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

		ORIGINAL DATE	2/14/07		
SPONSOR	Lujan, B	**LAST UPDATED**	3/8/07	**HB**	784/aHHGAC/aHAFC
SHORT TITLE	Native American Health Care Improvements Act			**SB**	
				ANALYST	Hanika Ortiz

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Non-Rec	Fund Affected
FY07	**FY08**		
	$10,000.0	Recurring	General Fund

(Parenthesis ( ) Indicate Expenditure Decreases)

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Non-Rec	Fund Affected
FY07	**FY08**	**FY09**		
	$10,000.0		Recurring	Native American health care improvement fund

(Parenthesis ( ) Indicate Revenue Decreases)

Relates/Duplicates Appropriations in the General Appropriation Act

SOURCES OF INFORMATION
LFC Files

Responses Received From
Indian Affairs Department (IAD)
New Mexico Finance Authority (NMFA)
Department of Financing and Administration (DFA)
Department of Health (DOH)
Health Policy Commission (HPC)
Public Education Department (PED)

SUMMARY

Synopsis of HAFC Amendment

The House Appropriations and Finance Committee Amendment extend the date to 2009 before revenues from the Fund are dispersed. The amendment requires any general fund appropriation be an amount equal to sixteen percent of money paid from revenue-sharing by Indian nations that have entered into class III gaming compacts, not to exceed $10 million. The amendment further extends the date to implement the provisions within the Act until 2008.

SIGNIFICANT ISSUES

Under New Mexico's Revenue-Sharing Agreement, a tribe shall pay the state sixteen percent (16%) of the net win. As used in the Revenue-Sharing Agreement, "net win" means the annual total amount wagered at a gaming facility on gaming machines less the following amounts:

(1) the annual amount paid out in prizes from gaming on gaming machines;
(2) the actual amount of regulatory fees paid to the state; and,
(3) the sum of $250 thousand per year as an amount representing tribal regulatory fees, with these amounts increasing by five percent (5%) each year.

Synopsis of HHGAC Amendment

The House Health and Government Affairs Committee Amendment adds 2 additional voting members who are Native American not living in tribal or reservation communities to the council; adds language to the bill to include the role of statewide existing behavioral health structures charged with planning for substance abuse and mental health issues and directs a portion of the appropriation toward the entity; and, reclassifies tribal liaison positions to existing "classified" positions within agencies.

Synopsis of Original Bill

House Bill 784 appropriates $10 million from the general fund to the DOH to enact the Native American Health Care Improvement Act to address chronic health disparities for Native Americans; creates a Native American Health Council and defines council membership, terms and duties including oversight to implement the Act; creates within the DOH the position of Deputy Secretary for Native American Health Improvement to oversee the council; creates a Native American Health Fund to plan, develop and coordinate healthcare infrastructure and services and to make grants from for proposed projects authorized by the council; adds tribal liaison positions to stakeholder agencies; allows NMFA to issue and sell Native American Health Care Capital Project bonds for the purpose of planning, designing, constructing, equipping, furnishing and landscaping health care facilities authorized by the council; and, establishes a separate "Native American Health Care Account" within NMFA to pay for expenses related to the sale of bonds.

FISCAL IMPLICATIONS

Current Federal funding for Native American Healthcare is derived from the US Department of Health and Human Services and the Department of Indian Health Service (IHS) According to IHS funding for Indian health services increased in FY05 by 3.2% and 0.5% for facilities. An

additional $2.5 million was appropriated from the clinic construction fund for the Zuni Pueblo. In FY06 funding for services increased while funding for facilities decreased by less than 1%.

The appropriation of $10 million contained in this bill is a recurring expense into the new Native American Health Care Improvement Fund from the general fund. Balances in the fund shall not revert to the general fund at the end of any fiscal year.

House Bill 784 appropriates $10 million from the general fund to the Native American Health Care Improvement Fund to be used as follows:

- $2.2 million to support development of local health care plans for Native Americans;
- $5.0 million for support, supplement or expansion of existing systems providing health care services to Native Americans;
- $500,000 for research and investigation at the Center for Native American Health at the University of New Mexico School of Medicine Health Sciences Center;
- $600,000 for recruitment and training of students and practitioners pursuing careers in medicine or research;
- $500,000 for research and epidemiological studies;
- $400,000 for technical assistance and outreach to implement the Act;
- $400,000 for information systems and tech support for tribal health care delivery systems;
- $400,000 for unmet behavioral health care needs in tribal communities.

The NMFA may issue and sell bonds not to exceed fifteen years at $10 million for the purpose of planning, designing, constructing, equipping, furnishing and landscaping health care facilities upon certification by the Secretary of Health.

The Secretary of Department of Health (DOH) shall create a bond account within the fund:

- to pay for the issuance of bonds, principal, interest, premiums and other related expenses;
- repayment of Native American health care capital project bonds issued by the NMFA;
- transfer money from bond account to NMFA Native American health care account on July 1 of each fiscal year to pay for such bonds;
- Bond account interest shall be credited to the bond account upon NMFA certification;
- Proceeds in the fund may be used for administration, staffing and implementing the Act not to exceed 10 percent or $250,000.

The account shall be held separate with the NMFA for the purposes related to the sale of the bonds. Also, the NMFA shall project by June 30 to the secretary of health of each fiscal year the revenue required to pay the principal, interest, premiums and expenses related to the bonds.

The council shall authorize grant funding based upon the council's priority list. Such grants may be terminated upon request of the council through the department if grant is not achieving pre-determined goals.

House Bill 784 creates a new fund and provides for continuing appropriations. The LFC has concerns with including continuing appropriation language in the statutory provisions for newly created funds, as earmarking reduces the ability of the legislature to establish spending priorities.

The proposed appropriation for this initiative was not included in the Governor's Executive

Budget request for FY08.

SIGNIFICANT ISSUES

DOH reports Native Americans in New Mexico have the highest health disparity when compared to other racial/ethnic groups when compared with the following health indicators: mental illness, suicide, alcoholism/drug addiction, cancer, diabetes, obesity, heart disease. There are inadequate federal and tribal resources available to address these health disparities. Indian Health Services is under funded and does not meet the current service needs of Indian people in the State and the Nation.

Based on the New Mexico American Indian Health Status Data Report, 2005 created by the New Mexico DOH, the five leading causes of death in New Mexico affecting the Native American population (2000-2002) were cancers, unintentional injuries, diseases of the heart, diabetes, chronic liver diseases, and cirrhosis. Native American Infant mortality decreased over the past 10 years but remains higher then all other ethnic groups (7.2 and 6.1 per 1,000 live births, respectively in 2002). For male Native Americans, the leading types of cancer are prostrate, colorectal, lung, kidney and stomach; for female Native Americans the leading types of cancers are breast, colorectal, ovarian, corpus, uterus and stomach. Within all Native American groups, shigellosis and campylobacter rates were higher than those of all ethnic groups combined.

PERFORMANCE IMPLICATIONS

The council is charged with developing a five-year strategic plan to address health care services and delivery through a multi-agency collaborative approach; prioritizing initiatives; preparing and revising an action plan on an annual basis; and, identifying requests for proposals for grant funding, capital outlay, capital improvement projects and research.

ADMINISTRATIVE IMPLICATIONS

HB 784 will require the DOH Secretary to appoint a Deputy Secretary and Native American Liaison. These, in turn, will convene a 16-member Native American Health Council membership to include the Health and Human Services Cabinet Secretaries, the Indian Affairs Secretary and other members appointed by the governor based on nominations from the 22 Tribes.

DFA estimates administrative fiscal impact for all state agencies involved is $426,500 (includes additional “exempt” tribal liaison positions) and is estimated using the median salary and benefits of comparable positions currently within state government. The bill specifies that proceeds in the account may be used for administration, staffing and implementing the Act not to exceed 10 percent or $250 thousand. The additional budget impact for state agencies after subtracting the allowed maximum amount from the DFA estimate is $176,500. If current “classified” tribal liaison positions become the “exempt” positions as described in the bill, the additional budget impact will be reduced.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

Relates to HJM 15; showing state support for the reauthorization of the federal Indian Health Improvement Act

Relates to HB 721; amending the County Maternal and Child Health Plan Act to include Native American tribes

TECHNICAL ISSUES

IAD reports the definition provided for "Native American" in the Act (page 3) may prevent the provisions of services provided under the Act to certain individuals who qualify for federal IHS services as "Indians" but who are NOT Tribal members. This is because a person need not be a member of a federally recognized Indian Tribe to qualify for IHS services; rather, services are provided to those who can establish that they possess at least ¼ Indian blood from a federally recognized Indian Tribe.

A possible definition that could be used in the Act is provided in the federal Indian Health Care Improvement Act, Public Law 94-437, copied below:

> *(c) "Indians" or "Indian", unless otherwise designated, means any person who is a member of an Indian tribe, as defined in subsection (d) hereof...such terms shall mean any individual who (1), irrespective of whether he or she lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member, or (2) is an Eskimo or Aleut or other Alaska Native, or (3) is considered by the Secretary of the Interior to be an Indian for any purpose, or (4) is determined to be an Indian under regulations promulgated by the Secretary.* (emphasis added)

As such, if an individual could establish that they qualify for IHS services, they could apply for the services provided under the Act

OTHER SUBSTANTIVE ISSUES

IAD reports The United States has a federal trust responsibility established by treaties, legislation, executive orders, and court rulings to provide health care services to members of federally recognized tribes. The primary federal agencies responsible to provide healthcare for Native American tribal members are the U.S. Department of Health and Human Services ("HHS") and the Indian Health Service ("IHS").

According to a study conducted by the U.S. Commission on Civil Rights, federal funding for Indian health care services is inadequate to address Native American health disparities:

> *"...The federal government spends less per capita on Native American health care than on any other group, for which it has this responsibility, including Medicaid recipients, prisoners, veterans, and military personnel. Annually, IHS spends 60 percent less on its beneficiaries than the average per person health care expenditure nationwide."*

According to the National Library of Medicine, the American Indians' diversity, coupled with their small population groups scattered throughout the United States, has made it difficult to provide a uniform, readily accessible health care system.

ALTERNATIVES

HSD suggests providing additional funding to existing DOH and other departments' health and behavioral health budgets explicitly designated to address the needs of Native American tribes, pueblos and Navajo Nation.

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

HSD, CYFD, DOH and ALTSD will continue to have "classified" tribal liaisons as employees whose purpose is to work specifically with Native Americans.

DOH, along with local health councils, will continue to plan and provide funding for Native American health needs to address health care disparities.

The Behavioral Health Purchasing Collaborative, along with the Behavioral Health Planning Council and two local collaboratives recognized explicitly to plan for the mental health and substance abuse needs of Native Americans, will continue to complete the planning process and will advise the Executive and the Legislature regarding Native American behavioral health needs.

AMENDMENTS

HSD has the following suggestions for amendments to improve the bill:

1. Page 19, line 9; page 21, line 1; page 22, line 16; and page 24, line 7; replace the word "exempt" with the word "classified." All these positions currently exist as classified positions and have individuals in those four classified positions.
2. To acknowledge the appropriate role for the existing behavioral health structures charged with planning for substance abuse and mental health issues, as follows:

    A. Page 9, Section 6(G) – Eliminate the words "alcohol and substance abuse and other critical behavioral health concerns," and create subsection H. to read as follows:

    > "H. provide input to the interagency behavioral health collaborative established in Section 9-7-4.1 and the behavioral health planning council established in Section 24-1-28 regarding the parts of the comprehensive behavioral health plan developed by the collaborative and the council to address the mental health and substance abuse needs of Native Americans in New Mexico;"

    B. Page 26, line 20 – before the word "to" insert "to the interagency behavioral health purchasing collaborative"; and line 23 – after the word "facilities" insert "and programs, in consultation with the behavioral health planning council".

Page 7 insert between line 1 and line 2, "(6) a member that represents the urban population in New Mexico."

AHO/nt