alec.org

ALEC American Legislative Exchange Council
LIMITED GOVERNMENT • FREE MARKETS • FEDERALISM

the STATE FACTOR

FEBRUARY 2017

A PUBLICATION OF THE AMERICAN LEGISLATIVE EXCHANGE COUNCIL

Overregulation Threatens Market-Driven Solutions in Dentistry

By Mia Palmieri Heck

Introduction

Access to efficient, affordable healthcare remains a significant challenge in the United States. Americans continue to experience an increase in the cost of care, a trend largely advanced by the massive expansion of regulation triggered by implementation of the Affordable Care Act (ACA). As a result, many healthcare providers are consolidating services in order to bring down healthcare costs.

In dentistry, the balance between managing the cost of care while improving quality has led to the development of a cost-saving business model reliant on services provided by Dental Support Organizations (DSOs). DSOs enable dentists to outsource non-clinical functions such as bookkeeping, human resources, billing and compliance services which in turn enables dentists to focus on what they were trained to do, which is to deliver quality dental care. This model gives dentists the ability to serve a greater number of patients, while the non-clinical administrative services that DSOs provide sort out complex regulatory and compliance issues, allowing dentists to accept a greater array of health insurance plans.

While the use of DSOs is practical and efficient, critics claim they encourage excessive dental care, induce fraudulent billing practices or encroach on the dentists' clinical decision making. Despite the lack of empirical data, some state licensing boards have attempted to hinder dentists' ability to contract with DSOs by extending their regulatory authority over non-licensees.

"In dentistry and other healthcare occupations, barriers to market translates into less access to patient care in terms of either cost, or supply of licensed professionals."

Dental Care in the U.S.

Poor oral healthcare has a direct correlation to a person's overall health, affecting adverse pregnancy outcomes, respiratory disease, cardiovascular disease and diabetes.[1] For the nearly eight million Americans with undiagnosed diabetes,[2] a visit to the dentist can often help detect early signs of gum disease (which has been associated with diabetes) enabling dentists to direct patients to a physician for further screening. Early detection can lead to both better health outcomes and reduced healthcare costs over the long term.

Former Surgeon General David Satcher noted the "silent epidemic of oral diseases is affecting our most vulnerable citizens—poor children, the elderly and many members of racial and ethnic minority groups."[3]

Not surprisingly, in recent year's health disparities between non-Hispanic white and minority communities have become more prevalent, presenting a serious challenge to health care professionals and policymakers. According to the Department of Health and Human Services (HHS) "…racial and ethnic minorities often receive poorer quality of care and face more barriers in seeking care including preventive care, acute treatment, or chronic disease management, than do non-Hispanic white patients." For children, disparities are often worse. According to the Centers for Disease Control and Prevention (CDC), "the greatest racial and ethnic disparity among children aged 2–4 years and aged 6–8 years is seen in Hispanic American and black, non-Hispanic children."

Statistics show even greater challenge for dental care among working-age adults. According to the Center for Disease Control, only 60 percent of adults aged 18–64 visit a dentist annually[4] and further, the American Dental Association (ADA) has estimated more than 181 million Americans did not visit a dentist in 2014.[5]

A 2013 U.S. Department of Health and Human Services (HHS) Medical Expenditure Panel Survey (MEPS) showed that among adults between the ages of 18–64, only 37 percent visited a dentist within the past 12 months.[6] Each of these findings illustrates the need for affordable dental care so that working-age adults can better monitor and assess potential diseases.

An October 2014 Health Policy Institute survey[7] among working-age adults analyzed barriers to dental care and aggregated them into two categories—financial barriers and supply-side barriers. The survey answers ranged from "Could not afford the cost" to "Insurance did not cover procedures." The supply-side respondents could choose from answers such as "Office not open at convenient time" and "Dental office is too far away." The 2011–2012 study found financial barriers to obtaining dental care was cited 12.7 percent, compared with supply-related barriers only cited 0.7 percent of the time.

Low-income, non-elderly adults consistently experience the highest level of financial barriers to healthcare, which is also shown to be higher in the dental sector than in other parts of healthcare.[8] Another study[9] revealed dental care utilization among working-age adults is at the lowest level since the survey began tracking dental care use in 1996.

There are roughly 195,000 licensed dentists in the United States. Although the ratio varies greatly between urban and rural areas within states, this averages to roughly 60 dentists

per 100,000 people. According to the American Student Dental Association, the average dental student graduates with a debt of $241,097. The average student loan debt for dental students has doubled since 2001, and in some cases can be as much as $400,000.[10]

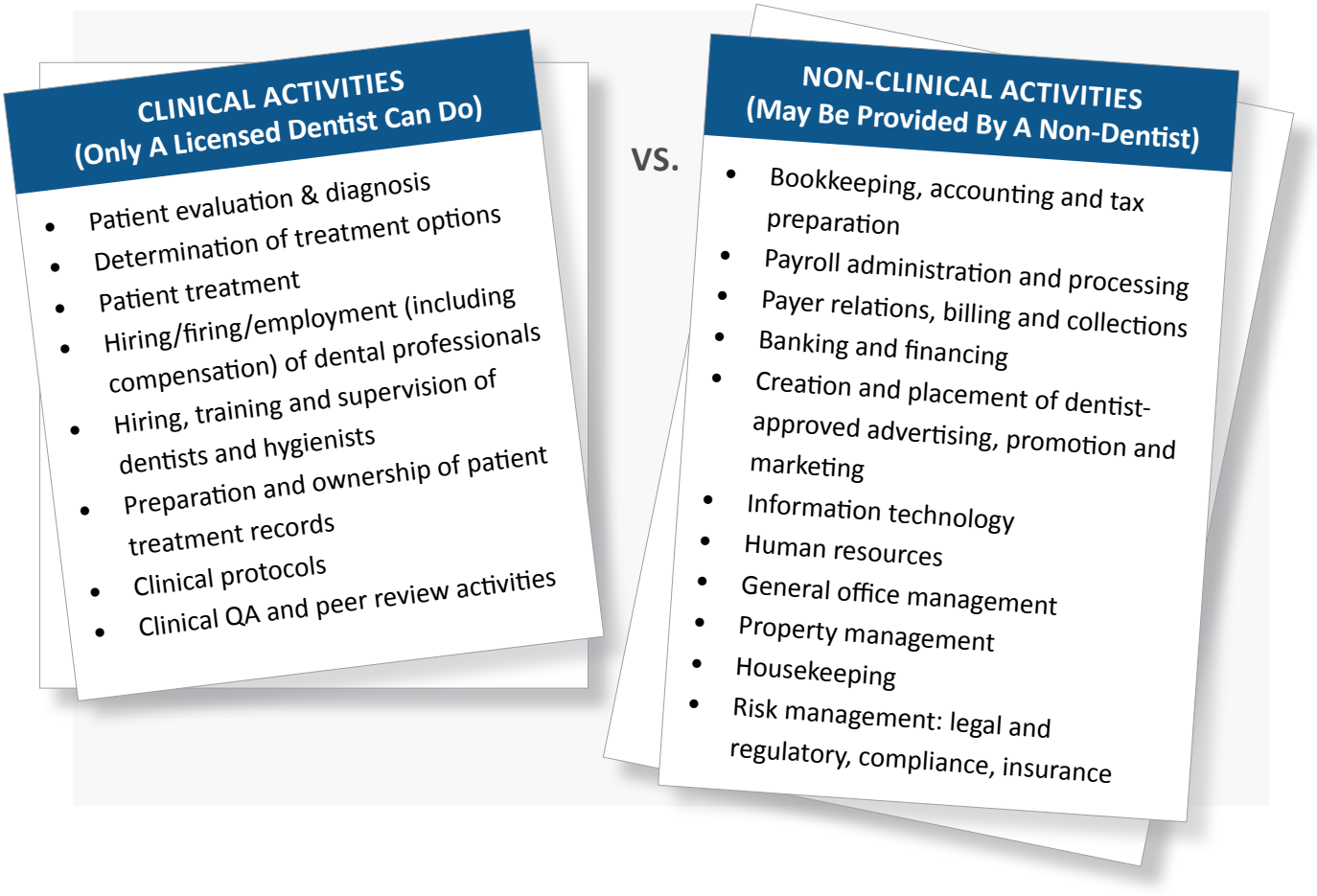
The challenges of costs, access and services in underserved areas combined with the increasing economic challenges facing graduating dental students point directly to the need for cost-effective, market-based solutions. One such solution is the use of Dental Support Organizations.

What is a Dental Support Organization?

First formed in the 1960's, a Dental Support Organization (DSO) is an entity that provides non-clinical business and administrative support services to dentists, most typically in a group practice setting. These services can include bookkeeping, payroll processing, billing and collections, advertising and marketing, human resources and regulatory compliance assistance. Outsourcing these non-clinical functions to an entity that specializes in each of these areas allows dentists to focus on what they were trained and licensed to do, which is to practice dentistry. [See Figure 1][11]

DSOs can also provide access to capital that might not otherwise be available to dentist-owners or, at least, might require them to negotiate and contract separately with lending institutions that may or may not have expertise in the various aspects of a dental practice. The access to capital enables dental practice owners to more readily expand, obtain the latest technology (both in terms of equipment and infrastructure such as electronic patient files), and attract associate dentists, hygienists and staff, all of which ultimately benefit patients.

FIGURE 1 CLINICAL ACTIVITIES VS. NON-CLINICAL ACTIVITIES



The Benefits of DSO-Supported Dental Practices

In the fight against oral health disease, DSO-supported dentists play a pivotal role. A 2012 policy brief estimated that DSO-supported dentists provided more than one-fifth of dental care services to children in Medicaid in 2009. According to the author, the DSO business model is "able to reduce operating costs" and provide flexible scheduling that recognizes the "impediments that many low-income families face with transportation and work arrangements."[12]

Studies have shown that dentists who use a DSO for non-clinical support services also bring significant cost savings and greater accessibility to high quality dental care for patients and payers, which is particularly relevant when providing care in underserved communities. DSO-supported dentists not only help expand access to oral healthcare, they also provide a real value to taxpayers. In a review of Texas Medicaid data from fiscal year 2011, the cost per patient per year at DSO-supported clinics was $483.89, compared to $711.54 at non-DSO-supported practices—an annual per patient savings of nearly one-third.[13] DSO-supported dentists also generally accept broader forms of payment, both public and private payers, and have increased accessibility to oral healthcare for states with managed care plans.[14]

"Studies have shown that dentists who use a DSO for non-clinical support services also bring significant cost savings and greater accessibility to high quality dental care for patients and payers."

Cost savings provided by DSO-supported dental practices have also been identified beyond the Medicaid setting. A 2012 study conducted by Dr. Donald H. Taylor, an associate professor at Duke University's Sanford School of Public Policy, found that DSO-supported practices charged, on average, 11 percent less than traditional practitioners.[15] Moreover, DSO-supported dental practices are frequently located in underserved areas, providing lower-income populations with treatment options that might not otherwise be available.

The National Hispanic Medical Association noted[16] that "the DSO structure has provided those who would otherwise be excluded from receiving care with a viable, reliable and cost-effective oral healthcare option." As public policy, DSOs offer a market-based solution that has been shown to provide efficient, low-cost dental care. When dentists are able to dedicate the majority of their time to providing clinical care instead of on complex billing and regulatory compliance issues, everyone benefits.

In 2015, ALEC adopted the resolution Opposing Restrictions on Contracting for Non-Clinical Dental Support Services.[17] The resolution noted the many benefits DSOs bring to expanding access to oral healthcare, and the need to protect a competitive marketplace and the advances to consumers. It also highlights that "state legislation or regulation should not discourage dentists from hiring DSOs as doing so would deny patients, dentists, third-party payers, state agencies and other consumers of dental services the benefits of competition resulting from the efficiencies that DSOs offer."

The Role of States in Promoting Market-Based Solutions

Every state has numerous professional licensing boards, established to help ensure public welfare and safety by maintaining and enforcing standards for professionals to operate in the state. These standards are often grounded in the need for proper education and training while providing the licensing boards with oversight and enforcement powers.

In the case of healthcare-related licensing boards, the need for oversight is readily apparent given the potential consequences of unlicensed activity. Until recently, there was very little interest in how a dentist might organize their non-clinical needs. Almost every state makes clear that only licensed individuals can provide clinical care and most explicitly or implicitly allow non-licensees to provide non-clinical administrative support services.

However, despite the many benefits DSOs provide to a dental practice, some state dental boards have either directly via their regulatory authority or through the legislative process, sought to restrict or limit a dentist's ability to contract with a DSO for non-clinical support services. This had led to both legal and public policy concerns about anti-competitive behavior.

The Risk and Impact of Anti-Competitive Actions

The priority of a licensing authority should be centered on protecting the public from harm, while maintaining the integrity of medical licensure in a jurisdiction. However, when legislative or regulatory restrictions negatively affect healthcare providers' ability to structure their business in a way that creates greater efficiencies in care delivery, it is clear government interference has exceeded its duty to protect the health and safety of consumers.

While there is a legitimate need for professional licensing boards, there is an equally compelling need to ensure they act in the public interest and not out of self-interest. In the healthcare industry, there is a history of anti-competitive behavior by licensing authorities, particularly when innovative models of care disturb the incumbent practices of medical professionals.

"The priority of a licensing authority should be centered on protecting the public from harm, while maintaining the integrity of medical licensure in a jurisdiction."

For example, in the early 1970s, the American Medical Association (AMA) prohibited physicians from entering into contract with Health Maintenance Organizations (HMOs) under the auspice of medical ethics.

With the passage of the Health Maintenance Organization Act of 1973, HMOs offered healthcare providers greater budget predictability through prepaid group plans to employers. At the time, the HMO model was a new and innovative payment structure, however was seen as a threat to existing healthcare providers who relied on direct-billing for each service provided to patients.

In 1975, the Federal Trade Commission (FTC) sued the AMA[18] for restricting doctors' ability to contract with HMOs. Through this process, the courts determined the underlying motivation for the AMA's restriction was to erect barriers to entry for the HMO business model, which was seen as an opportunity to lower healthcare cost inflation and increase competition and

choice in healthcare. Similarly, DSOs have been challenged through both regulatory and legislative efforts to restrict, and in some cases, ban their existence.

One example is that of the North Carolina (NC) State Board of Dental Examiners. The Board, consisting of mostly licensed dentists, sought to limit competition in the name of public safety. The Federal Trade Commission (FTC) challenged that claim. In 2015, the United States Supreme Court ultimately ruled that a licensing board made up of "active market participants" must have active state supervision or a clear legislative directive when undertaking anti-competitive action. The Court noted[19] that failing to do so would otherwise create an environment favoring some market participants over their competitors. Thus, in this case, the United States Supreme Court supported the lower courts decisions that the NC Board of Dental Examiners had unreasonably restrained trade in violation of the federal antitrust laws.

"While there is a legitimate need for professional licensing boards, there is an equally compelling need to ensure they act in the public interest and not out of self-interest."

Another example of regulatory overreach occurred in Texas in 2014 and 2015. The Texas State Board of Dental Examiners proposed new rules[20] restricting the ability of dentists to enter into contracts with 'unlicensed persons' for the provision of non-clinical functions of their dental practice. The board also sought to expand its authority to take disciplinary action against dentists who might chose to contract with a DSO without any mention or reference to its relevance to patient care or safety.

The Texas Board, made up largely of dentists appointed by the Governor, received overwhelming negative public comments including letters from legislators expressing concerns with the proposed rules as unnecessary and likely to reduce competition and raise the cost of dental services in the state. Among other comments was a letter from the Federal Trade Commission (FTC). The FTC noted that "Proposed regulations to limit commercial relationships between dentists and non-licensed entities should be carefully examined to determine if they are based on credible and well-founded safety, quality, or other legitimate justification… the proposed rules appear unnecessary to address any concerns about the independent judgment of dental professionals… we urge the Board to consider the potential anticompetitive effects of the proposed rules, including higher prices and reduced access to dental services... and to reject both proposed [rules]." The proposed rules were eventually withdrawn by the board.

In April 2016, the Texas Sunset Advisory Commission Staff Report[21] concluded "…the board, at the behest of dentist members, pursued significant rule changes more related to business practices than demonstrated public safety problems and despite widespread concern by stakeholders and other interests and a lack of broad consensus." The Report went on to say that "dentist board members have focused on matters that do not have a demonstrated public safety impetus, undermining the agency's processes and wasting its resources… At the behest of dentist members, the board has shown a propensity to push business-oriented matters without clear evidence of patient harm…" Thus, history is replete with instances where self-interested competitors attempt to use regulations to their own self benefit—and to the direct detriment of the public. Preserving, or trying to improve, the status quo has been the obvious motivation for those who have attempted to restrict innovation in healthcare.

In 2014, the Maryland State Board of Dental Examiners sought to adopt regulations making it virtually impossible for DSOs to operate in the state, despite having been there for 30 years. The administration was unwilling to approve the regulations, noting they involved matters of policy that required legislative consideration. As a result, in 2016, the dental board along with the Maryland State Dental Association sought legislation restricting the business functions a DSO could provide dentists. Although the legislation did not specifically mention DSOs, it would have restricted the ability of dentists to choose how they contract for non-clinical support services. Testimony during the hearings on the bill revealed only anecdotal and third-hand stories of DSO interference with clinical care. Since Maryland law already provides that only a licensed dentist may provide clinical care, any such interference is already illegal; suggesting the rationale for the legislation was rooted more in anti-competitive self-interest than concerns for public safety.

In Wisconsin, a state that specifically allows for a non-dentist to "own" a dental practice while still prohibiting a non-dentist from practicing dentistry, the State Dental Association sought legislation that would give the State Dental Board the authority to regulate entities such as DSOs on matters related to non-clinical activities. The bill failed, largely due to efforts state legislators—many who are members of ALEC—who diligently worked to oppose the anti-competitive and anti-free market nature of the proposed legislation.

Economic Consequences of Regulatory Overreach

Regulatory overreach of state licensing boards can discourage new market entrants by increasing business operating costs and unnecessary licensing requirements. In dentistry and other healthcare occupations, barriers to market translates into less access to patient care in terms of either cost, or supply of licensed professionals.

Restrictions such as additional reporting requirements and required approval over management agreements imposed on dentists whose practice outsources day-to-day operations through the use of a DSO will limit a dentists' ability to serve our most vulnerable. And further, at-risk populations such as those who receive care through the Medicaid program, or low-income working adults will suffer from these regulations that ultimately increase the cost of care. This has been shown in the findings above in the case of both Texas and North Carolina, who each have restrictive oversight over dentists' use of DSOs for non-clinical services. According to the Health Resources and Services Administration (HRSA) Dental Health Professional Shortage Areas designate 63 percent of the counties in Texas and 87 percent of counties in North Carolina to be underserved for dental services.

"Regulatory overreach of state licensing boards can discourage new market entrants by increasing business operating costs and unnecessary licensing requirements."

Limiting the Use of Non-Clinical Services Will Reduce Competition and Choice

In the previously mentioned case in Texas, the state licensing board governing dentists has enormous authority to oversee how a licensed dental professional can set up his or her private practice, restricting consumer access to lower cost and more widely accessible dental care. Board-promulgated authority over private business agreements between dental professionals and DSOs is bad public policy, and shows an unprecedented intrusion of regulation into the free market.

A number of organizations recognize both the legitimacy and value of DSOs. The Academy of General Dentistry noted that placing new regulations and restrictions on DSOs is unnecessary, stating "states do not need to create revolutionary laws… corporate practices in dentistry that comply with state laws and regulations… are functional modalities of dental practice."[22]

"Elected officials and regulators considering reforms and governing authority over state licensing boards should always consider incentives that will have the effect of encouraging free market innovation and growth of free market interests."

ALEC Policy Recommendations

Since 1973, the American Legislative Exchange Council (ALEC) has maintained its mission advancing limited government, free markets and federalism in public policy. All public policy solutions are viewed through that lens, including consideration of the proper authority of state occupational licensing boards.

Through the Resolution on Occupational Licensing,[23] ALEC affirms the liberty of individuals to conduct otherwise lawful commerce without unnecessary rules or other regulatory burdens imposed by a government entity. Further, unless the rules are absolutely necessary to protect the immediate health, safety or welfare of the public, ALEC opposes any restrictive measures that hinder both individual and economic growth.

When considering oversight of occupational licensing boards, elected officials should:

- Always consider regulatory oversight that increases economic opportunities, promotes competition and encourages innovation and growth of free market enterprises.[24]
- Use the least restrictive regulations necessary to protect consumers from present, significant and unsubstantiated harms that threaten public health and safety.
- Ensure occupational licensing boards determine a non-transferable authorization for an individual to perform a lawful occupation for compensation based on meeting personal qualifications established by the legislature.
- Only use highly restrictive and burdensome occupational licensing as the option of last resort after considering lesser regulations that will protect public safety.

Active supervision of occupational licensing boards is also a key piece to regulatory oversight of free market enterprises. ALEC supports independent supervision of state licensing entities, by a designee of either the legislature or by the state Attorney General, that determine boards rules and policies, ensuring they benefit consumers, not serve the private interests of providers of goods and services who the board regulates.

Conclusion

Regulatory overreach of our healthcare system can impact the market by discouraging new market entrants, decrease access and increase the cost of care. Elected officials and regulators considering reforms and governing authority over state licensing boards should always consider incentives that will have the effect of encouraging free market innovation and growth of free market interests. Promoting anything less will hinder innovative market-based solutions to the challenges we face in health and dental care in the U.S.

[End Notes]

1. Institute of Medicine, Report Brief, Advancing Oral Health in America (April 2011), available at: http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2011/Advancing-Oral-Health-in-America/Advancing%20Oral%20Health%202011%20Report%20Brief.pdf
2. Centers for Disease Control and Prevention, 2014 National Diabetes Statistics Report, Accessed November 2016: http://www.cdc.gov/diabetes/data/statistics/2014statisticsreport.html
3. US Department of Health and Human Services, "Oral Health in America: A Report of the Surgeon General–Executive Summary" 2000
4. Centers for Disease Control and Prevention (CDC) National Center for Health Statistics, Oral and Dental Health, Accessed November 2016: http://www.cdc.gov/nchs/fastats/dental.htm
5. American Dental Association, "Action for Dental Health–Year One: 2014, A Report to Congress," May 2014
6. American Dental Association, Oral Health and Well-Being in the United States Fact Sheet: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/OralHealthWell-Being-StateFacts/US-Oral-Health-Well-Being.pdf?la=en
7. American Dental Association Health Policy Institute, Most Important Barriers to Dental Care are Financial, Not Supply Related, By Thomas Wall, M.S. M.B.A., Kamyar Nasseh, Ph.D., Marko Vujicic, Ph.D., October 2014
8. American Dental Association Health Policy Institute, Financial Barriers to Dental Care Declining After a Decade of Increases, By Thomas Wall, M.S. M.B.A., Kamyar Nasseh, Ph.D., Marko Vujicic, Ph.D., October 2013
9. American Dental Association Health Policy Institute, Dental Care Utilization Rate Highest Ever among Children, Continues to Decline among Working-Age Adults, By Kamyar Nasseh, Ph.D.; Marko Vujicic, Ph.D., October 2014
10. American Student Dental Association, The Issues: Dental Student Debt, Accessed November 2016: http://www.asdanet.org/debt.aspx
11. Inside Dentistry website, Clinical Vs. Nonclinical Activities in the Dental Practice, Accessed September 2016: https://www.dentalaegis.com/id/2015/06/clinical-vs-nonclinical-activities-in-the-dental-practice?page_id=0#sthash.rouQRQen.dpuf
12. Burton L. Edelstein, DDS, MPH, "Dental Visits for Medicaid Children: Analysis and Policy Recommendations," June 2012
13. Arthur B. Laffer, Ph.D., "Dental Service Organizations: A Comparative Review," September 19, 2012
14. Stephen E. Thorne, BA, MHA, "End of the Solo Era?," DentalTown, April 2014
15. Donald H. Taylor, Ph.D., "Independent Review and Assessment of North Carolina Dental Health Marketplace Study," May 2012
16. National Hispanic Medical Association, Policy Brief: An Examination of Minority Populations and the Dental Service Organization Model in the United States, July 2015
17. American Legislative Exchange Council, Resolution Opposing Restrictions Contracting Non-Clinical Dental Support Services, Retrieved November 2016: https://www.alec.org/model-policy/resolution-opposing-restrictions-contracting-non-clinical-dental-support-services/
18. 638 F. 2d 443 - American Medical Association v. Federal Trade Commission Connecticut State: http://openjurist.org/638/f2d/443/american-medical-association-v-federal-trade-commission-connecticut-state-medical-society
19. Supreme Court 135 S. Ct. 1101 (2015)
20. U.S. Federal Trade Commission letter to Simon Salloum Assistant General Counsel Texas State Board of Dental Examiners, October 6, 2014
21. Texas Advisory Sunset Commission Staff Report, April, 2016
22. Academy of General Dentistry, "Investigative Report on the Corporate Practice of Dentistry," 2013
23. The American Legislative Exchange Council (ALEC) Resolution on Occupational Licensing, Accessed October 2016: https://www.alec.org/model-policy/resolution-on-occupational-licensing/
24. The American Legislative Exchange Council (ALEC) Occupational Board Reform Act, Accessed October 2016: https://www.alec.org/model-policy/occupational-board-reform-act/#_ftn1
25. Ibid.

MODEL **POLICY**

Resolution on Occupational Licensing

WHEREAS, [insert state here] oppose unnecessary and burdensome government regulations on commerce and individual citizens, and;

WHEREAS, [insert state here] opposes the implementation of occupational licenses, certifications, and or registrations unless needed to protect immediate health, safety, or welfare of the public, and;

WHEREAS, [insert state here] believes reducing occupational licensing requirements will increase economic prosperity and employment in the states, and;

WHEREAS, due to restrictive licensure requirements, states own the working "title" of hundreds of simple occupations thereby preventing individuals with on the job training, natural talent, honed skills, and formal education from using a job title without state approval, and;

WHEREAS, licensing requirements are often of little use to consumers and are instead used by private-sector entities to gain a competitive advantage through government intervention, and;

WHEREAS, many current types licensure should be made optional rather than mandatory as this may provide a competitive advantage for businesses who choose licensure while reducing costs for consumers, and;

WHEREAS, by restricting competition, licensing decreases the rate of job growth across the nation by an average of 29 percent. The total cost of licensing regulations in the United States is estimated at between $76.3 billion and $91.5 billion per year. In addition, by providing protection from competition, occupational regulation stifles innovation and entrepreneurship, thereby suppressing future economic growth, and;

WHEREAS, licensing requirements often create a burdensome barrier of entry for many individuals and often needlessly prevent individuals with criminal convictions, unrelated to the profession they are seeking to be licensed in and which pose little risk to the public, from working in their chosen field, and;

WHEREAS, [insert state here] supports the entrepreneurial spirit of Americans and their right to seek economic liberty and improve their standard of living;

NOW THEREFORE BE IT RESOLVED, state legislatures should review current occupational licensing laws in order to establish if commerce is better served by a less restrictive means such as voluntary registration and certification or no occupational regulation at all, and;

BE IT FURTHER RESOLVED, State legislatures should study the following criteria;

1. If state licensure requirements are overly restrictive and burdensome.
2. If costs to consumers are unnecessarily increased.
3. If licensure test questions and continuing education requirements are logical or relevant, and that they examine the rate of passage or failure.
4. How state employment is impacted by licensure requirements.
5. Consumer complaints and the enforcement activity of the board or commission.
6. If a less restrictive form of regulation, or no regulation would better serve the public.

Approved by ALEC Board of Directors on June 2008.

About the Author

Mia Palmieri Heck joined ALEC in August 2015. As the Health and Human Services (HHS) Task Force Director, Mia leads the nationwide effort to promote free market, pro-patient healthcare reforms at the state level. In her immediate past position she served as an executive at a Texas-based child and family services provider where she led the strategic planning and program development efforts for the agency.

From serving at the U.S. Department of Health and Human Services in the Administration of George W. Bush, to her work contributing to the design of community based models of care for at-risk populations, Mia's experience shows her early and lifetime commitment to advancing free market principles in the spheres of health and human services.

A proud Texan, Mia holds a Bachelor of Arts in Government from the University of Texas at Austin; she then later earned a Healthcare MBA from George Washington University in Washington, D.C.

About American Legislative Exchange Council

The American Legislative Exchange Council (ALEC) is America's largest nonpartisan, voluntary membership organization of state legislators. ALEC provides a unique opportunity for state lawmakers, entrepreneurs and citizen organizations to exchange ideas and develop pro-growth model policy based on research, analysis and proven business practices.

ALEC legislators represent more than 60 million Americans and ALEC private sector members create jobs for more than 30 million people across the country. Together, ALEC members discuss innovative policies and set priorities that have a measurable, positive impact on the states and nation.

The goal at ALEC is to foster efficient, effective, accountable and transparent government that respects hardworking taxpayers.

To learn more about how the American Legislative Exchange Council helps develop innovative solutions in partnership with lawmakers and business leaders, or to become a member, please visit www.alec.org.

ALEC American Legislative Exchange Council
LIMITED GOVERNMENT • FREE MARKETS • FEDERALISM

2900 Crystal Drive, Suite 600
Arlington, VA 22202

the STATE FACTOR

A PUBLICATION OF THE AMERICAN LEGISLATIVE EXCHANGE COUNCIL

To learn more about how the American Legislative Exchange Council helps develop innovative solutions in partnership with lawmakers and business leaders, or to become a member, please visit www.alec.org.

American Legislative Exchange Council
2900 Crystal Drive, Suite 600
Arlington, VA 22202
Tel: 703.373.0933
Fax: 703.373.0927
www.alec.org