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STATE OF ALASKA

TONY KNOWLES, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

P.O. BOX 110801
JUNEAU, ALASKA 99811-0801
PHONE: (907) 465-3030
FAX: (907) 465-3088

MEMORANDUM

DATE: June 21, 1995

TO: AnnaLee McConnell, Director
Office of Management and Budget
Office of the Governor

FROM: *Karen Perdue*
Karen Perdue
Commissioner

SUBJECT: Long Range Financial Planning Commission
Excise Taxes on Alcohol and Tobacco

Post-It™ brand fax transmittal memo 7671		of pages 13
To <i>Melissa</i>	From <i>Brad</i>	
Co.	Co.	
Dept.	Phone # <i>465-4677</i>	
Fax # <i>258-9869</i>	Fax # <i>3008</i>	

The Department of Health and Social urges the Office of Management and Budget to bring the issue of increasing the excise tax rate for tobacco products and alcoholic beverages to the attention of the Long Range Financial Planning Commission. Alcohol abuse and tobacco use are major health problems in Alaska and the department approaches the issue of excise taxes solely from a public health perspective. The Department of Health and Social Services is not responsible for collection of these taxes which are, and should remain, within the purview of the Department of Revenue. Additional revenues generated would be deposited directly into the state general fund.

Department of Health and Social Services Perspective

While recognizing that the increased revenues generated by an increase in excise taxes would help meet the overall budget shortfall, the Department of Health and Social Services believes that the primary benefit of increased alcohol and tobacco excise taxes would be an improvement in the overall health status of the Alaskans.

Should the Commission choose to examine this issue, the department also suggests that the Commission consider mechanisms for sharing a portion of any additional revenues generated with local communities. The State of Alaska currently shares some taxes and fees with local communities to help local governments deal with the impacts or share in the economic benefits of certain activities. One example is AS 04.11.610 in which fees charged for the license to sell alcoholic beverages are appropriated back to the communities where they were earned.

The Department of Health and Social Services is committed to the goal of encouraging and enabling local communities to plan, finance and implement local solutions to health and social problems created or aggravated by alcohol and tobacco use. Sharing alcohol and tobacco excise tax revenues with local governments would provide increased local resources to further this goal.

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Background on Alcohol Use and Taxation:

Alcohol consumption rates are directly linked with health, safety and social problems. Alaska has for many years had one of the highest alcoholic beverage consumption rates in the United States, ranking fourth highest in per capita consumption. Surveys of Alaskan youth provide startling responses. Over 70% of Alaskan students in grades 10-12 report having used alcohol at some time during their lives compared to only 46% nationally. Only 5% of youth 12-17 years of age in the entire United States use alcohol frequently (at least weekly). In Alaska, this level is reached by the seventh grade and peaks at 25% in grade eleven.

The economic costs to the State and business of alcohol abuse is high. In Alaska this cost has been estimated to be as high as \$500 million annually. Nationally it is estimated that as much as \$34 billion of health care costs are attributable to alcohol abuse each year.

Excise taxes on alcohol were last increased in 1983. Per capita consumption declined significantly after 1983 and continued to decline through 1991. Inflation has since offset the deterrent effect of the last tax increase, however, and consumption has begun to rise. Increasing taxes on alcoholic beverages will assist in reversing the trend of consumption and will assist Alaska in obtaining the goal of 2.0 gallons per capita from the current 3.33 gallons as identified in *Healthy Alaskans 2000*, the initiative aimed at improving the health status of all Alaskans.

Background on Tobacco Use and Taxation:

Tobacco use is an enormous health problem. Tobacco kills one out of three users and disables many more. Causal links have been established between tobacco use and a number of chronic diseases including: stroke, numerous kinds of cancers, coronary heart disease, chronic obstructive pulmonary disease, peripheral artery disease, and low birth weight baby risks.

Nearly 20% of deaths in Alaska are smoking related (one Alaskan dies each day due to smoking attributable causes.) The direct health care costs attributable to smoking in Alaska in one year (1991) were estimated at \$45.6 million for persons 35 years of age or older. This is the equivalent of \$220 per Alaskan 35 or older or \$941 per smoker 35 or older. Indirect costs in that same year, including lost earnings and productivity for persons disabled by smoking-related chronic disease or who died prematurely from smoking related causes was \$82 million.

Although there have been dramatic gains in recent decades in the campaign against tobacco smoking, tobacco use among youth continues to be a public health epidemic. Every day more than 3,000 American teenagers become regular smokers.

The Department of Health and Social Services supports increasing taxes on tobacco because increases in tobacco taxes: (1) saves lives; (2) saves money, especially health care costs; (3) generates revenue; (4) is fair; and (5) is popular. Nearly 90% of smokers start smoking by the age of 21 and increasing the price of tobacco has been demonstrated to decrease the number of users, especially among youth.

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Affordability of tobacco appears to be the most important determinant of the number of children who will start smoking. An increase in the cigarette excise tax may be the most effective approach to reducing tobacco use. Teenagers are much more responsive than adults to increases in the price of cigarettes because they have less disposable income and may be three times more sensitive to price increases than adults' consumption. Also children and teenagers are usually less addicted than many adult smokers and, therefore, more likely to be able to stop smoking when prices increase.

The benefits of increasing the tobacco tax will most immediately be seen in the drop in consumption by youth and in the decrease in the number of youth who begin to use tobacco products. Only a very small percentage of tobacco users begin as adults. Reducing the initiation of youth to tobacco use is the most important prevention objective of health professionals. Studies have shown that children and adolescents who start to use tobacco do not understand the nature of tobacco addiction and are unaware of or underestimate important health consequences of tobacco use. Children and adolescents who use tobacco are persuaded to do so through advertising and peer pressure resulting from media images, and because it is readily available as well as inexpensive. Research concludes that higher tobacco excise taxes significantly reduce the number of teenage tobacco users.

Data compiled in the United States, Canada, California, and the United Kingdom indicate that for every 10% increase in the inflation-adjusted price of tobacco, general consumption will fall by about 4% but, more significantly, it will drop by about 10% among youth.

American tobacco taxes are among the lowest percentage of total price of virtually any country in the world. In 1989, California voters approved a citizen's initiative to raise their cigarette excise tax by 25 cents. Cigarette smoking dropped 17% between 1989 and 1991, about twice the U.S. average. In Michigan, on May 1, 1994 the cigarette excise tax was raised from 50 cents to 75 cents per pack. Since then, legal sales of cigarettes have declined approximately 30 percent, and cigarette tax revenue for August 1994 was \$45.9 million, up from \$21.8 million in August 1993.

Conclusion

Alcohol abuse and tobacco use are major health problems in Alaska. Increasing excise tax on these products is a key strategy for decreasing use among Alaskans--particularly among youth. Excise tax increases will also generate additional revenues to the State.

Enclosed are the relevant sections of the state health plan, *Healthy Alaskans 2000*, which provide further information on this subject. If you require additional briefing materials, please don't hesitate to contact my office. The department very much appreciates your willingness to bring this matter to the attention of the Long Range Financial Planning Commission.

Enclosures

cc: Commissioner Condon, Dept. of Revenue
Pat Pourchot, Office of the Governor
Peter Nakamura, Director, Div. of PH
Loren Jones, Director, Div. of ADA

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IMPACT OF CAPS ON FEDERAL SHARE GROWTH RATE TO ALASKA'S MEDICAID PROGRAM

Summary

Alaska expects its Medicaid program to grow at a conservative 10.6% each year from Fiscal Year 1996 through 2002. Yet Congress is considering capping the annual growth of federal Medicaid expenditures at 8% for FY 96, 7% for FY 97, 6% for FY 98, and 4% for FY 99 and each year thereafter. These caps on Medicaid expenditures would reduce health care funding in Alaska by approximately \$467 million over seven years. Further, under current law, the caps would end Medicaid payment for all optional services, including long term home-based care and inpatient psychiatric services in five years. Services for medically complex children, and services for some non-AFDC minors will be eliminated by the 7th year. Finally, if reductions are managed by reducing rates paid to providers instead of or in addition to eliminating optional benefits, several rural hospitals may be forced to close.

The following discussion summarizes the potential service and budget impacts on Alaska's Medical Assistance program from growth rate caps. The impacts are based on an expenditure model which projects Medicaid costs:

- over seven years;
- growing at 10.6% each year;
- under current program conditions;
- with no significant facility expansions; and
- proceeding with planned program changes.

A 10.6% growth rate was selected based on historical growth rates ranging between 10 and 20 percent, recent reductions in state revenues, and Alaska's limitations in achieving savings from managed care and other popular cost containment strategies.

Background

Approximately one sixth of Alaska's population - 85,000 people - are eligible to receive Medicaid services. The federal government pays half of program benefits, and 50 to 90% of administrative costs. Overall, federal funds are 51% of expenditures. Administrative costs represent 4% of the Medicaid budget.

In 1994:

70,000 of these eligible Alaskans actually used services, which include everything from prescriptions, to preventive care for children, to nursing home care for the elderly.

From DHSS

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In 1994 - cont'd:

- Alaska spent \$273 million in the Medicaid Program, 50% federal funds; 50% state, as follows.

- nursing home services	18%
- hospital services	31%
- physician services	18%
- prescription drugs	4%
- inpatient psychiatric care	5%
- community mental health	5%
- Early childhood screening and immunization.	2%

Medicaid eligibility is based on income. Children in families receiving public assistance comprise 38% of all Medicaid-eligible Alaskans. However, only 17% of expenditures are made for children. In contrast, elderly Alaskans represent only 6% of Medicaid-eligible residents, but represent 14% of the expenditures.

The Department may limit services so long as the services provided are adequate in "amount, duration and scope" to meet the recipients' medical needs. The medical provider and the patient decide the medical need to be met, and the Department then pays the provider directly. While the Department may set reasonable prices to be paid for services, the payments must be high enough to insure continued access to medical services.

Alaska Statutes

Alaska's Medical Assistance Statute (AK 47.07.035) requires the Department to pay for mandatory services for eligible individuals, as described in federal law. It also lists *optional services and optional groups of eligible individuals* in order, with #1 being the lowest priority and #31 the highest (see attached list, page 5). Under current law, if the state and federal funds together cannot pay for all mandatory and optional services, DHSS meets its budget by cutting optional services, beginning with #1. These optional services are mostly adult-only services, and do not affect care for children, until the end of the list is reached. The state legislature eliminated the first ten services during 1995, and required the Department to institute co-payments by recipients.

Some optional services replace more expensive mandatory services. For instance, experience shows that treatment for substance abuse dramatically decreases medical costs for these patients later on. By eliminating treatment or targeted case management for substance abuse and mental health clients, appropriate needed medical services may not be received, and more expensive acute care services may eventually be required.

Another example is home and community based care for medically complex children, mental health and developmentally disabled patients. Non-institutional long term care, provided at home or in a community clinic, is far less expensive than institutional care, and meets the

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Department's policy to provide services as close to home as possible. Also, as home based services are strengthened, the state reduces its bed capacity for institutional care. Therefore as the optional services are cut, home-based long term care may be eliminated. This would then require patients to be treated in the more expensive institution setting, which no longer has room for them! Because of these paradoxes, the impacts described here are not precise nor all-inclusive.

Projected Impacts With a 8%, 7%, 6%, 5%, 4% Growth Caps

Given the above assumptions, Alaska's Medicaid budget will experience a cumulative shortfall of more than \$500 million over seven years (see attached table and chart) if the growth of the federal share is capped at 8% in FY 96, 7% in FY 97, 6% in FY 98, 5% in FY 99 and 4% in 2000 and each year thereafter. The impact estimate improves by \$15 million per year by if the IHS Medicaid expenditures are not capped.

The first year will produce an \$4.3 million shortfall which the state may manage by reducing services, or paying for them totally with state general funds. By year three, FY 98, the additional funding (or cuts) needed for one year is \$41 million; by 2002 it is \$164 million.

If the state does not or cannot pay for program growth, all optional services may be eliminated by FY 2001. Given the current fiscal gap, we believe the legislature will not replace these funds.

Optional services eliminated federal growth caps (assume IHS funds are capped):

By FY 98, physical therapy, and half of the personal care services will be cut off.

By FY 99 all prescribed drugs and 2/3 of the home and community-based waiver services are eliminated.

In FY 2000 residential care for the mentally retarded will be eliminated.

During the first quarter of 2002, all optional services are eliminated, including skilled nursing for patients under 21, and home-based services for medically complex children. The remaining six "options" on the list are really eligibility groups, whose costs are captured in the services estimates.

So, ironically, Alaska could have a Medicaid program that moves Medicaid recipients into institutional care - the most expensive kind of health care. Adults who need hospital psychiatric care may not receive it, while children who could be served at home may have to be treated in institutions.

Further reductions to achieve the overall spending reductions will have to be made by adjusting rates for mandatory services.

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Other Issues

The expenditure model does not address other questions raised by capping or block granting Medicaid which may have significant impact on Alaska, including:

Electronic Data Systems

In question is the federal funding for electronic data systems; the timing on this is extremely important. Alaska is in the process of designing and building a new Medicaid Management Information System (MMIS), as required by the state's agreement with the federal government. The current cost sharing for this systems work is 90% federal and 10% state, for a total cost of \$9 million. The system is to be up and running by September 1997; the department's FY 96 capital budget request includes \$800,000 for the state share of the procurement. Our outstanding questions, then are:

- Will new Medicaid legislation require the same type of data system?
- Will 90% federal funding continue long enough to complete the new MMIS?

Managed Care

Other states are able to project significant savings over time by using managed care as a cost containment measure. However, because so many communities in Alaska are sole-facility or sole-provider communities, this does not present real opportunity for lowering the Medicaid growth rate. Rather, Alaska's Medicaid growth is mostly attributed to medical inflation rate, population growth, and a senior population that is growing at four times the national average. The highest cost of care per person is for the oldest members of the population.

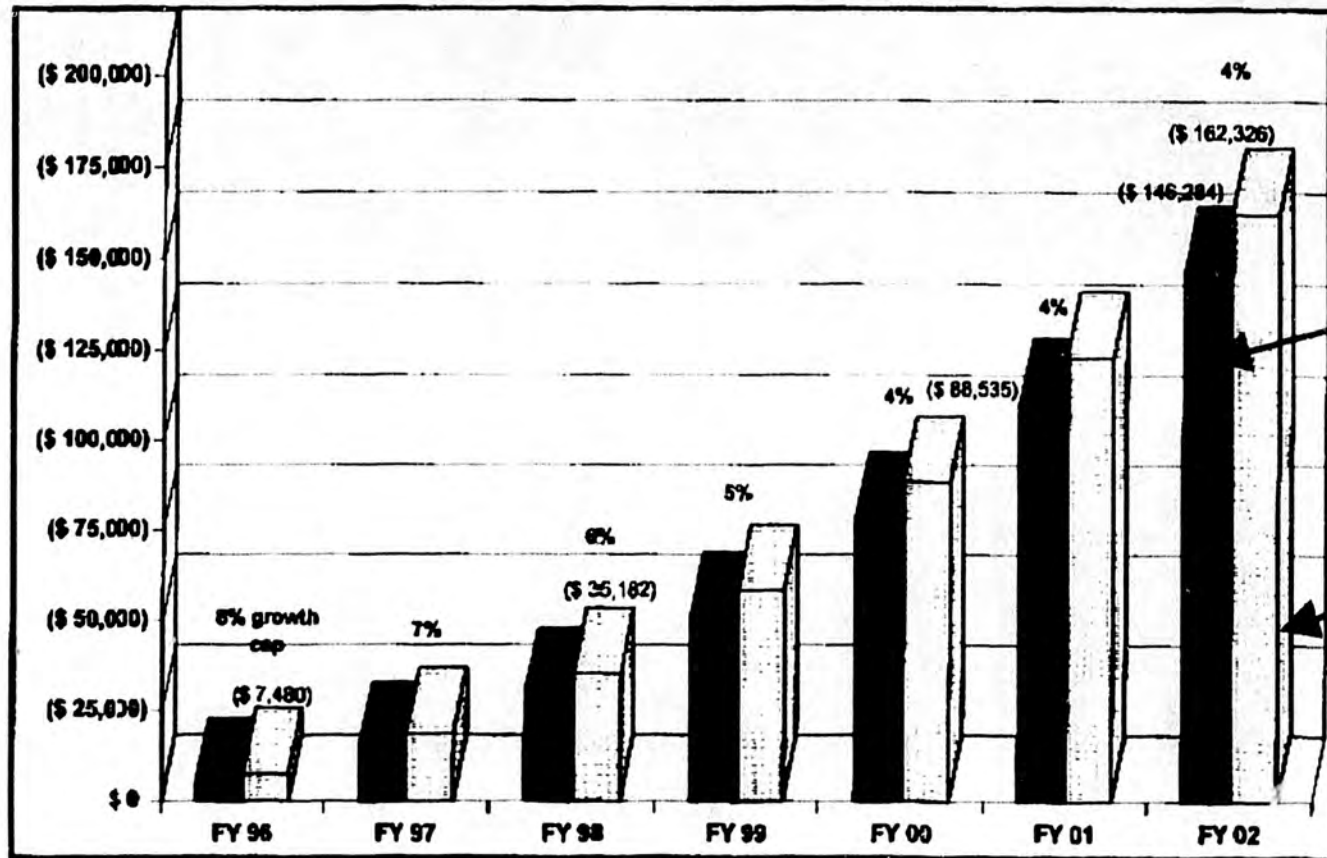
Although Alaska is exploring managed care for mental health, developmentally disabled and substance abuse clients, to ensure the most appropriate and cost effective treatment, we do not believe that managed care will significantly reduce the Medicaid rate of growth.

Boom/Bust Economy and Block Grants

Alaska's dependence on natural resources for its economic health will always produce fluctuations in the population and economy. These fluctuations are felt throughout state and private sectors, especially assistance programs. The flat funding of a Medicaid Block Grant will place significant stress on a state budget during downturns in the economy, requiring a greater proportion of state funding when state government has less to spend. The fact that Alaska's economic swings are frequently not in sync with those in the Lower 48 makes this more frustrating. During periods of increasing need for Medicaid, the federal block grant would create a large cost shift to the state.

Dollars Lost with Medicaid Growth Caps

(amounts in thousands of dollars)



■ Unfunded Costs - IHS No Cap 0 □ Unfunded Costs - IHS Capped 0

Federal, State growth capped - with no IHS cap \$434,133 million unfunded over 7 years

Federal, State and IHS capped \$493,386 million unfunded over 7 years

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Boren Amendment

Over half of the Medicaid expenditures in Alaska are payments to health facilities. Medicaid payments to hospitals and nursing homes must conform to the Boren Amendment, which is a part of federal Medicaid law. Because of this federal mandate, states are not able to adjust their Medicaid payments to reflect available funds. The result is that as available funds are reduced, a larger percentage of health care spending is diverted from less expensive community services to more expensive institutional services. Relief from the Boren amendment will give states greater flexibility in adjusting to funding reductions.

FY96 - FY02 Medicaid Expenditure Growth Cap Analysis
Department of Health and Social Services
Division of Medical Assistance
(Amounts in thousands of dollars)

BRU/Component	FY95 Authorized	8% FY96 Budget	7% FY97 Projected	6% FY98 Projected	5% FY99 Projected	4% FY00 Projected	4% FY01 Projected	4% FY02 Projected	Total 96 - 02
Medicaid Facilities	125,387.3	145,270	160,869	177,700	198,536	217,369	240,410	265,894	1,403,848
Medicaid Non-Facility	133,892.6	135,333	149,679	165,545	183,092	202,500	223,965	247,708	1,307,820
Indian Health Service	19,822.0	24,433	27,023	29,887	33,055	36,559	40,434	44,720	236,110
Medicaid State Programs	19,385.2	18,946	20,544	21,160	21,795	22,448	23,122	23,816	152,829
Waiver Services	8,881.5	11,248	12,441	13,780	15,218	16,832	18,616	20,589	108,706
Total Medical Assistance	307,368.6	336,231	370,355	408,051	449,697	495,708	546,547	602,724	3,209,313
Net Percent Change			10.15%	10.18%	10.21%	10.23%	10.26%	10.28%	Avg. 10.22%
Current Shares									
State Funds	141,348.1	149,449	165,022	182,239	201,272	222,315	245,579	271,300	1,437,176
Federal Funds	166,020.5	186,782	205,333	225,812	248,424	273,393	300,968	331,424	1,772,137
Shares with Capped Growth									
State Funds Capped	141,348.1	149,449	159,910	169,505	177,980	185,099	192,503	200,203	1,234,648
Federal share - IHS No Cap	166,020.5	182,327	195,970	208,971	221,093	232,118	243,816	256,237	1,540,532
Federal - IHS Capped	166,020.5	179,302	191,853	203,364	213,533	222,074	230,957	240,195	1,481,279
Unfunded Costs - IHS No Cap		(4,455)	(14,476)	(29,576)	(50,624)	(78,491)	(110,228)	(148,284)	(434,133)
Unfunded Costs - IHS Capped		(7,480)	(18,592)	(35,182)	(58,184)	(88,535)	(123,087)	(162,326)	(493,386)

ASSUMPTIONS:

1. 10.6% annual rate of growth in the Medicaid program across the projection period. This very conservative growth rate is used with consideration given to the unprecedented interest in health care spending, trends toward capitation and managed care, and the Alaska Legislature's interest in slowing Medicaid program growth together with its incongruent interest in refinancing state programs with federal Medicaid dollars. The program expenditure growth in the Medical Assistance components therefore continues at 10.6%, unless otherwise noted below.
2. Medicaid State Programs grow by 3% annually. This component funds reimbursable services agreements with other state agencies for Medicaid services, which the Legislature will ensure grows at a much slower rate than the balance of the program. This slightly reduces the 10.6% growth rate.
3. The amount of change to the program continues at the same historical rate. For example, changes in the amount, duration and scope of services offered, both positive (expansions) and negative (contractions) will continue at the same level as they have historically.
4. Growth rate includes modest changes in the Legislature's appropriation levels as well as health care inflation.
5. The eligibility caseload growth will continue at historical rates. For example, it reflects the addition of the next year of children born after January 1983 in compliance with the mandates of OBRA90.
6. No dramatic shifts will occur during the period. Dramatic swings in any one area are not included in the model and would invalidate projections.
7. No other cost shifts are made by the federal government to the state. An example would be if the Indian Health Services no longer provided outpatient hospital care. This model assumes that IHS Medicaid charges are not capped.
8. The Boren Amendment is not repealed by Congress. Additionally, not only is the Certificate of Need Moratorium statute passed; but when released, no new nursing home beds will be constructed.

6/14/95

**Preliminary Estimates
Cumulative Dollar Impacts of HR 4 Over 5 Years**

Funding Loss Estimates			
		5 Year Total	Comment
Title I	Cash Assistance AFDC, JOBS	(\$64,282,800)	Estimates range from \$50 - \$75 million. Level depends on whether or not the federal calculation includes Native JOBS funds. It appears not to include Native funds. However, not clear what is in base, so exact calculation not yet feasible.
Title II	Child Welfare	(\$5,000,000)	Federal estimate. Combines 23 programs; not yet clear what is in the base for each.
Title III	Child Care	(\$7,921,223)	Federal estimate may not include Native JOBS in base calculations.
	Nutrition	(\$40,000,000)	School-based meals, day care meals, WIC
Title IV	Immigrant Provisions	(\$17,225,018)	Legal and illegal aliens ineligible for benefits.
Title V	Food Stamps	(\$37,000,000)	
	Food Stamp Offsets	\$14,000,000	Savings created by reducing recipients in other titles.
Title VI - Social Security Provisions		(\$13,000,000)	Removes eligibility for some developmentally disabled children and adults whose disability is materially related to alcohol or drug addiction.
	Medicaid Cap on Growth Rate	(\$207,874,000)	By 2002 this number grows by \$285,400,000 to (\$493,400,000). This assumes that state also caps its share at federal rate.
Total Federal Funding Loss Over 5 Year		<u>(\$378,383,041)</u>	

Estimated Federal Funding Loss By Program Area Under HR 4							
Federal \$	1994	1995	1997	1998	1999	2000	5-Year Totals
Title I - Cash Assistance Block Grant							
# of Families - FY 94	12,942	13,757	14,455	15,178	15,937	16,734	102,213
# of Children	24,590	26,157	27,495	28,838	30,280	31,794	194,205
Block Grant Allocation ^{1,2}	\$51,669,000	\$51,669,000	\$51,669,000	\$51,669,000	\$51,669,000	\$51,669,000	\$308,345,000
Baseline Funding ³ & Projected Need ⁴ W/O Native	\$51,731,975	\$57,332,000	\$71,023,000	\$73,574,600	\$78,368,000	\$82,320,200	\$372,607,800
Baseline Funding ³ & Projected Need ⁴ W/ Native	\$52,855,451	\$59,309,180	\$72,774,618	\$76,413,349	\$80,234,016	\$84,245,717	\$382,978,861
Dollar Increase (Cut) in Funding ⁵ W/O Native in Base	(\$2,975)	(\$5,663,000)	(\$9,354,000)	(\$11,905,600)	(\$16,699,000)	(\$20,651,200)	(\$64,262,800)
Dollar Increase (Cut) in Funding ⁵ W/ Native in Base	(\$1,186,451)	(\$7,640,180)	(\$11,105,618)	(\$14,744,349)	(\$18,565,016)	(\$22,578,717)	(\$74,631,861)
Funds Reduction Based on Projected Need ⁴	-0.10%	-8.41%	-13.17%	-16.18%	-21.30%	-25.06%	-17.25%
Funds Reduction Based on Projected Need ⁴	-1.90%	-11.02%	-13.17%	-16.18%	-21.30%	-25.06%	-17.25%
Title II - Child Protection Block Grant							
# of Children - Average/year	9,972	10,984	11,904	18,510	19,991	21,590	
Block Grant Allocation ⁶	\$9,000,000	\$9,000,000	\$9,000,000	\$8,560,000	\$8,122,500	\$7,718,375	\$42,389,875
Baseline Funding ⁷ and Projected Need	\$7,639,587	\$9,000,000	\$9,000,000	\$9,499,500	\$10,259,460	\$11,080,217	\$48,839,177
Dollar Increase (Cut) in Funding ⁸	\$1,460,413	\$0	\$0	(\$949,500)	(\$2,136,960)	(\$3,363,842)	(\$4,989,860)
Funds Reduction Based on Projected Need		19.37%	0.00%	-10.00%	-20.83%	-30.36%	-10.22%
Title III - Child Care & Nutrition Block Grants							
Child Care Block Grant							
Avg. # of Families/month - FY 95	1,898	2,076	2,284	2,512	2,763	3,040	
Avg. # of Children/month - FY 95	3,060	3,366	3,703	4,073	4,480	4,928	
Block Grant Allocation ^{1,9}	\$6,757,000	\$6,757,000	\$6,757,000	\$6,757,000	\$6,757,000	\$6,757,000	\$39,786,000
Baseline Funding ^{7,10} and Projected Need ⁸	\$9,907,573	\$9,513,935	\$8,444,682	\$7,598,383	\$7,078,202	\$6,375,012	\$41,708,223
Dollar Increase (Cut) in Funding	(\$2,150,573)	(\$2,566,935)	(\$1,687,682)	(\$939,383)	(\$1,219,202)	(\$1,619,012)	(\$7,921,223)
Funds Reduction Based on Projected Need	-24.14%	-27.45%	-19.99%	-11.05%	-15.29%	-19.32%	-18.99%

End Notes:

1. Source: Federal Funds Information for States, Issue Brief - April 14, 1995 Vol 95-4 and CBO preliminary estimates
2. Federal estimate for allocation is \$63,000 below State's adjusted records (approximately 1%).
State records indicate expenditures of \$63,544,650 for State JOBS only.
Federal Source also uses a 2% reduction for adjustments when state claims against the fixed base are complete. This could be added back in or increased.
Apparently does not include Native JOBS funding of \$1,166,759
3. Includes Benefits, EA, State JOBS, using expenditure data, for a total of \$63.54 million.
Includes federal share of CSED collections which are not transferred to the Feds, but are transferred to DPA and credited to the federal match.
Does not include JOBS care child care funding - this is in Title III.
Includes 0.87% reduction for difference between obligations and expenditures (see 2 above).
Includes 2% reduction for final adjustments between states (see ² above)
4. Historical caseload growth over last 10 years was 7.65 percent
Over most recent five years, average caseload growth rate was 11.76 percent.
This projection assumes modest 5% growth unless otherwise noted.
5. Most federal literature estimates Alaska losses over five years at \$48 million.
6. Have no idea yet what is included in this estimated allocation - whether it is state-only.
Federal and National sources agree on this figure.
7. Includes only State and Native government child care.
8. Federal and national analyses all agree that \$5 million should be expected over five years.

This is prorated over three years FY 98-00 when no growth is accommodated, after initial increase.
9. **May not include Native Child Care set-asides.**
10. State Baseline **includes Native Child Care of \$876000 and Native Block Grant.**
Native and State JOBS Child Care need grew at 25-50% from 94-96;
All other program growth projected at 5% or less per year.

5/15/95