

The Maine Heritage Policy Center | July 2017

REJECT

Medicaid Expansion

Unaffordable, Unfair, Unpredictable



INTRODUCTION

Medicaid, which was created in 1965 as part of President Johnson’s “War on Poverty,” is a program that provides medical and health-related services to vulnerable populations; it is funded through a combination of federal and state resources. Historically, Medicaid eligibility has been limited to low-income children, pregnant women, parents of dependent children, the elderly, and those with disabilities. However, the Affordable Care Act (commonly known as “Obamacare” or ACA), as interpreted by the U.S. Supreme Court in 2012, gives states the option to extend Medicaid coverage to nonelderly childless adults earning up to 138 percent of the federal poverty line (currently, childless, able-bodied adults in Maine are not eligible for Medicaid benefits).¹ Since 2014, thirty-two states (including the District of Columbia) have chosen to expand their Medicaid programs under the ACA.²



Governor LePage has vetoed proposals to expand Medicaid five times.

The Maine Legislature and Governor LePage have repeatedly rejected proposals to expand Medicaid. Last year, a coalition of liberal and progressive organizations gathered enough signatures to put the issue on the ballot in November 2017.

This policy brief details the consequences of Medicaid expansion in Maine, drawing on data from Maine’s previous Medicaid expansion in 2002 and the experiences of other states that have chosen to expand their programs.

MAINE’S PREVIOUS EXPERIMENT WITH MEDICAID EXPANSION

In 2002, under Governor Angus King, Maine expanded Medicaid eligibility to childless adults earning up to 125 percent of the federal poverty line, much like what is being proposed today. While these reforms were overturned by the LePage administration, they provide valuable insights into what impact Medicaid expansion under the ACA might have in Maine.

At the time, proponents³ made many predictions regarding the beneficial effects of Medicaid expansion. Data collected in the intervening years clearly demonstrate that these claims were false. Unfortunately, many of the same arguments are still being offered in favor of Medicaid expansion.

¹ Mitchell, Alison. “Questions about the ACA Medicaid expansion.” Congressional Research Service, 2015. <http://uncoverobamacare.com/wp-content/uploads/2015/02/CRS-memo-Questions-About-the-ACA-Medicaid-Expansion-Jan.-2015.pdf>

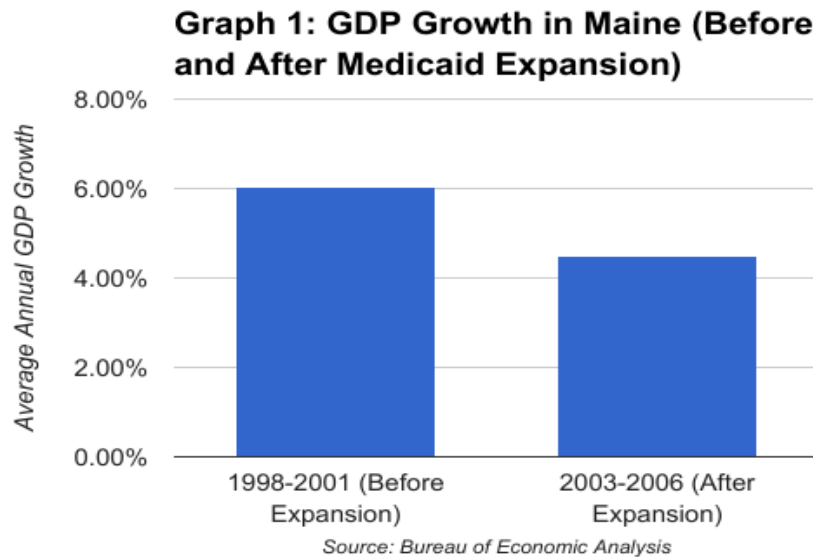
² Kaiser Family Foundation, “Status of State Action on the Medicaid Expansion Decision,” 2017. <http://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act>

³ Including Ann Woloson, then-Senior Health Policy Analyst at the Consumers for Affordable Health Care Foundation and Dr. Jacob Gerritsen, then-Chair of the Maine Medical Association’s Public Health Committee.

CLAIM

Medicaid expansion will provide a “huge boost” to Maine’s economy

FACT: There is no evidence that Medicaid expansion improved Maine’s economy. In fact, GDP growth in the years following the 2002 Medicaid expansion was substantially slower than during the previous years (see Graph 1). Other economic metrics also fail to support this prediction. The poverty rate, which had hovered around 10.5 percent from 2000 to 2002, surged to nearly 13 percent in 2006. And in 2010, more than seven years after the implementation of Medicaid



expansion, Maine ranked as the worst state in the country for business, according to Forbes.⁴

One of the reasons for Medicaid’s negative impact on state economic growth is that it creates a strong incentive for low-income workers to limit their earnings in order to gain (and retain) Medicaid coverage. This effect is largely a consequence of Medicaid’s eligibility structure which, unlike other welfare programs, does not phase-out gradually as one’s income rises. Instead, Medicaid coverage ends abruptly above a specified income threshold. If Medicaid expansion were to pass, childless, able-bodied Mainers earning up to 138 percent of the federal poverty line (FPL) would qualify for Medicaid, but those earning more than 138 percent of FPL would not be eligible for Medicaid benefits, which are estimated to be worth about \$5,855 per year, according to the Office of Program and Fiscal Review.⁵

⁴ Badenhausen, Kurt. “The Best States For Business And Careers.” Forbes, 2010. <https://www.forbes.com/2010/10/13/best-states-for-business-business-beltway-best-states.html>

⁵ Office of Fiscal and Program Review. Maine Legislature, 2014. http://www.mainelegislature.org/legis/bills/bills_126th/fiscalnotes/FN157802.htm

In 2015, the Census Bureau reported that 144,000 Mainers between the ages of 21 and 64 lived in households earning less than 138 percent of FPL. It also calculated that an additional 79,500 Mainers between the ages of 21 and 64 lived in households earning between 138 percent and 200 percent of FPL.⁶ While some of these are parents or disabled individuals who already qualify for Medicaid benefits, a large proportion consists of able-bodied, childless adults who would face strong incentives to reduce their earnings if Medicaid expansion were passed.

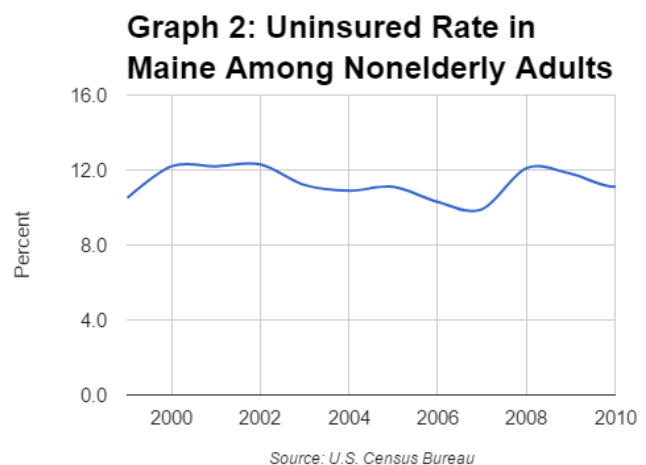
Several studies offer varying estimates of the labor market effect of Medicaid expansion, with most credible studies predicting a modest decline in labor force participation. A study published in *The Quarterly Journal of Economics* in 2014 analyzed the effects of a large-scale disenrollment of childless adults from Tennessee’s Medicaid program in 2005.⁷ The researchers found that “job search behavior, employment, and [private] health insurance coverage all increased almost immediately after the disenrollment,” suggesting that people had previously stayed out of the labor force to limit their earnings and remain eligible for Medicaid.

Maine desperately needs more people in its labor force, not fewer. As baby-boomers retire and the demands on existing government health programs grow even more severe, Maine needs to do all it can to encourage able-bodied adults to contribute productively to the economy. Medicaid expansion would undermine that objective.

CLAIM

Medicaid expansion reduces the uninsured rate

FACT: The uninsured rate among nonelderly adults in Maine remained remarkably stable in the aftermath of Medicaid expansion, due to a phenomenon called “crowd out.” Crowd out occurs when public health insurance programs are expanded and those who previously had private health insurance opt to enroll in the government program instead of continuing to personally finance their health insurance. In the aftermath of Medicaid expansion in Maine in 2002, the crowd out effect resulted in virtually no long-term change in the uninsured rate (see Graph 2). Instead, the



⁶ Small Area Health Insurance Estimates. U.S. Census Bureau, 2015. <https://www.census.gov/did/www/sahie/data/interactive/sahie.html>

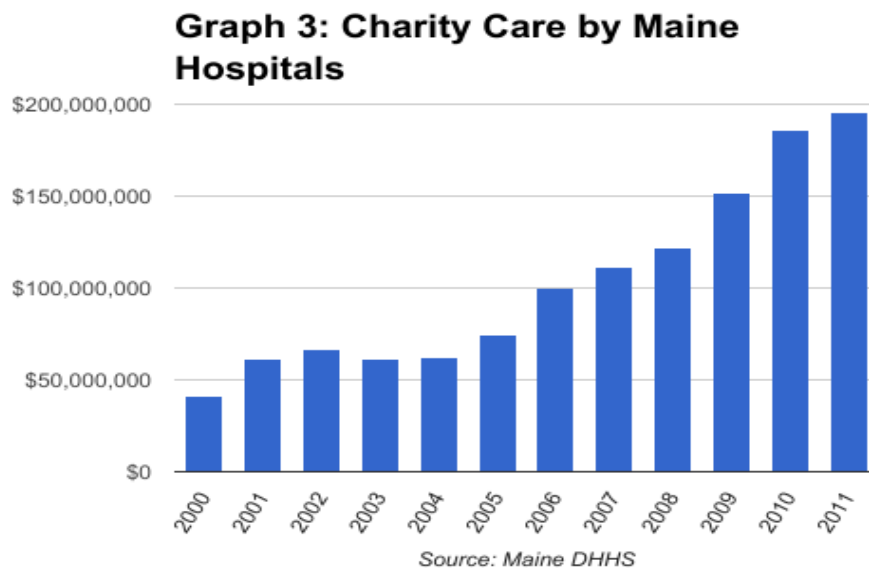
⁷ Garthwaite, C., Gross, T., & Notowidigdo, M. Public Health Insurance, Labor Supply, and Employment Lock. *The Quarterly Journal of Economics*, 2014. Available at: <http://www.kellogg.northwestern.edu/faculty/garthwaite/htm/tenncare-qje.pdf>

share of Mainers with employer-sponsored health insurance fell from 70 percent to 61 percent while the share of the population on Medicaid grew from 14 percent to 25 percent.

CLAIM

Medicaid expansion will reduce uncompensated care at hospitals and prevent “cost shifting” onto the privately insured

FACT: The 2002 Medicaid expansion had little effect on reducing uncompensated care. In fact, as Graph 3 shows, uncompensated care in Maine climbed steadily in the years after Medicaid expansion was implemented. There is also no evidence to support the idea that the 2002 Medicaid expansion reduced “cost shifting,” a phenomenon characterized by privately-insured patients being charged more in order to offset losses incurred due to uncompensated care. This finding is likely rooted in the fact that, as was noted above, the uninsured rate in Maine did not meaningfully drop after 2002; tens of thousands of low-income individuals still sought medical care without the ability to pay.



CLAIM

Medicaid expansion will save lives

FACT: This claim is based on crude, unscientific extrapolations, not sound scholarship. A 2012 study published in the highly-respected *New England Journal of Medicine* failed to detect a statistically significant reduction in Maine’s mortality rates in the aftermath of Medicaid expansion in 2002, compared to New Hampshire, which did not expand its Medicaid program at that time.⁸ A comparison of mortality rates in expansion and non-expansion states since 2014 also fails to support the assertion that Medicaid expansion has led to measurable improvement in public health. In fact, according to an analysis of data from the Centers for Disease Control and Prevention, states that expanded Medicaid in 2014 saw mortality increase by nine per 100,000 in 2015 while non-expansion states saw an increase of only six per 100,000.⁹

CLAIM

Medicaid expansion will only enroll an additional 11,000 people

FACT: Maine’s Medicaid expansion in 2002, combined with other changes to eligibility rules, led enrollment to climb from 200,000 in 2002 to 360,000 in 2011, an increase of 78 percent. Meanwhile, total Medicaid spending in Maine grew from \$1.4 billion in 2002 to \$2.6 billion in 2011, and nearly doubled as a share of the state budget.¹⁰

Proponents of Medicaid expansion frequently give low estimates for growth in enrollment in order to make the case that the overall cost of expansion will be low. Maine’s own experience, as well as the experiences of other states across the country, have repeatedly shown that these projections are inaccurate and drastically underestimate the growth of Medicaid, and the costs associated with that growth.

⁸ Sommers, B. D., Baicker, K., & Epstein, A. M. Mortality and Access to Care among Adults after State Medicaid Expansions. *New England Journal of Medicine*, 2012. Available at: <http://www.nejm.org/doi/full/10.1056/NEJMsa1202099#t=article>

⁹ Cass, Oren. “Will Repealing Obamacare Kill People?” Manhattan Institute, 2017. <https://www.manhattan-institute.org/html/will-repealing-obamacare-kill-people-10044.html>

¹⁰ Maine Medicaid – Important Facts. Maine Department of Health and Human Services, 2011. <http://www.maine.gov/dhhs/budget/supplemental-proposal.shtml>

HOW MUCH WOULD IT COST?

To understand the potential costs of Medicaid expansion, it is necessary to briefly delve into the details of Medicaid funding. Medicaid is funded jointly by the federal government and each of the states. The federal share is calculated through a formula (called the “Federal Medical Assistance Percentage,” or FMAP) which is based on a state’s per capita income, relative to the national average. As a result, poor states receive more federal Medicaid funding than wealthy states. In 2017, the FMAP ranged from about 50 percent to 75 percent; in other words, states paid between 25 and 50 percent of their Medicaid costs. Maine receives a federal match rate of approximately 64 percent.

The ACA provided enhanced federal Medicaid matching rates for individuals who receive coverage through the ACA Medicaid expansion.

These “newly-eligible” individuals are defined as nonelderly adults with family income up to 138 percent of the federal poverty line who would not have been eligible for Medicaid in the state as of December 1, 2009.

From 2014 to 2016, states that expanded their Medicaid programs received a 100 percent FMAP rate (i.e., full federal financing) for the cost of providing Medicaid coverage to newly-eligible individuals.

Beginning in 2017, the FMAP rate will phase down to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent afterward. These enhanced federal matching rates--which are significantly higher than the typical federal share of funding--can be tempting for states.

Graph 4 indicates the total estimated cost of Medicaid expansion in Maine, broken down between federal and state sources.

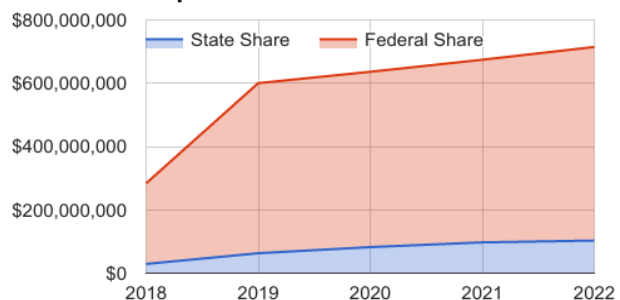
Although Graph 4 shows that only a small percentage of expansion costs

The Woodwork Effect Drives A Large Portion of the Costs of Medicaid Expansion

When public insurance programs are expanded and eligibility criteria are broadened, there is a well-documented surge in new enrollment from people who were already eligible for the program. Researchers call this phenomenon the woodwork effect, because it is caused by those previously eligible people who “come out of the woodwork” when eligibility is expanded to a new group.

Because the federal government’s enhanced Medicaid funding under the ACA only applies to newly-eligible populations, those who enroll in Medicaid because of the woodwork effect would impose a much larger cost on state taxpayers, since the federal government provides a lower level of financial reimbursement for these patients. The Maine Department of Health and Human Services estimates that 3,460 previously-eligible parents and 5,766 previously-eligible children would enroll in Medicaid if the program were expanded, at a cost of nearly \$50 million to the taxpayers of Maine.

Graph 4: Total Cost of Medicaid Expansion in Maine

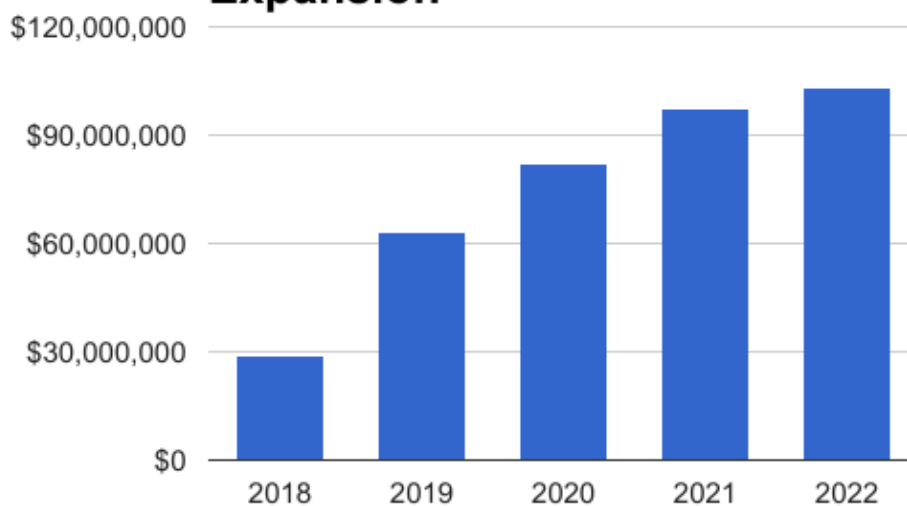


Source: Maine DHHS

would come from Maine’s budget, the idea that an influx of federal funding constitutes “free” money is merely an accounting trick, since taxpayers must ultimately be responsible for all federal spending.

Further, the direct costs to Maine taxpayers would be substantial, as shown in Graph 5. Over the next five fiscal years, state spending on Medicaid would total nearly \$400 million, reaching \$100 million in 2022 alone and increasing steadily in subsequent years as medical inflation outstrips the rate of personal income growth. To put that in perspective, expansion would require an annual tax increase of about \$180 on every household in Maine, or cuts to other programs (\$100 million is roughly equivalent to the combined annual budgets of the Department of Marine Resources, the Bureau of Motor Vehicles, and the Maine State Prison).¹¹

Graph 5: State Cost of Medicaid Expansion



Source: Maine DHHS

It’s important to keep in mind that most states that have expanded Medicaid since 2014 grossly underestimated enrollment and cost.

As the Foundation for Government Accountability noted in congressional testimony earlier this year, “newly-obtained data from twenty-four expansion states shows that at least 11.5 million able-bodied adults have now enrolled in ObamaCare expansion – an overrun of 110 percent, or more than double initial projections.

Some states have signed up more than four times as many able-bodied adults as they said would ever enroll.”¹² In addition to enrolling in unexpectedly large numbers, the Medicaid expansion population turns out to be more costly than originally projected.

¹¹ Maine Open Checkbook, 2016. <http://opencheckbook.maine.gov>

¹² Archambault, Josh. “Hearing on “Medicaid Oversight: Existing Problems and Ways to Strengthen the Program.” Foundation for Government Accountability, 2017. <http://docs.house.gov/meetings/IF/IF02/20170131/105493/HHRG-115-IF02-Wstate-ArchambaultJ-20170131.pdf>

According to a report by Medicaid’s chief actuary, per enrollee spending on expansion adults grew from \$5,511 in 2014 to \$6,365 in 2015, an increase of 15.5 percent.¹³ As a result, costs have skyrocketed, and some states have faced significant budget shortfalls (see Table 1).

Table 1: Significant Cost Overruns in Expansion States¹⁴

<i>State</i>	<i>Amount over Budget</i>	<i>Percent over Budget</i>	<i>Timeframe</i>
Alaska	\$61 million	42%	1 year
California	\$14.7 billion	222%	1.5 years
Colorado	\$550 million	45%	1.5 years
Illinois	\$2 billion	70%	2 years
Iowa	\$338 million	56%	1.5 years
Kentucky	\$3 billion	107%	2.5 years
New Mexico	\$600 million	45%	1.5 years
North Dakota	\$67 million	114%	1 year
Ohio	\$4.7 billion	87%	2.75 years
Oregon	\$2 billion	128%	1.5 years
West Virginia	\$198 million	46%	1 year

Will the Federal Government Continue to Offer Enhanced Funding for Medicaid Expansion?

Most estimates of the state costs of Medicaid expansion (including the Maine DHHS figures cited above) are predicated on the assumption that the federal government’s long-term contribution to the costs of Medicaid expansion will remain at 90 percent. Yet there is mounting evidence that the federal government will reduce its financial support for expansion states, driven by fiscal necessity in light of a gargantuan national debt. Economists are nearly unanimous in warning that dramatic cuts to entitlement programs (especially Social Security, Medicare, and Medicaid) are needed to stabilize the United States’ fiscal position and avoid a serious crisis in the decades ahead.

Medicaid is a major driver of federal spending. In 2016, Medicaid’s chief actuary projected that Medicaid costs would increase from \$576 billion in 2016 to nearly \$1 trillion in 2025. Over that ten-year period, Medicaid expansion will be responsible for \$806 billion of new spending, over the pre-

¹³ Actuarial Report on the Financial Outlook for Medicaid 2016. Department of Health and Human Services, 2016. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2016.pdf>

¹⁴ Archambault, Josh. “Hearing on “Medicaid Oversight: Existing Problems and Ways to Strengthen the Program.” Foundation for Government Accountability, 2017. <http://docs.house.gov/meetings/IF/IF02/20170131/105493/HHRG-115-IF02-Wstate-ArchambaultJ-20170131.pdf>

Affordable Care Act baseline.¹⁵ That's equivalent to about \$2,400 (in current dollars) for every resident of the United States. And remember, this merely represents the increase in spending caused by the *expansion* of Medicaid--it does not reflect the total cost of the Medicaid program, which is also expected to grow substantially in the coming years. In 2016, the Government Accountability Office warned that the expansion of federal health programs like Medicaid will continue to be a major driver of rising debt.¹⁶

President Trump and the Republican-controlled Congress have made repealing the ACA and reforming Medicaid top priorities. The American Health Care Act, which passed the House of Representatives in May and is being considered in the Senate, makes sweeping changes to Medicaid, and would substantially increase the state cost of expanding our program. While it is still unclear whether the Senate will approve this provision or make changes to it, there is little doubt that steps will be taken at the federal level to reform Medicaid to curb costs and limit enrollment.

Despite these realities, history teaches that social programs, once instituted, are difficult to eliminate. They become rooted in society, and people grow increasingly reliant on them for their basic needs. As a result, even if federal matching funds decline below 90 percent in the future and the taxpayers of Maine are forced to contribute much more than is currently estimated, it may not be politically feasible to repeal Medicaid expansion, or even scale it back to limit its budgetary impact. To avoid this, Maine voters should reject Medicaid expansion in the first place.

MEDICAID EXPANSION WOULD JEOPARDIZE HEALTH SERVICES FOR THE TRULY NEEDY

The ACA creates a perverse incentive for states to abdicate their responsibilities to care for their most vulnerable citizens--including children, the elderly, and the disabled--while providing generous health coverage to childless, able-bodied adults.

If Maine's Medicaid expansion turns out to be more expensive than expected, services for Maine's truly needy will be on the chopping block as legislators seek to reduce spending elsewhere in the budget.

To understand this, it's important to consider the federal government's role in reimbursing states for their Medicaid spending. As was discussed earlier, Maine currently receives a federal matching

¹⁵ Actuarial Report on the Financial Outlook for Medicaid 2016. Department of Health and Human Services, 2016. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2016.pdf>

¹⁶ The Nation's Fiscal Health. Government Accountability Office, 2017. <http://www.gao.gov/assets/690/682131.pdf>

rate of approximately 64 percent to cover most Medicaid recipients; the state pays only 36 cents of every dollar of Medicaid funding.

But the Affordable Care Act creates a two-tiered reimbursement system which offers states an enhanced reimbursement rate of at least 90 percent to cover newly-eligible childless adults. As a result, the state only pays approximately 10 cents of every dollars spent on newly-eligible adults.

If Medicaid costs run over budget, as they have in many states that have expanded their Medicaid programs, lawmakers will be forced to find additional funding through either higher taxes or spending cuts. But, thanks to the ACA's funding structure, Maine policymakers will have an incentive to cut from the truly needy first. Cutting benefits for newly-eligible adults would save just 10 cents out of every dollar cut while reducing funding for other Medicaid populations would save 36 cents on the dollar.

In several states that chose to expand their Medicaid programs, policymakers have already decided to reduce benefits for the truly needy to avoid budgetary imbalances in the face of mounting expansion costs.

Arizona, for example, eliminated coverage for heart, liver, lung, pancreas, and bone marrow transplants after an earlier Medicaid expansion cost taxpayers nearly four times what was expected.¹⁷ Truly vulnerable Medicaid patients in need of life-saving organ transplants did not receive them so that adults with no disabilities could continue to receive taxpayer-funded health care.

Arkansas Governor Asa Hutchinson has proposed nearly \$1 billion in cuts to the traditional Medicaid program. The governor said he "expects the cuts to come primarily from payments for services to patients with expensive medical needs, such as nursing-home residents, the developmentally disabled and the mentally ill."¹⁸

At the same time, about 3,000 Arkansans with disabilities are on the state's Medicaid waiting list. In Alaska, which expanded Medicaid in 2015, Governor Bill Walker has proposed to cut services for those with developmental disabilities.¹⁹

Despite the LePage administration's efforts to prioritize Medicaid services for the most vulnerable, there are still currently hundreds of Mainers with disabilities on Medicaid waitlists, unable to get the care they need.²⁰

One important reason for this is that reimbursement rates in Medicaid are extremely low, making it difficult for providers to attract high-quality staff. Instead of expanding Medicaid, policymakers

¹⁷ Archambault, Josh. "Nebraska's Medicaid Expansion Plan Puts Truly Needy Patients In Danger." *Forbes*, 2016. <https://www.forbes.com/sites/theapothecary/2016/03/15/nebraskas-medicaid-expansion-plan-puts-truly-needy-patients-in-danger/2/#2247248637f0>

¹⁸ Davis, Andy. "Backed by panel, governor to seek Medicaid changes." *Arkansas Democrat-Gazette*, 2015. <https://www.pressreader.com/usa/northwest-arkansas-democrat-gazette/20151217/283510794897864>

¹⁹ Archambault, Josh. "Hearing on "Medicaid Oversight: Existing Problems and Ways to Strengthen the Program." Foundation for Government Accountability, 2017. <http://docs.house.gov/meetings/IF/IF02/20170131/105493/HHRG-115-IF02-Wstate-ArchambaultJ-20170131.pdf>

²⁰ Lawlor, Joe. "Services for adults with acute intellectual disabilities feeling painful funding pinch." *Portland Press Herald*, 2017. <http://www.pressherald.com/2017/04/03/services-for-adults-with-acute-intellectual-disabilities-feeling-painful-funding-pinch/>

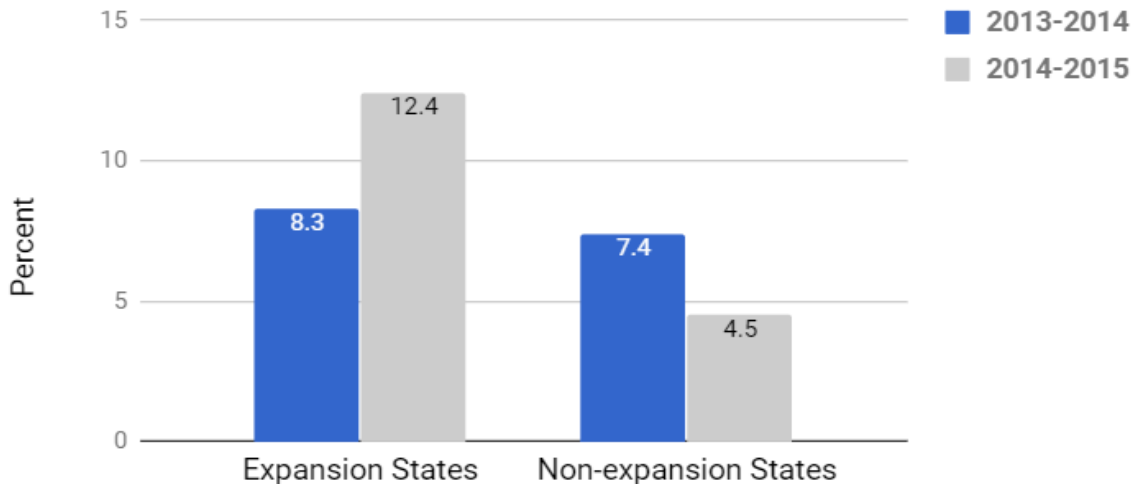
could increase Medicaid reimbursement rates for health care providers, which would make medical services more accessible for Maine’s current Medicaid population.

WHAT IMPACT WILL EXPANSION HAVE ON MAINE’S OPIOID EPIDEMIC?

While only Maine and one other state have seen Medicaid spending on anti-addiction medications decline between 2011 and 2016, the Maine DHHS’ overall substance abuse treatment and prevention spending increased over the same period. The department reviewed waitlists in late 2016 to identify persons still in need of services and appropriated an additional \$2.4 million to create 359 new slots for uninsured patients in medication-assisted treatment programs.²¹

Proponents of Medicaid expansion often assert that expansion will curb opioid use and reduce drug overdose deaths at the state level. However, data shows that expansion has only a modest impact, if any, on the number of drug overdose deaths experienced by individual states. Expansion is intended to provide treatment to previously uninsured segments of the population facing drug addiction, but there is little evidence that exists to suggest that expansion results in a reduction of drug overdose deaths.

Graph 6: Median Growth of Drug Overdose Deaths 2013-2015



Source: Centers for Disease Control and Prevention

²¹ <http://www.pressherald.com/2016/12/20/dhhs-to-dedicate-2-3-million-annually-to-new-medication-assisted-treatment-for-addiction/>

The five states that have the highest rates of death due to drug overdose – West Virginia, New Hampshire, Kentucky, Ohio, and Rhode Island – have all expanded their Medicaid programs under the ACA and saw increases in the number of drug overdoses in their respective states after expanding.

While this does not constitute enough evidence to conclude that Medicaid expansion is harmful or ineffective, it does undermine the claims of those who say that accepting expansion funds would significantly improve Maine’s capacity to address the opioid crisis.

At best, Medicaid expansion would have a modest effect on drug overdose deaths. States facing an alarming trend of opioid deaths likely felt more public pressure to expand in the first place, but it is probable that the epidemic is affecting more people than those seeking or receiving treatment, even with expanded eligibility. There are a number of other cultural, economic, and health disparities between states that make it difficult to entertain apples-to-apples comparisons or draw reliable conclusions about the positive impacts of Medicaid expansion on opioid use.

CONCLUSION

Supporters of Medicaid expansion paint a rosy picture. An economy booming as billions of federal dollars pour into the state. Thousands of lives saved because of free health care. The uninsured rate brought to all-time lows. But, as we’ve shown, these claims don’t withstand factual scrutiny.

Nearly any public policy seems favorable if only its benefits are considered. Stealing an apple from Peter to give it to Paul seems wonderful, if you focus on Paul’s elation and ignore Peter’s aggravation. Sound policy is not developed this way. The fact is that Medicaid expansion would damage Maine’s economy, increase the tax burden on thousands of struggling families, undermine the health care services of our most vulnerable neighbors, and do little to improve public health.

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