F I S C A L I M P A C T R E P O R T

SPONSOR HAFC **DATE TYPED** 3-3-05 **HB** 642/HAFCS

SHORT TITLE Interagency Native American Health Care Disparity Act **SB**

ANALYST Collard

APPROPRIATION

Appropriation Contained		Estimated Additional Impact		Recurring or Non-Rec	Fund Affected
FY05	FY06	FY05	FY06		
			Minimal	Minimal	General Fund

(Parenthesis ( ) Indicate Expenditure Decreases)

Relates to HB 342 and SB 1067

SOURCES OF INFORMATION
LFC Files

Responses Received From
Indian Affairs Department (IAD)
Department of Health (DOH)
Human Services Department (HSD)

SUMMARY

Synopsis of Bill

House Bill 642 enacts the Interagency Native American Health Care Disparity Act. It creates an interagency Native American health care disparity council and a Native American health care advisory committee. The bill also defines membership and the powers and duties.

The bill lays out the purposes of the act as follows:

- Assess health care disparities among the Native American population in comparison to other populations in the state;
- Research ways to coordinate health care programs for Native Americans that address the unique health care needs of Native Americans that are funded by the state or federal government;
- Coordinate information from state agencies to study the health care provided to Native Americans in New Mexico; and

- Provide an annual report to the governor and the Legislature on discovered disparities.

The Interagency Native American Health Care Disparity Council that is created in the bill is administratively attached to the Department of Health (DOH). The membership of the council is made up of the secretaries or designees of DOH, the Indian Affairs Department, the Human Services Department, the Children, Youth and Families Department, the Aging and Long-Term Services Department, the Corrections Department, and the Public Education Department, and the directors or designees of the Health Policy Commission and the Center for Native American Health at the University of New Mexico. The bill designates the secretaries of DOH and the Indian Affairs Department co-chair the council.

The council's duties are as follows:

- By May 1 of any year, the council will distribute data regarding Native American health care disparities or delivery of services funded or administered by members of the council to the advisory committee for the period ending on the previous December 31;
- By September 30, the council will provide a written report to the governor, the Legislature, and the advisory committee that outlines the status of Native American health care in New Mexico, compares availability, accessibility and quality provided to Native Americans versus other populations, and recommend improvements in services; and
- The council will inventory state funds spent on Native American health care, provide support and technical assistance for the Interagency Native American Health Care Disparity Act, consider the recommendations of the advisory committee and incorporate them in to the council's annual report and meet at least quarterly, or at the call of the co-chairs.

The Native American health care advisory committee that is created in the bill consists of 18 members, as follows: eight consumers of Native American health services that are specifically identified in the bill, five tribal government representatives, one urban Native American, two health care providers, one provider of traditional tribal medicine, and one provider of traditional western medicine.

The advisory committee's duties are as follows:

- Establish subcommittees as necessary to carry out the purpose and duties and address specific Native American health disparities;
- Identify ways to address access, availability and quality of health care for Native Americans with all founding sources;
- Submit recommendations by August 30 to the council to be included in the annual report on Native American health care disparities, including strategies for coordinated funding and greater availability of services;
- Promote recommendations for different Native American populations to begin addressing Native American health care costs; and
- Meet on a quarterly basis or at the call of the chair or vice chair, which will be selected by the membership.

The bill also allows for per diem and mileage for the advisory committee, contingent upon sufficient appropriations.

FISCAL IMPLICATIONS

There is no appropriation contained in this bill and it appears the only fiscal implication will be mileage and per diem for the advisory committee, if there are sufficient appropriations.

IAD notes future funding will be required to support the personnel, operation and program costs related to the council and committee.

As a member of the interagency council, HSD will also be a part of the interagency team that will contribute to writing and distributing annual reports. As written, the bill does not appropriate any dollars for this effort as well and HSD will have to cover this with participating state agencies.

ADMINISTRATIVE IMPLICATIONS

Because the council and the advisory committee are administratively attached to DOH, there will be some implications; however, DOH indicates the department could carry out the intent of the bill within existing resources.

HSD notes it will have to collaborate with the other state agencies on providing available data regarding access to health care or the delivery of health services, some of which is readily available. In addition, HSD will have to conduct an inventory on state funds that are spent on Native American health care services, which includes Medicaid. In order to provide such information as the bill reads, all participating state agencies, including HSD, will have to provide information regarding the number of Native Americans served, the services that were provided, and the dollars spent. Some state agencies will most likely not be able to meet this requirement due to scarce resources, inadequate infrastructure, or different data collection systems, thus, the state agencies will need to complete assessments and identify resources that will enable them to meet this requirement of the bill.

RELATIONSHIP

House Bill 642 relates to House Bill 342 which proposes to study urban Indian health solutions and Senate Bill 1067, which creates a multicultural health office.

TECHNICAL ISSUES

IAD notes it appears that the duties of the council and committee are duplicative. It may better serve the intent of the bill to create only the committee to advise the DOH secretary.

Regarding the make up of the advisory committee, in order for it to be more manageable and effective, IAD recommends that the membership consist of one urban Indian representative, one Pueblo representatives, one Apache representative, one Navajo representative, and one Indian Health Service representative for a total of five members. These five members would meet directly with the secretaries of DOH and IAD on a consistent basis, which could be quarterly.

OTHER SUBSTANTIVE ISSUES

IAD notes, in 2003, the state entered into an agreement with New Mexico's 22 Tribes through a

statement of policy and process which directs a government-to-government interaction between executive agencies and their Tribal counterparts on issues of mutual concern, such as health care. On February 1, 2005, the Governor signed an Executive Order directing state agencies, including DOH to adopt a pilot tribal consultation plan by July 1, 2005 to address the department's interaction with Tribal governments, communities, and/or individuals within New Mexico. Presently, the department works with Tribes and Indian organizations and will continue to strengthen these relationships.

IAD indicates the bill sponsor, the secretaries of DOH and HSD, the Deputy Secretary of IAD, tribal and urban Indian representatives and staff met to discuss the originally proposed Indian Health Care Act. During this meeting it was agreed upon that the best alternative to creating an Indian Health Division within DOH, would be to create an advisory council that would directly advise the secretary of DOH on a consistent basis. An advisory committee made up of tribal, Indian Health Service and urban Indian representatives would be the best first step to addressing the expressed concerns regarding Native American health care disparities and resources for health care services to Native Americans in New Mexico.

DOH notes according to the 2000 United States Census, New Mexico has a population of slightly fewer than 200 thousand Native Americans who compose 11 percent of the total population of the state. There is a wealth of research that indicates the severity of health related problems. In 2003, Ted Mala, Past President of the Association of American Indian Physicians stated that "more than 82 million Americans, including...American Indians… are at significantly higher risk for some of the most deadly and serious diseases facing our nation today… at the same time, access to health care is severely limited, and the cost of under treatment to society is immense."

There is no single tribal board to oversee the health needs and services for Native Americans. Individual boards exist, e.g., Indian Health Service (HIS) Health Boards, but none that collaborate formally and holistically in service planning and provision. Creation of an Indian Health Division could bring all interests together to develop comprehensive strategic health care plans.

Within the last two years DOH has improved tribal specific data collection and analysis by the creation of a Tribal Epidemiologist, within the Epidemiology and Response Division of DOH.

DOH indicates nationwide the healthcare status of Native Americans is significantly lower than the general population. When compared to general population, Native Americans are 770 percent more likely to die from alcoholism, 650 percent more likely to die from tuberculosis, 420 percent more likely to die from diabetes, 280 percent more likely to die from accidents and 52 percent more likely to die from pneumonia or influenza (National Indian Youth Council, Inc.).

Additionally, between 2000 and 2002, the leading causes of death for Native Americans residing in New Mexico were unintentional injuries, followed by cancer, disease of the heart, diabetes, and chronic liver diseases and cirrhosis. When compared to other races, Native Americans' rate of unintentional death rate per 100 thousand population in 2002 was 81, compared to 58.1 for Anglos. Native Americans die from diabetes at a rate of 71.5, per 100 thousand population, compared to all New Mexicans at a rate of 31.7 per 100 thousand population. This trend is also seen with nephritis, pneumonia/influenza, homicide, and chronic liver disease and cirrhosis.

Native American deaths totaled 7,691 from 1990 to 1999, accounting for 6.5 percent of resident deaths in New Mexico. Native American deaths in the United States were 0.4 percent. Health-

care disparities among the Native American population in New Mexico, among the largest in the nation, bring challenges to our health care system. According to National Healthcare Disparities Report, disparity can be defined as "the condition or fact of being unequal, as in age, rank or degree".

The DOH Health Systems Bureau Office of Primary Care and Rural Health has worked with many tribal and non-tribal organizations with the goal of improving access to health care, care coordination, resource allocation, and providing technical assistance. With these initiatives many rural counties like: San Juan, McKinley, Cibola, benefit. In 2003, 17 of the 33 New Mexico counties were designated as full or partial Health Professions Shortage Areas, posing a problem in providing health care to people in New Mexico. US Census Bureau, 2000 to 2002 data indicated that 22 percent of New Mexicans had no health insurance. Approximately 50.9 percent of New Mexico's children live below 200 percent of the poverty level. Many of these families are eligible for coverage under programs such as Medicaid.

The 2003 Social Indicators Report, by DOH, showed binge drinking among Native Americans has increased since 1997. The needs of the Native American population impose a strain on the under-funded IHS primary care system (Duran et al 2004), American Indians… experience significant disparities compared to whites for many health indicators. Rates for infant mortality among Native Americans are nearly one and a half times those of whites and age adjusted death rates of Indians in the IHS services areas (i.e., Indians living on or near reservations) were at least twice as high as United States rates for alcoholism, tuberculosis, diabetes, and accidents in 1992 to 1994. Cancer mortality rates for Indians increased between 1980 and 1997, while decreasing for whites.

As stated in 25 C.F.R. 900.3 (a)(2): "(b) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services."

HSD research indicates, according to a U.S. Commission on Civil Rights report, Native Americans are 670 percent more likely to die from alcoholism, 650 percent more likely to die from tuberculosis, and 318 percent more likely to die from diabetes and 204 percent more likely to suffer accidental death when compared with other groups. The substitute bill will provide an opportunity for state agencies to look into such disparities among Native Americans, with the input of an advisory committee that includes representation from federal and non-profit systems, and a traditional healing perspective.

AMENDMENTS

HSD suggests the language regarding the interagency council completing inventories of state funds spent on Native American health care services should be amended to give state agencies an opportunity to do assessments on where they stand today and how they can improve those positions to meet the requirement, rather than making them do inventories without adequate support and infrastructures.

KBC/rs