or reasonableness, the Board may either adopt the actions suggested by the Chief Administrative Law Judge to cure the defects or, in the alternative, submit the proposed rules to the Legislative Coordinating Commission for the Commission's advice and comment. The Board may not adopt the rules until it has received and considered the advice of the Commission. However, the Board is not required to wait for the Commission's advice for more than 60 days after the Commission has received the Board's submission.

If the Board elects to adopt the actions suggested by the Chief Administrative Law Judge and make no other changes and the Chief Administrative Law Judge determines that the defects have been corrected, it may proceed to adopt the rules. If the Board makes changes in the rules other than those suggested by the Administrative Law Judge and the Chief Administrative Law Judge, it must submit copies of the rules showing its changes, the rules as initially proposed, and the proposed order adopting the rules to the Chief Administrative Law Judge for a review of those changes before it may adopt the rules in final form.

After adopting the final version of the rules, the Board must submit them to the Revisor of Statutes for a review of their form. If the Revisor of Statutes approves the form of the rules, the Revisor will submit certified copies to the Administrative Law

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[2] *See* Minn. Stat. § 14.15, subd. 1.

[3] Public Exhibits 1-4 were received into the record during the hearing. The post-hearing submissions from members of the public have been marked and received into the record as Public Exhibits 5-61.

Judge, who will then review them and file them with the Secretary of State. When they are filed with the Secretary of State, the Administrative Law Judge will notify the Board, and the Board will notify those persons who requested to be informed of their filing.

Based upon all the testimony, exhibits, and written comments, the Administrative Law Judge makes the following:

FINDINGS OF FACT

Nature of the Proposed Rules

1. The Minnesota Board of Chiropractic Examiners is the regulatory agency charged with protecting public health and safety through effective licensure and enforcement of the statutes and rules governing the practice of chiropractic care.

2. The Board is proposing rules regulating the creation and implementation of prepayment chiropractic plans. Prepayment plans are agreements between a chiropractor and patient for future chiropractic treatment services for which payment is collected in advance. These plans are frequently used in the delivery of chiropractic services because they simplify the billing process for both the chiropractor and the patient when multiple treatments are recommended, and they typically are offered to patients at a discounted rate of care.

3. The Board states that the proposed rules will provide needed transparency and safeguards to patients regarding prepay plans and curb the potential for financial abuse on the part of chiropractors. Essentially, the proposed rule is a consumer protection measure. It would require chiropractors to deposit patients' prepay plan funds in an escrow account, provide patients with written plans, limit the number of treatment visits per plan to 50 or less, prohibit additional billing to a third-party payor, and provide the right to early cancellation and refund of unused payments.

4. The Board asserts that the proposed rule parts are necessary to address disagreements over the amount of money to be refunded to a patient who elects to end a prepayment plan early. The Board maintains that it has received an increasing number of complaints from patients who believe they were not refunded the correct amount of money when they terminated their prepay plans early.

5. The Board is proposing to regulate only those prepay plans for which payment in an amount of $1,000 or more is collected in advance of chiropractic treatment services. The Board contends that prepay plans for less than that amount are typically for short-term treatment regimens and are rarely the subject of complaints.

6. The Board states in its Statement of Need and Reasonableness that it was also motivated to propose the rule to address problems patients have encountered when using health care credit cards. These credit cards permit consumers to charge the entire cost of treatment in one transaction and then typically pay it off over the course of a year without interest. However, these cards may charge a high interest rate if the consumer fails to pay on time. According to the Board, the proposed rules are

intended to provide a consistent standard for the use of prepay plans, alone or in conjunction with health care credit cards.[4]

Rulemaking Legal Standards

7. Under Minnesota law, one of the determinations that must be made in a rulemaking proceeding is whether the agency has established the need for and reasonableness of the proposed rules by an affirmative presentation of facts.[5] In support of a rule, an agency may rely on legislative facts, namely general facts concerning questions of law, policy and discretion, or it may simply rely on interpretation of a statute, or stated policy preferences.[6] The Board prepared a Statement of Need and Reasonableness (SONAR) in support of its proposed rules. At the hearing, the Board primarily relied upon the SONAR as its affirmative presentation of need and reasonableness for the proposed rules. The SONAR was supplemented by comments made by staff and witnesses who spoke on behalf of the Board at the public hearing, and by the Board's written post-hearing submissions.

8. The question of whether a rule has been shown to be reasonable focuses on whether it has been shown to have a rational basis, or whether it is arbitrary, based upon the rulemaking record. Minnesota case law has equated an unreasonable rule with an arbitrary rule.[7] Arbitrary or unreasonable agency action is action without consideration and in disregard of the facts and circumstances of the case.[8] A rule is generally found to be reasonable if it is rationally related to the end sought to be achieved by the governing statute.[9] The Minnesota Supreme Court has further defined an agency's burden in adopting rules by requiring it to "explain on what evidence it is relying and how the evidence connects rationally with the agency's choice of action to be taken."[10]

9. Reasonable minds might be divided about the wisdom of a certain course of action. An agency is legally entitled to make choices between possible approaches so long as its choice is rational. It is not the role of the Administrative Law Judge to determine which policy alternative presents the "best" approach, since this would invade the policy-making discretion of the agency. The question is, rather, whether the choice made by the agency is one that a rational person could have made.[11]

10. In addition to need and reasonableness, the Administrative Law Judge must also assess whether the Board complied with the rule adoption procedure,

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[4] SONAR at 5.

[5] Minn. Stat. § 14.14, subd. 2; Minn. R. 1400.2100. Unless otherwise specified, all references to Minnesota Rules are to the 2009 version.

[6] *Mammenga v. Dept. of Human Services*, 442 N.W.2d 786 (Minn. 1989); *Manufactured Hous. Inst. v. Pettersen*, 347 N.W.2d 238, 244 (Minn. 1984).

[7] *In re Hanson*, 275 N.W.2d 790 (Minn. 1978); *Hurley v. Chaffee*, 231 Minn. 362, 43 N.W.2d 281, 284 (1950).

[8] *Greenhill v. Bailey*, 519 F.2d 5, 19 (8th Cir. 1975).

[9] *Mammenga*, 442 N.W.2d at 789-90; *Broen Mem'l Home v. Minnesota Dept. of Human Services*, 364 N.W.2d 436, 444 (Minn. Ct. App. 1985).

[10] *Manufactured Hous. Inst. v. Pettersen*, 347 N.W.2d at 244.

[11] *Federal Sec. Adm'r v. Quaker Oats Co.*, 318 U.S. 218, 233 (1943).

whether the proposed rules grant undue discretion, whether the Board has statutory authority to adopt the rules, whether the rules are unconstitutional or illegal, whether the rules involve an undue delegation of authority to another entity, or whether the proposed language is not a rule.[12]

11. Because the Board suggested changes to the proposed rules after original publication of the rule language in the State Register, it is also necessary for the Administrative Law Judge to determine if the new language is substantially different from that which was originally proposed. The standards to determine whether changes to proposed rules create a substantially different rule are found in Minn. Stat. § 14.05, subd. 2. The statute specifies that a modification does not make a proposed rule substantially different if the differences are within the scope of the matter announced in the notice of hearing and are in character with the issues raised in that notice; the differences are a logical outgrowth of the contents of the notice of hearing, and the comments submitted in response to the notice; and the notice of hearing provided fair warning that the outcome of that rulemaking proceeding could be the rule in question.[13]

12. In reaching a determination regarding whether modifications result in a rule that is substantially different, the Administrative Law Judge is to consider whether persons who will be affected by the rule should have understood that the rulemaking proceeding could affect their interests; whether the subject matter of the rule or issues determined by the rule are different from the subject matter or issues contained in the notice of hearing; and whether the effects of the rule differ from the effects of the proposed rule contained in the notice of hearing.[14]

Procedural Requirements of Chapter 14

13. The Minnesota Administrative Procedures Act[15] and the rules of the Office of Administrative Hearings[16] set forth certain procedural requirements that are to be followed during agency rulemaking.

14. On December 7, 2009, the Board published a Request for Comments on Possible Rules Governing Pre-paid Care Plans. The Request for Comments was published at 34 S.R. 825.[17]

15. By letter dated April 7, 2010, the Agency requested that the Office of Administrative Hearings review and approve its Additional Notice Plan.[18]

16. In a letter dated April 19, 2010, Administrative Law Judge Eric Lipman approved the Board's Additional Notice Plan contingent on the Board adding the

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[12] Minn. R. 1400.2100.
[13] Minn. Stat. §14.05, subd. 2(b).
[14] Minn. Stat. § 14.05, subd. 2(c).
[15] The provisions of the Act relating to agency rulemaking are codified in Minn. Stat. §§ 14.001-14.47.
[16] The OAH rules governing rulemaking proceedings are set forth in Minnesota Rules part 1400.2000 through 1400.2240.
[17] Ex. A..
[18] Ex. E.

Minnesota Chiropractic Association to its rulemaking mailing list if it was not already included on the list.[19]

17. As required by Minn. Stat. § 14.131, the Board asked the Commissioner of the Minnesota Management and Budget (MMB) to evaluate the fiscal impact and benefits of the proposed rules on local units of government.[20]

18. In a memo dated August 3, 2010, Jim King, MMB's Executive Budget Officer, reviewed the Board's proposed rule amendments and concluded that they will have no fiscal impact on local units of government.[21]

19. By letter dated December 2, 2010, the Board requested that the Office of Administrative Hearings schedule a hearing on the proposed rules and assign an Administrative Law Judge. Along with the letter, the Agency filed a proposed Dual Notice of Hearing, a copy of the proposed rules, and a draft of the Statement of Need and Reasonableness (SONAR).[22]

20. Administrative Law Judge Barbara L. Neilson was assigned to the rule hearing.

21. In a letter dated December 10, 2010, Administrative Law Judge Barbara L. Neilson approved the Board's Dual Notice.[23]

22. On December 14, 2010, the Board electronically mailed a copy of the SONAR to the Legislative Reference Library as required by law.[24]

23. On December 14, 2010, the Board posted its Dual Notice and SONAR on its website pursuant to its Additional Notice Plan.[25]

24. On December 16, 2010, the Board mailed the Notice of Hearing to all persons on its Rulemaking List.[26]

25. On December 23, 2010, the Board mailed copies of the Notice of Hearing, SONAR, and Proposed Rules to the Chairs of the Senate Health and Human Services Budget Committee, House Health Care and Human Services Reform Committee, and the House Health Care and Human Services Finance Committee. On the same date, the Board also mailed copies of the Notice of Hearing and SONAR to the Director of the Legislative Coordinating Commission.[27]

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[19] Ex. E.
[20] *See* Ex. G.
[21] Ex. G.
[22] Ex. E.
[23] Ex. E.
[24] Ex. D.
[25] Exs. E and F5.
[26] Ex. F5.
[27] Ex. H. *See* Minn. Stat. § 14.116.

26. On December 27, 2010, the Board published the Notice of Hearing in the State Register at 35 SR 942.[28]

27. The hearing on the proposed rules was held on February 16, 2011, at the Minnesota Board of Chiropractic Examiners. During the hearing, the Administrative Law Judge informed the Board that it would need to place all of the documents enumerated in Minn. R. 1400.2220 into the hearing record, and the record would remain open for the Board's submission. A representative sample of comments received from members of the public regarding the proposed rules was available for inspection during the hearing, as were the affidavits prepared by four members of the Board (Exhibit L). On February 17, 2011, the Board filed the following documents for inclusion in the hearing record:

A. the Request for Comments as published in the State Register on December 7, 2009 (34 State Reg. 825) with six public comments received in September 2010;[29]

B. a copy of the proposed rules dated November 30, 2010, including the Revisor's approval;[30]

C. a copy of the SONAR.[31]

D. the Certificate of Mailing a copy of the SONAR to the Legislative Reference Library on December 14, 2010;[32]

E. a copy of the Board's letter to Chief Administrative Law Judge Raymond Krause dated April 7, 2010, requesting approval of its Additional Notice Plan; a copy of Administrative Law Judge Eric Lipman's April 19, 2010, letter approving the Board's additional notice plan; a copy of the Board's December 2, 2010, letter requesting Chief Judge Krause to schedule a hearing on the proposed rules and enclosing the Board's Dual Notice and SONAR; and a copy of the December 10, 2010, letter from Administrative Law Judge Barbara L. Neilson approving the Board's Dual Notice.[33]

F. a copy of the Board's Dual Notice as published in the State Register on December 27, 2010 (35 SR 942).[34]

G. a Certificate attesting to the accuracy of the Board's mailing list; a Certificate attesting that the Dual Notice was mailed to all persons and associations on the Board's rulemaking list; a Certificate attesting that the Dual Notice and SONAR were posted on the Board's website pursuant to

[28] Ex. F.
[29] Ex. A.
[30] Ex. B.
[31] Ex. C.
[32] Ex. D.
[33] Ex. E.
[34] Ex. F-2.

the Board's Additional Notice Plan; and a Certificate that a link to the Dual Notice and proposed rules was emailed to all active, inactive, and suspended licensees in accordance with the Board's Additional Notice Plan.[35]

H. a copy of the memorandum from Jim King, Executive Budget Officer for Minnesota Management & Budget, regarding the fiscal impact and benefits of the proposed rules with respect to local governments;[36]

I. a copy of the Board's transmittal letter to the Chair of the Senate Health & Human Services Budget Committee, the Chair of the House Health Care and Human Services Reform Committee, the Chair of the House Health Care and Human Services Finance Committee, and the Director of the Legislative Coordinating Commission, enclosing the Board's Dual Notice, SONAR, and Proposed Rules.[37]

J. copies of public comments and hearing requests received from members of the public before the public hearing;[38]

K. a Certificate attesting to the Board's mailing of the Notice of Hearing to those who requested a hearing;[39] and

L. Affidavits from Board Members Richard R. Tollefson, D.C.; Teresa L. Marshall, D.C.; Matthew J. Anderson, D.C.; and Robert Daschner, D.C., supporting the proposed rules and commenting on the costs associated with the rules.[40] These affidavits were available during the hearing and were also placed on the Board's website.

28. Under Minn. Stat. § 14.116, an agency is required to give notice of proposed rules to both the chairs *and* the ranking minority members of the legislative policy and budget committees with jurisdiction over the subject matter of the proposed rules, Here, the Board certified that it provided proper notice to the chairs of those committees, but did not provide any evidence that it gave notice to the ranking minority members. The Board's apparent failure to provide notice of the proposed rules to the ranking minority members constitutes a procedural defect in these rules. However, it is evident that the Board provided notice of the rules to the Legislative Coordinating Commission and also broadly disseminated notice to members of the public. Moreover, there is no evidence that the oversight deprived any person or entity of an opportunity to participate meaningfully in the rulemaking process. Under the circumstances, the Administrative Law Judge concludes that the Board's failure to notify the ranking minority members of the relevant legislative committees constituted a harmless error under Minn. Stat. § 14.15, subd. 5(1).

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[35] Ex. F-3, F-4, F-5 and F-6.
[36] Ex. G.
[37] Ex. H.
[38] Exs. I and J.
[39] Ex. K.
[40] Ex. L.

29. The Administrative Law Judge finds that in all other respects the Board met the procedural requirements under applicable law and rules.

Additional Notice

30. Minn. Stat. §§ 14.131 and 14.23 require that the SONAR contain a description of the Board's efforts to provide additional notice to persons who may be affected by the proposed rules. The Board submitted an additional notice plan to the Office of Administrative Hearings. The additional notice plan was reviewed and approved by Judge Lipman on April 19, 2010. In addition to notifying persons on the rulemaking mailing list maintained by the Board, the Board represented that it would post the Dual Notice and draft rule language on its website and send the Dual Notice and draft rule language by e-mail to "all active, inactive, and suspended licensees that have an email address registered with the Board."[41] During the rulemaking proceeding, the Board certified that the Dual Notice, SONAR and proposed rule language had been posted on its website and that the Dual Notice and proposed rules had been sent via e-mail to all active, inactive, and suspended licensees with an e-mail address listed with the Board.[42]

31. In its post-hearing comments, the Board stated that it held public meetings on the proposed rule for over a year, beginning in September 2009 and ending in November 2010, and that it e-mailed notification of the proposed rule to over 2600 licensed chiropractors on December 23, 2010.[43]

32. The Administrative Law Judge finds that the Board has fulfilled its additional notice requirements.

Statutory Authority

33. The general statutory authority of the Board to adopt or amend rules is set forth in Minn. Stat. § 148.08, which authorizes the Board to

> promulgate rules necessary to administer sections 148.01 to 148.105 to protect the health, safety, and welfare of the public, including rules governing the practice of chiropractic, and defining terms, whether or not used in sections 148.01 to 148.105, if the definitions are not inconsistent with the provisions of 148.01 to 148.105.[44]

34. The Administrative Law Judge concludes that the Board has general statutory authority under Minn. Stat. § 148.08 to adopt the proposed rules.

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[41] Ex. E.
[42] Exs. F-5 and F-6
[43] Board's March 7, 2011, Response to Comments at 9; Ex. M-1 (Testimony of Dr. Spicer) at 1.
[44] SONAR at 2 *citing* Minn. Stat. § 148.08.

Impact on Farming Operations

35. Minn. Stat. § 14.111 imposes an additional requirement calling for notification to be provided to the Commissioner of Agriculture when rules are proposed that affect farming operations. In addition, where proposed rules affect farming operations, Minn. Stat. § 14.14, subd. 1b, requires that at least one public hearing be conducted in an agricultural area of the state.

36. There is no evidence that the proposed rules affect farming operations. Accordingly, the Administrative Law Judge concludes that the Board was not required to notify the Commissioner of Agriculture.

Regulatory Analysis in the SONAR

37. Minn. Stat. § 14.131 requires an agency adopting rules to consider seven factors in its Statement of Need and Reasonableness. Each of these factors, and the Board's analysis, are discussed below.

38. The first factor requires "a description of the classes of persons who probably will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule." In its SONAR, the Board stated that the classes of persons that will be affected by the proposed rules will be doctors of chiropractic and their patients who use prepayment plans and/or health care credit cards to pay for chiropractic care.[45] The discussion of this factor in the SONAR did not specifically address the classes of persons who will bear the costs or the classes who will benefit from the proposed rule.

39. The second factor requires consideration of "the probable costs to the agency and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues." In the SONAR, the Board states that it is the only agency responsible for implementing and enforcing the Board's rules. It acknowledges that it may incur minimal additional costs associated with enforcing the proposed rule's new requirements, but it believes its annual budget of $160,000 for expenses relating to legal services provided by the Office of the Attorney General should be sufficient. Moreover, the Board contends that over time the new requirements should reduce complaints and enforcement costs by clarifying the criteria under which doctors of chiropractic may implement these prepayment plans. The Board also states that the proposed rules will have no impact on the State's general fund since the Board receives an appropriation for its budget from the State's special revenue fund.[46]

40. The third factor requires "a determination of whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule." The

[45] SONAR at 10.
[46] SONAR at 10-11.

Board stated in the SONAR that there were no less costly or less intrusive methods available to bring about the proposed changes other than rulemaking by the Board.[47]

41. The fourth factor requires "a description of any alternative methods for achieving the purpose of the proposed rule that were seriously considered by the agency and the reasons why they were rejected in favor of the proposed rule." The Board states in its SONAR that it considered no other methods for achieving the purpose of the proposed rule. While the Board concedes that some of the objectives of the proposed rule may be achieved through education and outreach, the Board asserts that these efforts are costly and yield inconsistent results. The Board maintains that only by establishing standards and criteria in rule will the public be sufficiently protected.[48]

42. The fifth factor specifies that the agency must assess "the probable costs of complying with the proposed rule, including the portion of the total costs that will be borne by identifiable categories of affected parties, such as separate classes of governmental units, businesses, or individuals." In the SONAR, the Board merely stated that it "anticipates minimal costs will be associated in complying with this rule amendment to any affected party and certainly no costs would meet [the $25,000 threshold referenced in Minn. Stat. § 14.127]."[49]

43. In a written comment and in oral testimony at the hearing, Dr. Todd Crabtree objected to the Board's lack of analysis regarding the potential costs of complying with the proposed rules. Dr. Crabtree contends that the costs of complying with the rule could run as high as $25,000 for an individual practice. Dr. Crabtree bases this amount on the cost of purchasing sophisticated billing software, which he estimates to be in excess of $10,000, and the need to increase staff hours or hire additional staff to perform the new accounting requirements. Dr. Crabtree predicts that these costs will be prohibitive for some clinics and that they will simply choose not to offer prepay plans.[50] Numerous other individuals noted that they agreed with the concerns raised by Dr. Crabtree.[51]

44. In a similar comment and testimony at the public hearing, Dr. Jeffrey Danielson stated that the proposed rule will force him to hire another staff member to manage the different accounts and track all the charges and deposits. According to Dr. Danielson, the cost of adding a new employee will be "upwards of $25,000 per year" and he estimates new billing software will cost approximately $500 to $1,000.[52]

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[47] SONAR at 11.
[48] SONAR at 12.
[49] SONAR at 13.
[50] Exs. I-1 and 4; Hearing Testimony of Dr. Crabtree.
[51] *See, e.g.,* Exs. I-1 (Dr. Erin Anderson), I-6 (Dr. David Butler), I-12 (Dr. Jeff Danielson), I-17 (Dr. Scott Halida), I-20 (Dr. Jeremy Heidt), I-21 (Dr. Trent Iverson), I-23 (Dr. Brenda Kress), I-31 (Dr. Kyle Nye), I-32 (Dr. Dave Phillips), I-43 (Drs. Warren and Heidi Zook), J-30 (Dr. Jeffrey McComb); Public Ex. 7 (Tory Robson).
[52] Public Ex. 37; Hearing Testimony of Dr. Danielson. *See also* Ex. 46 (Dr. Derek Fisher).

45. Several other individuals objected in written submissions and hearing testimony to the costs that they believe will be incurred if the proposed rules are adopted. For example, Dr. Brian Tasky asserted that the proposed rule will result in burdensome administrative costs for chiropractors. Dr. Tasky noted that chiropractors typically run very small businesses and many have no staff at all.[53] Similarly, Dr. Barbara Kaiser stated that the proposed rule will require chiropractic clinics to overhaul their billing software, accounting practices, and daily paperwork. Dr. Kaiser maintained that chiropractors will either have to hire staff to perform the new administrative duties, or reduce their patient care hours to do the tasks themselves. In her view, either option will result in lost revenue to the chiropractor.[54]

46. In his hearing testimony on behalf of the Board, Dr. Larry Spicer, the Board's Executive Director, addressed the costs associated with the proposed rules. He indicated that the costs for establishing an escrow account would likely run between $0 and $50 per month, depending on the bank, plus additional costs to print checks and deposit receipts that he projected would not exceed $200.[55] He provided print-outs from the websites of TCF Bank, Bremer Bank, Wells Fargo, FirstBank, Bank of America, and Affinity Plus Federal Credit Union in support of this estimate.[56] Dr. Spicer pointed out that the statutes applicable to rulemaking do not require an agency to undertake a formal "cost study."[57] Dr. Spicer and the Board reject Dr. Crabtree's assertion that highly sophisticated (and expensive) billing software is necessary to comply with the rules. Instead, the Board maintains that basic accounting/billing systems that most clinics already have in place are sufficient to calculate the amount of prepay fees to refund to a patient who terminates the plan earlier. And the Board insists that the hiring of additional staff would not be necessary. For all of these reasons, the Board contends that there are no requirements in the proposed rules that would force businesses to pay in excess of $25,000 in the first year.[58]

47. Dr. Howard Fidler, a licensed chiropractor and Board member, also provided testimony in support of the proposed rules at the hearing. Dr. Fidler indicated that most chiropractic offices already use computer programs to manage their financial accounts, and asserted that these programs are easy to operate and can quickly be modified. He also stated that it is very easy with basic billing software to keep an accurate account of patients' services and funds. He testified that his clinic would not need any additional software or staff to carry out the requirements of the proposed rules. In addition, he estimated that it would cost no more than $20 per month to open and maintain an escrow account. In his opinion, the costs associated with the proposed rules would be marginal and would not approach $25,000 in the first year.[59]

48. During the hearing, the Board also entered into the record affidavits from four Board members (Richard R. Tollefson, D.C.; Teresa L. Marshall, D.C.; Matthew J.

[53] Public Ex. 24; *see also* Hearing Testimony of Dr. Jeff McComb.
[54] Public Ex. 20.
[55] Ex. M-1 (Testimony of Dr. Spicer) at 6.
[56] Ex. O.
[57] Ex. M-1 at 6.
[58] Ex. M-1 at 5-8.
[59] Ex. M-2.

Anderson, D.C.; and Robert Daschner, D.C.) who supported the proposed rules and commented on the costs associated with the rules. These Board members disagreed with Dr. Crabtree's claim that the costs of complying with the rule could run as high as $25,000 for the first year. In their opinion, the only possible costs will be minimal and well under $25,000 per year. For example, Dr. Tollefson indicated that the accounting software necessary for prepay plans needs to be in place regardless of the rule, and estimated that the cost of an escrow banking accounting could range from $0 to $500 per year.[60] Dr. Marshall stated that it is very easy to modify software to keep track of charges and payments. She does not believe that additional office staff would be necessary to implement the proposed rules and estimated that the cost of opening an additional bank account would be minimal.[61] Dr. Anderson indicated that his office would not require any additional staff or any new software to implement and maintain compliance with the proposed rule, and estimated that there would be no cost to open and maintain an additional bank account.[62] Dr. Daschner asserted that the proposed rules would not place an undue burden on chiropractic offices. He indicated that he purchased a chiropractic business office software program several years ago for less than $3,000 and did not anticipate the proposed rules would require any changes or updates to that software or require significant additional staff. He noted that his current business account banking fees were approximately $250-$350 per year and anticipated that the cost associated with opening an additional bank account to manage the escrowed funds would be fairly minimal.[63]

49. The sixth factor requires a description of "the probable costs or consequences of not adopting the proposed rule, including those costs or consequences borne by identifiable categories of affected parties, such as separate classes of government units, businesses, or individuals." In the SONAR, the Board notes that it has received numerous complaints regarding prepayment plans and it anticipates that such complaints will only increase if the criteria and limitations established by proposed rules are not adopted.[64]

50. The seventh and final factor requires "an assessment of any differences between the proposed rule and existing federal regulations and a specific analysis of the need for and reasonableness of each difference." In the SONAR, the Board noted that federal regulations are not a consideration because the federal government is not involved in licensing doctors of chiropractic.[65]

51. The Administrative Law Judge finds that the Board's SONAR did not adequately identify the classes of persons who will bear the costs of the proposed rules and the classes who will benefit from the proposed rules, as required by the first regulatory factor, or adequately assess the probable costs to individuals and businesses of complying with the proposed rules in its SONAR, as required by the fifth regulatory

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[60] Ex. L-1.
[61] Ex. L-2.
[62] Ex. L-3.
[63] Ex. L-4.
[64] SONAR at 13.
[65] SONAR at 5.

factor. This constitutes a procedural defect in the rules. The Administrative Law Judge concludes, however, that this was a harmless error under Minn. Stat. § 14.15, subd. 5(2), because the Board took corrective action to cure the defect by addressing who will bear the costs and receive the benefits of the proposed rules more fully during the hearing, and there is no evidence that the Board's failure to include a more detailed discussion of anticipated costs and benefits in the SONAR deprived any person or entity of an opportunity to participate meaningfully in the rulemaking process. The Administrative Law Judge further concludes that the Board has adequately considered the other regulatory factors required by Minn. Stat. § 14.131.

Performance-Based Regulation

52. The Administrative Procedure Act also requires that an agency describe in its SONAR how it has considered and implemented the legislative policy supporting performance-based regulatory systems set forth in Minn. Stat. § 14.002.[66] A performance-based rule is one that emphasizes superior achievement in meeting the agency's regulatory objectives and maximum flexibility for the regulated party and the agency in meeting those goals.[67]

53. In its SONAR, the Board indicated that, in developing the proposed rules, it attempted to draft criteria and restrictions narrowly and with as much flexibility as feasibly possible to still meet its objectives of protecting the public's interests with respect to prepayment plans.[68] In his hearing testimony, Dr. Larry Spicer stated that instead of prohibiting the practice of prepay plans altogether, the Board chose to regulate those plans valued at $1,000 or more.[69]

54. The Administrative Law Judge finds that the Board has met the requirements set forth in § 14.131 for assessing the impact of the proposed rules, including consideration and implementation of the legislative policy supporting performance-based regulatory systems.

Consultation with the Commissioner of Management and Budget

55. Under Minn. Stat. § 14.131, the Agency is also required to "consult with the commissioner of management and budget to help evaluate the fiscal impact and fiscal benefits of the proposed rule on units of local government."

56. The Board consulted with the Office of Management and Budget, and in a response dated August 3, 2010, the Minnesota Management and Budget's Executive Budget Officer Jim King concluded that the proposed rules "will have no fiscal impact on local units of government."[70]

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[66] Minn. Stat. § 14.131.
[67] Minn. Stat. § 14.002.
[68] SONAR at 15.
[69] Ex. M-1 (Testimony of Dr. Spicer) at 10-11.
[70] Ex. G.

57. The Administrative Law Judge finds that the Board has met the requirements set forth in Minn. Stat. § 14.131.

Compliance Costs for Small Businesses and Cities

58. Under Minn. Stat. § 14.127, the Board must "determine if the cost of complying with a proposed rule in the first year after the rule takes effect will exceed $25,000 for: (1) any one business that has less than 50 full-time employees; or (2) any one statutory or home rule charter city that has less than ten full-time employees." The Board must make this determination before the close of the hearing record, and the Administrative Law Judge must review the determination and approve or disapprove it.

59. The Board's SONAR included a single sentence which addressed both the fifth regulatory factor and the requirements of Minn. Stat. § 14.127. In that sentence, the Board merely stated in conclusory fashion that it "anticipates minimal costs will be associated in complying with this rule amendment to any affected party and certainly no costs would meet those thresholds."[71]

60. As noted above in Findings 43-45 above, several Doctors of Chiropractic objected during this rulemaking proceeding to the Board's minimal analysis of costs in the SONAR and contended that the actual costs associated with the proposed rules would be much higher. However, as reflected in Findings 46-48 above, the Board provided further explanation and documentation in support of its cost assessment during the hearing, in response to comments from those opposed to the proposed rules.

61. The Administrative Law Judge finds that, by the close of the record the Board did make the determination required by Minn. Stat. § 14.127, subd. 1, and approves its determination that costs of compliance for small businesses and cities will not exceed the cost threshold established by that statute. It is evident that the costs of establishing and maintaining an escrow account will be nominal, and the Administrative Law Judge is not persuaded that costs associated with additional staff time or with purchasing or upgrading a computer billing program will exceed $25,000 for a chiropractor's business in the first year after the rules are effective.

Adoption or Amendment of Local Ordinances

62. Under Minn. Stat. § 14.128, the agency must determine if a local government will be required to adopt or amend an ordinance or other regulation to comply with a proposed agency rule. The agency must make this determination before the close of the hearing record, and the Administrative Law Judge must review the determination and approve or disapprove it.[72]

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[71] SONAR at 13.

[72] Minn. Stat. § 14.128, subd. 1.

63. The Board concludes that the proposed rules will have no effect on any division of local government that would require the adoption or amendment of an ordinance or other regulation to comply with the rules.[73]

64. The Administrative Law Judge finds that the Board has made the determination required by Minn. Stat. § 14.128 and approves that determination.

Analysis of the Proposed Rules

65. This Report is limited to discussion of the portions of the proposed rules that received critical comment or otherwise need to be examined; it will not discuss each comment or rule part. Persons or groups who do not find their particular comments referenced in this Report should know that all comments, including those made prior to the hearing, have been carefully read and considered.

66. The proposed rule sets out criteria for the creation and implementation of prepayment chiropractic plans. The Board defines "prepay plans" as any agreement between a chiropractor and patient for a course of future chiropractic treatment services for which payment in an amount of $1,000 or more is collected in advance of the services.

67. The proposed rule would require chiropractors to establish escrow accounts for prepay plan fund deposits, require prepay plans to be in writing, limit the number of treatment visits per plan, prohibit additional billing to a third-party payor, and provide the right to early cancellation and refund of unused payments.

68. Prior to the hearing, the Board received a number of general comments from practitioners in the field. These commentators stressed that prepay plans provide patients the option of paying for a course of treatment in advance, at a discounted rate. According to the commentators, such plans make chiropractic treatment more affordable for the patients and ensure doctors' reimbursement. Many of those filing comments expressed concern that the proposed rules will place unnecessary limits and burdensome administrative requirements on their ability to continue offering prepay plans to their patients.[74] Likewise, several chiropractors testified at the hearing that their patients are very satisfied with prepay plans and view these plans as an affordable and cost-effective way to obtain chiropractic care.[75]

69. The Board also received comments throughout the rulemaking proceeding from patients who like the option of being able to prepay for chiropractic care. These patients stated that prepaying allows them to budget for and afford chiropractic care, which is typically an out-of-pocket expense due to limited insurance coverage. They also stated that they like the convenience of being able to visit the chiropractor

[73] SONAR at 15.
[74] Ex. I and Ex. J-27.
[75] *See, e.g.*, Hearing Testimony of Timothy Guthman, Nathan Saj, and Liz Raymond (student).

whenever needed without the worry or hassle of paying for each treatment on the date it is provided.[76]

70. In a written comment submitted February 28, 2011, the Minnesota Chiropractic Association (MCA) stated its opposition to the rules as proposed. The MCA maintains that the rules are not necessary, as only a small number of complaints have been filed with the Board regarding prepay plans. The MCA also contends that rather than promulgating rules with detailed administrative requirements, the Board should simply issue guidelines or advisory opinions regarding prepay plans to licensed chiropractors via its webpage and newsletter.[77] This sentiment, that the Board should issue guidelines or opinions, was also expressed by Dr. Todd Crabtree and Kathleen Gergen-Mandel. In contrast, Dr. John Reid submitted a written comment in support of the proposed rules,[78] and Dr. Robert Staeheli testified at the hearing that he strongly supports the proposed rule and commended the Board for setting clear standards of ethical conduct.

71. During the hearing and in its post-hearing comments, the Board responded that it does not have authority under the rules to issue guidelines or advisory opinions. It also pointed out that doing so may be viewed as unpromulgated rulemaking and could be contested on that basis by licensees. Moreover, the Board stated that results of articles or guidance published on its webpage and newsletter are often uneven based on readership, whereas the rules will apply to the entire licensed community.[79]

72. The Board further demonstrated that, since 2005, it has seen an increase in the number of complaints from patients regarding prepay plans. The complaints typically concern the alleged failure of a chiropractor to fully refund a patient's unused portion of prepay funds when that patient elects to terminate a prepay plan early. According to Dr. Larry Spicer, the Board received 6 complaints regarding prepay plans during calendar years 2005-2007, and 39 complaints regarding prepay plans in 2008-2010. Moreover, the Board noted that complaints and concerns regarding prepay plans have grown nationwide. The Board points out that Dynamic Chiropractic, the profession's leading newspaper, ran a series of articles on the subject of prepay plans in the mid-1990s. In addition, the Federation of Chiropractic Licensing Board's (FCLB) Fraud Prevention Committee published a paper in 2006 on the subject of prepay plans. The Committee focused on the increase in complaints regarding "poor reimbursement management" in the event of early termination of plans by patients. The Committee concluded that patients should have full disclosure of how the plans work, including reimbursement in the event of early termination, and recommended that patients' monies be placed in an escrow account to prevent co-mingling with other funds. The

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[76] *See, e.g.*, Public Exs. 2 (Susan Parsons), 3 (Misty Marshall), 12 (JoAnn Fager), 13 (Donna Miller), 14 (Norman Christiansen), 33 (Nancy Bonkoski), 35 (Shauna Voigt), 36 (Ruth Erkkila), 47 (Marty, Selena, Yilana and Leila Pagano and Paul and Rosalind Watkins), 48 (Kathy Fiedler), 49 (Ronn and Carrie Rockensock), 50 (Ann Tanko and Kellee, Marty, Maddox, and Mavin Knutson), and 52 (Jeff Duncan, Kim Ranweiler, Kyle and Johanna Puelston, Robert & Deanna Dennis, and Rick Smisson).

[77] Public Ex. 41. *See also* Public Exs. 29 and 32.

[78] Ex. I-36.

[79] Board's March 7, 2011, Response Comments at 4; Ex. M at 5-6 (Test. of Spicer).

Board also pointed out that some states have gone so far as to prohibit prepay plans entirely.[80]

73. The Board contends that the proposed rule is needed to provide clear standards to licensed chiropractors on how prepay plans may be implemented. The goal of the proposed rule is to provide written disclosure to the patient regarding the terms of the prepay plan and to safeguard the patient's money in a separate escrow account.[81]

74. The Administrative Law Judge finds that the Board has proper discretion and authority to choose to adopt rules governing prepay plans rather than follow another approach.

75. The Administrative Law Judge finds that the Board has demonstrated, by an affirmative presentation of facts, the need for and reasonableness of all rule provisions not specifically discussed in this Report. The Administrative Law Judge also finds that all provisions not specifically discussed are authorized by statute and there are no other problems that would prevent the adoption of the rules.

Part-by-Part Analysis of Proposed Part 2500.7000 – Prepay Plans

Minn. Rule 2500.7000, Subpart 1

76. The Board has proposed describing "Prepay plans" at Subpart 1 as follows:

> Subpart 1. **Description**. Any arrangement between a chiropractor and a patient for the purposes of entering into an agreement for a course of future treatment for which funds in an amount of $1,000 or more is collected in advance of these services shall be considered a prepay plan within the meaning of this part. Prepay plans shall include a written statement describing all fees for services, goods, appliances, supplements, or any other benefit considered part of the plan.

77. In its SONAR, the Board states that it considers $1,000 to be a reasonable threshold for triggering the requirements of this proposed rule. According to the Board, prepay plans for services valued under $1,000 are typically short-term treatment regimens and rarely result in disputes over termination of the plan or reimbursement.[82]

78. A number of individuals commenting on the proposed rules questioned the rationale for establishing the $1,000 threshold. David Wulff, Attorney at Law, commented that the rule and its requirements should apply to all prepay plans and not just those in an amount of $1,000 or more. Mr. Wulff stated that it makes no sense to withhold the rule's safeguards from patients who prepay $999 to a doctor. According to Mr. Wulff, if the doctor is honest and the plan legitimate, he or she should have no

[80] Ex. M-1 (Test. of Spicer) at 3-4, 9-10.
[81] Ex. M-1 (Testimony of Dr. Spicer) at 3-5; Board's March 7, 2011, Post-Hearing Response at 1-2.
[82] SONAR at 8.

qualms about conforming to the rule's requirements.[83] Dr. Cathi Hammond similarly commented that the proposed rules should apply to all prepay plans and not just those over $1,000.[84]

79. In his testimony at the hearing, Dr. Larry Spicer stated that the $1,000 threshold and the 50-visit limit per plan were "established strictly for the purpose of limiting the patient's potential loss, should there be a dispute as to plan termination procedures." He noted that, during the course of drafting the rule language, the Board heard from chiropractors who offer prepay plans valued at under $1,000 (such as 10-visit plans for $600). These smaller plans rarely result in complaints to the Board. Instead, the complaints most frequently received by the Board involve disputes over much larger sums of money. Accordingly, the Board determined that setting $1,000 as the threshold amount for triggering the rule requirements would best serve the needs of patients, chiropractors and the Board.[85]

80. The Administrative Law Judge finds that the $1,000 threshold is consistent with the Board's goal of protecting patients while minimizing the administrative burden on chiropractors who offer smaller prepay plans. Accordingly, it is concluded that the Board has demonstrated the need for and reasonableness of the proposed $1,000 threshold.

81. Mr. Wulff also suggested that the Board define the words "services, goods, appliances, supplements" and "benefit" used in Subpart 1. He further noted that Subpart 2 of the proposed rules only refers to "services, goods or appliances," and Subpart 3 only refers to "services," and recommended that the Board be consistent in its use of this terminology throughout the rule to avoid confusion.[86] The Board did not provide any response to Mr. Wulff's suggestions. No one else suggested that the terms used in the proposed rules require definition. The Administrative Law Judge concludes that neither the failure to define these terms in the proposed rules nor the use of slightly different terminology in Subparts 1, 2, and 3 renders the rules defective. However, in the interests of consistency, the Board is urged to use the same terminology throughout the rule.

82. Mr. Wulff commented generally that the rule should prohibit chiropractors from offering discounts in connection with prepay plans. He contends that such discounts violate federal Medicare/Medicaid "anti-kickback" statutes, as well as state law (Minn. Stat. § 62J.23), and unduly influence prospective patients to purchase health care services.[87] In its post hearing comments, the Board stated that it takes no position on the legality of chiropractors offering discounts to patients who prepay for a course of treatment. The Board notes that its proposed rule makes no reference to discounts and therefore it is not in conflict with federal or state law.[88] The Administrative Law Judge

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[83] Ex. I-41.
[84] Ex. I-18.
[85] Ex. M-1 (Testimony of Dr. Spicer) at 9.
[86] Ex. I-41.
[87] Ex. I-41.
[88] Board's March 7, 2011, Response Comments at 7.

agrees with the Board's assessment, and finds no conflict between the proposed rules and state and federal law.

83. In a written comment dated January 27, 2011, Kathryn Berger, Compensation Attorney Principal, submitted a comment on behalf of the Department of Labor and Industry (DOLI). DOLI informed the Board that worker's compensation laws prohibit the use of prepaid plans when the doctor is treating a patient for a workers' compensation injury. DOLI pointed out that Minn. Stat. § 176.135, subd. 7, requires a health care provider to submit charges for treatment of a workers' compensation injury to the workers' compensation insurer or self-insured employer, along with medical records or reports that substantiate the nature of the charge and its relationship to the work injury. The statute further provides, "[a] health care provider shall not collect, attempt to collect, refer a bill for collection, or commence an action for collection against the employee, employer, or any other party until the information required by this section has been furnished." The insurer is required to pay or deny the charges within 30 days of receiving all required information.[89] According to DOLI, entering into prepay plans for treatment of a workers' compensation injury would be prohibited by Minn. Stat. § 176.135, subd. 7, because the chiropractor would be collecting payment from the employee before submitting the charges to the insurer.[90]

84. To ensure that chiropractors who enter into prepay agreements with their patients do not inadvertently violate the workers' compensation law, DOLI recommended that the subtitle of Subpart 1 be changed from "Description" to "Scope," and that the following sentence be added to the end of Subpart 1: "A chiropractor shall not offer, enter into, or continue a prepay plan where one is prohibited by law." The Administrative Law Judge finds that the failure of the proposed rules to include the language recommended by DOLI does not render them defective. DOLI's proposed additional language would merely state the obvious—that persons must not violate the law—and does not add any clarity or guidance to the proposed rules.

85. The Administrative Law Judge concludes that the Board has demonstrated that Subpart 1 is needed and reasonable to define what types of arrangements are encompassed within the term "prepay plan" and are thus subject to the rule. The Board has also presented a rational basis for applying the provisions of the proposed rule only to prepay plans costing $1,000 or more.

86. While there is no defect in the language of Subpart 1 as proposed, the Administrative Law Judge recommends that the Board consider revising Subpart 1 as follows:

> Subpart 1. **Description.** Any arrangement or agreement between a chiropractor and a patient ~~for the purposes of entering into an agreement~~ for a course of future treatment for which funds in an amount of $1,000 or more is collected in advance of these services shall be considered a prepay plan within the meaning of this part. ~~Prepay plans shall include a~~

[89] Minn. Stat. § 176.135, subd. 6; Minn. R. 5221.0600.
[90] Ex. I-2.

~~written statement describing all fees for services, goods, appliances, supplements, or any other benefit considered part of the plan.~~

The suggested revision would improve the readability of the rule and limit the language to that needed to describe the types of plans covered by the rules. The Administrative Law Judge recommends that the second sentence be deleted as unnecessary, since Subpart 3 of the proposed rules requires that plans be in writing and list the covered services. The Administrative Law Judge finds that the above modifications would not render Subpart 1 substantially different that the rules as originally proposed.

Minn. Rule part 2500.7000, Subpart 2

87. Subpart 2 requires that any payments made in advance of services rendered be deposited into a separate designated escrow account. As originally proposed, Subpart 2 stated:

Subp. 2. **Escrow account.**

A. Any funds received as part of a prepay plan shall be deposited into a separate designated escrow account, and shall not be commingled with a chiropractor's personal or business account.

(1) All instruments, including checks and deposit slips, shall bear the phrase "Escrow Account."

(2) The chiropractor shall maintain a clear accounting of all funds received, including the date and from whom the funds were received.

(3) The chiropractor shall maintain a clear accounting of all disbursements including the dates and to whom the disbursements were made, and to which patient the disbursements are to be applied or accounted for.

(4) If the account is an interest-bearing account, the interest shall be applied to the patient's balance. In the event of early termination, the patient shall be provided with a pro rata share of the interest.

B. Funds may only be transferred out of the escrow account for the following reasons:

(1) After services, goods, or appliances have been provided to the patient, and only in the amounts specifically related to the services, goods, or appliances provided.

(2) To reimburse the patient any amounts owed following a notice by either the patient or the chiropractor to terminate

the prepay plan. Any amounts shall be transferred according to the written agreement.

C. The chiropractor shall cause a reconciliation of the escrow account to be made no less than quarterly, and shall retain a copy of the reconciliations and all supporting documents for no less than seven years.

88. In the SONAR, the Board stated that the proposed escrow requirement will ensure that chiropractors maintain sufficient funds in a separate account to reimburse those patients who elect to terminate prepay plans earlier.[91]

89. Dr. Josh Watkins[92] and several other individuals who commented on the proposed rules stated that the language of the proposed rule was unclear regarding whether chiropractors would be required to establish separate escrow accounts for each individual patient who enters into a prepay plan valued at over $1,000, or whether they would be permitted to set up one escrow account for all patients with prepay funds of $1,000 or more.

90. In its response comments, the Board clarified that its intent was for chiropractors to establish one escrow account for all of their patients' prepay funds, and not to require that a separate escrow account be created for each patient.[93]

91. Some of those who commented on the proposed rules provided some support for the ease with which an escrow account could be maintained. For example, Margo Davis, business administrator for Dr. Amy Wilcockson's office, testified during the hearing that her office handled escrow accounts all the time and indicated that it was no problem. Lori Goodsell, D.C., acknowledged in her testimony that escrow accounts were a great idea and were easy to maintain. And Jennifer Zea, D.C., filed a written comment in which she also supported placing prepay funds into a separate escrow account.[94]

92. Numerous other individuals objected to the requirement that chiropractors place prepay plan funds in a separate escrow account. Dr. Josh Watkins commented that even if the rule is intended to require that only one escrow account be established per clinic for all prepayment patients, the accounting requirements will be burdensome.[95] Similarly, Jason Gerard, D.C., stated that having to create escrow accounts for prepay plans of $1,000 or more will be overly onerous for chiropractors and potentially will require the hiring of additional employees to carry out the accounting requirements, such as determining interest distribution and conducting quarterly reconciliations.[96] Dr. Jason Baker estimated that it will cost him an additional $1,500 a year to have an accountant manage an escrow account in accordance with the

[91] SONAR at 6.
[92] Public Ex. 15 (Dr. Josh Watkins).
[93] Board's March 7, 2011, Response Comments at 9.
[94] Public Ex. 53.
[95] Public Ex. 15.
[96] Ex. I-15. *See also*, Ex. J-2 (comment from Dr. Jamy Antoine).

proposed rule. [97]Dr. Jamy Antoine also contended that the proposed rule would place a substantial financial burden on chiropractic clinics throughout the state. In Dr. Antoine's view, the accounting and escrow requirements associated with the proposed rules will require chiropractors to purchase billing software and hire at least one full time accounting specialist to track payments, charges, insurance co-payments, and interest accrual.[98] Dr. Brian Boyd and Dr. Paul Moon also objected to the burdens imposed by the escrow account requirement. Dr. Boyd maintained that such a requirement is unnecessary given the requirements under Subpart 3 that all prepay plans be in writing and explain in detail the reimbursement policies and formulae.[99]

93. David Wulff suggested that Subpart 2A be modified to require that chiropractors deposit the prepay funds into an interest-bearing escrow account that is insured by the FDIC to give patients an added layer of protection.[100]

94. Dr. Amy Wilcockson commented that the requirement in Subpart 2 A(4) that the refund of a patient's money in the event of an early termination must include the patient's pro-rata share of any interest earned in the escrow account would be an administrative nightmare.[101] Similarly, Representative Jim Abeler commented that requiring that interest earned on funds in the escrow account be returned to patients who cancel will add considerable complexity to recordkeeping while yielding little value to the patient in light of the small amount of interest involved.[102] In response to these post-hearing comments, the Board stated that it will delete proposed Subpart 2 A(4), governing application of interest to patients' escrowed funds, in its entirety.[103]

95. Several of those commenting on the proposed rules questioned what the Board intended by the requirement that chiropractors "cause a reconciliation of the escrow account" quarterly.[104] For example, Representative Abeler suggested that the Board clarify what effort needs to be exerted to "reconcile" the escrow account. If the rule is merely aimed at requiring chiropractors to keep the account records up to date, Representative Abeler acknowledged that would be reasonable.[105] In its post-hearing response, the Board confirmed that the requirement in the proposed rule is simply intended to ensure that reasonable attention is paid to the account and it is not permitted to remain unreconciled indefinitely. The Board stated that the process should be no more involved than the typical business practice associated with periodic bank account reconciliation.[106]

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[97] Ex. J-3.
[98] Ex. J-2.
[99] Ex. A-2 and I-29.
[100] Ex. I-41.
[101] Public Ex. 59.
[102] Public Ex. 51; Hearing Testimony of Dr. Wilcockson.
[103] Board's March 7, 2011, Response Comments at 5.
[104] Some of those commenting on the proposed rules erroneously believed that they required a *daily* reconciliation or accounting of these monies.
[105] Public Ex. 51.
[106] Ex. M-1 at 8 (Test. of Spicer).

96. The Administrative Law Judge finds that Subpart 2, as modified by the Board, has been shown to be needed and reasonable. The Administrative Law Judge finds the requirement that chiropractors deposit prepay plan funds into an escrow account and "reconcile" the account quarterly to be needed and reasonable. Separating the patients' money from the chiropractor's personal or business account is a reasonable safeguard and one that many professions require to limit clients' exposure to financial loss. The Administrative Law Judge also concludes that the Board's decision to delete the original requirement in Subpart 2 A(4) that the escrow account bear interest and that practitioners provide a pro rata share of the interest to the patient in the event of a refund to be needed and reasonable. This modification was made by the Board in response to persuasive comments by members of the regulated public, and avoids the creation of a situation in which a significant administrative burden is imposed on chiropractors with limited benefit for patients.. The Administrative Law Judge concludes that the modification does not render the subpart substantially different from the rules as originally proposed.

97. Although the language of Subpart 2 as modified by the Board is not defective, the Administrative Law Judge recommends the following additional modifications be made to item A for readability and to clarify that chiropractors or clinics need only establish one FDIC-insured escrow account for all of the prepay funds they receive:

Subp. 2. **Escrow account**.

A. ~~Any~~ All funds received ~~as part of a~~ in connection with prepay plans shall be deposited into a ~~separate~~ designated escrow account insured by the FDIC, and shall not be commingled with a chiropractor's personal or business account.

(1) All instruments, including checks and deposit slips, shall bear the phrase "Escrow Account."

(2) The chiropractor shall maintain an ~~clear~~ accounting of all funds received, including the date and from whom the funds were received.

(3) The chiropractor shall maintain an ~~clear~~ accounting of all disbursements including the dates and to whom the disbursements were made, and to which patient the disbursements are to be applied or accounted for.

The further modifications suggested by the Administrative Law Judge would serve to clarify the proposed rules and would not constitute a substantial change from the rules as originally proposed.

Minn. Rule 2500.7000, Subpart 3

98. Subpart 3 requires that all prepay plans be in writing and include specific information. The subpart reads as follows:

Subp. 3. **Written plans.** All prepay plans shall be in writing, signed by both the chiropractor and the patient, with a copy provided to the patient and a copy maintained in the patient's record, and shall include at least the following:

A. A list of all services which are covered and which are not covered by the plan.

B. A list of all fees related to the services described in item A.

C. A statement that an accounting can be requested by the patient at any time. This accounting shall:

(1) be provided to the patient within 14 days of a written or verbal request;

(2) be separately initialed by the patient; and

(3) itemize all fees used to calculate any reimbursement.

D. A clear explanation of the reimbursement policies and formulae which are used in returning unused funds to the patient in the event of early termination by either the chiropractor or the patient. This explanation should be separately initialed by the patient. As part of this explanation, a representative example should be provided to the patient.

E. A clear explanation of any policy suspending the plan in the event of a new injury, such as an auto injury or worker's compensation injury. This explanation shall be separately initialed by the patient.

F. The plan shall include a provision for the patient to be notified in writing when the patient's account reaches a zero balance. This document shall be signed by both the patient and the chiropractor, with a copy given to the patient and a copy maintained in the patient's file.

99. In a written comment and testimony at the hearing, Ms. Gergen-Mandel noted that she generally agrees with the requirement that prepay plans be in writing.[107] Likewise, Dr. Jennifer Zea noted in her written comment that she favors having patients and chiropractors sign a written agreement that lays out the terms of the plan and the refund policy.[108]

100. In a post-hearing comment, Representative Jim Abeler, D.C., expressed concern regarding the requirements in Subparts 3C, 3E and 6 that patients initial certain provisions of the written plan. Representative Abeler pointed out that patients may not be able to initial documents sent electronically or come into the office and the requirement may inadvertently cause the chiropractor to be in violation of the rule.[109] In

[107] Public Ex. 29; Hearing Testimony of K. Gergen-Mandel.
[108] Public Ex. 53.
[109] Public Ex. 51.

its post-hearing response, the Board indicated that it concurred with these concerns and was merely interested in "providing a verifiable assurance that the patient was furnished with the documentation in question." The Board stated that it "will consider a modification to the language that accomplishes this goal, without limiting such assurance to a patient-initialed/signed document," but did not propose specific language changes.[110]

101. David Wulff recommended that the Board add a provision to Subpart 3 requiring that all prepay plans automatically terminate in 12 months and that any remaining funds in the escrow account be refunded to the patients. Mr. Wulff said that such a provision would protect patients from having their money tied up for extensive periods of time and it would address situations where patients simply forget that they have money remaining in their fund.[111]

102. Like Mr. Wulff, Dr. Cathi Hammond recommended that prepay plans automatically expire after 12 months and that any unused funds after 12 months be refunded to the patient within 14 days of the plan's expiration. According to Dr. Hammond, patients can start feeling better after a couple of visits and then simply forget about their unused pre-paid visits. She also expressed concern that requiring chiropractors to notify patients when their prepay plan accounts have reached a zero balance will require a lot of extra work and expense for chiropractors. She suggested that patients instead be required to affirmatively request written notification by initialing the provision at the time the patient is signing the written plan.[112] The Board did not respond to this suggestion.

103. In a written comment, DOLI recommended revising Subpart 3E to clarify that prepay plans may violate workers' compensation law when used for treatment of workers' compensation injuries,. DOLI contends that Subpart 3E of the proposed rules suggests that chiropractors have discretion to suspend prepay plans in the event of a workers' compensation injury. DOLI recommends the following revisions to ensure that chiropractors who enter into prepay agreements with patients do not inadvertently violate workers' compensation law:

> Subp. 3. **Written plans**.
>
> . . .
>
> E. A clear explanation of any policy suspending the plan in the event of a new injury, ~~such as an auto injury or workers' compensation injury~~ and a statement that the plan will be discontinued during treatment of a workers' compensation injury for which an insurer or self-insured employer is liable. This explanation and statement shall be separately initialed by the patient.[113]

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[110] Board's Post-Hearing Response at 5.
[111] Ex. I-41.
[112] Ex. I-18.
[113] Ex. I-2.

104. In response to DOLI's comments, the Board proposed to modify Subpart 3E of the rules by deleting the word "suspending" and replacing it with the word "modifying." The Administrative Law Judge agrees that it is appropriate to make this change in language, and finds that it would not render the rules substantially different from the rules as originally proposed. The Board apparently declined to make the other changes suggested by DOLI. The Administrative Law Judge concludes that the rules are not rendered defective by their failure to include DOLI's interpretation of applicable statutes and rules. The Board may, if it wishes, consider adding in Subpart 3E cross-references to applicable workers' compensation statutes and rules, and such cross-references would not constitute a substantial change.

105. The Administrative Law Judge finds as a general matter that the Board has demonstrated that it is needed and reasonable to require that prepay plans covered by the rule be in writing, signed by the chiropractor and the patient, and contain certain specified information. Because the patient is already required to sign the written plan, the Board's proposal to modify the rule to delete the requirements set forth in Subpart 3C(2) and the second sentence of Subpart 3D for the separate initialing of provisions has also been shown to be reasonable and necessary. This modification was made in response to comments received during the rulemaking proceeding and does not render the rules as finally proposed significantly different from the rules as originally proposed.

106. The Administrative Law Judge concludes that there are two defects in Subpart 3. These defects are described below.

107. First, the Administrative Law Judge concludes that Subpart 3, item A is defective because the Board has not shown that it is needed or reasonable to require that chiropractors list "*all* services . . . which are *not* covered" by the plan. That list could be virtually endless. To correct this defect, and in keeping with Mr. Wulff's earlier comment urging consistency in terminology, the Administrative Law Judge recommends that item A be revised to simply require that written prepay plans include "A list of all services, goods and appliances that are covered by the plan."

108. Second, the Administrative Law Judge finds that the last sentence in Subpart 3, item D is defective because it is impermissibly vague. As originally proposed, that sentence stated that a "representative example should be provided to the patient." The sentence is defective because it is not clear what the phrase "representative example" means and the use of the word "should" makes the act discretionary. Stating in rule that a practitioner "should" do something that is not clearly described is so indefinite as to not meet the statutory definition of "rule." To correct this defect, the Board could (1) delete the last sentence in its entirety; or (2) modify the language to explain more clearly what is meant by "a representative sample" and indicate that such a sample "shall" be provided to the patient.

109. The Administrative Law Judge further suggests that the Board consider making some wording changes to Subpart 3 to eliminate redundant terminology and clarify its provisions. In Subpart 3, item C, it is recommended that the Board replace the word "can" with the word "may." In Subpart 3, items D and E, it is suggested that the Board delete the word "clear" before the word "explanation" as unnecessary. The

Administrative Law Judge also recommends that the Board consider deleting the last sentence of Subpart 3, item F. The first sentence of item F makes it clear that the written prepay plan itself must include a provision informing the patient that he or she will be notified in writing when the account reaches a zero balance. However, the last sentence of item F implies that the explanation must be contained in a *separate* document. For this reason, it is recommended the last sentence be deleted for clarity. Finally, it is recommended that the first sentence in item F be modified to read as follows: "A provision that the patient will be notified in writing when the patient's account reaches a zero balance." This modification is suggested to ensure that the language of item F parallels that of items A-E.

110. The Administrative Law Judge also urges the Board to consider adding an item G to address the right of cancellation that is currently discussed in Subpart 6 of the proposed rules. Since the Board is proposing that the three-day right of cancellation be a required provision of the plan, it makes sense to make this clear in Subpart 3. If the Board chooses to do this, it should delete Subpart 6 and instead include language similar to the following in the new item G:

> G. A statement that the patient has the right to cancel the prepay plan without penalty within three business days of entering into the plan by submitting a written and signed cancellation form and, upon receipt of the cancellation notice, the chiropractor shall have seven days to fully refund any unused funds to the patient.

111. If the Board chooses to make the above changes recommended by the Administrative Law Judge, they would not constitute substantial changes under Minn. Stat. § 14.05, subd. 2.

Minn. Rule 2500.7000, Subpart 4

112. Subpart 4 of the proposed rules limits the number of treatments that can be included in each prepay plan but allows for renewal of the plan after it is exhausted:

> Subp. 4. **Limitation on number of service treatment dates per plan**
>
> A. No prepay plan may be based upon a package which would exceed 50 visits.
>
> B. A plan may not be renewed until the visits in the previous plan have been exhausted.

113. In the SONAR, the Board states that limiting prepay plans to 50 visits protects patients by providing them the opportunity to reevaluate whether they want to continue with care. The Board points out that nothing in the proposed rule places any cap on the total number of treatments a patient may receive from a chiropractor.

Rather, this subpart limits the number of visits per plan, and requires only that the patient and doctor renew any prepay plans after 50 visits.[114]

114. Numerous interested parties testified and provided written comments objecting to the proposed 50-visit limit per plan as arbitrary and asserting that it constituted an unlawful interference with their rights to freely contract with patients.[115] For example, in testimony given at the hearing and in a subsequent written comment, Kathleen Gergen-Mandel objected to the proposed limit because she believes the terms of a prepay agreement should be left up to the discretion of the doctor and patient. According to Ms. Gergen-Mandel, whether the prepay plan involves five visits, 50 visits or 100 visits should be of no concern to the Board.[116]

115. Some commentators misinterpreted the proposed rule provision as limiting the total number of allowable treatment visits for a *patient*, rather than simply the number of treatments encompassed under a single *plan*.[117] Other commentators questioned whether the 50-visit limit per plan applies to family plans or just to plans for single individuals. At the hearing, Dr. Laurie Goodsell testified that she treats a very athletic couple and their four children every other week. According to Dr. Goodsell, if the 50-visit limit were applied to that entire family, she would have to renew the plan frequently.[118] Others noted that the 50-visit limit per plan means that a single plan would not be long enough for a person who wants to be treated once per week for a year.[119]

116. In contrast, Mr. Wulff commented that the proposed limit of 50 treatments per plan is unduly large. He maintains that the rule should err on the side of protecting patients against being induced into agreeing to prepay excessively large amounts. He also noted that the rule does not address the amount of money a patient may prepay and put at risk. Mr. Wulff recommended that Subpart 4A be revised to read: "No prepay plan may exceed a total of 50 visits or $2,000, whichever is less."[120]

117. In its written response, the Board reiterated that the 50-visit limit applies to the plan and not the patient. Should an individual receive 50 treatments under a prepay plan and wish to continue with care, he or she is free to execute a new prepay plan with the chiropractor. The Board states that the rule is meant to protect patients by creating a pause in the course of treatment so that the patient has the opportunity to reassess the goals and costs of continued care. It pointed out that the proposed rule is designed to place some limitations on a doctor's control of a patient's finances and ensure that the control is returned to the patient at some juncture. The Board acknowledged that the rule language is unclear as to whether the 50-visit limit would apply to family plans covering more than one individual. The Board explained that its intent was that the 50-treatment limit would apply only to a single patient and not to an entire family. The

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[114] SONAR at 7.
[115] *See, e.g.,* Ex. A-2; Hearing Testimony of Drs. Shawn Preisler, Tim Fargo, Pete Wuerdemann, and Jason Louie.
[116] Public Ex. 29; Hearing Testimony of K. Gergen-Mandel.
[117] *See* Exs. I-1, I-3, I-5, I-15, I-38, and J-4.
[118] Hearing Testimony of Dr. Laurie Goodsell; *see also* Hearing Testimony of Margo Davis.
[119] Public Ex. 27; Hearing Testimony of Dr. Katie Cowles and Liz Raymond.
[120] Ex. I-41.

Board indicated that it "proposes to submit a language change to reflect the intention of such a plan applying on a per-patient basis," but did not yet do so.[121]

118. A number of commentators stated that the 50-visit limit and renewal requirements of this subpart will create burdensome paperwork for chiropractors who typically have little, if any, staff to handle data entry. Andy Kuecher, D.C., estimated in his written comment that this proposed subpart would add "a minimum of 15-20 hours per month" to his work load.[122]

119. The Administrative Law Judge finds the 50-treatment limit per individual plan has been shown to be needed and reasonable. The approach taken in the proposed rules is rationally related to the Board's goal of limiting a patient's financial exposure without unduly interfering with the chiropractor's treatment plan, and falls within the policy-making discretion of the Board. The Board indicated its willingness to clarify that the rules are not intended to apply a 50-visit limit to a plan that covers more than one individual, but did not propose language for consideration. The Administrative Law Judge agrees that it would be advisable to clarify whether and in what fashion the proposed rules apply to family prepay plans. It is not clear from the Board's response whether it wishes to exclude family plans from the rule altogether, or whether it wishes to cover both individual and family plans and merely clarify that such plans shall not be based on a package of more than 50 visits *per individual*. Although it is not anticipated that either of these two approaches would render the rules substantially different from the rules as originally proposed, the Board must submit proposed language for consideration and review if it chooses to adopt either approach.

Minn. Rule 2500.7000, Subpart 5

120. Subpart 5 of the proposed rules prohibits chiropractors from billing "a reimbursement entity or a patient for any amount exceeding what is actually earned and disbursed to the chiropractor."

121. In its SONAR, the Board states that this provision is meant to prevent chiropractors who agree to discounted fees from billing a third party payor a greater (non-discounted) fee. The chiropractor is required under this provision to bill for actual charges rather than retail charges.[123]

122. Dr. Crabtree asserted that this provision of the proposed rules was in direct conflict with "Jim's Law," Minn. Stat. § 62J.83.[124] That statute specifies that, "[n]otwithstanding any provision of Chapter 148 or any other provision of law to the contrary, a health care provider may provide care to a patient at a discounted payment amount, including care provided for free." The statute goes on to state that it "does not apply in a situation in which the discounted payment amount is not permitted under federal law." In a separate comment, Representative Abeler (the sponsor of section

[121] Board's March 7, 2011, Post-hearing Response Comments at 6-7; *see also* Ex. M-1 (Testimony of Dr. Spicer) at 11.
[122] Ex. A-2.
[123] SONAR at 7.
[124] Public Ex. 4 (Dr. Todd Crabtree) at 5-6.

62J.83) also asserted that, if chiropractors are required to bill health insurance plans (third party payors) at the discounted prepayment rate, it would violate the spirit of Minn. Stat. § 62J.83. Representative Abeler recommended that Subpart 5 of the proposed rules be revised to apply only to billing entities such as credit card companies.[125]

123. In its post-hearing response, the Board pointed out that the proposed rule does not specifically allow or disallow discounts. Consequently, the Board asserted that the proposed rule does not conflict with the spirit or letter of Minn. Stat. § 62J.83.[126]

124. The Administrative Law Judge agrees with the Board that the proposed rule does not specifically allow or prohibit discounts in connection with prepay plans. Accordingly, it is concluded that there is no conflict between the proposed rule and Minn. Stat. § 62J.83.

Minn. Rule 2500.7000, Subpart 6

125. Subpart 6 requires that persons entering into a prepay plan with a chiropractor shall be given three business days to cancel the plan with no penalties assessed for cancellation. Under item D, if a patient pays for care under a prepay plan and then elects to cancel the plan within the cancellation period, the chiropractor must fully refund any unused portion within 48 hours of receiving the notice of cancellation.

126. In its SONAR, the Board states that a three-day right of cancellation is needed to protect vulnerable patients who may feel pressured by the practitioner to agree to such plans. According to the Board, a three-day right of cancellation will provide patients with sufficient time to reconsider their decision and rescind it if they feel it is not in their best interest.[127]

127. Dr. Thomas Schmidt commented that the rule should define more clearly what constitutes a "true cancellation" triggering the 48-hour refund.[128]

128. At the hearing, Dr. Rebekah Oakland-Garey stated that 48 hours was too short a time period to refund money in the event a patient opts to cancel a prepay plan. She explained that many chiropractors devote only one day a week to administrative duties, and recommended that the Board modify the provision to give chiropractors seven calendar days in which to refund a patient's money.[129] In its post-hearing comment, the Board agreed with Dr. Oakland-Garey and has proposed revising the language in Subpart 6D to give chiropractors seven calendar days in which to refund a patient's money.[130]

129. David Wulff commented that the three-day right to cancel provision is unnecessary because patients should have the right to cancel or terminate a prepay

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[125] Public Ex. 51.
[126] Board's March 7, 2011, Response Comments at 7.
[127] SONAR at 7.
[128] Ex. I-38.
[129] Testimony of Dr. Rebekah Okland-Garey.
[130] Board's March 7, 2011, Response Comments at 7.

plan at any time for any reason and upon termination be entitled to an accounting of their funds, interest and disbursements, and full reimbursement of all funds and interest remaining in the escrow account.[131] Dr. Brian Boyd also commented that patients should have the right to cancel a prepay plan at any time and be reimbursed according to the terms of the written agreement.[132]

130. The Administrative Law Judge finds that the Board has adequately demonstrated that the proposed rule provision recognizing a three-day right of cancellation is needed and reasonable. The Board has broad authority under Minn. Stat. § 148.08 to adopt rules necessary to protect the health, safety and welfare of the public, including rules governing the practice of chiropractic. As noted above, an agency is legally entitled to make choices between possible approaches so long as its choice is rational,[133] and is entitled to rely on policy preferences in support of a rule.[134] It is not the proper role of the Administrative Law Judge to invade the policy-making discretion of the agency and attempt to determine that another policy alternative presents the "best" approach.[135] The Board has also shown that the modification to allow refunds within seven calendar days rather than 48 hours is warranted and does not constitute a substantial change in the rules.

131. If the Board opts to retain Subpart 6 rather than move its requirements to a new item under Subpart 3 as recommended by the Administrative Law Judge above (see Finding 110), the Administrative Law Judge recommends that two additional modifications be made to Subpart 6 for clarity. First, in item A of Subpart 6, the Administrative Law Judge recommends that the Board delete the word "clear" at line 3.18 as superfluous, and also delete the phrase "and shall be separately initialed by the patient" at lines 3.18 and 3.19 as discussed earlier in this Report. Second, the Administrative Law Judge recommends that the Board delete the phrase "or otherwise acknowledged" in item A(2), line 3.23, due to its vagueness. The Administrative Law Judge concludes that these suggested modifications to the rule do not render it substantially different from the rule as originally proposed.

132. DOLI recommended that the Board add a new Subpart 7 to ensure that chiropractors are aware that prepay plans may violate workers' compensation laws prohibiting the collection of payment before the charges are submitted to the insurer.[136] As noted above, the Administrative Law Judge concludes that the rules are not rendered defective by their failure to include DOLI's interpretation of applicable statutes and rules.

Based on the Findings of Fact, the Administrative Law Judge makes the following:

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[131] I-41.
[132] Ex. J-6.
[133] *See, e.g., Federal Sec. Adm'r v. Quaker Oats Co.*, 318 U.S. 218, 233 (1943).
[134] *Mammenga v. Dept. of Human Services*, 442 N.W.2d 786 (Minn. 1989); *Manufactured Hous. Inst. v. Pettersen*, 347 N.W.2d 238, 244 (Minn. 1984).
[135] *Federal Sec. Adm'r v. Quaker Oats Co.*, 318 U.S. 218, 233 (1943).
[136] Ex. I-2.

CONCLUSIONS

1. The Board gave proper notice of the hearing in this matter. The Board has fulfilled the procedural requirements of Minn. Stat. § 14.14 and all other procedural requirements of law or rule.

2. The Board has demonstrated its statutory authority to adopt the proposed rules, and has fulfilled all other substantive requirements of law or rule within the meaning of Minn. Stat. §§ 14.05, subd. 1; 14.15, subd. 3; and 14.50 (i) and (ii), except as noted in Finding 108.

3. The Board has demonstrated the need for and reasonableness of the proposed rules by an affirmative presentation of facts in the record within the meaning of Minn. Stat. §§ 14.14, subd. 4; and 14.50 (iii), except as noted in Finding 107.

4. The amendments to the proposed rules suggested by the Board after publication of the proposed rules in the State Register are not substantially different from the proposed rules as published in the State Register within the meaning of Minn. Stat. § 14.05, subd. 2, and 14.15, subd. 3.

5. The Administrative Law Judge has suggested action to correct the defects cited in Conclusions 2 and 3, as noted in Findings 107 and 108.

6. Due to Conclusions 2 and 3, this Report has been submitted to the Chief Administrative Law Judge for his approval pursuant to Minn. Stat. § 14.15, subd. 3.

7. Any Findings that might properly be termed Conclusions and any Conclusions that might properly be termed Findings are hereby adopted as such.

8. A Finding or Conclusion of need and reasonableness with regard to any particular rule subsection does not preclude and should not discourage the Board from further modification of the proposed rules based upon this Report and an examination of the public comments, provided that the rule finally adopted is based on facts appearing in this rule hearing record.

Based on the Conclusions, the Administrative Law Judge makes the following:

RECOMMENDATION

IT IS RECOMMENDED that the proposed rules, as modified, be adopted, except where otherwise noted above.

Dated: April 14, 2011.

Barbara L. Neilson

BARBARA L. NEILSON
Administrative Law Judge

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