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Chairman Nava, Vice Chairman Kaye, and members of the Little Hoover Commission, thank you for the opportunity to present testimony about the importance of occupational licensing and the role state licensing boards can play in promoting opportunities for upward mobility that do not jeopardize public safety.

The California Nurses Association (CNA) represents over 90,000 Registered Nurses (RNs) in California. CNA members see themselves first and foremost as patient advocates and understand that effective patient advocacy must extend beyond the bedside and into the broader communities in which we live. For this reason, CNA has a long history of engaging with state agencies and policy makers on matters involving public health and patient safety. As a labor union focused on patient safety and improving the health of Californians, CNA recognize that licensure is crucial to protecting patients and ensuring healthy communities.

THE VALUE OF OCCUPATIONAL LICENSING GENERALLY:

The purpose of occupational licensing boards is to protect public health and safety by ensuring minimum standards of competency. Licensing is critical in industries in which incompetent or negligent practitioners can inflict serious harm on individual consumers or on the public at large. However, licensing is also critical in industries in which it is difficult for consumers to understand, interpret, or obtain information on the quality of services available to them, leaving them vulnerable to exploitation. Often these two situations overlap, as is the case with the health care industry, in which the consequences of professional negligence or incompetence have life or death implications, and the highly technical nature of the work makes it extremely difficult for consumers to evaluate the quality of the services available to them.

In many situations, the provider or seller is capable of knowing the quality of his service or product, but the buyer is not. This phenomenon, known as “informational asymmetry,” refers to situations in which service providers have large advantages over consumers with respect to information.[1] This phenomenon is typical in industries where professional services require a high degree of technical knowledge or skill. In such industries, determining whether a professional is meeting minimum standards can itself require specialized expertise. For example, it is difficult for a patient to ascertain the exact quality of a physician's services. The Supreme Court made reference to this power imbalance when it stated that:

[1] Akerloff, George. A., The Market for "Lemons", Quality Uncertainty and the Market Mechanism, Quarterly Journal of Economics, Vol. 84, No. 3 (Aug.,1970), pg. 488-500

> [T]he quality of professional services tends to resist either calibration or monitoring by individual patients or clients, partly because of the specialized knowledge required to evaluate the services, and partly because of the difficulty in determining whether, and the degree to which, an outcome is attributable to the quality of services (like a poor job of tooth-filling) or to something else (like a very tough walnut).[2]

In that case, the Court concluded that the "existence of such significant challenges to informed decision-making by the customer for professional services" justifies government intervention in protecting patients.[3] Licensure, a government intervention which establishes minimum quality standards, is extremely beneficial for protecting consumers in markets which are characterized by informational asymmetry.[4] As the economist H. E. Leland has pointed out:

> If there were no licensing standards, "doctors" could range from those who are highly qualified to those who are "quacks." Doctors know their own abilities…Patients, on the other hand, have difficulty in distinguishing the relative qualities of physicians.[5]

Without minimum quality standards consumers in asymmetric markets face an impossible burden of evaluating their choices with dire and potentially life-threatening consequences.

By reducing the uncertainty regarding quality in asymmetric markets, licensing can also promote market stability.[6] As the economist George Akerloff describes, "the presence of people who wish to pawn bad wares as good wares tends to drive out the legitimate business."[7] Consider the case of physicians. Without licensing, both highly qualified physicians and totally unqualified quacks are free to market themselves as "doctors." Economist H.E. Leland writes that in such a situation:

> Doctors (or potential doctors) with above-average opportunities elsewhere may not be willing to remain in (or enter) the market, since the price they receive will reflect the lower average quality of service. Their withdrawal from the market lowers the average quality of medical services, the price falls, and further erosion of high-quality physicians occurs…the market may degenerate until only quacks are practicing medicine.[8]

The notion that the impact of licensing regimes is to drive up wages and drive out competition has been refuted by a recent study out of the University of Vermont and University of California, Riverside. The study examined the licensure of registered nurses and found that the shift from certification to licensure had a minimal effect on wages and no affect whatsoever on participation, meaning that it did not result in fewer people joining the profession.[9] Insofar as there was an effect on wages, the benefits accrued mostly to minority workers, whose wages rose faster after the advent of licensing than they did not for non-minority workers.[10] Taken as a whole, the results of the study

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[2] *California Dental Association v. Federal Trade Commission*, 526 U.S. 756 (1999)
[3] This particular case concerned government regulation protecting patients form false, misleading, or irrelevant information in the advertising of professional services, but the justification carries to licensing as well.
[4] Leland, H.E. Quacks, Lemons, and Licensing: A Theory of Minimum Quality Standards", Journal of Political Economy, 87, 1328-1346
[5] *Ibid*
[6] *Ibid*
[7] Akerloff, The Market for "Lemons"
[8] Leland, Quacks, Lemons, and Licensing
[9] Law, Marc T., and Mindy S. Marks. "From Certification to Licensure: Evidence from Registered and Practical Nurses in the United States, 1950-1970." *The European Journal of Comparative Economics* 10, no. 2 (May 1, 2013): 177.
[10] *Ibid*

were consistent with the public interest theory of occupational licensing, which posits that by providing a guarantor of quality, occupational licensing gradually increases the demand for professional services and thus increases participation in the profession.[11] These findings refute the assertion that licensing inevitably leads to increased wages and restricted competition, which was made to the Little Hoover Commission at the hearing on February 4th.

THE STATE'S ROLE IN PROTECTING THE PUBLIC:

In markets characterized by informational asymmetry, in which it is extremely difficult for consumers to monitor the quality of the services available to them, the state is in the best position to protect consumers from harm. Outside of occupational licensing, other societal checks, such as the filing of malpractice lawsuits, voluntary certification, and mechanisms from the private sector, are woefully inadequate in protecting consumers from incompetent and unethical practitioners.

The fundamental problem with malpractice lawsuits and other civil suits as a means of protecting consumers and weeding out incompetent practitioners is that they are inherently *reactive* rather than *proactive*. In order to file a lawsuit, a consumer must have already been harmed by the negligent or incompetent actions of the practitioner, sometimes with tragic results. By contrast, the bulk of what licensing boards do is *proactive*—they work to ensure that professionals who are inadequately trained or otherwise not competent to practice safely cannot enter the profession until they are ready. The work of licensing boards is to prevent harm from occurring in the first place, not just to remedy harm once it's already occurred. Furthermore, unlike the investigations and prosecutions undertaken by occupational licensing boards, which are paid for by licensing and application fees, malpractice lawsuits can put a strain on public resources, overburdening an already crowded court system.

Additionally, when opponents of licensure argue that consumers should seek protection and redress through courts, they are severely underestimating the financial and social capital necessary to pursue justice through the court system. People in the low and middle-income brackets face high barriers to obtaining justice in civil proceedings, including the financial burden of paying for a lawyer and missing work to attend legal proceedings. By contrast, anyone can file a complaint with a licensing board. For example, if a patient believes their nurse acted negligently, incompetently, or engaged in illegal activities related to their professional responsibilities, the patient can easily submit a complaint form to the Board of Registered Nursing (BRN) at no personal expense. The BRN will conduct an investigation of all complaints over which it has authority.[12] The right of individuals to pursue civil action against practitioners pales in comparison to the ease and accessibility of the board complaint process, which enables members the public to advocate for their own safety.

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[11] *Ibid*

[12] The Board can only investigate RNs who are licensed by the Board, applicants for licensure, or individuals who hold themselves out to the public as RNs. The Board can only investigate complaints that, if found to be valid, are violations of the Nursing Practice Act or other Board-adopted regulations. Complaints involving allegations not within the jurisdiction of this Board will be referred to other agencies which may be better able to assist the complainant. Allegations not within the authority of the Board include fee/billing disputes, general business practices, personality conflicts, and providers licensed by other boards/bureaus. Find more information on the BRN's complaint process at http://www.rn.ca.gov/enforcement/complaint.shtml#who.

Another solution commonly put forth as an alternative to licensure is a system of credentialing or voluntary certification, usually by private certification agencies. This purported societal check is also wholly inadequate for protecting health care consumers.

In testimony presented to the Little Hoover Commission on February 4, 2016, Professor Morris Kleiner wrote that certification is preferable to licensure because "it gives consumers more choices for the kinds of services they need. It gives consumers the right to choose the level of quality they think is appropriate for them rather than having members of an occupation decide what is the level of skill that is necessary for consumers."[13] In other words, Professor Kleiner posits that some consumers might "choose" lower quality services, ostensibly in order to take advantage of a lower price. When you pick it apart, this argument is actually rather disturbing. As mentioned above, in industries that require a high degree of technical knowledge and skill, consumers are at a severe disadvantage when it comes to information. In the health care industry, for instance, consumers are typically unable to gauge the quality of services available to them or to determine what "level of skill is necessary" to correct a given problem or treat a given condition. Thus, a consumer who "*chooses"* to receive low quality health care is unlikely even to realize they are making such a choice.

Furthermore, it is crucially important to realize that consumers don't always get to *choose* who their providers will be. This is often the case in the health care industry. When a person calls 911 and gets transported to the hospital, they do not choose which paramedic will arrive to pick them up, which nurses will provide care at the ER, or which physician will make a diagnosis. Often in health care, you simply get what you get. The consumer is in a vulnerable position in these circumstances and benefits from the state setting and administering standards for minimum competency.

This lack of meaningful choice is especially true for low-income and under-served communities. A patient attending a free clinic has little to no "choice" in who will be their health care provider. Given the scarcity of doctors accepting Medi-Cal patients, recipients increasingly have little to no choice in their provider. Were we as a society to do away with mandatory minimum qualifications and replace it with a system in which patients "choose" low-quality care, it is not unreasonable to contend the resulting system will be one in which wealthy people receive high quality care from competent practitioners, and the poor are forced to accept low quality care from unregulated, self-appointed "practitioners." The resulting system would be a disaster for low-income and marginalized Californians, which directly conflicts with the stated goals of this Commission.

Opponents of occupational licensure have also proposed consumer-review systems and other accountability mechanisms out of the private industry as an alternative to licensure. These mechanisms are riddled with problems and cannot possibly be trusted to protect consumers. At the Little Hoover Commission hearing on February 4, Professor Kleiner cited the consumer review systems used by apps like Uber, Lyft, and Airbnb. The irony of referencing these systems as a viable means of protecting the public is that these same companies are consistently accused of allowing incompetent, negligent, and criminally dangerous people to interact with customers, sometimes with tragic results. Websites like WhosDrivingYou.Org compile lists of safety incidents involving Uber and Lyft drivers, including attacks, kidnappings, and a chillingly long list of sexual harassment and rape.[14]

[13] Testimony of Professor Morris Kleiner, Presented to the Little Hoover Commission, February 2, 2016.
[14] For more information, follow the links at http://www.whosdrivingyou.org/rideshare-incidents.

The idea that a voluntary customer review system can adequately protect consumers from harm is even more outrageous when one recalls the above-mentioned "informational asymmetry." In industries that involve a high degree of technical skill, it is not always possible for a consumer to know whether the care they received was adequate or met minimum standards. If a health care professional misses a diagnosis, the patient may not suffer the results for several years. If they prescribe the wrong treatment and the patient suffers, the patient may believe they are suffering from the underlying condition, and not from the improper treatment. Likewise, if an electrician rewires a house with faulty wiring, the house may not catch fire right away, but burn down several years later. In the mean time the consumer is none the wiser; she may even write a glowing review.

Finally, consumer-review systems from the private industry are characterized by rampant corruption, including a thriving marketplace for fake reviews.[15] Companies like Yelp! have been accused of manipulating their ratings systems in order to sell advertising—effectively extorting businesses by offering them higher ratings if they pay for more ads.[16] In fact, the Ninth Circuit Court of Appeals recently ruled that Yelp! has the right to continue engaging in these practices, despite the fact that it harms businesses and consumers alike.[17] This no doubt, is the kind of "protection" we can expect from the private sector. The state is infinitely better equipped to provide meaningful protections against negligence, incompetence, and abuse.

THE VALUE OF PROFESSIONAL MEMBERS ON OCCUPATIONAL LICENSING BOARDS AND THE IMPLICATIONS OF *NORTH CAROLINA DENTAL*:

The fact that monitoring the safety and quality of services tends to require specialized knowledge and skill is precisely why most regulatory boards include professional members—because they are better equipped to examine the highly technical matters that boards regulate and to make decisions about competency, safe practice, and professional conduct in their respective fields.

In California, some boards have a majority of public members, while others have a majority of professional members. Given the highly technical nature of the healing arts professions, it is typical for professional members to outnumber public members on those boards, though not by a lot. The Board of Registered Nursing, for example, is composed of four public members and five registered nurses. The professional members represent different areas of practice, including two direct-patient care nurses, an advanced practice nurse, a nurse administrator, and a nurse educator.[18]

Following the recent Supreme Court decision in *North Carolina Board of Dental Examiners versus Federal Trade Commission* (*NC Dental*), there has been speculation about the implications of that decision on California's licensing boards. I understand that it is not the intention of the Commission to focus on this issue. However, I have been asked to briefly elaborate on my comments at the

[15]Tuttle, Brad, *9 Reasons Why You Shouldn't Trust Online Reviews*, Time Magazine, at http://business.time.com/2012/02/03/9-reasons-why-you-shouldnt-trust-online-reviews/.
[16] Egelko, Bob, *Yelp can manipulate ratings, court rules*, SFGate, at http://www.sfgate.com/news/article/Yelp-can-give-paying-clients-better-ratings-5731200.php.
[17] Levitt v. Yelp! Inc., 765 F.3d 1123, 1137 (9th Cir. 2014)
[18]BPC § 2702(c)

Commission's Feb 4, 2016 hearing, in which I stated that *NC Dental* does not require a reconstitution of licensing board membership or any other radical changes to occupational licensing.

NC Dental established that professional licensing boards on which a "controlling number" of decision makers are "active market participants" are immune from antitrust actions as long as they act pursuant to clearly articulated state policy to replace competition with regulation and their decisions are actively supervised by the state.[19]

NC Dental did *not* establish a bright-line test for determining what constitutes "active state supervision." Instead, the standard is "flexible and context-dependent," meaning that it must be established on a case-by-case basis.[20] The opinion did clarify, however, that adequate state supervision does *not* require day-to-day involvement or micromanagement of the board's operations and decisions.[21] All that is required for that the oversight mechanisms in place provide "realistic assurance that a private party's anticompetitive conduct promotes state policy, rather than merely the party's individual interests."[22]

In reviewing the state oversight mechanisms in place for California's occupational licensing boards, the California Attorney General opined that board members can "act with reasonable confidence" when pursuing the bulk of their functions, including disciplinary decisions and the promulgation of regulations.[23]

The AG's opinion also reminds us to consider this issue in light of two key facts: First, even if board members do not have state action immunity, that does not in any way mean that there has been or is more likely to be an antitrust violation.[24] Second, most actions taken by licensing boards do not implicate federal antitrust laws to begin with.[25] In other words, California does not need to be "brought into compliance" with *NC Dental.* One person who testified at the LHC hearing on February 4 stated that California is currently "in violation" of *NC Dental.* That is simply not true.

One thing that is clear is that radical changes to board composition are neither a necessary nor effective response to *NC Dental*. For one thing, the opinion did not establish with certainty what proportion of public to professional members would guarantee state-action immunity for board members in antitrust actions.[26] As the AG notes:"As long as the legal questions raised by *North*

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[19] *North Carolina State Bd. of Dental Examiners v. F.T.C.* (2015) 547 U.S. ___, 135 S. Ct. 1101

[20] *North Carolina Dental*, 135 S.Ct. at p. 1116.

[21] *Ibid.*

[22] *Ibid.*

[23] The former is characterized by due process procedures, availability of administrative mandamus review, and participation of state actors such as board executive officers, investigators, prosecutors, and administrative law judges. The latter requires public notice, written justification, Director review, and review by the Office of Administrative Law. See, Attorney General's Opinion 15-402 (Sept. 10, 2015) at p 8

[24] *Id. at 8*

[25] *Id.* at 8

[26] The NC Dental decision specifically declined to establish what constitutes a "controlling number." Some have speculated that a majority of professional members is a "controlling number." However, the court did not use the term "majority," although it would have been simple enough to do so. As the dissenting opinion in NC Dental points out, this omission may indicate that the Court meant to "leave open the possibility that something less than a majority might suffice in particular circumstances." *North Carolina Dental*, 135 S.Ct. at p. 1123 (dis. opn. of Alito, J.).

Carolina Dental remain unresolved, radical changes to board composition are likely to create a whole new set of policy and practical challenges, with no guarantee of resolving the immunity problem."[27]

The AG also spoke to the public policy advantages of staffing boards with professionals as evidence for why changes to board composition would *not* be the most effective response to *NC Dental*:

> The combination of technical expertise, practiced judgment, and orientation to prevailing ethical norms is probably impossible to replicate on a board composed entirely of public members. Public confidence must also be considered. Many consumers would no doubt share the sentiments expressed by Justice Breyer during oral argument in the *North Carolina Dental* case: "[W]hat the State says is: We would like this group of brain surgeons to decide who can practice brain surgery in this State. I don't want a group of bureaucrats deciding that. I would like brain surgeons to decide that."[28]

There are other, far less radical solutions to the state immunity problem, such as implementing minor improvements to the current indemnification scheme for board members and providing training to board members on antitrust concepts.[29] These relatively simple tweaks should be pursued in lieu of a radical overhaul of board composition, which would entail a loss of the expertise and resources that help the boards achieve their public protection goals.

CNA'S ROLE IN WORKING WITH STATE LICENSING BOARDS TO PROMOTE UPWARD MOBILITY AND INCREASE DIVERSITY WITHIN THE NURSING PROFESSION:

State licensing boards can—and often do—play an integral role in ensuring that there are pathways to competency and participation in the profession which, at the same time, are protective of public safety. A person wishing to become an RN in California may choose from three types of board-approved pre-licensure nursing programs: a Bachelor of Science in Nursing (BSN), which takes 4 years and is offered at many state universities and private colleges, an Entry Level Masters Program in Nursing (ELM), which is designed for adults who already have a baccalaureate degree in another field, and an Associate Degree in Nursing (ADN), which takes 2-3 years and is offered at many community colleges, making it an attractive option for many lower-income people. The BRN will also issue licenses to nurses who have pursued one of two alternative routes to licensure, including the LVN to RN 30-Unit Option,[30] and an option for military corpsmen that allows them to sit for the licensure exam if they have completed RN level education and clinical experience.[31]

The LVN to RN 30-Unit Option is an 18-24 month program of study through which a licensed vocational nurse (LVN) can quickly meet the requirements to sit for the RN licensure exam.[32] The option was "designed as a career ladder for California LVNs wishing to become registered nurses."[33] This is a *non-graduate* option for obtaining RN licensure, meaning it does not require an additional

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[27] Attorney General's Opinion 15-402 (Sept. 10, 2015) at p 11
[28] *Id.* at p 10
[29] For a more comprehensive discussion of these alternatives, please see Section IV of Attorney General Opinion No. 15-402, beginning on page 15.
[30] 16 CCR §1429.
[31] BPC, §2736(b); 16 CCR §1418.
[32] 16 CCR §1429.
[33] http://www.rn.ca.gov/careers/steps.shtml.

degree, making it much less expensive and more accessible to low-income people.[34] The BRN has the responsibility of approving the courses required for the 30-Unit Option, thus ensuring that these programs, while providing opportunities for upward mobility, are also protective of patient safety.[35,36]

As a labor union, CNA has consistently advocated for expanded access to the profession and opposed attempts to erect barriers to practice that are not necessary for patient safety. To understand our interest in these issues, it helps to have some historical background on CNA. Prior to the early 1990s, CNA was affiliated with the American Nurses Association (ANA). ANA has long pushed for baccalaureate degrees to be required for entry into the nursing profession.[37] When CNA dissafilliated from ANA and direct care nurses took over the leadership roles in the organization, CNA began focusing on expanding access to the profession as a front and center issue. Since that time, the union has openly and consistently supported the LVN to RN 30-unit option, the associate's degree option, and other alternative pathways into the nursing profession.

CNA has taken an active role in working with the legislature and the BRN to increase diversity and opportunities for upward mobility within the nursing profession. One of several examples is SB 1245 (Kuehl)—legislation CNA sponsored in 2004 requiring the Chancellor of the California State University, in consultation with the BRN, to expand the Entry Level Master's (ELM) programs in nursing. In sponsoring this legislation, CNA's goal was to increase access to the nursing profession, particularly for low-income people. At the time, RN programs in California were filled to capacity, making it difficult for people to enter the profession. Many of the students applying to the Associate's Degree Nursing (ADN) programs already had a baccalaureate degree in another subject. Thus, applicants with no prior degrees were competing with baccalaureate students for limited positions in ADN programs. By offering an alternative route for students with baccalaureate degrees, spaces were freed up for low-income students without prior degrees whose only opportunities for a nursing education might be through the community college system.[38]

Another way CNA has worked with the legislature and the BRN to increase diversity in the nursing profession is by advocating for funding for nursing scholarship programs. CNA provided strong support to SB 358 (Figeuroa) in 2003, which increased the biennial license renewal fee[39] collected

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[34] Nurses who pursue this route should be aware that it is unique to California. Licensing boards in other states do not recognize this option and will not grant them RN licensure.

[35] 16 CCR §1429.

[36] Similarly, the Vocational Nursing Practice Act allows for an alternative path to licensure for LVNs based on equivalent education or experience. Often referred to as "the equivalency method," this option allows applicants to sit for the LVN licensure exam if they can provide documentation of 51 months of paid general duty inpatient bedside nursing experience in a clinical facility and completion of a 54-theory-hour pharmacology course. The equivalency method permits unlicensed individuals who have had extensive inpatient bedside nursing care experience, plus a limited amount of formal education, to demonstrate that they have acquired sufficient basic nursing knowledge to be eligible for the licensure examination. Similar to the LVN to RN 30-unit option, people who pursue a vocational nursing license through this route will not be able to practice as an LVN in other states. See, BPC § 2873; 16 CCR § 2516(b).

[37] Smith, T., (October 5, 2009) "A Policy Perspective on the Entry into Practice Issue" OJIN: The Online Journal of Issues in Nursing Vol. 15 No. 1.

[38] A second reason for sponsoring this legislation was to increase the availability of faculty qualified to teach in the ADN programs, thus expanding access to those programs and to the profession more generally. At the time, a shortage of nurse faculty was having the effect of limiting access to the profession. The goal of this legislation was to quickly generate a larger pool of RNs with advanced degrees who would be eligible to become nursing educators, particularly in associate's degree programs at community colleges, which typically require faculty to have master's degrees in lieu of a doctorate. After this legislation was passed into law, CNA continued to actively advocate for funding for the Entry-Level Masters Degree programs in the budget proposal the following year.

[39] SB 358 increased the biennial fee from $5 to $10

from RNs for the RN Education Program within the Health Professions Education Foundation (HPEF), which provides loans and scholarships to nursing students. HPEF is the "state's only non-profit foundation statutorily created to encourage persons from underrepresented communities to become health professionals and increase access to health providers in medically underserved areas."[40]

CNA also sponsored the original legislation that created the California RN Education Program within the HPEF (formerly the Minority Health Professions Education Foundation).[41] This bill established that the scholarships would be designated for persons from demographically underrepresented groups or persons who agreed to work after graduation in underserved areas of the state. CNA sponsored this legislation with the explicit goal of encouraging students from underrepresented minority groups to enroll in nursing, thus increasing diversity in the profession.[42] The BRN was in full support of this legislation.[43]

CNA believes that alternative routes to licensure are critical to maintaining and enhancing diversity in nursing and to enabling low-income people to access the profession. That is why we have consistently advocated for policies that expand these options and taken a firm stance against those which would ratchet up the requirements for entry to the profession. Incidentally, this is one of the main reasons CNA opposes Compact Licensure, discussed in more detail below.

OPPORTUNITIES TO ASSESS THE IMPACT OF BRN REGULATIONS ON LOW-INCOME AND MINORITY APPLICANTS:

The BRN is statutorily required to collect, analyze, and publish workforce data from its licensees to be used for future workforce planning. Amongst other information, the Board collects data on the race, ethnicity, gender, and languages of its licensees.[44] In order to do this, the Board administers a biennial RN workforce survey and convenes a Nursing Workforce Advisory Committee. In addition, the BRN has commissioned various studies on the subject on diversity, including a 2012 study from UCSF titled "The Diversity of California's Registered Nursing Workforce"[45] These studies and surveys have been used to guide decision making to ensure that it is geared towards enhancing diversity in the profession and increasing access to culturally competent care.

There are also regular opportunities to assess the impact of board regulations on low-income and minority applicants and to provide input on possible improvements. When the Board considers proposing regulations, it conducts pre-notice public discussions before commencing the formal rulemaking process. These meetings are very well attended, with members of the public and representatives from stakeholder groups from across the ideological spectrum. As an example, the BRN is currently hosting public discussions concerning potential regulations to update the standards for Nurse Practitioners (NPs). After reviewing the initial draft, CNA became concerned that the

[40] http://www.oshpd.ca.gov/HPEF/About_Us.html
[41] Senate Bill No. 1267 (Maddy), 1988.
[42] Bill Analysis, Senate Bill No. 1267 (Maddy, 1988), Assembly committee on Health, p.2
[43] *Id*. at p. 4
[44] BPC § 2717
[45] Renae Waneka, MPH and Joanne Spetz, PhD, *The Diversity of California's Registered Nursing Workforce,* 2012, at http://www.rn.ca.gov/pdfs/schools/diversity.pdf.

requirement for all NPs to be nationally certified would discourage upward mobility. CNA expressed these concerns in a letter to the Board dated August 31, 2015.[46]

The BRN has held three public hearings on this subject so far, and CNA has continued to express concerns and engage in healthy dialogue with board members and stakeholders who disagree. Hearings like these provide ample opportunity to assess the impact of board regulations on low-income and minority applicants and provide input on possible improvements. CNA and other groups have used the workforce and diversity data published by the Board in order to advocate for policy that enhances upward mobility and the Board has been responsive to those concerns.

RN MOBILITY AND THE NURSING LICENSURE COMPACT:

All 50 states require RNs to be licensed in order to practice.[47] Obtaining a license typically requires passing a licensure examination and meeting certain state-specific education and "good character" requirements. All 50 states, however, use the same licensing exam: the National Council Licensure Examination (NCLEX-RN). Once a nurse is licensed in one jurisdiction, applying for licensure in another state is streamlined by a process called endorsement (otherwise known as reciprocity). When a nurse applies for licensure by endorsement, the second state bases its licensure decision upon verification of licensure in the original state and upon meeting any additional licensure requirements that go beyond those of the original state. California uses the process of endorsement to screen applicants with current and active RN licensure in another U.S. state or Canada.

In addition to the process of endorsement, which makes it simpler to move between states, California also has several provisions to streamline the process for spouses or domestic partners of military personnel, who may face barriers to employment due to frequent moves. Starting in 2013, each licensing program under the Department of Consumer Affairs is required to expedite the licensure process for spouses and domestic partners of active members of the Armed Forces who are assigned to a duty station in California, provided that they hold a current, active, and unrestricted license in another jurisdiction.[48] In addition to expedited licensure, legislation enacted during the 2014 Session (AB 186, Maienschein) requires certain boards, including the BRN,[49] to issue temporary licenses for such applicants, which expire after 12 months or upon issuance of an expedited license.[50] This is an excellent example of how specific problems of access can be solved without abandoning the entire licensing scheme and the public protection it provides.

Another model for nurse licensure is the Nurse Licensure Compact (NLC), a system whereby member states agree to recognize licenses held by nurses in other compact states. Nurses in a compact state

[46] In this letter, CNA made the following statement: The requirement that all NPs must be credentialed by a national accreditation agency will make it significantly more costly and cumbersome for NPs to practice in California…This added expense will likely discourage RNs from becoming NPs, inhibit upward mobility for nurses from lower economic backgrounds, and discourage diversity in the field.
[47] http://www.nursinglicensure.org/articles/rn-licensing.html
[48] BPC § 115.5.
[49] This requirement applies to registered nurses licensed by the Board of Registered Nursing, vocational nurses and psychiatric technicians licensed by the Board of vocational Nursing and Psychiatric Technicians of the State of California, speech-language pathologists and audiologist licensed by the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board, veterinarians licensed by the Veterinary Medical Board, all licensees licensed by the Board for Professional Engineers, Land Surveyors, and Geologists, and all licenses issued by the Medical Board of California.
[50] BPC § 115.6.

thus receive a single "multi-state" license from their home state, which enables them to practice temporarily in other compact states.

CNA is against the Nurse Licensure Compact for three key reasons: (1) joining the compact would severely inhibit California's ability to protect the public from harm; (2) joining the compact would restrict opportunities for upward mobility by eliminating alternative pathways to licensure; and (3) adoption of the compact does not actually result in increased nurse mobility.

(1) Joining the NLC would severely inhibit California's ability to protect the public from harm:

Joining the NLC would undermine public safety by restricting California's authority to set standards that apply to ***all*** nurses practicing in the state, limiting California's ability to require criminal history checks, and prohibiting California from knowing who is practicing in the state at any given time.

Once in the Compact, states must agree to recognize the licenses granted to RNs in other compact states. However, a compact nurse is only required to meet the qualifications for licensure in her home state, not necessarily the state where she practices.[51] This is significant because the standards for qualification vary widely from state to state. Consider, for example, the standards for continuing education. Nine of the current compact states do not require any continuing education whatsoever.[52] California, by contrast, requires 30 hours of continuing education every two years.[53] If California joined the compact, it would have to recognize the licenses of nurses from the nine states that require no continuing education. In a field that evolves as quickly as healthcare, continuing education is critical to maintaining competency and safe practice. Thus, joining the Compact would jeopardize California's ability to protect patients by undermining continuing education requirements.

Joining the compact would also restrict California's ability to do criminal background checks and monitor the criminal activity of nurses practicing in the state. The original compact language[54] did not require fingerprinting or criminal background screening of applicants for RN licensure.[55] By contrast, California law requires fingerprints and criminal background checks for all applicants.[56] Any nurses who applied for licensure in California before fingerprinting was required or for whom fingerprints are no longer on file must submit fingerprints as a condition of license renewal, which occurs biennially.[57] This ensures that there are fingerprints on record for *all* nurses working in California. The Department of Justice uses the fingerprint data to report any criminal activity of a licensee directly to the Board.[58]

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[51] Nurse Licensure Compact (2015), Article III(c)(1), at https://www.ncsbn.org/NLC_Final_050415.pdf.
[52] Arizona, Colorado, Idaho, Maine, Maryland, Missouri, South Dakota, Tennessee, and Wisconsin have no continuing education requirements for RNs seeking to renew their license. See, http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/State/Legislative-Agenda-Reports/NursingEducation/CE-Licensure-Chart.pdf.
[53] BPC § 2811.5; 16, CCR § 1451(b).
[54] In order to join the Nurse Licensure Compact, states are required to enact the Model NLC Legislation without any material differences. The original Model NLC Legislation was adopted in November 6, 1998 and is the Model Legislation currently enacted in 25 states. It will now be superseded by the Model Legislation adopted May 4, 2015.
[55] Nurse Licensure Compact, Final Version, November 6, 1998, at https://www.ncsbn.org/Nurse_Licensure_Compact.pdf
[56] BPC § 144.
[57] 16, CCR § 1419 (b).
[58] The Board may take disciplinary action against a licensed nurse or deny an application for licensure if the nurse has been conviction of a felony or of any offense "substantially related to the qualifications, functions, and duties of a registered nurse."16, CCR § 2761(f)

The revised Model NLC Legislation does require all applicants to submit fingerprints and undergo criminal background checks.[59] However, this new requirement applies only to nurses seeking licensure *for the first time*, meaning that any compact nurse who currently holds or is renewing her multi-state license will *not* have to meet this requirement unless it happens to be required by her home state. At least six states currently in the compact do not conduct criminal background checks or require fingerprints.[60] The original compact language was promulgated in 1998 and the revised language came out in 2015. This means that any nurse who has been licensed in the last 17 years in a compact state that does not require fingerprinting would be free of this requirement.

The fingerprinting requirement is essential to the BRN's ability to protect the public. Criminal history may not be relevant to a person's fitness for certain professions. Nurses, however, have intimate contact with patients in their most vulnerable state. The licensing board must be able to consider whether an applicant's criminal history or ongoing criminal activity poses a danger to patients.

Joining the compact would mean that nurses working in the same state would be held to different standards. Take, for example, a nurse from Colorado and a nurse from California. If California joined the Compact, nurses from Colorado would be able to practice here despite the fact that they are not required to engage in *any* continuing education at all and, if licensed before 2015, are not required to undergo a criminal background check or submit fingerprints to the DOJ. A nurse from California, even if she were to practice in Colorado, would be required to submit fingerprints, undergo a criminal history check, and engage in at least 30 hours of continuing education every two years.

Furthermore, by joining the Compact, California would lose the right to even know who was practicing nursing in the state at any given time. The compact denies states the authority to require compact nurses to notify the licensing board when they enter the state to practice. This creates several problems. First, the Board would have no means of knowing if a potentially dangerous nurse entered California to practice, which would hinder the board's ability to protect the public. Second, it would limit California's ability to capture nursing workforce data and estimate workforce needs, including needs related to diversity and cultural competence.

(2) Joining the compact would diminish opportunities for upward mobility:

Contrary to the intention of this commission, joining the Nurse Licensure Compact would have the effect of reducing access to the nursing profession for low-income Californians and limiting opportunities for upward mobility. As mentioned above, in order to join the Compact, California would be required to enact the 2015 NLC Model Legislation, which sets specific qualification standards for nurse licensure. With regards to education, the Model Legislation dictates that, in order for an applicant to obtain a multistate license, she must have ***graduated*** from a board-approved RN prelicensure education program.[61] While this may seem innocuous, the key word here is "graduated." The alternative routes to licensure discussed above, including the 30-Unit LVN-to-RN option and the military experience option, are *non-graduate* programs. Nurses who take advantage of those routes to licensure have not "*graduated* from a board-approved program," and so they would be ineligible for licensure under the Compact. In addition to the alternative routes that

[59] Nurse Licensure Compact (2015), Article III(b)
[60] The six states are: Colorado, Maine, Montana, Nebraska, Virginia, and Wisconsin.
[61] Nurse Licensure Compact, Model Legislation, (c)(2)(i), at https://www.ncsbn.org/NLC_Final_050415.pdf

California already recognizes, joining the Compact would restrict the state's ability to implement new and innovative paths to RN licensure that do not require formal (and expensive) degrees.

(3) Evidence suggests that adoption of the NLC does not actually make nurses more mobile:

Ostensibly, The Nursing Licensure Compact was created in order to provide greater mobility for nurses and to improve access to nursing care in general. And yet there are several indications that joining the NLC does not actually increase nurse mobility. First, it is important to keep in mind that compact licensure does not allow for completely unencumbered movement across state lines. The NLC permits a nurse to hold only one active compact license at a time in her primary state of residence.[62] A licensee may pursue a *temporary* working assignment in another state using her multi-state license, but if she needs to relocate permanently she must actually apply for licensure by endorsement in the new state of residence, just as she would under the current regime.

Furthermore, the NLC has been in various stages of implementation for the last 15 years,[63] and yet there is actually no evidence that it has led to greater nurse mobility or increased labor supply. A recent study from 2015 examines data on over 1.5 million nurses and finds that adoption of compact licensure has had ***no effect*** on a variety of labor market outcomes such as labor force participation, employment levels, hours worked, earnings, and likelihood of working across state lines.[64] This null effect persisted even for nurses living near a border between two compact states—exactly the nurses who were expected to be most impacted by the adoption of compact licensure.[65]

Given how weak the links are between compact licensure and nurse mobility, we must look more deeply at some of the other motivations behind compact licensure, including the promotion of telemedicine. The *Findings and Declaration of Purpose* section of the NLC Model Legislation speaks just as much to nurse mobility as it does to the expansion and proliferation of telemedicine.[66] Compact agreements allow the practice of nursing across state lines using information technology. Telemedicine is frequently used to enhance the profits of health care companies by limiting access to in-person care. Compact licensure allows major health care companies to outsource the provision of certain health care services to states where providers are less regulated and lower paid. When you take a closer look at compact licensure, it is not a stretch to conclude that it has less to do with increasing mobility for nurses and more to do with outsourcing jobs out of California and enhancing profit for health care companies at the expense of patient care.

Adopting compact licensure requires the state to forfeit its ability to set high standards for safety and care of its citizens as well as its flexibility to create alternative pathways to competency that encourage diversity and upward mobility. This is a lot to give up, especially considering that evidence suggests that there is *no* benefit in terms of enhancing nurse mobility and labor supply.

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[62] Nurse Licensure Compact (2015), Article IV(b), at https://www.ncsbn.org/NLC_Final_050415.pdf.
[63] The NLC was first implemented by Maryland in 1999. Nine of the 25 compact states had implemented the NLC by 2000, and 17 states had implemented the NLC by 2005.
[64]Christina DePasquale and Kevin Strange, "Labor Supply Effects of Occupational Regulation: Evidence from the Nurse Licensure Compact," 2015, at http://www-personal.umich.edu/~kstange/DePasqualeStangeSept2015.pdf
[65] Ibid.
[66] NLC (2015) Article I(a)(3)-(4). ("3. The expanded mobility of nurses and the use of advanced communication technologies as part of our nation's health care delivery system require greater coordination and cooperation among states in the areas of nurse licensure and regulation; 4. New practice modalities and technology make compliance with individual state nurse licensure laws difficult and complex").