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AMENDING THE NATIVE HAWAIIAN HEALTH CARE IMPROVEMENT ACT TO REVISE AND EXTEND THAT ACT

NOVEMBER 10, 2004.—Ordered to be printed

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Mr. CAMPBELL, from the Committee on Indian Affairs,
submitted the following

R E P O R T

[To accompany S. 702]

The Committee on Indian Affairs, to which was referred the bill (S. 702), a bill to amend the Native Hawaiian Health Care Improvement Act to revise and extend that Act, having considered the same, reports favorably thereon without amendment and recommends that the bill do pass.

PURPOSE

The purpose of S. 702, a bill to provide for the reauthorization of the Native Hawaiian Health Care Improvement Act, is to improve the health status of Native Hawaiians through the continuation of a comprehensive health promotion and disease prevention effort that involves health education in Native Hawaiian communities, and the provision of health services using health care providers trained in western medicine and traditional Native Hawaiian healers. In areas where there is an underutilization of existing health care delivery systems that have the capacity to provide culturally-relevant health care services, S. 702 provides authority for the Secretary of the Department of Health and Human Services to enter into contracts with Native Hawaiian health care systems to provide health care referral services to Native Hawaiian patients. S. 702 is intended to assure the continuity of the health care programs that are provided to Native Hawaiians under the authority of Public Law 100-579.

As enacted in 1988, the Native Hawaiian Health Care Improvement Act is premised upon the findings and recommendations of the Native Hawaiian Health Research Consortium report to the Secretary of the Department of Health and Human Services of December, 1985. That report clearly indicates that the underutilization of existing health care services by Native Hawaiians can be traced to the absence of culturally-relevant services in which traditional Native Hawaiian concepts of healing are lacking, as well as to a general perception in the Native Hawaiian community that health care services, which are fundamentally based on concepts of Western medicine, will not effect the healing or cure of diseases and illnesses afflicting Native Hawaiian people.

HISTORICAL BACKGROUND

The islands that now compose the State of Hawai'i were governed by a monarchy of Native Hawaiians until 1893. The Native Hawaiian government was recognized as an independent sovereign nation by foreign governments, and treaty relationships were established with the United States (Treaty of Friendship, Commerce, and Navigation of 1849; Treaty of Commercial Reciprocity, January 30, 1875.) Expanded trade with the United States resulted in increased western influence in the islands, and in 1893, the government of the Kingdom of Hawai'i was overthrown in an insurrection engineered by a group of western businessmen in an effort to secure the annexation of Hawai'i to the United States. The United States minister in Hawai'i ordered one company of marines and two companies of sailors to be landed, and the minister then recognized a new provisional government even before Queen Liliuokalani's lines of defense had surrendered. Although the provisional government sought immediate annexation by the United States, President Grover Cleveland refused to submit a treaty of annexation to the Senate, finding that the provisional government lacked the popular support of the Native Hawaiian population and that the government would not have been established but for the lawless and unauthorized military intervention of the United States (see Pub. L. No. 103-150). Upon the inauguration of William McKinley as the new President of the United States in 1897, however, the western businessmen that sought annexation were able to change the official U.S. position, and in 1898, Hawai'i became a territory of the United States.

Prior to European contact, it was estimated that there were 400,000 Native Hawaiians in the Hawaiian Islands. By 1919, the Native Hawaiian population had been reduced to 22,600, and many were concluding that the native people of Hawai'i were a "dying race," (see S. Rep. No. 108-85, at 13-14 (2004)) and that if they were to be saved from extinction, they must have the means of regaining their connection to the land, the '*aina*.' Accordingly, in 1920, the Hawaiian Homes Commission Act was enacted into law by the U.S. Congress, establishing a land base that could serve as a permanent homeland for Native Hawaiians and encouraging agricultural pursuits. The Act placed approximately 203,000 acres under the jurisdiction of the Hawaiian Homes Commission, a branch of the territorial government established for the purpose of "rehabilitating" persons of at least fifty percent Native Hawaiian ancestry through a return to pastoral life. The Act also authorized

the Commission to undertake “activities having to do with the economic and social welfare of the homesteaders.” (See generally Hawaiian Homes Commission Act, 42 Stat. 108 (July 9, 1921))

Hawai‘i was admitted into the Union of States in 1959. Under the Hawaii Admission Act, the title to the lands set aside under the Hawaiian Homes Commission Act was transferred from the United States to the State of Hawai‘i. The Admissions Act requires the State to hold the lands “as a public trust * * * for the betterment of the conditions of Native Hawaiians * * * and their use for any other object shall constitute a breach of trust for which suit may be brought by the United States” (Hawaii Statehood Admissions Act, Pub. L. No. 86–3, § 5(f), 73 Stat. 4 (Mar. 18, 1959)).

BACKGROUND

Language contained in the 1984 Supplemental Appropriations Act, Public Law 98–396, directed the Department of Health and Human Services to conduct a comprehensive study of the health care needs of Native Hawaiians. The study was conducted under the aegis of Region IX of the Department by a consortium of health care providers and professionals from the State of Hawai‘i in a predominantly volunteer effort, organized by Alu Like, Inc., a Native Hawaiian organization. An island-wide conference was held in November of 1985 in Honolulu to provide an opportunity for members of the Native Hawaiian community to review the study’s findings. Recommended changes were incorporated in the final report of the Native Hawaiian Health Research Consortium, and the study was formally submitted to the Department of Health and Human Services in December of 1985. The Department submitted the report to the Congress on July 21, 1986, and the report was referred to the Select Committee on Indian Affairs (S. Rep. No. 108–85 (2004)).

Because the Consortium report’s findings as to the health status of Native Hawaiians were compared only to other populations within the State of Hawai‘i, the Select Committee requested that the Office of Technology Assessment (OTA), an independent agency of the Congress, undertake an analysis of Native Hawaiian health statistics as they compared to national data in other United States populations. Using the same population projection model that was employed in OTA’s April 1986 report on Indian Health Care (U.S. Congress, Office of Technology Assessment, Indian Health Care, OTA–H–290 (Washington, DC: U.S. Government Printing Office, April 1986)) to American Indian and Alaska Native populations, and based on additional information provided by the Department of Health and the Office of Hawaiian Affairs of the State of Hawai‘i, the Office of Technology Assessment report contains the following findings:

The Native Hawaiian population living in Hawai‘i consists of two groups, Hawaiians and part-Hawaiians, who are distinctly different in both age distributions and mortality rates. Hawaiians comprise less than five percent of the total Native Hawaiian population and are much older than the young and growing part-Hawaiian populations.

Overall, Native Hawaiians have a death rate that is thirty-four percent higher than the death rate for the United States all races, but this composite masks the great

differences that exist between Hawaiians and part-Hawaiians. Hawaiians have a death rate that is 146 percent higher than the U.S. all races rate. Part-Hawaiians also have a higher death rate, but only 17 percent greater. A comparison of age-adjusted death rates for Hawaiians and part-Hawaiians reveals that Hawaiians die at a rate 110 percent higher than part-Hawaiians, and this pattern persists for all except one of the 13 leading causes of death that are common to both groups.

As in the case of the U.S. all races population, Hawaiian and part-Hawaiian males have higher death rates than their female counterparts. However, when Hawaiian and part-Hawaiian males and females are compared to their U.S. all races counterparts, females are found to have more excess deaths than males. Most of these excess deaths are accounted for by diseases of the heart and cancers, with lesser contributions from cerebrovascular diseases and diabetes mellitus.

Diseases of the heart and cancers account for more than half of all deaths in the U.S. all races population, and this pattern is also found in both the Hawaiian and part-Hawaiian populations, whether grouped by both sexes or by male or female. However, Hawaiians and part-Hawaiians have significantly higher death rates than their U.S. all races counterparts, with the exception of part-Hawaiian males, for whom the death rate from all causes is approximately equal to that of U.S. all races males.

One disease that is particularly pervasive is diabetes mellitus, for which even part-Hawaiian males have a death rate 128 percent higher than the rate for U.S. all races males. Overall, Native Hawaiians die from diabetes at a rate that is 222 percent higher than for the U.S. all races. When compared to their U.S. all races counterparts, deaths from diabetes mellitus range from 630 percent higher for Hawaiian females and 538 percent higher for Hawaiian males, to 127 percent higher for part-Hawaiian females and 128 percent higher for part-Hawaiian males. (Id.)

These findings clearly establish that the health status of Native Hawaiians is significantly worse than that of other U.S. population groups, and that in a number of areas, the evidence is compelling that Native Hawaiians constitute a population group for whom the mortality rate associated with certain diseases exceed that for other U.S. populations in alarming proportions.

Native Hawaiians premise the high mortality rates and the incidence of disease that far exceed that of other populations in the United States upon the breakdown of the Hawaiian culture and belief systems, including the banning of the use of traditional healing practices, that was brought about by western settlement, as well as the influx of western diseases to which the native people of the Hawaiian Islands lacked immunities.

In 1998, an organization of Native Hawaiian health care providers, Papa Ola Lokahi, updated the health care statistics from the original E Ola Mau report. Additionally Papa Ola Lokahi extrapolates the data that the Hawai'i State Department of Health

annually gathers on Native Hawaiians from the Department's behavioral risk assessment and health surveillance survey. The findings from those assessments revealed that—

With respect to cancer, Native Hawaiians have the highest cancer mortality rates in the State of Hawai'i (216.8 out of every 100,000 male residents and 191.6 out of every 100,000 female residents), rates that are 21 percent higher than that for the total State male population (179.0 out of every 100,000 residents) and 64 percent higher than that for the total State female population (117.0 per 100,000). Native Hawaiian males have the higher cancer mortality rates in the State of Hawai'i for cancers of the lung, colon, rectum, colorectum, and for all cancers combined, and the highest years of productive life lost from cancer in the State of Hawai'i. Native Hawaiian females have the highest cancer mortality rates in the State of Hawai'i for cancers of the lung, liver, pancreas, breast, corpus uteri, stomach, colon, rectum, and for all cancers combined.

With respect to breast cancer, Native Hawaiians have the highest mortality rates in the State of Hawai'i, and nationally Native Hawaiians have the third highest mortality rates due to breast cancer. Native Hawaiians have the highest mortality rates from cancer of the cervix and lung cancer in the State of Hawai'i, and Native Hawaiian males have the third highest mortality rates due to prostate cancer in the State.

For the year 2000, Native Hawaiians had the highest mortality rate due to diabetes mellitus in the State of Hawai'i, with full-blood Hawaiians having a mortality rate that is 518 percent higher than the rate for the statewide population of all other races.

In 1990, Native Hawaiians represented 44 percent of all asthma cases in the State of Hawai'i for those 18 years of age and younger, and 35 percent of all asthma cases reported, and in 1999, the Native Hawaiian prevalence rate for asthma was 69 percent higher than the rate for the total statewide population.

With respect to heart disease, the death rate for Native Hawaiians is 68 percent higher than for the entire State of Hawai'i, and Native Hawaiian males have the greatest years of productive life lost in the State of Hawai'i. The death rate for Native Hawaiians from hypertension is 84 percent higher than that for the entire State, and the death rate from stroke for Native Hawaiians is 20 percent higher than for the entire State.

Native Hawaiians have the lowest life expectancy of all population groups in the State of Hawai'i. Between 1910 and 1980, the life expectancy of Native Hawaiians from birth has ranged from 5 to 10 years less than that of the overall State population average, and the most recent data for 1990 indicates that Native Hawaiian life expectancy at birth is approximately 5 years less than that of the total State population.

With respect to prenatal care, as of 1998, Native Hawaiian women have the highest prevalence of having had no

prenatal care during their first trimester of pregnancy, representing 44 percent of all such women statewide. Over 65 percent of the referrals to Healthy Start in fiscal year 1996 and 1997 were Native Hawaiian newborns, and in every region of the State of Hawai'i, many Native Hawaiian newborns begin life in a potentially hazardous circumstance.

In 1996, 45 percent of the live births to Native Hawaiians mothers were infants born to single mothers. Statistics indicated that infants born to single mothers have a higher risk of low birth weight and infant mortality. Of all low birth weight babies born to single mothers in the State of Hawai'i, 44 percent were Native Hawaiians.

In 2000, Native Hawaiians had the highest number of fetal deaths in Hawai'i. Twenty-one percent of all fetal deaths in the State were associated with expectant Native Hawaiian mothers and 37 percent of those Native Hawaiian mothers were under the age of 25 years.

These and other health status statistics contained in the findings section of S. 702 clearly establish that the health care challenges that the Native Hawaiian health care systems were established to address require reauthorization of the Native Hawaiian Health Care Improvement Act.

NATIVE HAWAIIAN HEALTH CARE MASTER PLAN AND NATIVE HAWAIIAN HEALTH CARE SYSTEMS

The concepts embodied in S. 702 are the result of the Committee's work with Native Hawaiian health care professionals and others who are dedicated to improving the health status of Native Hawaiians. It is based on the beliefs of those with whom the Committee has consulted, that to insure that Native Hawaiians are able to achieve the healthful harmony of the self (body, mind, and spirit) or *lokahi*, with others and all of nature, and to assure that Native Hawaiians are able to function effectively as citizens and leaders in their own homeland, there must be a restoration of cultural traditions, an integration of traditional healing methods in the health care delivery system, and a collective effort to restore to the Native Hawaiian, a sense of self-esteem and self-worth, for his or her culture, as well as for the individual.

E Ola Mau, a group of Native Hawaiian health care professionals, proposed that this effort begin with the development of a health care master plan, based on a bio-psycho-socio-cultural-political model that would be aimed at identifying significant events and factors related to specific health care needs and issues. E Ola Mau proposed that this master plan be implemented at every societal level (individual, household, community, county, and state) in the Hawaiian Islands. It is its goal to have this Native Hawaiian way of dealing with health, eventually become an institutional part of the State's health policy for both Native Hawaiian and other citizens of the State of Hawai'i.

After much debate and careful consideration in the Native Hawaiian community and amongst those concerned with the health status of Native Hawaiians, a consensus was reached that Papa Ola Lokahi, the Native Hawaiian Health Board, should be the

mechanism through which Native Hawaiian health care systems would be developed, coordinated, administered, monitored, and continually revised to meet the changing health care needs of the Native Hawaiian population. Papa Ola Lokahi is currently composed of five organizations:

- (1) The Office of Hawaiian Affairs, an agency of the State which was established pursuant to the authority of amendments made to the Constitution of the State of Hawai'i in 1978 to assure the well-being and to advance the interests of Native Hawaiians;
- (2) E Ola Mau, a nonprofit organization of Native Hawaiian professionals dedicated to insuring that Native Hawaiians achieve a healthful harmony of self (body, mind, and spirit) with others and all of nature, and become productive citizens and leaders in their homeland;
- (3) Alu Like, a Federally-funded Native Hawaiian agency that promotes vocational training and the founding of community-based organizations that promote health, education, and economic development for Native Hawaiians;
- (4) The University of Hawai'i; and the
- (5) The Office of Hawaiian Health within the State Department of Health.

Papa Ola Lokahi has assumed the primary responsibility of overseeing the development and maintenance of a Native Hawaiian Comprehensive Health Care Master Plan. Papa Ola Lokahi also is the entity responsible for certifying to the Secretary of Health and Human Services the qualifications and capabilities of Native Hawaiian organizations that petition the Secretary to carry out, pursuant to contracts with the Secretary, the provisions of the Act.

The Native Hawaiian Health Care Act of 1988, Pub. L. No. 100-579, 102 Stat. 2916, authorized Papa Ola Lokahi, the Native Hawaiian Health Board, to—

- Designate a chairman and vice-chairman from among its member organizations and such other officers as may be deemed necessary to carry out its responsibilities under the Act;
- Adopt bylaws and such other internal regulations or procedures as may be deemed necessary to carry out its responsibilities under the Act;
- Certify to the Secretary that a Native Hawaiian organization meets the definition of “Native Hawaiian organization” as set forth in the Act;
- Certify to the Secretary that a Native Hawaiian organization has the qualifications and capacity to provide the services or perform contract requirements pursuant to a contract with the Secretary;
- Oversee the development of a comprehensive Native Hawaiian health care master plan;
- Assure the conduct of health status and health care needs assessments of Native Hawaiian communities desiring to participate in Native Hawaiian health care programs; and
- Coordinate the activities and functions of all Native Hawaiian organizations operating health care programs pursuant to contracts with the Secretary.

The Native Hawaiian Health Care Act of 1988, Pub. L. No. 100-579, 102 Stat. 2916 (Oct. 31, 1988) envisions a comprehensive health care system that is community-based, building upon the Native Hawaiian *‘ohana* system¹ and incorporating traditional healing (*la ‘au lapa ‘au*) practices with western medical services to provide a health care system that will be culturally sensitive and responsive to the needs of Native Hawaiian communities.

As originally enacted, Public Law 100-579 authorized the establishment of Native Hawaiian Healing Centers on each of the islands comprising the State of Hawai‘i, upon the acceptance of and in consultation with the Native Hawaiian communities on those islands, and wherever possible, using existing health care facilities and health care providers now serving the Native Hawaiian communities on those islands. These centers were intended to lead and coordinate the development and implementation of a statewide Native Hawaiian health care system which would include: (1) a research and monitoring staff, state-certified neighborhood counselors, outreach workers and health educators, traditional Native Hawaiian healers, and Native Hawaiian cultural educators; (2) primary health care providers; (3) primary health care facilities, using existing health care facilities where practicable and acceptable to the local Native Hawaiian community; (4) participation by the State Department of Health, Office of Hawaiian Health in the provision of disease prevention and health promotion programs, as well as a multidisciplinary approach to Native Hawaiian health care which would include nursing, dental hygiene, nutrition education, maternal and infant child care education; and (5) other Federal, State, county, community, and private organizations and agencies that could provide services which meet the health care needs of their respective communities.

The development of the master plan by Papa Ola Lokahi was intended to include:

- (1) Work with Native Hawaiian communities which support the establishment of a Native Hawaiian Health Center;
- (2) Conducting a community health needs assessment survey for participating communities;
- (3) Facilitating the development, establishment, and effective functioning of such Centers on the islands of O‘ahu, Moloka‘i, Maui, Hawai‘i, Lana‘i, Kaua‘i and Ni‘ihau; and
- (4) Coordinating the work of relevant agencies and organizations to provide participating communities with:
 - (a) Direct health care services and health education, including maternal and child health care and mental health care;
 - (b) Instruction in the Native Hawaiian language, cultural beliefs, and traditions with an emphasis on health concepts and practices;
 - (c) Training and education of health care providers and educators and cultural educators in health promotion and disease prevention;

¹The *‘ohana* system is based upon the fundamental unit of societal interaction for Native Hawaiians in which a family or an organization is led by a *haku* (the recognized leader), whose function is to coordinate and facilitate the expertise and resources of the various households or affiliated organizations in order to accomplish a task or resolve a problem. The households or affiliated organizations are in turn led by a *po‘o* (the head of the household or designated leader of the organization).

(d) Basic and applied research and monitoring of Native Hawaiian health care approaches to validate outcomes and create standards of quality care;

(e) Development of health care services, training and education that would have a Native Hawaiian perspective as its primary focus;

(f) Development of Native Hawaiian community health counselors, outreach workers, educators, and community health aide training programs;

(g) Prevention-oriented health care services in medical, dental, nutrition, mental health, and in other designated areas as needs assessments may identify as necessary;

(h) Data collection related to prevention of diseases and illnesses among Native Hawaiians;

(i) Medical and general health-related research into the diseases that are most prevalent among Native Hawaiians;

(j) Mental health research in areas of mental health problems that are most prevalent in the Native Hawaiian population;

(k) Ongoing health planning for further development of the Native Hawaiian health care system; and

(l) The provision of health care referral services when certain health care services are not available within the Native Hawaiian Health Center.

Following enactment of the Native Hawaiian Health Care Improvement Act, the Papa Ola Lokahi Board incorporated and began working with health care providers on each island on the development of a master plan and an island-specific plan for the provision of primary health care and health care referral services. Those involved in the planning effort ultimately determined that the health care needs of Native Hawaiians would be better served by the establishment of five Native Hawaiian health care systems which could be composed of as many health care centers as might be necessary to serve the health care needs of Native Hawaiians on each island.

Accordingly, Papa Ola Lokahi certified to the Secretary that five health care systems qualified as Native Hawaiian organizations for purposes of entering into contracts with the Secretary, and plans for the provision of primary health care services or health care referral services were submitted to the Secretary in 1990. The first contract awards were 13 made in October of 1991, and since that time, the health care systems have been engaged not only in the implementation of the plans approved by the Secretary, but the provision of health care services. The plans for each health care system vary according to the availability of and access to existing health care resources on each island and the need for health care services. Currently, all five Native Hawaiian health care systems have become incorporated as 501(c)(3) non-profit health care organizations.

In general, the capacity to provide critical health care services exists only on the island of O'ahu, and thus, it has long been the pattern that if a patient requires hospitalization and complex surgery or treatment, the patient would be referred to a health care provider on the island of O'ahu and would have to incur the costs associated with air travel to O'ahu. However, it is not uncommon

that treatment requiring advanced medical technology must be secured in the continental United States.

The Native Hawaiian Health Care Improvement Act provides authority for the provision of health promotion, disease prevention, and primary health care services to Native Hawaiians who reside in the State of Hawai'i. Federal planning funds first became available in July of 1990. However, Papa Ola Lokahi incorporated in February 1989 and was able to initiate its organizing activities in July 1989 with funds provided by the Hawai'i State legislature. Between July 1989 and December 1990, informational meetings and organizational activities took place throughout the State, resulting in the establishment or recognition of the five Native Hawaiian health care systems which would assume the responsibility for providing services: (1) Ho'ola Lahui Hawai'i for Kaua'i and Ni'ihau; (2) Ke Ola Mamo for O'ahu; (3) Na Pu'uwai for Moloka'i and Lana'i; (4) Hui No Ke Ola Pono for Maui; and (5) Hui Malama Ola Na 'Oiwī for Hawai'i. Papa Ola Lokahi provided planning funds and technical assistance to these five health care systems, which then developed their service plans from January through June 1991, applied for funding under the Native Hawaiian Health Care Act in July 1991, and were awarded service grants in October of 1991.

The basic set of services that all five health care systems must provide include: (1) outreach services to inform Native Hawaiians of the availability of health services; (2) education in health promotion and disease prevention of the Native Hawaiian population by Native Hawaiian health care practitioners, community outreach workers, counselors, and cultural educators, whenever possible; (3) services of physicians, physicians assistants, nurse practitioners or, other health professionals; (4) immunizations; (5) prevention and control of diabetes, high blood pressure, and otitis media; (6) pregnancy and infant care; and (7) improvement of nutrition.

In the initial stages, because the five health care systems needed to gain experience in managing health services and because of limited funds, each health care system concentrated on outreach, health assessments, case management, and disease prevention and health promotion activities, with the ultimate objective of providing the full range of health and medical services that are available through a typical primary health care center, and working with traditional healers so that their services would also be more readily available to Native Hawaiians.

Now that the five island-wide Native Hawaiian health care systems are established and engaged in the provision of health care services, Papa Ola Lokahi's role is to provide technical support and training to the five health care systems, work with each of the systems to develop a statewide, cooperative Native Hawaiian health system, develop research activities and capacities within the five health care systems, and evaluate how well the objectives of the Native Hawaiian Health Care Improvement Act are being met.

The goals and objectives, as well as the services provided by each of the five Native Hawaiian health care systems is contained in Appendix A of the committee report.

Through the work of the five Native Hawaiian health care systems, on an annual basis, 20,000 Native Hawaiians continue to benefit from the range of health care services provided by the systems.

NATIVE HAWAIIAN HEALTH CARE PROFESSIONS SCHOLARSHIPS

The Native Hawaiian Health Care Improvement Act also provides authority for the provision of scholarships to Native Hawaiians who are seeking higher education opportunities in the health care professions. The Native Hawaiian Health Scholarship Program has been administered by the Kamehameha Schools, but S. 702 will transfer administration of these scholarships to Papa Ola Lokahi.

Scholarships awarded thus far have resulted in: bachelors of science degrees in nursing, clinical psychology doctoral degrees, dentists, dental hygienists, osteopathic physicians, allopathic physicians, masters degrees in public health, masters degrees in social work, nurse midwives, nurse practitioners, doctors of psychology, and registered nurses. Many of the scholarship recipients have completed their studies and their service payback requirements and are practicing in the Native Hawaiian community.

REAUTHORIZATION PROCESS

In order to assure the maximum involvement of Native Hawaiians in the development of a bill to reauthorize the Native Hawaiian Health Care Improvement Act (the Act), from December of 1997 through January of 1998, eight island *'aha* (island-wide conferences) were held involving more than 1,200 individuals in an effort to identify the principle Native Hawaiian health and wellness issues and concerns. In March 1998, a statewide Native Hawaiian Health and Wellness Summit, Ka 'Uhane Lokahi, was held on the island of O'ahu, bringing together more than 600 people to identify potential health and wellness issues and concerns. In January 1999, a Native Hawaiian Health Forum was convened to discuss major health care trends and strategies for health care and wellness developed by the indigenous peoples of North America and Aotearoa (New Zealand).

In March 1999, the Executive Directors of the Native Hawaiian health care systems, the members of the Papa Ola Lokahi Board, and the Director of the Native Hawaiian Health Scholarship Program met to review the Act and to incorporate recommendations from the *'aha*, the summit, and the health forum for inclusion in a bill to reauthorize the Native Hawaiian Health Care Improvement Act. Thereafter, a series of public meetings were held to discuss and review a draft reauthorization bill and based upon the comments received, the bill was further refined and then circulated in the Native Hawaiian community. A final draft of the bill, incorporating and responding to recommendations received from the Native Hawaiian community, was submitted to the Congress.

SUMMARY OF MAJOR PROVISIONS

S. 702 extends the existing program authorities of the Act and authorizes appropriations in such sums as may be necessary through fiscal year 2009. The bill contains extensive findings on the current health status of Native Hawaiians including the incidence and mortality rates associated with various forms of cancer, diabetes, asthma, circulatory diseases, infectious disease and illness, and injuries, as well as statistics on life expectancy, maternal

and child health, births, teen pregnancies, fetal mortality, mental health, and health professions education and training.

The bill further refines the role of Papa Ola Lokahi and the Native Hawaiian health care systems, providing authority for the establishment of additional health care systems to serve the islands of Lanaʻi and Niʻihau. The Board of Papa Ola Lokahi has been expanded to include the five Native Hawaiian health care systems, the Native Hawaiian Health Task Force, the Hawaiʻi State Primary Care Association (which represents the community health centers), the Native Hawaiian Physicians Association, and such other organizations as the Papa Ola Lokahi Board will admit based upon a satisfactory demonstration of a record of contribution to the health and well-being of Native Hawaiians.

The 1992 amendments to the Act adopted the relevant health objectives of the U.S. Surgeon General's Healthy People 2000 objectives as goals to be met by the Native Hawaiian health care systems. S. 702 establishes new objectives that the Native Hawaiian health care systems must meet based on the objectives in the U.S. Surgeon General's Healthy People 2010.

S. 702 proposes that the providers of health care services, including traditional Native Hawaiian healers, who provide services under the aegis of the Native Hawaiian health care systems be treated as members of the Public Health Service for purposes of Federal Tort Claims Act coverage (28 U.S.C. 1346(b) and 2671–2680).

The bill also provides authorization for Papa Ola Lokahi to carry out Native Hawaiian demonstration projects of national significance in areas such as the education of health professionals, the integration of western medicine with complementary health practices including traditional Native Hawaiian healing practices, the use of tele-wellness and telecommunications in chronic disease management and health promotion and disease prevention, the development of an appropriate model of health care for Native Hawaiians and other indigenous people, the development of a centralized data base and information system relating to the health care status, health care needs, and wellness of Native Hawaiians, and the establishment of a Native Hawaiian Center of Excellence for Nursing at the University of Hawaiʻi at Hilo, a Native Hawaiian Center of Excellence for Mental Health at the University of Hawaiʻi at Manoa, a Native Hawaiian Center of Excellence for Maternal Health and Nutrition at the Waimanalo Health Center, a Native Hawaiian Center of Excellence for Research, Training, and Integrated Medicine at Molokaʻi General Hospital, and a Native Hawaiian Center of Excellence for Complementary Health and Health Education and Training at the Waianae Coast Comprehensive Health Center.

THE PROVISION OF FEDERAL PROGRAMS TO NATIVE HAWAIIANS

In the exercise of the plenary power vested in the Congress in Article I, section 8, clause 3 of the United States Constitution, the Congress has exercised its authority to address the conditions of the aboriginal, indigenous, native people of the United States, including the aboriginal, indigenous, native people of the states of Alaska and Hawaiʻi. More than one hundred and sixty Federal laws have been enacted to address the conditions of Native Hawai-

ians (see for example, S. Rep. No. 108–85). The authority of the Congress to enact legislation to address the conditions of Native Hawaiians is set forth more fully in Appendix B to the committee report.

FEDERAL DELEGATION OF AUTHORITY TO THE STATE OF HAWAII

For the past two hundred and ten years, the United States Congress, the Executive Branch, and the U.S. Supreme Court have recognized certain legal rights and protections for America's indigenous peoples. Since the founding of the United States, Congress has exercised a constitutional authority over indigenous affairs and has undertaken an enhanced duty of care for America's indigenous peoples. This has been done in recognition of the sovereignty possessed by the native people—a sovereignty which pre-existed the formation of the United States. The Congress' exercise of its constitutional authority is also premised upon the status of the indigenous people as the original inhabitants of this nation who occupied and exercised dominion and control over the lands over which the United States subsequently acquired jurisdiction.

The United States has long recognized the existence of a special political relationship with the indigenous people of the United States. As Native Americans—American Indians, Alaska Natives, and Native Hawaiians—the United States has recognized that they are entitled to special rights and considerations, and the Congress has enacted laws to give expression to the respective legal rights and responsibilities of the Federal government and the native people (see for example, S. Rep. No. 108–85).

From time to time, with the consent of the affected States, the Congress has sought to more effectively address the conditions of the indigenous people by delegating Federal responsibilities to various states. In 1959, the State of Hawai'i assumed the Federally-delegated responsibility of administering 203,500 acres of land that had been set aside by Congress in 1921 for the benefit of the native people of Hawai'i under the Hawaiian Homes Commission Act.² In addition, the State agreed to the imposition of a public trust upon all of the lands ceded to the State upon admission.³ One of the five purposes for which the public trust was established is the "betterment of the conditions of native Hawaiians[.]"⁴ The Federal authorization for this public trust clearly anticipated that the State's constitution and laws would provide for the manner in which the terms of trust would be carried out.⁵

In 1978, the citizens of the State of Hawai'i exercised the Federally-delegated authority by amending the State constitution in furtherance of the special relationship with Native Hawaiians. The delegates to the 1978 constitutional convention recognized that Native Hawaiians had no other homeland, and thus that the protection of Native Hawaiian subsistence rights to harvest the ocean's resources, to fish the freshwater streams, and to hunt and gather, as well as the protection of Native Hawaiians' rights to exercise their rights to self-determination and self-governance, and to pre-

² Id., § 4; Haw. Const., Art. XVI, § 7.

³ Id., § 5(f); Haw. Const. Art. XII, § 4.

⁴ Id., § 5(f); Haw. Const. Art. XII, § 4.

⁵ Id.

serve their culture and language, could only be accomplished within their native homeland, the present State of Hawai‘i.

Hawai‘i’s adoption of amendments to the State constitution to fulfill the special relationship with Native Hawaiians is consistent with the practice of other states that have established special relationships with the native inhabitants of their areas. Fourteen states have extended recognition to Indian tribes that are not recognized by the Federal government, and thirty-two states have established commissions and offices to address matters of policy affecting the indigenous citizenry.

SECTION-BY-SECTION ANALYSIS

Section 1. Short title

The title of the Act is the Native Hawaiian Health Care Improvement Reauthorization Act of 2003.

Section 2. Findings

Subsection (a) sets forth the findings of the Congress with regard to the historical and legal basis for a Federal program designed to address the health care needs of Native Hawaiians. Subsection (b) sets forth the unmet needs and serious health disparities affecting Native Hawaiians, including chronic diseases and illnesses, infectious diseases and illnesses, injuries, dental health, life expectancy, maternal and child health, mental health, and health professions education and training.

Section 3. Definitions

This section sets forth the definitions of terms used in the Act.

Section 3(1) defines “Department” to mean the Department of Health and Human Services.

Section 3(2) defines “disease prevention” to include immunizations, control of high blood pressure, control of sexually transmissible diseases, the prevention and control of chronic diseases, control of toxic agents, occupational safety and health, injury prevention, fluoridation of water, control of infectious agents, and provision of mental health care.

Section 3(3) defines “health promotion” to include pregnancy and infant care, including prevention of fetal alcohol syndrome, cessation of tobacco smoking, reduction in the misuse of alcohol and harmful illicit drugs, improvement of nutrition, improvement in physical fitness, family planning, control of stress, reduction of major behavioral risk factors and promotion of healthy lifestyle practices, and integration of cultural approaches to health and well-being.

Section 3(4) defines “health service” as the services of physicians, physician’s assistants, nurse practitioners, nurses, dentists, and other health care professionals; diagnostic laboratory and radiologic services; preventive health services, including perinatal services, well child services, family planning services, nutrition services, home health services, sports medicine and athletic training, and other enhanced health or wellness services; emergency medical services, including first responders, emergency medical technicians, and mobile intensive care technicians; transportation services as required for adequate patient care; preventive dental services; and

pharmaceutical and medicament services; mental health services, including those of psychologists and social workers; genetic counseling services; health administration services, including those services of health program administrators; health research services, including those with advanced degrees in medicine, nursing, psychology, social work, and other related health programs; environmental health services, including those provided by epidemiologists, public health officials, medical geographers and medical anthropologists, and those specializing in biological, chemical, and environmental health determinants; primary care services that may lead to specialty or tertiary care; and complementary healing practices, including those performed by traditional Native Hawaiian healers.

Section 3(5) defines “Native Hawaiian” as any individual who is a descendant of the aboriginal people who, prior to 1778, occupied and exercised sovereignty in the area that now constitutes the State of Hawaii as evidenced by genealogical records, kama‘aina (long-term community residents) witness verification from Native Hawaiian kupuna (elders) or birth records of the State of Hawai‘i or any State or territory of the United States.

Section 3(6) defines “Native Hawaiian health care system” as any of up to 8 entities that has the following characteristics: is organized under Hawai‘i law; provides or arranges for health services for Native Hawaiians in the State; is a public or nonprofit private entity; has Native Hawaiians significantly participating in the planning, management, provision, monitoring, and evaluation of health services; addresses the health care needs of an island’s Native Hawaiian population, and; is recognized by Papa Ola Lokahi for the purpose of planning, conducting, or administering programs, authorized by this Act for the benefit of Native Hawaiians, and as having the qualifications and the capacity to provide the services and meet the requirements under the contract each Native Hawaiian health care system enters into with the Secretary or the grant each Native Hawaiian health care system receives from the Secretary under this Act.

Section 3(7) defines “Native Hawaiian Health Center” as an organization that provides primary health care services and which Papa Ola Lokahi has certified has met the following criteria: a governing board with a membership that has a minimum of fifty-percent (50%) Native Hawaiians; has demonstrated cultural competency in a predominantly Native Hawaiian community; has a patient population that is either made up of individuals at least fifty-percent of whom are Native Hawaiian or serves not less than 2,500 Native Hawaiian clients annually.

Section 3(8) defines “Native Hawaiian Health Task Force” as a task force established by the State Council of Hawaiian Homestead Associations that implements health and wellness strategies in Hawai‘i’s Native Hawaiian communities.

Section 3(9) defines “Native Hawaiian organization” as a public or nonprofit organization that serves Native Hawaiian interests and which Papa Ola Lokahi has recognized for purposes of planning, conducting, or administering programs authorized under this Act.

Section 3(10) defines “Office of Hawaiian Affairs” and “OHA” as the governmental entity established under the Hawai‘i State Con-

stitution which is charged with the responsibility of formulating policy relating to Native Hawaiian affairs.

Section 3(11) defines “Papa Ola Lokahi” as an organization composed of public and private organizations focusing on improving the health status of Native Hawaiians. It is governed by a board, whose members may include representatives from: E Ola Mau; the Office of Hawaiian Affairs; Alu Like, Inc.; the University of Hawai‘i; the Hawai‘i State Department of Health; the Native Hawaiian Health Task Force; Hawai‘i State Primary Care Association; Ahahui O Na Kauka; Ho‘ola Lahui Hawai‘i (or a health care system serving the islands of Kaua‘i or Ni‘ihau); Ke Ola Mamo (or a health care system serving the island of O‘ahu); Na Pu‘uwai (or a health care system serving the islands of Molokai and Lana‘i); Hui No Ke Ola Pono (or a health care system serving the island of Maui); Hui Malama Ola Ha ‘Oiwi (or a health care system serving the island of Hawai‘i); other Native Hawaiian health care systems that Papa Ola Lokahi certifies and recognizes; and such other member organizations as the Board of Papa Ola Lokahi may admit from time to time, based upon a satisfactory demonstration of a record of contribution to the health and well-being of Native Hawaiians. However, organizations will not be added to Papa Ola Lokahi if the Secretary determines that an organization has not developed a mission statement with clearly defined goals and objectives for its contributions to the Native Hawaiian health care systems and an action plan for carrying out those goals and objectives.

Section 3(12) defines “Secretary” as the Secretary of the U.S. Department of Health and Human Services.

Section 3(13) defines “State” as the State of Hawai‘i.

Section 3(14) defines “traditional Native Hawaiian healer” as a practitioner who is of Hawaiian ancestry and has the knowledge, skills and experience in direct personal health care of individuals, and whose knowledge, skills, and experience are based on demonstrated learning of Native Hawaiian healing practices acquired by direct practical association with Native Hawaiian elders and the oral traditions transmitted from generation to generation.

Section 4. Declaration of national Native Hawaiian health policy

This section establishes the policy of the Act.

Section 4 (a) and (b) establish that it is the United States’ policy, in fulfilling its special responsibilities and legal obligations to the indigenous people of Hawai‘i which result from the unique and historical relationship between the United States and the indigenous people of Hawai‘i, to raise the health status of Native Hawaiians to the highest practicable level and to provide existing Native Hawaiian health care programs with the resources necessary to effectuate this policy. Section 4 also expresses Congress’ intent to raise Native Hawaiians’ health status by 2010 to at least the standards contained within the Surgeon General’s Healthy People 2010, and to incorporate within health programs the following activities: integration of cultural approaches to health and well-being; increasing the number of health and allied-health care providers who can provide culturally competent care; increasing the use of traditional Native Hawaiian foods in peoples’ diets and dietary preferences including those of students and the use of traditional foods in school feeding programs; identifying and instituting Native Hawaiian cul-

tural values and practices within the corporate cultures of organizations and agencies providing health services to Native Hawaiians; facilitating the provision of Native Hawaiian healing practices by Native Hawaiian healers for those clients desiring such assistance; supporting training and education activities and programs in traditional Native Hawaiian healing practices by Native Hawaiian healers; and demonstrating the integration of health services for Native Hawaiians, particularly those that integrate mental, physical, and dental services in health care.

Section 4(c) directs the Secretary to provide the President with a report on the progress made toward meeting the national policy of the Act which will be included in the President's report to the Congress under section 12.

Section 5. Comprehensive health care master plan for Native Hawaiians

Section 5(a)(1) authorizes the Secretary to make a grant or enter into a contract with Papa Ola Lokahi for the purpose of coordinating, implementing, and updating the Native Hawaiian comprehensive health care master plan which is designed to promote comprehensive health promotion and disease prevention services, to maintain and improve Native Hawaiian health status, and to support community-based initiatives reflective of holistic health care.

Section 5(a)(2) requires Papa Ola Lokahi and the Office of Hawaiian Affairs to consult with the Native Hawaiian health care systems, the Native Hawaiian health centers, and the Native Hawaiian community in carrying out section 5, and authorizes Papa Ola Lokahi and the Office of Hawaiian Affairs to enter into memoranda of understanding or agreement to acquire joint funding and for purposes of addressing other issues to accomplish the objectives of this section.

Section 5(a)(3) requires that within eighteen (18) months of the Act's enactment that Papa Ola Lokahi, in cooperation with the Office of Hawaiian Affairs and other appropriate State and Federal agencies, prepare and submit a study report to the Congress detailing the impact of current Federal and State health care financing mechanisms and policies on Native Hawaiians' health and well-being. The report will include the impact of cultural competency, risk assessment data, eligibility requirements and exemptions, reimbursement policies and capitation rates currently in effect for service providers, and any other information that may be important to improving the health status of Native Hawaiians as it relates to health care financing, including barriers to health care. The report's recommendations will be submitted to the Secretary for review and consultation with Native Hawaiians.

Section 5(b) authorizes the appropriation of such sums as may be necessary to coordinate, implement, and update the master plan and to prepare the health care financing study report.

Section 6. Functions of Papa Ola Lokahi and Office of Hawaiian Affairs

This section sets forth the functions of Papa Ola Lokahi and amends the previous Act to include the Office of Hawaiian Affairs.

Section 6(a)(1) authorizes Papa Ola Lokahi to carry out the following responsibilities:

(A) Coordinating, implementing, and updating the comprehensive health care master plan under section 5;

(B) Training and education of individuals providing health services;

(C) Identifying and researching the diseases that are most prevalent among Native Hawaiians, including behavioral, biomedical, epidemiological, and health services; and,

(D) Developing and maintaining an institutional review board for all research projects involving all aspects of Native Hawaiian health.

Section 6(a)(2) authorizes Papa Ola Lokahi to receive special project funds that may be appropriated for the purpose of conducting research on the health status of Native Hawaiians or for the purpose of addressing the health care needs of Native Hawaiians.

Section 6(a)(3) authorizes Papa Ola Lokahi to serve as a clearinghouse for the collection and maintenance of data associated with the health status of Native Hawaiians; the identification and research into diseases affecting Native Hawaiians; the availability of Native Hawaiian project funds, research projects, and publications; the collaboration of research in Native Hawaiian health; and the timely dissemination of information pertinent to the Native Hawaiian health care systems.

Section 6(b) requires the Secretary and the Secretaries of other Federal departments consult with Papa Ola Lokahi and to provide Papa Ola Lokahi and the Office of Hawaiian Affairs with at least one annual accounting of funds and services provided in carrying out the Act's policy. This accounting will include, but not be limited to, the following: the amount of funds expended explicitly for and benefitting Native Hawaiians; the number of Native Hawaiians impacted by these funds; the collaborations made with Native Hawaiian groups and organizations in the expenditure of these funds; and the amount of funds used for Federal administrative purposes and for the provision of direct services to Native Hawaiians.

Section 6(c)(1) requires that Papa Ola Lokahi provide annual recommendations to the Secretary regarding the allocation of all amounts appropriated under this Act.

Section 6(c)(2) requires that Papa Ola Lokahi, to the extent possible, coordinate and assist the health care programs and services to Native Hawaiians.

Section 6(c)(3) requires the Secretary to consult with Papa Ola Lokahi and make recommendations for Native Hawaiian representation on the President's Advisory Commission on Asian Americans and Pacific Islanders.

Section 6(d) authorizes Papa Ola Lokahi to act as a statewide infrastructure to provide technical support and coordination of training and technical assistance to the Native Hawaiian health care systems and the Native Hawaiian health centers.

Section 6(e)(1) authorizes Papa Ola Lokahi to enter into agreements or memoranda of understanding with relevant institutions, agencies, or organizations that are capable of providing health-related resources or services to the Native Hawaiians, the Native Ha-

waiian health care systems, or resources for carrying out the national policy of this Act.

Section 6(e)(2) addresses health care financing as follows:

Subsection (A) requires that Federal agencies providing health care financing and health care programs consult with Native Hawaiians, Papa Ola Lokahi, and organizations providing Native Hawaiian health care services prior to adopting any policy or regulation which may impact on service provision or health insurance coverage. The consultation is to include but not be limited to identifying the impact of proposed policies, rules, or regulations.

Subsection (B) requires the State of Hawaii to engage in meaningful consultation with Native Hawaiians, Papa Ola Lokahi, and organizations providing Native Hawaiian health care services prior to making any changes or initiating new programs.

Subsection (C) authorizes the Office of Hawaiian Affairs, in concert with Papa Ola Lokahi, to develop consultative, contractual, or other arrangements with the following: the Centers for Medicare and Medicaid Services; the agency of the State which administers or supervises the administration of a State plan or waiver approved under Title XVIII, XIX, or XXI of the Social Security Act for payment of all or part of the health care services to Native Hawaiians who are eligible for medical assistance under such a State plan or waiver; or with any other Federal agency or agencies providing Native Hawaiians with full or partial health insurance. Such arrangements may include but are not limited to appropriate reimbursement for health care services including capitation and fee for service rates for Native Hawaiians who are entitled to insurance, scope of services provided, or any other matters which enable Native Hawaiians to maximize health insurance benefits provided by Federal and State health insurance programs.

Section 6(e)(3) provides that the Department and other Federal agencies that provide health care services may include the services of traditional Native Hawaiian healers and traditional healers providing traditional health care practices as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603). Such services are to be exempt from national accreditation reviews.

Section 7. Native Hawaiian health care

This section addresses the Secretary's authority to enter into contracts and grants with Native Hawaiian health care systems for the provision of Native Hawaiian health care and health care referral services and the responsibilities of the Native Hawaiian health care systems.

Section 7(a) authorizes the Secretary to consult with Papa Ola Lokahi and make grants to or enter into contracts with one or more Native Hawaiian health care systems for the purpose of providing comprehensive health promotion and disease prevention services, as well as health care services to Native Hawaiians who desire and are committed to bettering their own health. The Secretary may enter into grants or contracts with not more than 8 Native Hawaiian health care systems.

Section 7(b) authorizes the Secretary to also make a grant to, or enter into a contract with, Papa Ola Lokahi for purposes of planning Native Hawaiian health care systems to serve the health

needs of Native Hawaiian communities on the islands of O‘ahu, Moloka‘i, Maui, Hawai‘i, Lana‘i, Kaua‘i, Kaho‘lawe, and Ni‘ihau.

Section 7(c) specifies that each qualified entity receiving funds under section 7(a) must ensure that the following health services are either provided or provision is arranged for: outreach services to inform and assist Native Hawaiians in accessing health services; health promotion and disease prevention education for Native Hawaiians by, wherever possible, Native Hawaiian health care practitioners, community outreach workers, counselors, cultural educators, and other disease prevention providers; services of individuals providing health services; collection of data related to the prevention of diseases and illnesses among Native Hawaiians; and support of culturally appropriate activities enhancing health and wellness including land-based, water-based, ocean-based, and spiritually-based projects and programs. These services may be provided by traditional Native Hawaiian healers, when appropriate.

Section 7(d) provides that individuals who provide medical, dental, or other services under subsection (7)(a)(1) for a Native Hawaiian health care system shall be treated as if they were members of the Public Health Service and shall be covered under the provisions of section 224 of the Public Health Service Act (42 U.S.C. 233).

Section 7(e) requires that a Native Hawaiian health care system receiving funds under subsection 7(a) may serve as a Federal loan repayment facility. This facility must be designed to enable health and allied-health professionals to remit payments to loans provided to such professionals under any Federal loan program.

Section 7(f) specifies that the Secretary may not make a grant or enter into a contract as authorized under subsection 7(a) unless the qualified entity agrees that the grant or contract amount will not, directly or through contract, be expended for the following: health care services except as described in section 7(c)(1); the purchase or improvement of real property (other than minor remodeling of existing improvements to real property); or the purchase of major medical equipment.

Section 7(g) provides that the Secretary may not make a grant or enter into a contract with any qualified entity under subsection 7(a) unless the qualified entity agrees that, whether health services are provided directly or through contract, health services under the grant or contract will be provided regardless of payment ability and the entity will impose a charge for the delivery of health services which will be made according to a public schedule of charges and will be adjusted to reflect the income of the individual involved.

Section 7(h) authorizes the appropriation of sums as may be necessary to carry out the general and planning grant activities and health services under subsections 7(a), 7(b), and 7(c) for fiscal years 2004 through 2009.

Section 8. Administrative grant for Papa Ola Lokahi

This section authorizes the Secretary to make a grant or enter into a contract with Papa Ola Lokahi for its administrative functions.

Section 8(a) authorizes the Secretary to make grants to or enter into contracts with Papa Ola Lokahi for the following: the coordination, implementation, and appropriate updating of the comprehen-

sive health care master plan; training and education for providers of health services; identification of and research into the diseases that are most prevalent among Native Hawaiians, including behavioral, biomedical, epidemiological and health services; a clearing-house function for the collection and maintenance of data associated with the health status of Native Hawaiians, the identification of and research into diseases affecting Native Hawaiians, and the availability of Native Hawaiian project funds, research projects, and publications; the establishment and maintenance of an institutional review board for all health-related research involving Native Hawaiians; the coordination of the health care programs and services provided to Native Hawaiians; and the administration of special project funds.

Section 8(b) authorizes the appropriation of sums as may be necessary to carry out the activities in subsection 8(a) for each of fiscal years 2004 through 2009.

Section 9. Administration of grants and contracts

This section sets forth the terms and conditions under which the Secretary makes grants or enters into contracts.

Section 9(a) specifies that within any grants made or contracts entered include terms and conditions that the Secretary considers necessary or appropriate to ensure that the grant or contract objectives are achieved.

Section 9(b) requires that the Secretary periodically evaluate the performance of and compliance with grants and contracts under this Act.

Section 9(c) restricts the Secretary's authority to make any grant or enter into any contract under this Act with an entity unless the entity:

- (1) Agrees to establish such procedures for fiscal control and fund accounting as may be necessary to ensure proper disbursement and accounting with respect to the grant or contract;
- (2) Agrees to ensure the confidentiality of records maintained on individuals receiving health services under the grant or contract;
- (3) With respect to health services provided to any population of Native Hawaiians, a substantial portion of whom has a limited ability to speak the English language, has developed and has the ability to carry out a reasonable plan to provide health services under the grant or contract through individuals who are able to communicate with that population in the language of that population and in the most appropriate cultural context, and has designated at least one individual, fluent in both English and the appropriate language, to assist in carrying out the plan;
- (4) With respect to health services that are covered under title XVIII, XIX, or XXI of the Social Security Act, including any State plan, or under any other Federal health insurance plan, if the entity will provide under the grant or contract any such health services directly, the entity has entered into a participation agreement under such plans and the entity is qualified to receive payments under such plan, or if the entity will provide under the grant or contract any such health services

through a contract with an organization, the organization has entered into a participation agreement under such plan, and the organization is qualified to receive payments under such plan; and

(5) Agrees to submit an annual report to the Secretary and to Papa Ola Lokahi that describes the use and costs of health services provided under the grant or contract, including the average cost of health services per user, and that provides such other information the Secretary determines to be appropriate.

Section 9(d) addresses the Secretary's evaluation of contracts entered into by the Secretary.

Subsection (1) provides that when the Secretary's evaluation reveals that an entity has not complied with or satisfactorily performed a contract entered into under section 7, that before the contract is renewed the Secretary must attempt to resolve the areas of noncompliance or unsatisfactory performance and modify the contract to prevent future noncompliance or unsatisfactory performance.

Subsection (2) provides that if the Secretary determines that the noncompliance or unsatisfactory performance cannot be resolved and prevented in the future, the Secretary shall not renew that entity's contract and is authorized to enter into a new section 7 contract with a qualified entity, as defined in section 7(a)(3), that provides services to the same population of Native Hawaiians that was served by the entity whose contract was not renewed.

Subsection (3) specifies that in determining whether to renew an entity's contract under the Act, the Secretary shall consider the results of the evaluations undertaken under the authority of section 9.

Subsection (4) specifies that the contracts the Secretary enters under this Act must be in accordance with all Federal contracting laws and regulations, but that the Secretary has the discretion to negotiate contracts without advertising and may be exempt from subchapter III of chapter 31, United States Code.

Subsection (5) specifies that payments made under any contract entered into under this Act may be made in advance, by means of reimbursement, or in installments and shall be made on such conditions as the Secretary deems necessary to carry out the purposes of this Act.

Section 9(e) provides that for each fiscal year during which an entity receives or expends funds pursuant to a grant or contract under the Act, that entity is to submit an annual report to the Secretary and to Papa Ola Lokahi on the entity's activities under the grant or contract, the amounts and purposes for which Federal funds were expended, and such other information as the Secretary may request. The reports and records of any entity concerning any grant or contract under this Act shall be subject to audit by the Secretary, the Inspector General of the Department of Health and Human Services, and the Comptroller General of the United States.

Section 9(f) provides that the Secretary shall allow as a cost of any grant made or contract entered into under this Act, the cost of an annual private audit by a certified public accountant.

Section 10. Assignment of personnel

This section addresses the assignment of personnel by the Secretary.

Section 10(a) authorizes the Secretary to enter into an agreement with Papa Ola Lokahi or any of the Native Hawaiian health care systems for assigning personnel from Department of Health and Human Services with expertise for the purpose of conducting research or providing comprehensive health promotion and disease prevention services to Native Hawaiians.

Section 10(b) specifies that any personnel assignment the Secretary agrees to under the authority of subsection 10(a) is to be treated as an assignment of Federal personnel to a local government that is made in accordance with subchapter VI of chapter 33 of title 5 of the United States Code.

Section 11. Native Hawaiian health scholarships and fellowships

Section 11(a) provides that subject to the availability of funds appropriated under the authority of subsection 11(c), the Secretary is to provide funds through a direct grant or a cooperative agreement with Papa Ola Lokahi for the purpose of providing scholarship assistance to Native Hawaiian students.

Section 11(b) provides authority for employees of the Native Hawaiian Health Care Systems and the Native Hawaiian Health Centers to have a priority for these scholarships.

Section 11(c)(1) specifies that subsection 11(a) is to be provided in correspondence with the need for each type of health care professional to serve the Native Hawaiian community as Papa Ola Lokahi identifies; to the maximum extent practicable, the Secretary is to select scholarship recipients from a list of eligible applicants Papa Ola Lokahi submits; the obligated service requirement for each scholarship recipient is to be fulfilled through service, in order of priority, in any one of the Native Hawaiian health care systems; Native Hawaiian health centers; health professions shortage areas, medically underserved areas, or geographic areas or facilities similarly designated by the U.S. Public Health Service in the State of Hawai'i; a Native Hawaiian organization that serves a geographical area with a significant Native Hawaiian population; any public or non-profit organization providing services to Native Hawaiians; or any of the uniformed services of the United States. The placement service for a scholarship shall assign each Native Hawaiian scholarship recipient to one or more appropriate sites for service in accordance with this section.

Subsection (E) further specifies that counseling, retention, and other support services will be available to scholarship recipients and other scholarship and financial aid programs recipients enrolled in appropriate health professions training programs.

Subsection (F) provides that, after consultation with Papa Ola Lokahi, financial assistance may be provided to scholarship recipients while they are fulfilling their service requirement in any one of the Native Hawaiian health care systems or Native Hawaiian health centers.

Subsection (G) allows for the provision of scholarships to Native Hawaiians who are enrolled in an appropriate distance learning program offered by an accredited educational institution.

Section 11(c)(2) provides that the financial aid provided through fellowships may be provided by Papa Ola Lokahi to Native Hawaiian health professionals who are Native Hawaiian community health representatives, outreach workers, health program administrators in professional training programs; to Native Hawaiians who provide health services; or Native Hawaiians in certificated programs provided by traditional Native Hawaiian healers. The financial assistance may include a stipend or reimbursement for costs associated with participating in the program.

Section 11(c)(3) provides that scholarship recipients in health professions designated in section 338A of the Public Health Service Act shall have the same rights and benefits of members of the National Health Service Corps while fulfilling their service requirements.

Section 11(c)(4) provides that the financial assistance provided under section 11 shall be deemed “Qualified Scholarships” for purposes of section 117 of the Internal Revenue Code of 1986 (26 U.S.C.117).

Section 11(d) authorizes the appropriation of such sums as may be necessary for the purpose of funding the scholarship assistance under subsections 11(a) and 11(c)(2) for fiscal years 2004 through 2009.

Section 12. Report

This section provides that at the time the budget is submitted, the President is to transmit a report to Congress for each fiscal year on the progress made in meeting the Act’s objectives. The report should include a review of programs established or assisted pursuant to the Act and an assessment and recommendation of additional programs or assistance necessary to provide health services to Native Hawaiians and to ensure a health status for Native Hawaiians which are on par with the general population’s health services and health status.

Section 13. Use of Federal Government facilities and sources of supply

This section authorizes organizations that receive grants or contracts to have access to Federal property and supplies.

Section 13(a) authorizes the Secretary to allow organizations, in carrying out their grants or contracts authorized under the Act, to use existing facilities and equipment therein or under the Secretary’s jurisdiction, under such terms and conditions as may be agreed upon for their use and maintenance.

Section 13(b) authorizes the Secretary to donate any personal or real property determined to be in excess of the needs of the Department or the General Services Administration to organizations that receive contracts or grants for purposes of carrying out such contract or grants.

Section 13 (c) authorizes the Secretary to acquire excess or surplus Federal government personal or real property for donation to organizations that receive grants or contracts under this Act, provided that the Secretary determines that the property is appropriate for the organization’s use for the purpose for which the contract or grant was authorized.

Section 14. Demonstration projects of national significance

This section authorizes demonstration projects to improve the health status of Native Hawaiians.

Section 14(a) authorizes the Secretary to consult with Papa Ola Lokahi and allocate appropriated amounts under this or any other Act to carry out Native Hawaiian demonstration projects of national significance. The project areas of interest may include the following:

(A) The development of a centralized database and information system relating to Native Hawaiian health care status, health care needs, and wellness;

(B) The education of health professionals, and other individuals in higher learning institutions, in health and allied health programs in healing practices, including Native Hawaiian healing practices;

(C) The integration of Western medicine with complementary healing practices including traditional Native Hawaiian healing practices;

(D) The use of tele-wellness and telecommunications in chronic and infectious disease management and health promotion and disease prevention;

(E) The development of appropriate models of health care for Native Hawaiians and other indigenous people including the provision of culturally competent health services, related activities focusing on wellness concepts, and the development of appropriate kupuna care programs, and the development of financial mechanisms and collaborative relationships leading to universal access to health care; and

(F) the establishment of Native Hawaiian Centers of Excellence for Nursing at the University of Hawai'i at Hilo; for Mental Health at the University of Hawai'i at Manoa; for Maternal Health and Nutrition at the Waimanalo Health Center; and for Research, Training, and Integrated Medicine at Moloka'i General Hospital; and for Complementary Health and Health Education and Training at the Waianae Coast Comprehensive Health Center. Papa Ola Lokahi and any centers established under this paragraph shall be deemed qualified as Centers of Excellence under the Public Health Service Act.

Section 14(b) provides that funds allocated for demonstration projects under subsection 14(a) shall not result in a reduction of funds required by the Native Hawaiian health care systems, Native Hawaiian Health Centers, the Native Hawaiian Health Scholarship Program, or Papa Ola Lokahi to carry out their respective responsibilities under this Act.

Section 15. Rule of construction

This section specifies that nothing in this Act will be construed to restrict the authority of the State of Hawai'i to license health practitioners.

Section 16. Compliance with Budget Act

This section provides that any new spending authority described in section 401(c)(2)(A) or (B) of the Congressional Budget Act of 1974 which is provided under the authority of the Act is to be effec-

tive only for any fiscal year to the extent or in such amounts as are provided in appropriation Acts.

Section 17. Severability

This section specifies that if any provision of the Act or application of any provision of the Act to any person or circumstance is held to be invalid, the remainder of the Act will be unaffected.

LEGISLATIVE HISTORY

S. 702 was introduced on March 25, 2003, by Senator Daniel K. Inouye, for himself and Senator Daniel K. Akaka, and was referred to the Committee on Indian Affairs. No hearings were held on S. 702, however, during the 106th Congress, the Committee did hold a series of hearings on S. 1929 which is the predecessor bill to S. 702 and was nearly identical in its provisions to S. 702. Those hearings were as follows: Moloka'i and Kaua'i (January 18, 2000); Maui (January 19, 2000); Hilo, Hawai'i (January 20, 2000); O'ahu (January 21, 2000); Kona, Hawai'i and Lana'i (March 16, 2000).

COMMITTEE RECOMMENDATION AND TABULATION OF VOTE

The Committee on Indian Affairs, on May 14, 2003, in an open business meeting, by a unanimous vote, recommended that the Senate pass S. 702, a bill to reauthorize and amend the Native Hawaiian Health Care Improvement Act.

COST AND BUDGETARY CONSIDERATIONS

The cost estimate for S. 702 as calculated by the Congressional Budget Office, is set forth below:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, June 3, 2003.

Hon. BEN NIGHTHORSE CAMPBELL,
Chairman, Committee on Indian Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 702, the Native Hawaiian Health Care Improvement Reauthorization Act of 2003.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Alexis Ahlstrom.

Sincerely,

DOUGLAS HOLTZ-EAKIN,
Director.

Enclosure.

S.702—Native Hawaiian Health Care Improvement Reauthorization Act of 2003

Summary: S. 702 would reauthorize the Native Hawaiian Health Care Program, funded from within the Health Resources and Services Administration's Consolidated Health Center Program, through 2009.

The bill would authorize the appropriation of such sums as may be necessary for fiscal years 2004 through 2009. Assuming the ap-

appropriation of the necessary amounts, CBO estimates that implementing S. 702 would cost about \$5 million in 2004 and \$53 million over the 2004–2009 period. (That estimate assumes that annual appropriations are adjusted for inflation. Without such adjustments, the six-year total would be \$50 million.)

The bill would extend provisions under section 224 of the Public Health Service Act to providers in Hawaiian health systems. That section authorizes settlements and awards for tort claims to be paid out of the Treasury's Judgment Fund. Those payments are considered direct spending, regardless of whether the health program involved is an entitlement program or subject to appropriation. CBO estimates those payments would total less than \$500,000 in 2004 and less than \$500,000 over the 2004–2009 period.

S. 702 contains no private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA). The bill would require the state of Hawaii to consult with Na'ive Hawaiians, Papa Ola Lokahi (an umbrella organization composed of groups involved in Native Hawaiian health), and health care organizations that provide services to Native Hawaiians before making policy changes or implementing new programs. That requirement would be an intergovernmental mandate as defined in UMRA, but CBO estimates that the costs of the mandate would be minimal and would not exceed the threshold established in that act (\$59 million in 2003, adjusted annually for inflation).

Estimated cost to the Federal Government: The estimated budgetary impact of S. 702 is shown in the following table. The costs of this legislation would fall within budget functions 550 (health) and 800 (general government).

	By fiscal year, in millions of dollars—						
	2003	2004	2005	2006	2007	2008	2009
SPENDING SUBJECT TO APPROPRIATION ¹							
With Adjustments for Inflation							
Native Hawaiian Health Center Program Spending Under Current Law:							
Budget Authority ²	9	0	0	0	0	0	0
Estimated Outlays	7	4	*	0	0	0	0
Proposed Changes:							
Estimated Authorization Level ³	0	9	9	10	10	10	10
Estimated Outlays	0	5	9	9	10	10	10
Native Hawaiian Health Center Program Spending Under S. 702:							
Estimated Authorization Level	9	9	9	10	10	10	10
Estimated Outlays	7	9	9	9	10	10	10

¹ This bill also would increase direct spending, but by less than \$500,000 a year.

² The 2003 level is the amount appropriated for that year for the Native Hawaiian Health Care Program.

³ The proposed changes include annual adjustments for inflation for the bill's authorizations of "such sums as necessary." Without such inflation adjustments, the six-year totals of costs would be about \$3 million lower.

Note.—* = less than \$500,000.

Basis of estimate: For the purposes of this estimate, CBO assumes that the bill will be enacted by the end of fiscal year 2003 and that the necessary appropriations will be provided for each fiscal year.

Spending subject to appropriation

Native Hawaiian Health Care Program. S. 702 would authorize the appropriation of such sums as necessary for 2004 through 2009 for the extension of activities carried out under the Native Hawai-

ian Health Care Program. These activities include the provision of health care at Native Hawaiian health centers and health systems; granting scholarships to students dedicated to providing health care to Native Hawaiians; administration of the program; and the development of strategies to improve the health status of Native Hawaiians. The bill would authorize increasing from five to eight the number of health systems receiving grants, and would authorize the establishment of a fellowship program for health care workers.

CBO estimates that these activities could be carried out with 2003 appropriation levels adjusted for inflation, plus additional funding for the increase in the number of health systems receiving grants. Those systems would be added to the program gradually over the next few years, according to information provided by Papa Ola Lokahi. Assuming the appropriation of \$9 million in 2004, and adjustments for inflation in 2005 through 2009, CBO estimates the cost of these provisions would be \$5 million in 2004 and \$53 million over the 2004–2009 period.

Direct spending

Under current law, settlements and tort claims arising from the actions of licensed health care providers in federally funded health centers are paid from the Treasury's Judgment Fund. The bill would expand that coverage to include tort claims arising from the actions of licensed providers within the Native Hawaiian health systems, as well as non-licensed providers and traditional Hawaiian health providers. Based on past experience with spending from the Judgment Fund for providers covered under section 224, as well as information on the number and license status of newly covered providers, CBO estimates the cost of this provision to be less than \$500,000 in each year and less than \$500,000 over the 2004–2009 period.

Impact on state, local, and tribal governments: The bill would require the state of Hawaii to consult with Native Hawaiians, Papa Ola Lokahi, and health care organizations that provide services to Native Hawaiians before making policy changes or implementing new programs. That requirement would be an intergovernmental mandate as defined in UMRA, but CBO estimates that the costs of the mandate would be minimal and would not exceed the threshold established in that act (\$59 million in 2003, adjusted annually for inflation).

Impact on the private sector: S. 702 contains no private-sector mandates as defined in UMRA.

Estimate prepared by: Federal Costs: Alexis Ahlstrom; Impact on State, Local, and Tribal Governments: David Conway; and Impact on the Private Sector: Julie Lee.

Estimate approved by: Peter H. Fontaine, Deputy Assistant Director for Budget Analysis.

EXECUTIVE COMMUNICATIONS

The Committee received no communications from the Executive branch of government on S. 702.

REGULATORY AND PAPERWORK IMPACT

Paragraph 11(b) of rule XXVI of the Standing Rules of the Senate requires each report accompanying a bill to evaluate the regulatory and paperwork impact that would be incurred in carrying out the bill. The Committee believes that S. 702 will have a minimal impact on regulatory or paperwork requirements.

CHANGES IN EXISTING LAW

UNITED STATES CODE ANNOTATED

TITLE 42—THE PUBLIC HEALTH AND WELFARE

CHAPTER 122—NATIVE HAWAIIAN HEALTH CARE

§ 11701. Findings

【The Congress finds that:】 (a) GENERAL FINDINGS.—*Congress finds that—*

(1) Native Hawaiians 【comprise】 *begin their story with the Kumulipo, which details the creation and inter-relationship of all things, including the evolvement of Native Hawaiians as healthy and well people;*

(2) NATIVE HAWAIIANS.—

(A) *are a distinct and unique indigenous people with a historical continuity to the original inhabitants of the Hawaiian archipelago 【whose society was organized as a Nation prior to the arrival of the first nonindigenous people in 1778】 within Ke Moananui, the Pacific Ocean; and*

(B) *have a distinct society that was first organized almost 2,000 years ago;*

(3) *the health and well-being of Native Hawaiians are intrinsically tied to the deep feelings and attachment of Native Hawaiians to their lands and seas,*

(4) *the long-range economic and social changes in Hawai'i over the 19th and early 20th centuries have been devastating to the health and well-being of Native Hawaiians;*

(5) *Native Hawaiians have never directly relinquished to the United States their claims to their inherent sovereignty as a people or over their national territory, either through their monarchy or through a plebiscite or referendum;*

【(2) The】 (6) *the Native Hawaiian people are determined to preserve, develop and transmit to future generations, 【their ancestral territory, and their cultural identity】 in accordance with their own spiritual and traditional beliefs, their customs, practices, language, 【and】 social institutions【.】, ancestral territory, and cultural identity;*

(7) *in referring to themselves, Native Hawaiians use the term 'Kānaka Maoli', a term frequently used in the 19th century to describe the native people of Hawai'i;*

【(3)】 (8) *The constitution and statutes of the State of Hawai'i【:】—*

(A) acknowledge the distinct land rights of Native Hawaiian people as beneficiaries of the public lands trust; and

(B) reaffirm and protect the unique right of the Native Hawaiian people to practice and perpetuate their cultural and religious customs, beliefs, practices, and language[.];

[(4) At] (9) *at* the time of the arrival of the first nonindigenous people in Hawaii in 1778, the Native Hawaiian people lived in a highly organized, self-sufficient, subsistence social system based on communal land tenure with a sophisticated language, culture, and religion[.];

[(5) A] (10) *a* unified monarchical government of the Hawaiian Islands was established in 1810 under Kamehameha I, the first King of Hawaii[.];

[(6) Throughout] (11) *throughout* the 19th century [and] until 1893, the United States[:]—

(A) recognized the independence of the Hawaiian Nation;

(B) extended full and complete diplomatic recognition to the Hawaiian Government; and

(C) entered into treaties and conventions with the Hawaiian monarchs to govern commerce and navigation in 1826, 1842, 1849, 1875, and 1887[.];

[(7)] (12) [In the year] *in* 1893, *John L. Stevens*, the United States Minister assigned to the sovereign and independent Kingdom of Hawai'i, [John L. Stevens,] conspired with a small group of non-Hawaiian residents of the Kingdom, including citizens of the United States, to overthrow the indigenous and lawful [Government] government of Hawai'i[.];

[(8) In] (13) *in* pursuance of that conspiracy[,]—

(A) the United States Minister and the naval representative of the United States caused armed [naval] forces of the United States *Navy* to invade the sovereign Hawaiian Nation in support of the overthrow of the indigenous and lawful Government of Hawai'i; and

(B) *after that overthrow*, the United States Minister [thereupon] extended diplomatic recognition of a provisional government formed by the conspirators without the consent of the native people of Hawai'i or the lawful Government of Hawai'i, in violation of—

(i) treaties between the [two nations and of international law.] *Government of Hawai'i and the United States*; and

(ii) *international law*,

[(9) In] (14) *in* a message to Congress on December 18, 1893, [then] President Grover Cleveland—

(A) reported fully and accurately on [these] *those* illegal actions[.];

(B) [and] acknowledged that by [these] *those* acts, described by the President as acts of war, the government of a peaceful and friendly people was overthrown[.]; and

(C) [the President] concluded that a [“]substantial wrong has thus been done which a due regard for our national character as well as the rights of the injured people required that we should endeavor to repair[”].];

[(10)] (15) Queen Lili'uokalani, the lawful monarch of Hawai'i, and the Hawaiian Patriotic League, representing the aboriginal citizens of Hawai'i, promptly petitioned the United States for redress of [these] *those* wrongs and [for] restoration of the indigenous government of the Hawaiian nation, but [this petition was not acted upon.] *no action was taken on that petition;*

(16) *in 1993, Congress enacted Public Law 103-150 (107 Stat.1510), in which Congress—*

(A) *acknowledged the significance of those events; and*

(B) *apologized to Native Hawaiians on behalf of the people of the United States for the overthrow of the Kingdom of Hawai'i with the participation of agents and citizens of the United States, and the resulting deprivation of the rights of Native Hawaiians to self-determination;*

[(11) In] (17) *in 1898, the United States—*

(A) *annexed Hawai'i through [the Newlands] Resolution No. 55 (commonly known as the 'Newlands Resolution') (30 Stat. 750), without the consent of, or compensation to, the indigenous people of Hawai'i or [their] the sovereign government [who were thereby] of those people; and*

(B) *denied those people the mechanism for expression of their inherent sovereignty through self-government and self-determination[, of their lands and ocean resources[.];*

[(12) Through] (18) *through the Newlands Resolution and the [1900 Organic Act, the United States] Act of April 30, 1900 (commonly known as the '1900 Organic Act') (31 Stat. 141, chapter 339), Congress—*

(A) *received [1.75 million] 1,750,000 acres of [lands] land formerly owned by the Crown and Government of the Hawaiian Kingdom; and*

(B) *exempted the [lands] land from then-existing public land laws of the United States by mandating that the revenue and proceeds from [these lands] that land be ["used solely for the benefit of the inhabitants of the Hawaiian Islands for education and other public purposes["], thereby establishing a special trust relationship between the United States and the inhabitants of Hawai'i[.];*

[(13) In] (19) *in 1921, Congress enacted the Hawaiian Homes Commission Act, 1920 (42 Stat. 108, chapter 42), which—*

(A) *designated 200,000 acres of the ceded public [lands] land for exclusive homesteading by Native Hawaiians[.]; and*

(B) *[thereby affirming] affirmed the trust relationship between the United States and [the] Native Hawaiians, as expressed by [then] Secretary of the Interior Franklin K. Lane, who was cited in the Committee Report of the [United States] Committee on Territories of the House of Representatives [Committee on Territories] as stating, ["One thing that impressed me . . . was the fact that the natives of the islands [who are our wards, I should say, and] . . . for whom in a sense we are trustees, are*

falling off rapidly in numbers and many of them are in poverty.["];

[(14) In] (20) in 1938, [the United States] Congress again acknowledged the unique status of the *Native Hawaiian* people by including in the Act of June 20, 1938 (52 Stat. 781[et seq.]), a provision—

(A) to lease [lands] *land* within the extension to Native Hawaiians; and

(B) to permit fishing in the area ["'only by native Hawaiian residents of said area or of adjacent villages and by visitors under their guidance["];

[(15) Under] (21) under the Act [entitled "An Act to provide for the admission of the State of Hawaii into the Union," approved March 18, 1959 (73 Stat. 4)] of March 18, 1959 (48 U.S.C. prec. 491 note; 73 Stat.4), the United States—

(A) transferred responsibility for the administration of the Hawaiian [Home Lands] *home lands* to the State [of Hawai'i]; but

(B) reaffirmed the trust relationship [which] *that* existed between the United States and the *Native Hawaiian* people by retaining the exclusive power to enforce the trust, including the power to approve land exchanges[, and legislative amendments affecting the rights of beneficiaries under [such] *that* Act[.];

[(16) Under] (22) under the Act [entitled "An Act to provide for the admission of the State of Hawai'i into the Union", approved March 18, 1959 (73 Stat. 4)] referred to in paragraph (21), the United States—

(A) transferred responsibility for administration over portions of the ceded public lands trust not retained by the United States to the State [of Hawai'i]; but

(B) reaffirmed the trust relationship [which] *that* existed between the United States and the *Native Hawaiian* people by retaining the legal responsibility of the State for the betterment of the conditions of Native Hawaiians under section 5(f) of [the Act entitled "An Act to provide for the admission of the State of Hawai'i into the Union", approved March 18, 1959 (73 Stat. 4, 6).] *that* Act (73 Stat. 6);

(23) in 1978, the people of Hawai'i—

(A) amended the constitution of Hawai'i to establish the Office of Hawaiian Affairs; and

(B) assigned to that Office the authority—

(i) to accept and hold in trust for the *Native Hawaiian* people real and personal property transferred from any source;

(ii) to receive payments from the State owed to the *Native Hawaiian* people in satisfaction of the pro rata share of the proceeds of the public land trust established by section 5(f) of the Act of March 18, 1959 (48 U.S.C. prec 491 note, 73 Stat. 6);

(iii) to act as the lead State agency for matters affecting the *Native Hawaiian* people; and

(iv) to formulate policy on affairs relating to the *Native Hawaiian* people;

[(17) The] (24) *the* authority of the Congress under the [United States] Constitution to legislate in matters affecting the aboriginal or indigenous [peoples] *people* of the United States includes the authority to legislate in matters affecting the native [peoples] *people* of Alaska and Hawai‘i[.];

(25) *the United States has recognized the authority of the Native Hawaiian people to continue to work toward an appropriate form of sovereignty, as defined by the Native Hawaiian people in provisions set forth in legislation returning the Hawaiian Island of Kaho ‘olawe to custodial management by the State in 1994;*

[(18) In] (26) *in* furtherance of the trust responsibility for the betterment of the conditions of Native Hawaiians, the United States has established a program for the provision of comprehensive health promotion and disease prevention services to maintain and improve the health status of the Hawaiian people[.];

(27) *that program is conducted by the Native Hawaiian Health Care Systems, and Papa Ola Lokahi;*

(28) *health initiatives implemented by those and other health institutions and agencies using Federal assistance have been responsible for reducing the century-old morbidity and mortality rates of Native Hawaiian people by—*

(A) *providing comprehensive disease prevention;*

(B) *health promotion activities; and*

(C) *increasing the number of Native Hawaiians in the health and allied health professions;*

(29) *those accomplishments have been achieved through implementation of—*

(A) *the Native Hawaiian Health Care Act of 1988 (Public Law 100–579); and*

(B) *the reauthorization of that Act under section 9168 of the Department of Defense Appropriations Act, 1993 (Public Law 102–396; 106 Stat. 1948);*

[(19) This] (30) *the* historical and unique legal relationship between the United States and Native Hawaiians has been consistently recognized and affirmed by [the] Congress through the enactment of *more than 160* Federal laws [which] *that* extend to the Native Hawaiian people the same rights and privileges accorded to American Indian, Alaska Native, Eskimo, and Aleut communities, including—

(A) *the Native American Programs Act of 1974* [[42 U.S.C.A. 2991 et seq.]] (42 U.S.C. 2991 et seq.);

(B) *the American Indian Religious Freedom Act* [[42 U.S.C.A. 1996]] (42 U.S.C. 1996);

(C) *the National Museum of the American Indian Act* [[20 U.S.C.A. § 80q et seq.]] (20 U.S.C. 80q et seq.); and

(D) *the Native American Graves Protection and Repatriation Act* [[25 U.S.C.A. 3001 et seq.]] (25 U.S.C. 3001 et seq.);

[(20) The] (31) *the* United States has [also] recognized and reaffirmed the trust relationship to the Native Hawaiian people through legislation [which] *that* authorizes the provision of services to Native Hawaiians, specifically[.],—

(A) the Older Americans Act of 1965 [(42 U.S.C.A. § 3001 et seq.),] (42 U.S.C. 3001 et seq.);

(B) the Developmental Disabilities Assistance and Bill of Rights Act Amendments of 1987[,] (42 U.S.C. 6000 et seq.);

(C) the Veterans' Benefits and Services Act of 1988[,] (Public Law 100-322);

(D) the Rehabilitation Act of 1973 [(29 U.S.C.A. 701 et seq.),] (29 U.S.C. 701 et seq.);

(E) the Native Hawaiian Health Care Act of 1988[,] (42 U.S.C. 11701 et seq.);

(F) the Health Professions Reauthorization Act of 1988[,] (Public Law 100-607, 102 Stat. 3122);

(G) the Nursing Shortage Reduction and Education Extension Act of 1988[,] (Public Law 100-607; 102 Stat. 3153);

(H) the Handicapped Programs Technical Amendments Act of 1988[,] (Public Law 100-630);

(I) the Indian Health Care Amendments of 1988[,] (Public Law 100-713); and

(J) the Disadvantaged Minority Health Improvement Act of 1990[,] (Public Law 101-527);

[(21) The] (32) *the* United States has [also] affirmed [the] *that* historical and unique legal relationship to the Hawaiian people by authorizing the provision of services to Native Hawaiians to address problems of alcohol and drug abuse under the Anti-Drug Abuse Act of 1986[,] (21 U.S.C. 801 note, Public Law 99-570);

(33) *in addition, the United States—*

(A) *has recognized that Native Hawaiians, as aboriginal, indigenous, native people of Hawai'i, are a unique population group in Hawai'i and in the continental United States, and*

(B) *has so declared in Office of Management and Budget Circular 15 in 1997 and Presidential Executive Order No. 13125, dated June 7, 1999, and*

[(22) Despite] (34) *despite* [such services,] *the United States having expressed in Public Law 103-150 (107 Stat. 1510) its commitment to a policy of reconciliation with the Native Hawaiian people for past grievances—*

(A) *the unmet health needs of the Native Hawaiian people [are] remain severe, and*

(B) *the health status of the Native [Hawaiians] Hawaiian people continues to be far below that of the general population of the United States.*

(b) *FINDING OF UNMET NEEDS AND HEALTH DISPARITIES.—Congress finds that the unmet needs and serious health disparities that adversely affect the Native Hawaiian people include the following:*

(1) *CHRONIC DISEASE AND ILLNESS.—*

(A) *CANCER.—*

(i) *IN GENERAL.—With respect to all cancer—*

(I) *Native Hawaiians have the highest cancer mortality rates in the State (216.8 out of every 100,000 male residents and 191.6 out of every 100,000 female residents), rates that are 21 percent*

higher than the rate for the total State male population (179.0 out of every 100,000 residents) and 64 percent higher than the rate for the total State female population (117.0 per 100,000);

(II) Native Hawaiian males have the highest cancer mortality rates in the State for cancers of the lung, colon, rectum, and colorectum, and for all cancers combined;

(III) Native Hawaiian females have the highest cancer mortality rates in the State for cancers of the lung, liver, pancreas, breast, corpus uteri, stomach, colon, and rectum, and for all cancers combined;

(IV) Native Hawaiian males have 8.7 years of productive life lost as a result of cancer in the State, the highest years of productive life lost in that State, as compared with 6.4 years for all males; and

(V) Native Hawaiian females have 8.2 years of productive life lost as a result of cancer in the State as compared with 6.4 years for all females in the State;

(ii) BREAST CANCER.—With respect to breast cancer—

(I) Native Hawaiians have the highest mortality rate in the State from breast cancer (30.79 out of every 100,000 residents), a rate that is 33 percent higher than that for Caucasian Americans (23.07 out of every 100,000 residents) and 106 percent higher than that for Chinese Americans (14.96 out of every 100,000 residents); and

(II) nationally, Native Hawaiians have the third highest mortality rate as a result of breast cancer (25.0 out of every 100,000 residents) behind African Americans (31.4 out of every 100,000 residents) and Caucasian Americans (27.0 out of every 100,000 residents).

(iii) CANCER OF THE CERVIX.—Native Hawaiians have the highest mortality rate as a result of cancer of the cervix in the State (3.65 out of every 100,000 residents), followed by Filipino Americans (2.69 out of every 100,000 residents) and Caucasian Americans (2.61 out of every 100,000 residents).

(iv) LUNG CANCER.—Native Hawaiian males and females have the highest mortality rates as a result of lung cancer in the State, at 74.79 per 100,000 for males and 47.84 per 100,000 females, which rates are higher than the rates for the total State population by 48 percent for males and 93 percent for females.

(v) PROSTATE CANCER.—Native Hawaiian males have the third highest mortality rate as a result of prostate cancer in the State (21.48 out of every 100,000 residents), with Caucasian Americans having the highest mortality rate as a result of prostate cancer (23.96 out of every 100,000 residents).

(B) DIABETES.—With respect to diabetes, in 2000—

(i) *Native Hawaiians had the highest mortality rate as a result of diabetes mellitus (38.8 out of every 100,000 residents) in the State, which rate is 138 percent higher than the statewide rate for all racial groups (16.3 out of every 100,000 residents); and*

(ii) *full-blood Hawaiians had a mortality rate as a result of diabetes mellitus of 93.3 out of every 100,000 residents, which is 518 percent higher than the rate for the statewide population of all other racial groups.*

(C) *ASTHMA.—With respect to asthma—*

(i) *in 1990, Native Hawaiians comprised 44 percent of all asthma cases in the State for those 18 years of age and younger, and 35 percent of all asthma cases reported, and*

(ii) *in 1999, the Native Hawaiian prevalence rate for asthma was 129.6 out of every 1,000 residents, which was 69 percent higher than the rate for all others combined in the State (76.7 out of every 1,000 residents).*

(D) *CIRCULATORY DISEASES.—*

(i) *HEART DISEASE.—With respect to heart disease—*

(I) *the mortality rate for Native Hawaiians as a result of heart disease (372.3 out of every 100,000 residents) is 68 percent higher than the rate for the entire State (221.9 out of every 100,000 residents); and*

(II) *Native Hawaiian males have the greatest years of productive life lost in the State, because Native Hawaiian males lose an average of 15.5 years and Native Hawaiian females lose an average of 8.2 years as a result of heart disease, as compared with 7.5 years for all males, and 6.4 years for all females, in the State.*

(ii) *HYPERTENSION.—With respect to hypertension—*

(I) *the mortality rate for Native Hawaiians as a result of hypertension (3.5 out of every 100,000 residents) is 84 percent higher than that for the entire State (1.9 out of every 100,000 residents);*

(II) *Native Hawaiians have substantially higher prevalence rates of hypertension than—*

(aa) *those observed statewide; and and*

(bb) *those of any other ethnic group in Hawai'i; and*

(III) *the prevalence rate of hypertension for Native Hawaiians is 37.9 percent, 11 percent higher than that for all others in the State (34.1 percent).*

(iii) *STROKE.—The mortality rate for Native Hawaiians as a result of stroke (72.0 out of every 100,000 residents) is 20 percent higher than that for the entire State (60 out of every 100,000 residents).*

(2) *INFECTIOUS DISEASE AND ILLNESS.—With respect to infectious disease and illness—*

(A) *in 1998, Native Hawaiians comprised 20 percent of all deaths resulting from infectious diseases in the State for all ages; and*

(B) the incidence of acquired immune deficiency syndrome for Native Hawaiians is at least twice as high per 100,000 residents (10.5 percent) than that for any other non-Caucasian group in the State.

(3) *INJURIES.*—With respect to injuries—

(A) the mortality rate for Native Hawaiians as a result of injuries (32.0 out of every 100,000 residents) is 16 percent higher than that for the entire State (27.5 out of every 100,000 residents);

(B) 32 percent of all deaths of individuals between the ages of 18 and 24 years of age resulting from injuries were Native Hawaiian; and

(C) the 2 primary causes of Native Hawaiian deaths in that age group were motor vehicle accidents (30 percent) and intentional self-harm (39 percent).

(4) *DENTAL HEALTH.*—With respect to dental health—

(A) Native Hawaiian children exhibit among the highest rates of dental caries in the United States, and the highest in the State as compared with the 5 other major ethnic groups in the State;

(B) the average number of decayed or filled primary teeth for Native Hawaiian children aged 5 through 9 years was 4.3, as compared with 3.7 for all children in the State and 1.9 for all children in the United States; and

(C) the proportion of Native Hawaiian children aged 5 through 12 years with unmet dental treatment needs (defined as having active dental caries requiring treatment) is 40 percent, as compared with 33 percent for all other racial groups in the State.

(5) *LIFE EXPECTANCY.*—With respect to life expectancy—

(A) Native Hawaiians have the lowest life expectancy of all population groups in the State;

(B) between 1910 and 1980, the life expectancy of Native Hawaiians from birth has ranged from 5 to 10 years less than that of the overall State population average, and

(C) the most recent tables for 1990 show Native Hawaiian life expectancy at birth (74.27 years) to be about 5 years less than that of the total State population (78.85 years).

(6) *MATERNAL AND CHILD HEALTH.*—

(A) *IN GENERAL.*—With respect to maternal and child health, for 2000

(i) 39 percent of all deaths of children under the age of 18 years in the State were Native Hawaiian; and

(ii) perinatal conditions accounted for 38 percent of all Native Hawaiian deaths in that age group.

(B) *PRENATAL CARE.*—With respect to prenatal care—

(i) as of 1998, Native Hawaiian women have the highest prevalence (24 percent) of having had no prenatal care during the first trimester of pregnancy, as compared with the 5 largest ethnic groups in the State;

(ii) of the mothers in the State who received no prenatal care throughout their pregnancies in 1996, 44 percent were Native Hawaiian;

(iii) over 65 percent of the referrals to *Healthy Start* in fiscal years 1996 and 1997 were Native Hawaiian newborns; and

(iv) in every region of the State, many Native Hawaiian newborns begin life in a potentially hazardous circumstance, far higher than any other racial group.

(C) *BIRTHS.*—With respect to births—

(i) in 1996, 45 percent of the live births to Native Hawaiian mothers were infants born to single mothers, a circumstance which statistics indicate puts infants at higher risk of low birth weight and infant mortality;

(ii) in 1996, of the births to Native Hawaiian single mothers, 8 percent were low birth weight (defined as a weight less than 2,500 grams); and

(iii) of all low birth weight infants born to single mothers in the State, 44 percent were Native Hawaiian.

(D) *TEEN PREGNANCIES.*—With respect to births—

(i) in 1993 and 1994, Native Hawaiians had the highest percentage of teen (individuals who were less than 18 years of age) births (8.1 percent), as compared with the rate for all other racial groups in the State (3.6 percent);

(ii) in 1998, nearly 49 percent of all mothers in the State under 19 years of age were Native Hawaiian;

(iii) in 1998, Native Hawaiians comprised 31 percent (1,425) of all live births to mothers with medical risk factors in the State (4,559); and

(iv) lower rates of abortion (approximately 33 percent lower than for the statewide population) among Hawaiian women may account, in part, for that higher percentage of live births.

(E) *FETAL MORTALITY.*—With respect to fetal mortality—

(i) in 2000, Native Hawaiians had the highest number of fetal deaths in the State; and

(ii)(I) 21 percent of all fetal deaths in the State were associated with expectant Native Hawaiian mothers; and

(II) 37 percent of those Native Hawaiian mothers were under the age of 25 years.

(7) *MENTAL HEALTH.*—

(A) *ALCOHOL AND DRUG ABUSE.*—With respect to alcohol and drug abuse—

(i) Native Hawaiians represent 38 percent of the total admissions to substance abuse treatment programs funded by the Department of Health, Alcohol, Drugs and Other Drugs of the State;

(ii) in 2000, the prevalence of cigarette smoking by Native Hawaiians was 31.0 percent, a rate that is 57 percent higher than that for the total population in the State, which is 19.7 percent;

(iii) Native Hawaiians have the highest prevalence rate of acute alcohol drinking (19.6 percent), a rate that is 40 percent higher than that for the total population in the State;

(iv) the chronic alcohol drinking rate among Native Hawaiians is 54 percent higher than that for all other racial groups in the State;

(v) in 1991, 40 percent of the Native Hawaiian adults surveyed reported having used marijuana, as compared with 30 percent for all other racial groups in the State; and

(vi) 9 percent of the Native Hawaiian adults surveyed reported that they use or have used marijuana within the year preceding the survey, as compared with 6 percent for all other racial groups in the State.

(B) *CRIME.*—With respect to crime—

(i) in 1998, of the 7,789 arrests that were made for property crimes in the State, arrests of Native Hawaiians comprised 23 percent;

(ii) Native Hawaiians comprised 40 percent of juvenile arrests in 1998, the largest percentage of all juvenile arrests in that year;

(iii) in the period of 1996 through 1998, the overrepresentation of Native Hawaiian juvenile arrests for index crimes and Part II offenses increased by 6 percent and 2 percent, respectively;

(iv) in 1998, Native Hawaiians represented 22 percent of the 2,423 adults arrested for drug-related offenses in the State;

(v) Native Hawaiians are overrepresented in the prison population in the State;

(vi) of the 2,260 incarcerated Native Hawaiians, 70 percent are between 20 and 40 years of age;

(vii) in 1995 and 1996, Native Hawaiians comprised 36.5 percent of the sentenced felon prison population in Hawaii, as compared with 20.5 percent for Caucasian Americans, 3.7 percent for Japanese Americans, and 6 percent for Chinese Americans;

(viii) in 2002, Native Hawaiians comprised 40 percent of the total sentenced felon population in the State, as compared with 25 percent for Caucasian Americans, 12 percent for Filipino Americans, 6 percent for Japanese Americans, and 5 percent for Samoans; and

(ix) based on anecdotal information from inmates at the Halawa Correction Facilities, Native Hawaiians are estimated to comprise between 60 and 70 percent of all inmates in the State.

(8) *OBESITY.*—Native Hawaiians have the highest prevalence rate of overweightness and obesity (69.4 percent), a rate that is 38 percent higher than that for the total State population (50.2 percent).

(9) *HEALTH PROFESSIONS EDUCATION AND TRAINING.*—With respect to health professions education and training—

(A)(i) Native Hawaiians who are at least 25 years of age have a comparable rate of high school completion as compared with all people in the State who are at least 25 years of age; but

(ii) *the rate of baccalaureate degree achievement among Native Hawaiians is 6.9 percent, which is less than the average in the State (15.76 percent);*

(B) *Native Hawaiian physicians make up 4 percent of the total physician workforce in the State; and*

(C)(i) *in fiscal year 1999, Native Hawaiians comprised—*

(I) *9 percent of those individuals who earned Bachelor's degrees;*

(II) *15 percent of those individuals who earned 2-year diplomas; and*

(III) *6 percent of those individuals who earned Master's degrees; and*

(ii) *in 1997, Native Hawaiians comprised less than 1 percent of individuals who earned doctoral degrees at the University of Hawai'i.*

§ 11702. Declaration of [policy] National Native Hawaiian Health Policy

(a) [CONGRESS] *DECLARATION.*—[The] Congress [hereby] declares that it is the policy of the United States, in fulfillment of [its] special responsibilities and legal obligations *of the United States* to the indigenous people of Hawaii resulting from the unique and historical relationship between the United States and the [Government of the] indigenous people of Hawai'i—

(1) to raise the health status of Native Hawaiians to the highest [possible] *practicable* health level; and

(2) to provide [existing] Native Hawaiian health care programs with all resources necessary to effectuate [this] *that* policy.

(b) INTENT OF CONGRESS.—It is the intent of the Congress that—[the Nation meet the following health objectives with respect to Native Hawaiians by the year 2000:]

(1) [Reduce coronary heart disease deaths to no more than 100 per 100,000.] *health care programs having a demonstrated effect of substantially reducing or eliminating the overrepresentation of Native Hawaiians among those suffering from chronic and acute disease and illness, and addressing the health needs of Native Hawaiians (including perinatal, early child development, and family-based health education needs), shall be established and implemented, and*

(2) [Reduce stroke deaths to no more than 20 per 100,000.] *the United States—*

(A) *raise the health status of Native Hawaiians by the year 2010 to at least the levels described in the goals contained within Healthy People 2010 (or successor standards); and*

(B) *incorporate within health programs in the United States activities defined and identified by Kanaka Maoli, such as—*

(i) *incorporating and supporting the integration of cultural 60 approaches to health and well-being, including programs using traditional practices relating to the atmosphere (lewa lani), land ('aina), water (wai), or ocean (kai);*

(ii) *increasing the number of Native Hawaiian health and allied-health care providers who provide care to or have an impact on the health status of Native Hawaiians;*

(iii) *increasing the use of traditional Native Hawaiian foods those in—*

(I) *the diets and dietary preferences of people, including those of students; and*

(II) *school feeding programs;*

(iv) *identifying and instituting Native Hawaiian cultural values and practices within the corporate cultures of organizations and agencies providing health services to Native Hawaiians;*

(v) *facilitating the provision of Native Hawaiian healing practices by Native Hawaiian healers for individuals desiring that assistance;*

(vi) *supporting training and education activities and programs in traditional Native Hawaiian healing practices by Native Hawaiian healers; and*

(vii) *demonstrating the integration of health services for Native Hawaiians, particularly those that integrate mental, physical, and dental services in health care.*

[(3) Increase control of high blood pressure to at least 50 percent of people with high blood pressure.

[(4) Reduce blood cholesterol to an average of no more than 200 mg/dl.

[(5) Slow the rise in lung cancer deaths to achieve a rate of no more than 42 per 100,000.

[(6) Reduce breast cancer deaths to no more than 20.6 per 100,000 women.

[(7) Increase Pap tests every 1 to 3 years to at least 85 percent of women age 18 and older.

[(8) Increase fecal occult blood testing every 1 to 2 years to at least 50 percent of people age 50 and older.

[(9) Reduce diabetes-related deaths to no more than 34 per 100,000.

[(10) Reduce the most severe complications of diabetes as follows:

[(A) end-stage renal disease to no more than 1.4 in 1,000;

[(B) blindness to no more than 1.4 in 1,000;

[(C) lower extremity amputation to no more than 4.9 in 1,000;

[(D) perinatal mortality to no more than 2 percent; and

[(E) major congenital malformations to no more than 4 percent.

[(11) Reduce infant mortality to no more than 7 deaths per 1,000 live births.

[(12) Reduce low birth weight to no more than 5 percent of live births.

[(13) Increase first trimester prenatal care to at least 90 percent of live births.

[(14) Reduce teenage pregnancies to no more than 50 per 1,000 girls age 17 and younger.

[(15) Reduce unintended pregnancies to no more than 30 percent of pregnancies.

[(16) Increase to at least 60 percent the proportion of primary care providers who provide age-appropriate preconception care and counseling.

[(17) Increase years of healthy life to at least 65 years.

[(18) Eliminate financial barriers to clinical preventive services.

[(19) Increase childhood immunization levels to at least 90 percent of 2-year-olds.

[(20) Reduce the prevalence of dental caries to no more than 35 percent of children by age 8.

[(21) Reduce untreated dental caries so that the proportion of children with untreated caries (in permanent or primary teeth) is no more than 20 percent among children age 6 through 8 and no more than 15 percent among adolescents age 15.

[(22) Reduce edentulism to no more than 20 percent in people age 65 and older.

[(23) Increase moderate daily physical activity to at least 30 percent of the population.

[(24) Reduce sedentary lifestyles to no more than 15 percent of the population.

[(25) Reduce overweight to a prevalence of no more than 20 percent of the population.

[(26) Reduce dietary fat intake to an average of 30 percent of calories or less.

[(27) Increase to at least 75 percent the proportion of primary care providers who provide nutrition assessment and counseling or referral to qualified nutritionists or dieticians.

[(28) Reduce cigarette smoking prevalence to no more than 15 percent of adults.

[(29) Reduce initiation of smoking to no more than 15 percent by age 20.

[(30) Reduce alcohol-related motor vehicle crash deaths to no more than 8.5 per 100,000 adjusted for age.

[(31) Reduce alcohol use by school children age 12 to 17 to less than 13 percent.

[(32) Reduce marijuana use by youth age 18 to 25 to less than 8 percent.

[(33) Reduce cocaine use by youth age 18 to 25 to less than 3 percent.

[(34) Confine HIV infection to no more than 800 per 100,000.

[(35) Reduce gonorrhea infections to no more than 225 per 100,000.

[(36) Reduce syphilis infections to no more than 10 per 100,000.

[(37) Reduce significant hearing impairment to a prevalence of no more than 82 per 1,000.

[(38) Reduce acute middle ear infections among children age 4 and younger, as measured by days of restricted activity or school absenteeism, to no more than 105 days per 100 children.

[(39) Reduce indigenous cases of vaccine-preventable diseases as follows:

- [(A) Diphtheria among individuals age 25 and younger to 0;
- [(B) Tetanus among individuals age 25 and younger to 0;
- [(C) Polio (wild-type virus) to 0;
- [(D) Measles to 0;
- [(E) Rubella to 0;
- [(F) Congenital Rubella Syndrome to 0;
- [(G) Mumps to 500; and
- [(H) Pertussis to 1,000; and

[(40) Reduce significant visual impairment to a prevalence of no more than 30 per 1,000.]

(c) REPORT.—The Secretary shall submit to the President, for inclusion in each report required to be [transmitted] *submitted* to [the] Congress under section [11710 of this title] 12, a report on the progress made [in each area] toward meeting [each of the objectives described in subsection (b) of this section.] *the national policy described in this section.*

§ 11703. Comprehensive health care master plan for Native Hawaiians

(a) DEVELOPMENT.—

(1) *IN GENERAL.*—The Secretary may make a grant to, or enter into a contract with, Papa Ola Lokahi for the purpose of coordinating, implementing, and updating a Native Hawaiian comprehensive health care master plan *that is* designed—

(A) to promote comprehensive health promotion and disease prevention services;

(B) [and] to maintain and improve the health status of Native Hawaiians; *and* [The master plan shall be based upon an assessment of the health care status and health care needs of Native Hawaiians. To the extent practicable, assessments made as of the date of such grant or contract shall be used by Papa Ola Lokahi, except that any such assessment shall be updated as appropriate.]

(C) *to support community-based initiatives that are reflective of holistic approaches to health.*

(2) CONSULTATION.—

(A) *IN GENERAL.*—*In carrying out this section, Papa Ola Lokahi and the Office of Hawaiian Affairs shall consult with representatives of—*

- (i) *the Native Hawaiian health care systems;*
- (ii) *the Native Hawaiian health centers; and*
- (iii) *the Native Hawaiian community.*

(B) MEMORANDA OF UNDERSTANDING.—*Papa Ola Lokahi and the Office of Hawaiian Affairs may enter into memoranda of understanding or agreement for the purpose of acquiring joint funding, and for other such purposes as are necessary, to accomplish the objectives of this section.*

(3) HEALTH CARE FINANCING STUDY REPORT.—

(A) *IN GENERAL.*—*Not later than 18 months after the date of enactment of the Native Hawaiian Health Care Improvement Reauthorization Act of 2003, Papa Ola Lokahi, in cooperation with the Office of Hawaiian Affairs and other appropriate agencies and organizations in the State*

(including the Department of Health and the Department of Human Services of the State) and appropriate Federal agencies (including the Centers for Medicare and Medicaid Services), shall submit to Congress a report that describes the impact of Federal and State health care financing mechanisms and policies on the health and well-being of Native Hawaiians.

(B) COMPONENTS.—The report shall include—

(i) information concerning the impact on Native Hawaiian health and well-being of—

(I) cultural competency;

(II) risk assessment data,

(III) eligibility requirements and exemptions; and

(IV) reimbursement policies and capitation rates in effect as of the date of the report for service providers;

(ii) such other similar information as may be important to improving the health status of Native Hawaiians, as that information relates to health care financing (including barriers to health care); and

(iii) recommendations for submission to the Secretary, for review and consultation with the Native Hawaiian community.

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as **may be** *are* necessary to carry out subsection (a) **[of this section]**.

§ 11704. Functions of Papa Ola Lokahi and Office of Hawaiian Affairs

(a) **[RESPONSIBILITY] IN GENERAL.**—Papa Ola Lokahi—

(1) shall be responsible for [the]—

[(1)] *(A) the coordination, implementation, and updating, as appropriate, of the comprehensive health care master plan [developed pursuant to] under section [11703 of this title] 5;*

[(2)] *(B) the training and education of individuals providing health services [for the persons described in section 11705(c)(1)(B) of this title];*

[(3)] *(C) the identification of and research (including behavioral, biomedical, epidemiological, and health service research) into the diseases that are most prevalent among Native Hawaiians[, including behavioral, biomedical, epidemiological, and health services]; and*

(D) the development and maintenance of an institutional review board for all research projects involving all aspects of Native Hawaiian health, including behavioral, biomedical, epidemiological, and health service research;

(2) may receive special project funds (including research endowments under section 736 of the Public Health Service Act (42 U.S.C. 293)) made available for the purpose of—

(A) research on the health status of Native Hawaiians; or

(B) addressing the health care needs of Native Hawaiians; and

(3) shall serve as a clearinghouse for—

(A) the collection and maintenance of data associated with the health status of Native Hawaiians;

(B) the identification and research into diseases affecting Native Hawaiians;

(C) the availability of Native Hawaiian project funds, research projects, and publications;

(D) the collaboration of research in the area of Native Hawaiian health; and

(E) the timely dissemination of information pertinent to the Native Hawaiian health care systems.

[(4) the development of an action plan outlining the contributions that each member organization of Papa Ola Lokahi will make in carrying out the policy of this chapter.]

[(b) SPECIAL PROJECT FUNDS.—Papa Ola Lokahi [is authorized to] may receive special project funds that may be appropriated for the purpose of research on the health status of Native Hawaiians or for the purpose of addressing the health care needs of Native Hawaiians.]

(b) CONSULTATION.—

(1) IN GENERAL.—The Secretary and the Secretary of each other Federal agency shall—

(A) consult with Papa Ola Lokahi; and

(B) provide Papa Ola Lokahi and the Office of Hawaiian Affairs, at least once annually, an accounting of funds and services provided by the Secretary to assist in accomplishing the purposes described in section 4.

(2) COMPONENTS OF ACCOUNTING.—The accounting under paragraph (1)(B) shall include an identification of—

(A) the amount of funds expended explicitly for and benefiting Native Hawaiians;

(B) the number of Native Hawaiians affected by those funds;

(C) the collaborations between the applicable Federal agency and Native Hawaiian groups and organizations in the expenditure of those funds; and

(D) the amount of funds used for—

(i) Federal administrative purposes; and

(ii) the provision of direct services to Native Hawaiians.

[(c) CLEARINGHOUSE.—Papa Ola Lokahi shall serve as a clearinghouse for:

[(1) the collection and maintenance of data associated with the health status of Native Hawaiians;

[(2) the identification and research into diseases affecting Native Hawaiians;

[(3) the availability of Native Hawaiian project funds, research projects and publications;

[(4) the collaboration of research in the area of Native Hawaiian health; and

[(5) the timely dissemination of information pertinent to the Native Hawaiian health care systems.]

(c) FISCAL ALLOCATION AND COORDINATION OF PROGRAMS AND SERVICES.—

(1) *RECOMMENDATIONS.*—*Papa Ola Lokahi shall provide annual recommendations to the Secretary with respect to the allocation of all amounts made available under this Act.*

(2) *COORDINATION.*—*Papa Ola Lokahi shall, to the maximum extent practicable, coordinate and assist the health care programs and services provided to Native Hawaiians under this Act and other Federal laws.*

(3) *REPRESENTATION ON COMMISSION.*—*The Secretary, in consultation with Papa Ola Lokahi, shall make recommendations for Native Hawaiian representation on the President's Advisory Commission on Asian Americans and Pacific Islanders.*

[(d) *COORDINATION OF PROGRAMS AND SERVICES.*—*Papa Ola Lokahi shall, to the maximum extent possible, coordinate and assist the health care programs and services provided to Native Hawaiians.*]

[(e)] (d) *TECHNICAL SUPPORT.*—*Papa Ola Lokahi shall [act as a] provide statewide infrastructure to provide technical support and coordination of training and technical assistance to—*

- (1) *the Native Hawaiian health care systems; and*
- (2) *the Native Hawaiian health centers.*

[(f)] (e) *RELATIONSHIPS WITH OTHER AGENCIES.*—

(1) ***Authority.***—*Papa Ola Lokahi [is authorized to] may enter into agreements or memoranda of understanding with relevant institutions, agencies, or organizations that are capable of providing—*

- (A) *health-related resources or services to Native Hawaiians and the Native Hawaiian health care systems; or*
- (B) *resources or services for the implementation of the national policy described in section 4.*

(2) *HEALTH CARE FINANCING.*—

(A) *FEDERAL CONSULTATION.*—

(i) *IN GENERAL.*—*Before adopting any policy, rule, or regulation that may affect the provision of services or health insurance coverage for Native Hawaiians, a Federally agency that provides health care financing and carries out health care programs (including the Centers for Medicare and Medicaid Services) shall consult with representatives of—*

- (I) *the Native Hawaiian community;*
- (II) *Papa Ola Lokahi; and*
- (III) *organizations providing health care services to Native Hawaiians in the State.*

(ii) *IDENTIFICATION OF EFFECTS.*—*Any consultation by a Federal agency under clause (i) shall include an identification of the effect of any policy, rule, or regulation proposed by the Federal agency.*

(B) *STATE CONSULTATION.*—*Before making any change in an existing program or implementing any new program relating to Native Hawaiian health, the State shall engage in meaningful consultation with representatives of—*

- (i) *the Native Hawaiian community;*
- (ii) *Papa Ola Lokahi; and*
- (iii) *organizations providing health care services to Native Hawaiians in the State.*

(C) *CONSULTATION ON FEDERAL HEALTH INSURANCE PROGRAMS.*—

(i) *IN GENERAL.*—*The Office of Hawaiian Affairs, in collaboration with Papa Ola Lokahi, may develop consultative, contractual, or other arrangements, including memoranda of understanding or agreement, with—*

(I) *the Centers for Medicare and Medicaid Services;*

(II) *the agency of the State that administers or supervises the administration of the State plan or waiver approved under title XVIII, XIX, or XXI of the Social Security Act (42 U.S.C. 1395 et seq.) for the payment of all or a part of the health care services provided to Native Hawaiians who are eligible for medical assistance under the State plan or waiver; or*

(III) *any other Federal agency providing full or partial health insurance to Native Hawaiians.*

(ii) *CONTENTS OF ARRANGEMENTS.*—*An arrangement under clause (i) may address—*

(I) *appropriate reimbursement for health care services, including capitation rates and fee-for-service rates for Native Hawaiians who are entitled to or eligible for insurance;*

(II) *the scope of services; or*

(III) *other matters that would enable Native Hawaiians to maximize health insurance benefits provided by Federal and State health insurance programs.*

(3) *TRADITIONAL HEALERS.*—

(A) *IN GENERAL.*—*The provision of health services under any program operated by the Department of another Federal agency (including Department of Veterans Affairs) may include the services of—*

(i) *traditional Native Hawaiian healers; or*

(ii) *traditional healers providing traditional health care practices (as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).*

(B) *EXEMPTION.*—*Services described in subparagraph (A) shall be exempt from national accreditation reviews, including reviews conducted by—*

(i) *the joint Commission on Accreditation of Healthcare Organizations; and*

(ii) *the Commission on Accreditation of Rehabilitation Facilities.*

§ 11705. Native Hawaiian health care [systems]

(a) **COMPREHENSIVE HEALTH PROMOTION, DISEASE PREVENTION, AND [PRIMARY] OTHER HEALTH SERVICES.**—

(1) **[(A)] GRANTS AND CONTRACTS.**—*The Secretary, in consultation with Papa Ola Lokahi, may make grants to, or enter into contracts with 1 or more Native Hawaiian health care systems [, any qualified entity] for the purpose of providing comprehensive health promotion and disease prevention services,*

as well as [primary] *other* health services, to Native Hawaiians *who desire and are committed to bettering their own health.*

[(B)] (2) *LIMITATION ON NUMBER OF ENTITIES.*—[In making grants and entering into contracts under this paragraph, the Secretary shall give preference to Native Hawaiian health care systems and Native Hawaiian organizations and, to the extent feasible, health promotion and disease prevention services shall be performed through Native Hawaiian health care systems.] *The Secretary may make a grant to, or enter into a contract with, not more than 8 Native Hawaiian health care systems under this subsection for any fiscal year.*

[2] (b) *PLANNING GRANT OR CONTRACT.*—In addition to [paragraph (1)] *grants and contracts under subsection (a),* the Secretary may make a grant to, or enter into a contract with, Papa Ola Lokahi for the purpose of planning Native Hawaiian health care systems to serve the health needs of Native Hawaiian communities on each of the islands of O‘ahu, Moloka‘i, Maui, Hawai‘i, Lana‘i, Kaua‘i, *Kaho‘lawe*, and Ni‘ihau in the State [of Hawai‘i].

[(b) *QUALIFIED ENTITY.*—An entity is a qualified entity for purposes of subsection (a)(1) of this section if the entity is a Native Hawaiian health care system.]

(c) *HEALTH SERVICES TO BE PROVIDED.*—

(1) *IN GENERAL.*—Each recipient of funds under subsection (a)[(1) of this section shall] *may provide or arrange for*—[the following services:]

(A) outreach services to inform and assist Native Hawaiians [of the availability of] *in accessing* health services;

(B) education in health promotion and disease prevention [of the] *for* Native [Hawaiian population by] *Hawaiians that, wherever [possible] practicable, is provided by*—

(i) Native Hawaiian health care practitioners[.];

(ii) community outreach workers[.];

(iii) counselors[, and];

(iv) cultural educators; *and*

(v) other disease prevention providers;

(C) services of [physicians, physicians’ assistants, nurse practitioners or other health professionals] *individuals providing health services;*

(D) [immunizations] *collection of data relating to the prevention of diseases and illnesses among Native Hawaiians; and*

(E) [prevention and control of diabetes, high blood pressure, and otitis media;] *support of culturally appropriate activities that enhance health and wellness, including land-based, water-based, ocean-based, and spiritually-based projects and programs.*

[(F) pregnancy and infant care; and

[(G) improvement of nutrition.

[(2) In addition to the mandatory services under paragraph (1), the following services may be provided pursuant to subsection (a)(1) of this section:

[(A) identification, treatment, control, and reduction of the incidence of preventable illnesses and conditions endemic to Native Hawaiians;

[(B) collection of data related to the prevention of diseases and illnesses among Native Hawaiians; and

[(C) services within the meaning of the terms “health promotion”, “disease prevention”, and “primary health services”, as such terms are defined in section 11711 of this title, which are not specifically referred to in paragraph (1) of this subsection.]

[(3)] (2) *TRADITIONAL HEALERS*.—The health care services referred to in [paragraphs (1) and (2)] *paragraph (1)* [which] *that* are provided under grants or contracts under subsection (a)[(1) of this section] may be provided by traditional Native Hawaiian healers, *as appropriate*.

[(d) LIMITATION OF NUMBER OF ENTITIES.—During a fiscal year, the Secretary under this chapter may make a grant to, or hold a contract with, not more than 5 Native Hawaiian health care systems.]

(d) *FEDERAL TORT CLAIMS ACT*.—*An individual who provides a medical, dental, or other service referred to in subsection (a)(1) for a Native Hawaiian health care system, including a provider of a traditional Native Hawaiian healing service, shall be—*

(1) treated as if the individual were a member of the Public Health Service; and

(2) subject to section 224 of the Public Health Service Act (42 U.S.C. 233).

[(e) MATCHING FUNDS.—

[(1) The Secretary may not make a grant or provide funds pursuant to a contract under subsection (a)(1) of this section to a Native Hawaiian health care system—

[(A) in an amount exceeding 83.3 percent of the costs of providing health services under the grant or contract; and

[(B) unless the Native Hawaiian health care system agrees that the Native Hawaiian health care system or the State of Hawai‘i will make available, directly or through donations to the Native Hawaiian health care system, non-Federal contributions toward such costs in an amount equal to not less than \$1 (in cash or in kind under paragraph (2) for each \$5 of Federal funds provided in such grant or contract.

[(2) Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government or services assisted or subsidized to any significant extent by the Federal Government may not be included in determining the amount of such non-Federal contributions.

[(3) The Secretary may waive the requirement established in paragraph (1) if—

[(A) the Native Hawaiian health care system involved is a nonprofit private entity described in subsection (b) of this section; and

[(B) the Secretary, in consultation with Papa Ola Lokahi, determines that it is not feasible for the Native Hawaiian health care system to comply with such requirement.]

(e) *SITE FOR OTHER FEDERAL PAYMENTS*.—

(1) *IN GENERAL.*—A Native Hawaiian health care system that receives funds under subsection (a) may serve as a Federal loan repayment facility.

(2) *REMISSION OF PAYMENTS.*—A facility described in paragraph (1) shall be designed to enable health and allied-health professionals to remit payments with respect to loans provided to the professionals under any Federal loan program.

(f) *RESTRICTION ON USE OF GRANT AND CONTRACT FUNDS.*—The Secretary [may] shall not make a grant to, or enter into a contract with, [any] an entity under subsection (a) [(1) of this section] unless the entity agrees that[,] amounts received [pursuant to such subsection] under the grant or contract will not, directly or through contract, be expended—

(1) for any [purpose] service other than [the purposes] a service described in subsection (c) [of this section] (1);

[(2) to provide inpatient services;

[(3) to make cash payments to intended recipients of health services; or]

[(4)] (2) to purchase or improve real property (other than minor remodeling of existing improvements to real property); or

(3) to purchase major medical equipment.

(g) *LIMITATION ON CHARGES FOR SERVICES.*—The Secretary [may] shall not make a grant to, or enter into a contract with, [any] an entity under subsection (a) [(1) of this section] unless the entity agrees that, whether health services are provided directly or [through] under a contract—

(1) any health [services] service under the grant or contract will be provided without regard to the ability of an individual receiving the health service to pay for the health [services] service; and

(2) the entity will impose [a charge] for the delivery of such a health [services, and such charge] service a charge that is—

(A) [will be] made according to a schedule of charges that is made available to the public, and

(B) [will be] adjusted to reflect the income of the individual involved.

(h) *AUTHORIZATION OF APPROPRIATIONS.*—

(1) *GENERAL GRANTS.*—There are authorized to be appropriated such sums as [may be] are necessary to carry out subsection (a) for each of fiscal years [1993] 2004 through [2001] 2009 [to carry out subsection (a)(1) of this section].

(2) *PLANNING GRANTS.*—There are authorized to be appropriated such sums as [may be] are necessary to carry out subsection [(a)(2) of this section] (b) for each of fiscal years 2004 through 2009.

(3) *HEALTH SERVICES.*—There are authorized to be appropriated such sums as are necessary to carry out subsection (c) for each of fiscal years 2004 through 2009.

§ 11706. Administrative grant for Papa Ola Lokahi

(a) *IN GENERAL.*—In addition to any other grant or contract under this [chapter] Act, the Secretary may make grants to, or enter into contracts with, Papa Ola Lokahi for—

(1) coordination, implementation, and updating (as appropriate) of the comprehensive health care master plan developed [pursuant to section 11703 of this title] *under section 5*;

(2) training and education for [the persons described in section 11705(c)(1)(B) of this title] *providers of health services*;

(3) identification of and research [into the diseases that are most prevalent among Native Hawaiians,] (including behavioral, biomedical, [epidemiological] *epidemiologic*, and health [services] *service research*) *into the diseases that are most prevalent among Native Hawaiians*;

[(4) the development of an action plan outlining the contributions that each member organization of Papa Ola Lokahi will make in carrying out the policy of this chapter;]

[(5)] (4) a clearinghouse function for—

(A) the collection and maintenance of data associated with the health status of Native Hawaiians;

(B) the identification and research into diseases affecting Native Hawaiians; and

(C) the availability of Native Hawaiian project funds, research projects and publications;

(5) *the establishment and maintenance of an institutional review board for all health-related research involving Native Hawaiians*;

(6) the coordination of the health care programs and services provided to Native Hawaiians; and

(7) the administration of special project funds.

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as [may be] *are necessary to carry out subsection (a) for each of fiscal years [1993] 2004 through [2001] 2009 [to carry out 80 subsection (a) of this section].*

§ 11707. Administration of grants and contracts

(a) TERMS AND CONDITIONS.—The Secretary shall include in any grant made or contract entered into under this [chapter] *Act* such terms and conditions as the Secretary considers necessary or appropriate to ensure that the objectives of [such] *the* grant or contract are achieved.

(b) PERIODIC REVIEW.—The Secretary shall periodically evaluate the performance of, and compliance with, grants and contracts under this [chapter] *Act*.

(c) ADMINISTRATIVE REQUIREMENTS.—The Secretary [may] *shall* not make a grant or enter into a contract under this [chapter] *Act* with an entity unless the entity—

(1) agrees to establish such procedures for fiscal control and fund accounting as [may be] *the Secretary determines are necessary to ensure proper disbursement and accounting with respect to the grant or contract*;

(2) agrees to ensure the confidentiality of records maintained on individuals receiving health services under the grant or contract;

(3) with respect to providing health services to any population of Native Hawaiians, a substantial portion of which has a limited ability to speak the English language—

(A) has developed and has the ability to carry out a reasonable plan to provide health services under the grant or

contract through individuals who are able to communicate with the population involved in the language and cultural context that is most appropriate; and

(B) has designated at least **[one]** 1 individual**[,]** *who is* fluent in **[both]** English and the appropriate language**[,]** to assist in carrying out the plan;

(4) with respect to health services that are covered **[in the plan of the State of Hawai'i approved]** *under a program* under title XVIII, XIX, or XXI of the Social Security Act **[42 U.S.C.A. § 1396 et seq.]** (42 U.S.C. 1395 et seq.) *(including any State plan), or under any other Federal health insurance plan—*

(A) if the entity will provide under the grant or contract any **[such]** *of those* health services directly—

(i) **[the entity]** has entered into a participation agreement under *each* such **[plans]** *plan*; and

(ii) **[the entity]** is qualified to receive payments under **[such]** *the* plan; and

(B) if the entity will provide under the grant or contract any **[such]** *of those* health services through a contract with an organization—

(i) *ensures that* the organization has entered into a participation agreement under *each* such plan; and

(ii) *ensures that* the organization is qualified to receive payments under **[such]** *the* plan; and

(5) agrees to submit to the Secretary and **[to]** Papa Ola Lokahi an annual report that—

(A) describes the **[utilization]** *use* and costs of health services provided under the grant or contract (including the average cost of health services per user); and

(B) **[that]** provides such other information as the Secretary determines to be appropriate.

(d) CONTRACT EVALUATION.—

(1) *DETERMINATION OF NONCOMPLIANCE.*—If, as a result of evaluations conducted by the Secretary, the Secretary determines that an entity has not complied with or satisfactorily performed a contract entered into under section **[11705 of this title]** 7, the Secretary shall, **[prior to]** *before* renewing **[such]** *the* contract**[,]**—

(A) attempt to resolve the areas of noncompliance or unsatisfactory performance; and

(B) modify **[such]** *the* contract to prevent future occurrences of **[such]** the noncompliance or unsatisfactory performance.

(2) *NONRENEWAL.*—If the Secretary determines that **[such]** *the* noncompliance or unsatisfactory performance *described in paragraph (1) with respect to an entity* cannot be resolved and prevented in the future, the Secretary—

(A) shall not renew **[such]** *the* contract with **[such]** *the* entity; and

(B) **[is authorized to]** *may* enter into a contract under section **[11705 of this title]** 7 with another entity referred to in section **[11705(b)]** 7(a)(3) **[of this title]** that provides services to the same population of Native Hawaiians **[which is]** served by the entity **[whose contract is]** *the*

contract with which was not renewed by reason of this [subsection] paragraph.

[(2)] (3) *CONSIDERATION OF RESULTS*.—In determining whether to renew a contract entered into with an entity under this [chapter] Act, the Secretary shall consider the results of the [evaluation] *evaluations conducted* under this section.

[(3)] (4) *APPLICATION OF FEDERAL LAWS*.—[All contracts] *Each contract* entered into by the Secretary under this [chapter] Act shall be in accordance with all Federal contracting laws [and] (*including regulations*), except that, in the discretion of the Secretary, such [contracts] *a contract* may—

(A) be negotiated without advertising; and

(B) [may] be exempted from [the provisions of the Act of August 24, 1935 (40 U.S.C. 270a et seq.)] *subchapter III of chapter 31, United States Code*.

[(4)] (5) *PAYMENTS*.—A [Payments] *payment* made under any contract entered into under this [chapter] Act—

(A) may be made—

(i) in advance[.];

(ii) by means of reimbursement[.]; or

(iii) in installments; and

(B) shall be made on such conditions as the Secretary [deems] *determines to be* necessary to carry out [the purposes of] this [chapter] Act.

[(e)] *LIMITATION ON USE OF FUNDS FOR ADMINISTRATIVE EXPENSES*.—Except for grants and contracts under section 11706 of this title, the Secretary may not grant to, or enter into a contract with, an entity under this chapter unless the entity agrees that the entity will not expend more than 10 percent of amounts received pursuant to this chapter for the purpose of administering the grant or contract.]

[(f)] (e) *REPORT*.—

(1) *IN GENERAL*.—For each fiscal year during which an entity receives or expends funds [pursuant to] *under* a grant or contract under this [chapter] Act, [such] *the* entity shall submit to the Secretary and to Papa Ola Lokahi [a quarterly] *an annual* report [on] *that describes*—

(A) *the* activities conducted by the entity under the grant or contract;

(B) the amounts and purposes for which Federal funds were expended; and

(C) such other information as the Secretary may request.

(2) *AUDITS*.—The reports and records of any entity [which concern] *concerning* any grant or contract under this [chapter] Act shall be subject to audit by—

(A) the Secretary[.];

(B) the Inspector General of the Department of Health and Human Services[.]; and

(C) the Comptroller General of the United States.

[(g)] (f) *ANNUAL PRIVATE AUDIT*.—The Secretary shall allow as a cost of any grant made or contract entered into under this [chapter] Act the cost of an annual private audit conducted by a certified public accountant *to carry out this section*.

§ 11708. Assignment of personnel

(a) IN GENERAL.—The Secretary [is authorized to] *may* enter into an agreement with [any entity under which the Secretary is authorized to assign] *Papa Ola Lokahi or any of the Native Hawaiian health care systems for the assignment of* personnel of the Department of Health and Human Services with relevant expertise [identified by such entity to such entity on detail] for the [purposes] *purpose of—*

(1) *conducting research; or*

(2) providing comprehensive health promotion and disease prevention services *and health services* to Native Hawaiians.

(b) APPLICABLE FEDERAL PERSONNEL PROVISIONS.—Any assignment of personnel made by the Secretary under any agreement entered into under [the authority of] subsection (a) [of this section] shall be treated as an assignment of Federal personnel to a local government that is made in accordance with subchapter VI of chapter 33 of [Title] *title 5, United States Code.*

§ 11709. Native Hawaiian health scholarships *and Fellowships*

(a) ELIGIBILITY.—Subject to the availability of [funds] *amounts* appropriated under [the authority of] subsection (c) [of this section], the Secretary shall provide to *Papa Ola Lokahi, through a direct grant or a cooperative agreement,* funds [through a direct grant or a cooperative agreement to Papa Ola Lokahi] for the purpose of providing scholarship assistance to students who *are Native Hawaiians.* [—]

[(1) meet the requirements of section 254*l* of this title, and

[(2) are Native Hawaiians.]

(b) PRIORITY.—*A priority for scholarships under subsection (a) may be provided to employees of—*

(1) *the Native Hawaiian Health Care Systems; and*

(2) *the Native Hawaiian Health Centers.—*

[(b)] (c) TERMS AND CONDITIONS.—

(1) SCHOLARSHIP ASSISTANCE.—

(A) IN GENERAL.—The scholarship assistance [provided] under subsection (a) [of this section] shall be provided [under the same terms and subject to the same conditions, regulations, and rules that apply to scholarship assistance provided under section 254*l* of this title, provided that—] *in accordance with subparagraphs (B) through (G).*

[(A)] (B) NEED.—[the] *The* provision of scholarships in each type of health [care] profession training shall correspond to the need for each type of health [care] professional [identified in the Native Hawaiian comprehensive health care master plan implemented under section 11703 of this title] to serve the Native Hawaiian [health care systems] *community in providing health services,* as identified by Papa Ola Lokahi[;].

[(B) the primary health services covered under the scholarship assistance program under this section shall be the services included under the definition of that term under section 11711(8) of this title;]

(C) ELIGIBLE APPLICANTS.—[to] *To* the maximum extent practicable, the Secretary shall select scholarship recipi-

ents from a list of eligible applicants submitted by [the] Papa [Oka] Ola Lokahi[;].

(D) *OBLIGATED SERVICE REQUIREMENT.*—

(i) *IN GENERAL.*—An [the] obligated service requirement for each scholarship recipient (*except for a recipient receiving assistance under paragraph (2)*) shall be fulfilled through [the full-time clinical or nonclinical practice of the health profession of the scholarship recipient, in an] *service, in order of priority [that would provide for practice—], in—*

(I)[(i) first, in] any [one] of the [five] Native Hawaiian health care systems; [and]

(II) *any of the Native Hawaiian health centers;*

(III) *1 or more health professions shortage areas, medically underserved areas, or geographic areas or facilities similarly designated by the Public Health Service in the State;*

(IV) *a Native Hawaiian organization that serves a geographical area with a significant Native Hawaiian population;*

(V) *any public agency or non-profit organization providing services to Native Hawaiians; or*

(VI) *any of the uniformed services of the United States.*

[(ii) second, in—

[(I) a health professional shortage area or medically underserved area located in the State of Hawaii; or

[(II) a geographic area or facility that is—

[(aa) located in the State of Hawaii; and

[(bb) has a designation that is similar to a designation described in subclause (I) made by the Secretary, acting through the Public Health Service;]

(ii) *ASSIGNMENT.*—*The placement service for a scholarship shall assign each Native Hawaiian scholarship recipient to 1 or more appropriate sites for service in accordance with clause (i).*

(E) *COUNSELING, RETENTION, AND SUPPORT SERVICES.*—[the] *The provision of academic and personal counseling, retention and other support services—*

(i) *shall not be limited to scholarship recipients [,] under this section; and*

(ii) [but shall also include] *shall be made available to recipients of other scholarship and financial aid programs enrolled in appropriate health professions training programs[;].*

(F) *FINANCIAL ASSISTANCE.*—[the obligated service of a scholarship recipient shall not be performed by the recipient through membership in the National Health Service Corps; and] *After consultation with Papa Ola Lokahi, financial assistance may be provided to a scholarship recipient during the period that the recipient is fulfilling the service requirement of the recipient in any of—*

(i) *the Native Hawaiian health care systems; or*

(ii) *the Native Hawaiians health centers.*

[(G) the requirements of sections 254d through 254k of this title, section 254m of this title, other than subsection (b)(5) of that section, and section 254n of this title applicable to scholarship assistance provided under 254l of this title shall not apply to the scholarship assistance provided under subsection (a) of this section.]

(G) *DISTANCE LEARNING RECIPIENTS.*—A scholarship may be provided to a Native Hawaiian who is enrolled in an appropriate distance learning program offered by an accredited educational institution.

[(2) The Native Hawaiian Health Scholarship program shall not be administered by or through the Indian Health Service.]

(2) *FELLOWSHIPS.*—

(A) *IN GENERAL.*—Papa Ola Lokahi may provide financial assistance in the form of a fellowship to a Native Hawaiian health professional who is—

(i) a Native Hawaiian community health representative, outreach worker, or health program administrator in a professional training program;

(ii) a Native Hawaiian providing health services;

or

(iii) a Native Hawaiian enrolled in a certificated program provided by traditional Native Hawaiian healers in any of the traditional Native Hawaiian healing practices (including lomi-lomi, la'au lapa'au, and ho'oponopono).

(B) *TYPES OF ASSISTANCE.*—Assistance under subparagraph (A) may include a stipend for, or reimbursement for costs associated with, participation in a program described in that paragraph.

(3) *RIGHTS AND BENEFITS.*—An individual who is a health professional designated in section 338A of the Public Health Service Act (42 U.S.C. 254l) who receives a scholarship under this subsection while fulfilling a service requirement under that Act shall retain the same rights and benefits as members of the National Health Service Corps during the period of service.

(4) *NO INCLUSION OF ASSISTANCE IN GROSS INCOME.*—Financial assistance provided under this section shall be considered to be qualified scholarships for the purpose of section 117 of the Internal Revenue Code of 1986.

[(c)] (d) *AUTHORIZATION OF APPROPRIATIONS.*—There are authorized to be appropriated such sums as [may be] are necessary to carry out subsections (a) and (c)(2) for each of fiscal years [1993] 2004 through [2001] 2009 [for the purpose of funding the scholarship assistance provided under subsection (a) of this section].

§ 11710. Report

For each fiscal year, the [The] President shall, at the time at which the budget of the United States is submitted under section 1105 of [Title] title 31, United States Code, submit [for each fiscal year transmit] to [the] Congress a report on the progress made in meeting the [objectives] purposes of this [chapter] Act, including—

(1) a review of programs established or assisted [pursuant to this chapter] *in accordance with this Act*; and

(2) an assessment of and recommendations [of] for additional programs or additional assistance necessary to provide, at a minimum, [provide] health services to Native Hawaiians, and ensure a health status for Native Hawaiians, [which] that are at a parity with the health services available to, and the health status of, the general population.

SEC. 13. USE OF FEDERAL GOVERNMENT FACILITIES AND SOURCES OF SUPPLY

(a) *IN GENERAL.*—The Secretary shall permit an organization that enters into a contract or receives grant under this Act to use in carrying out projects or activities under the contract or grant all existing facilities under the jurisdiction of the Secretary (including all equipment of the facilities), in accordance with such terms and conditions as may be agreed on for the use and maintenance of the facilities or equipment.

(b) *DONATION OF PROPERTY.*—The Secretary may donate to an organization that enters into a contract or receives grant under this Act, for use in carrying out a project or activity under the contract or grant, any personal or real property determined to be in excess of the needs of the Department or the General Services Administration.

(c) *ACQUISITION OF SURPLUS PROPERTY.*—The Secretary may acquire excess or surplus Federal Government personal or real property for donation to an organization under subsection (b) if the Secretary determines that the property is appropriate for use by the organization for the purpose for which a contract entered into or grant received by the organization is authorized under this Act.

SEC. 14. DEMONSTRATION PROJECTS OF NATIONAL SIGNIFICANCE

(a) *AUTHORITY AND AREAS OF INTEREST.*—

(1) *IN GENERAL.*—The Secretary, in consultation with Papa Ola Lokahi, may allocate amounts made available under this Act, or any other Act, to carry out Native Hawaiian demonstration projects of national significance.

(2) *AREAS OF INTEREST.*—A demonstration project described in paragraph (1) may relate to such areas of interest as—

(A) the development of a centralized database and information system relating to the health care status, health care needs, and wellness of Native Hawaiians;

(B) the education of health professionals, and other individuals in institutions of higher learning, in health and allied health programs in healing practices, including Native Hawaiian healing practices;

(C) the integration of Western medicine with complementary healing practices, including traditional Native Hawaiian healing practices;

(D) the use of telewellness and telecommunications in—
(i) chronic and infectious disease management, and
(ii) health promotion and disease prevention;

(E) the development of appropriate models of health care for Native Hawaiians and other indigenous people, including—

- (i) the provision of culturally competent health services;
 - (ii) related activities focusing on wellness concepts;
 - (iii) the development of appropriate kupuna care programs; and
 - (iv) the development of financial mechanisms and collaborative relationships leading to universal access to health care; and
- (F) the establishment of—
- (i) a Native Hawaiian Center of Excellence for Nursing at the University of Hawai'i at Hilo;
 - (ii) a Native Hawaiian Center of Excellence for Mental Health at the University of Hawai'i at Manoa,
 - (iii) a Native Hawaiian Center of Excellence for Maternal Health and Nutrition at the Waimanalo Health Center;
 - (iv) a Native Hawaiian Center of Excellence for Research, Training, and Integrated Medicine at Molokai General Hospital; and
 - (v) a Native Hawaiian Center of Excellence for Complementary Health and Health Education and Training at the Waianae Coast Comprehensive Health Center.

(3) *CENTERS OF EXCELLENCE.*—Papa Ola Lokahi, and any centers established under paragraph (2)(F), shall be considered to be qualified as Centers of Excellence under sections 485F and 903(b)(2)(A) of the Public Health Service Act (42 U.S.C. 287c-32, 299a-1).

(b) *NONREDUCTION IN OTHER FUNDING.*—The allocation of funds for demonstration projects under subsection (a) shall not result in any reduction in funds required by the Native Hawaiian health care systems, the Native Hawaiian Health Centers, the Native Hawaiian Health Scholarship Program, or Papa Ola Lokahi to carry out the respective responsibilities of those entities under this Act.

§ 11711. Definitions

[For purposes of this chapter] In this Act:

(1) *DEPARTMENT.*—The term 'Department' means the Department of Health and Human Services.

[(1)](2) DISEASE PREVENTION.—The term **["']disease prevention['"]** includes—

- (A) immunizations~~[],~~;
- (B) control of high blood pressure~~[],~~;
- (C) control of sexually transmittable diseases~~[],~~;
- (D) prevention and control of ~~[],~~ chronic diseases;
- (E) control of toxic agents~~[],~~;
- (F) occupational safety and health~~[],~~;
- (G) ~~[],~~ accident injury prevention~~[],~~;
- (H) fluoridation of water~~[],~~;
- (I) control of infectious agents~~[],~~; and
- (J) provision of mental health care.

[(2)] (3) HEALTH PROMOTION.—The term **["']health promotion['"]** includes—

- (A) pregnancy and infant care, including prevention of fetal alcohol syndrome[.];
 - (B) cessation of tobacco smoking[.];
 - (C) reduction in the misuse of alcohol and *harmful illicit drugs*[.];
 - (D) improvement of nutrition[.];
 - (E) improvement in physical fitness[.];
 - (F) family planning[, and];
 - (G) control of stress[.];
 - (H) *reduction of major behavioral risk factors and promotion of healthy lifestyle practices; and*
 - (I) *integration of cultural approaches to health and well-being (including traditional practices relating to the atmosphere (lewa lani), land ('aina), water (wai), and ocean (kai).*
- (4) *HEALTH SERVICE.*—The term 'health service' means—
- (A) *service provided by a physician, physician's assistant, nurse practitioner, nurse, dentist, or other health professional;*
 - (B) *a diagnostic laboratory or radiologic service,*
 - (C) *a preventive health service (including a perinatal service, well child service, family planning service, nutrition service, home health service, sports medicine and athletic training service, and, generally, any service associated with enhanced health and wellness);*
 - (D) *emergency medical service, including a service provided by a first responder, emergency medical technician, or mobile intensive care technician;*
 - (E) *a transportation service required for adequate patient care;*
 - (F) *a preventive dental service,*
 - (G) *a pharmaceutical and medicant service;*
 - (H) *a mental health service, including a service provided by a psychologist or social worker;*
 - (I) *a genetic counseling service;*
 - (J) *a health administration service, including a service provided by a health program administrator;*
 - (K) *a health research service, including a service provided by an individual with an advanced degree in medicine, nursing, psychology, social work, or any other related health program;*
 - (L) *an environmental health service, including a service provided by an epidemiologist, public health official, medical geographer, or medical anthropologist, or an individual specializing in biological, chemical, or environmental health determinants;*
 - (M) *a primary care service that may lead to specialty or tertiary care; and*
 - (N) *a complementary healing practice, including a practice performed by a traditional Native Hawaiian healer.*
- [(3)](5) *NATIVE HAWAIIAN.*—The term ["']Native Hawaiian["'] means any individual who is [—] *Kanaka Maoli* (a descendant of the aboriginal people who, prior to 1778, occupied and exercised sovereignty in the area that now constitutes the State), as evidenced by—

(A) **[a citizen of the United States, and]** *genealogical records*;

(B) **[a descendant of the aboriginal people, who prior to 1778, occupied and exercised sovereignty in the area that now constitutes the State of Hawai‘i, as evidenced by—]** *kama‘aina witness verification from Native Hawaiian Kupuna (elders); or*

[(i) genealogical records,

[(ii) Kupuna (elders) or Kama‘aina (long-term community residents) verification, or]

[(iii)] (C) birth records of the State [of Hawai‘i] or any other State or territory of the United States.

[(4)] (6) NATIVE HAWAIIAN HEALTH [CENTER] CARE SYSTEM.—The term **["Native Hawaiian health [center] care system"]** means **[an entity]** *any of up to 8 entities in the State that—*

(A) **[which]** is organized under the laws of the State **[of Hawai‘i]**;

(B) **[which]** provides or arranges for *the provision of health [care] services [through practitioners licensed by the State of Hawai‘i, where licensure requirements are applicable]* *for Native Hawaiians in the State*;

(C) **[which]** is a public or nonprofit private entity **[, and]**;

(D) **[in which]** *has* Native **[Hawaiian health practitioners]** *Hawaiians* significantly **[participate]** *participating* in the planning, management, *provision*, monitoring, and evaluation of health services**[.]**;

(E) *addresses the health care needs of an island’s Native Hawaiian population; and*

(F) *is recognized by Papa Ola Lokahi—*

(i) for the purpose of planning, conducting, or administering programs, or portions of programs, authorized by this Act for the benefit of Native Hawaiians; and

(ii) as having the qualifications and the capacity to provide the services and meet the requirements under—

(I) the contract that each Native Hawaiian health care system enters into with the Secretary under this Act; or

(II) the grant each Native Hawaiian health care system receives from the Secretary under this Act.

[(5)] (7) [NATIVE HAWAIIAN ORGANIZATION] NATIVE HAWAIIAN HEALTH CENTER.—The term **["Native Hawaiian [organization"] Health Center"]** means any organization**[—]** *that is a primary health care provider that—*

(A) **[which serves the interests of Native Hawaiians,]** *has a governing board composed of individuals, at least 50 percent of whom are Native Hawaiians;*

(B) **[which is—]** *has demonstrated cultural competency in a predominately Native Hawaiian community;*

(C) *serves a patient population that—*

(i) [recognized by Papa Ola Lokahi for the purpose of planning, conducting, or administering programs (or portions of programs) authorized under this chapter

for the benefit of Native Hawaiians, and] *is made up of individuals at least 50 percent of whom are Native Hawaiian; or*

(ii) [certified by Papa Ola Lokahi as having the qualifications and capacity to provide the services, and meet the requirements, under the contract the organization enters into with, or grant the organization receives from, the Secretary under this chapter,] *has not less than 2,500 Native Hawaiians as annual users of services; and*

[(C) in which Native Hawaiian health practitioners significantly participate in the planning, management, monitoring, and evaluation of health services, and]

(D) [which is a public or nonprofit private entity,] *is recognized by Papa Ola Lokahi as having met each of the criteria described in subparagraphs (A) through (C).*

[(6)] (8) NATIVE HAWAIIAN [health care system—] *HEALTH TASK FORCE.*—The term [“Native Hawaiian [health care system”] *Health Task Force*’ means [an entity—] *a task force established by the State Council of Hawaiian Homestead Associations to implement health and wellness strategies in Native Hawaiian communities.*

[(A) which is organized under the laws of the State of Hawai‘i,

[(B) which provides or arranges for health care services through practitioners licensed by the State of Hawai‘i, where licensure requirements are applicable,

[(C) which is a public or nonprofit private entity,

[(D) in which Native Hawaiian health practitioners significantly participate in the planning, management, monitoring, and evaluation of health care services,

[(E) which may be composed of as many Native Hawaiian health centers as necessary to meet the health care needs of each island’s Native Hawaiians, and

[(F) which is—

[(i) recognized by Papa Ola Lokahi for the purpose of planning, conducting, or administering programs, or portions of programs, authorized by this chapter for the benefit of Native Hawaiians, and

[(ii) certified by Papa Ola Lokahi as having the qualifications and the capacity to provide the services and meet the requirements under the contract the Native Hawaiian health care system enters into with the Secretary or the grant the Native Hawaiian health care system receives from the Secretary pursuant to this chapter.]

[(7)] (9) [Papa ola lokahi—] *NATIVE HAWAIIAN ORGANIZATION.*—The term ‘Native Hawaiian organization’ means any organization that—

(A) [The term “Papa Ola Lokahi” means an organization composed of—] *serves the interests of Native Hawaiians; and*

[(i) E Ola Mau;

[(ii) the Office of Hawaiian Affairs of the State of Hawai‘i;

- [(iii) Alu Like Inc.;
- [(iv) the University of Hawai'i;
- [(v) the Office of Hawaiian Health of the Hawaii State Department of Health;
- [(vi) Ho'ola Lahui Hawai'i, or a health care system serving the islands of Kaua'i and Ni'ihau, and which may be composed of as many health care centers as are necessary to meet the health care needs of the Native Hawaiians of those islands;
- [(vii) Ke Ola Mamo, or a health care system serving the island of O'ahu, and which may be composed of as many health care centers as are necessary to meet the health care needs of the Native Hawaiians of that island;
- [(viii) Na Pu'uwai or a health care system serving the islands of Moloka'i and Lana'i, and which may be composed of as many health care centers as are necessary to meet the health care needs of the Native Hawaiians of those islands;
- [(ix) Hui No Ke Ola Pono, or a health care system serving the island of Maui, and which may be composed of as many health care centers as are necessary to meet the health care needs of the Native Hawaiians of that island;
- [(x) Hui Malama Ola Ha'Oiwi or a health care system serving the island of Hawai'i, and which may be composed of as many health care centers as are necessary to meet the health care needs of the Native Hawaiians of that island; and
- [(xi) such other member organizations as the Board of Papa Ola Lokahi may admit from time to time, based upon satisfactory demonstration of a record of contribution to the health and well-being of Native Hawaiians, and upon satisfactory development of a mission statement in relation to this chapter, including clearly defined goals and objectives, a 5-year action plan outlining the contributions that each organization will make in carrying out the policy of this chapter, and an estimated budget.]

(B) [Such term does not include any such organization identified in subparagraph (A) if the Secretary determines that such organization has not developed a mission statement with clearly defined goals and objectives for the contributions the organization will make to the Native Hawaiian health care systems, and an action plan for carrying out those goals and objectives.] *(i) is recognized by Papa Ola Lokahi for planning, conducting, or administering programs authorized under this Act for the benefit of Native Hawaiians; and*

(ii) is a public or nonprofit private entity.

[(8)] (10) [Primary health services] OFFICE OF HAWAIIAN AFFAIRS.—The term 'Office of Hawaiian Affairs' means the governmental entity that—

[The term "primary health services" means—]

(A) **【services of physicians, physicians' assistants, nurse practitioners, and other health professionals;】** *is established under Article XII, sections 5 and 6 of the Hawai'i State Constitution; and*

(B) **【diagnostic laboratory and radiologic services;】** *charged with the responsibility to formulate policy relating to the affairs of Native Hawaiians.*

【(C) preventive health services (including children's eye and ear examinations to determine the need for vision and hearing correction, perinatal services, well child services, and family planning services);

【(D) emergency medical services;

【(E) transportation services as required for adequate patient care;

【(F) preventive dental services; and

【(G) pharmaceutical service, as may be appropriate for particular health centers.】

【(9) (11) 【SECRETARY】 PAPA OLA LOKAHI.—

【The term "Secretary" means the Secretary of Health and Human Services.】

(A) *IN GENERAL.—The term "Papa Ola Lokahi" means an organization that—*

(i) is composed of public agencies and private organizations focusing on improving the health status of Native Hawaiians; and

(ii) governed by a board the members of which may include representation from—

(I) E Ola Mau;

(II) the Office of Hawaiian Affairs;

(III) Alu Like, Inc.;

(IV) the University of Hawai'i;

(V) the Hawai'i State Department of Health;

(VI) the Native Hawaiian Health Task Force;

(VII) the Hawai'i State Primary Care Association;

(VIII) Ahahui O Na Kauka, the Native Hawaiian Physicians

(IX) Ho 'ola Lahui Hawai'i, or a health care system serving the islands of Kaua'i or Ni'ihau (which may be composed of as many health care centers as are necessary to meet the health care needs of the Native Hawaiians of those islands);

(X) Ke Ola Mamo, or a health care system serving the island of O'ahu (which may be composed of as many health care centers as are necessary to meet the health care needs of the Native Hawaiians of that island);

(XI) Na Pu'uwai or a health care system serving the islands of Moloka'i or Lana'i (which may be composed of as many health care centers as are necessary to meet the health care needs of the Native Hawaiians of those islands);

(XII) Hui No Ke Ola Pono, or a health care system serving the island of Maui (which may be composed of as many health care centers as are

necessary to meet the health care needs of the Native Hawaiians of that island);

(XIII) Hui Malama Ola Na ‘Oiwi, or a health care system serving the island of Hawai‘i (which may be composed of as many health care centers as are necessary to meet the health care needs of the Native Hawaiians of that island);

(XIV) such other Native Hawaiian health care systems as are certified and recognized by Papa Ola Lokahi in accordance with this Act; and

(XV) such other member organizations as the Board of Papa Ola Lokahi shall admit from time to time, based on satisfactory demonstration of a record of contribution to the health and well-being of Native Hawaiians.

(B) EXCLUSION.—*The term “Papa Ola Lokahi” does not include any organization described in subparagraph (A) for which the Secretary has made a determination that the organization has not developed a mission statement that includes—*

(i) clearly-defined goals and objectives for the contributions the organization will make to—

(I) Native Hawaiian health care systems, and

(II) the national policy described in section 4;

and

(ii) an action plan for carrying out those goals and objectives.

[(10)] (12) [TRADITIONAL NATIVE HAWAIIAN HEALER.—] **SECRETARY.**—*The term “Secretary” means the Secretary of Health and Human Services.*

[The term “traditional Native Hawaiian healer” means a practitioner—

[(A) who—

[(i) is of Hawaiian ancestry, and

[(ii) has the knowledge, skills, and experience in direct personal health care of individuals, and

[(B) whose knowledge, skills, and experience are based on demonstrated learning of Native Hawaiian healing practices acquired by—

[(i) direct practical association with Native Hawaiian elders, and

[(ii) oral traditions transmitted from generation to generation.]

(13) STATE.—*The term “State” means the State of Hawai‘i.*

(14) TRADITIONAL NATIVE HAWAIIAN HEALER.—*The term “traditional Native Hawaiian healer” means a practitioner—*

(A) who—

(i) is of Native Hawaiian ancestry; and

(ii) has the knowledge, skills, and experience in direct personal health care of individuals; and

(B) the knowledge, skills, and experience of whom are based on demonstrated learning of Native Hawaiian healing practices acquired by—

(i) direct practical association with Native Hawaiian elders, and

(ii) *oral traditions transmitted from generation to generation.*

§ 11712. Rule of construction

Nothing in this [chapter] Act [shall be construed to restrict] *restricts* the authority of the State [of Hawai‘i] to [license] *require licensing of, and issue licenses to,* health practitioners.

§ 11713. Compliance with Budget Act

Any new spending authority [(described in [subsection (c)(2)] subparagraph (A) or (B) of section [651] 401(c) (2) of [Title 2]) *the Congressional Budget Act of 1974 (2 U.S.C. 651 (c) (2))*] [which] *that* is provided under this [chapter] Act shall be effective for any fiscal year only to such extent or in such amounts as are provided *for in Acts of appropriation* [Acts].

§ 11714. Severability

If any provision of this [chapter] Act, or the application of any such provision to any person or [circumstances] *circumstance*, is [held] *determined by a court of competent jurisdiction* to be invalid, the remainder of this [chapter] Act, and the application of [such] *the* provision [or amendment] to a [persons or circumstances] *person or circumstance* other than [those] *that* to which [it] *the* provision is held invalid, shall not be affected [thereby] *by that holding*.

APPENDIX A

GOALS AND OBJECTIVES AND HEALTH CARE SERVICES PROVIDED BY THE FIVE NATIVE HAWAIIAN HEALTH CARE SYSTEMS

Islands of Kaua'i and Ni'ihau

To serve the health care needs of Native Hawaiians on the islands of Kaua'i and Ni'ihau, Ho'ola Lahui Hawai'i is a nonprofit organization dedicated to elevating the health status and overall living conditions of Native Hawaiians. Ho'ola Lahui Hawaii has established offices in Waimea and Anahola which serve as a base from which outreach is provided to the East and West sides of Kaua'i. Service to the island of Ni'ihau is provided through the office in Waimea. Ho'ola Lahui Hawaii is working with existing health and health-related organizations in an effort to assure access to services for Native Hawaiians that were either inaccessible or unacceptable. Ho'ola Lahui Hawai'i is organized around the concept of *lokahi* (unity in all aspects of life) in which they seek to maintain a balance of body, mind, and soul. As a community-based organization, the concern of Ho'ola Lahui Hawai'i for Native Hawaiians grows out of a shared history, for those involved in Ho'ola Lahui Hawai'i are Native Hawaiian.

Ho'ola Lahui Hawai'i provides health education and teaching on cancer, diabetes, hypertension, high cholesterol, gout, hygiene, and diet/exercise. Ho'ola Lahui Hawai'i also conducts monitoring on blood pressure, blood sugar, weight, and diet. Ho'ola Lahui Hawai'i offers information and referral to outside agencies through case management. In addition, Ho'ola Lahui Hawai'i is sponsoring the traditional Native Hawaiian diet regimen on the island of Kaua'i. Ho'ola Lahui Hawai'i completed one diet project in Waimea in conjunction with the State Department of Health and started another in Kapa'a in May of 1992.

Traditional healing is also an area Ho'ola Lahui Hawai'i addresses with sponsorship of a statewide *la'au lapa'au* (training in traditional medicine) in the spring of 1992 in conjunction with E Ola Mau and Ka Wai Ola 'o Kalani. In addition, Ho'ola Lahui Hawai'i offers *lomi lomi* (traditional massage therapy). Ho'ola Lahui Hawai'i intends to expand its services to include health education and teaching on sexually-transmitted diseases, family planning, maternal and infant care, and alcohol/substance abuse. Ho'ola Lahui Hawai'i's plans include establishing a health education component in kindergarten, elementary, and high schools, tailored to the physical and psychological needs of the particular age group.

Island of O'ahu

Ke Ola Mamo is committed to improving the health status of Native Hawaiians on the island of O'ahu through the development of a system of culturally-competent services that build upon rather than duplicate the existing health care service delivery system. Through outreach referral and case consultation, Ke Ola Mamo's goal is the empowerment of Native Hawaiian families and individuals to access appropriate health care services; the development of partnerships with existing health care services in a collaborative effort to improve access to health care; and working with Native Hawaiian communities and neighborhoods to assist them in meeting their health care needs.

In 1986, there were 137,481 Native Hawaiians living on the island of O'ahu, who comprise approximately two-thirds of the total Native Hawaiian population in the entire State of Hawai'i. The Native Hawaiian population living on O'ahu can be roughly divided into three equal groups by geographic location; those living on the leeward coast, including Pearl City; those living on the windward and north coasts; and those living in the urban Honolulu complex. There are estimated to be at least 20 distinct communities and neighborhoods where Native Hawaiian families reside. At the outset of its work, Ke Ola Mamo selected four of these communities to develop service delivery projects. Three projects involve rural communities: the Waimanalo community, the Wai'anae community, and the Ko'olaupua community. A fourth project is being proposed as a community education and planning process for the urban Honolulu communities with future service implementation proposals.

Island of Moloka'i

The goal of Na Pu'uwai is to raise the health status of the Native Hawaiian residents of the island of Moloka'i, including Kalaupapa, and the island of Lana'i to the highest possible level and to encourage the maximum participation of Native Hawaiians to achieve this goal. The strategy of the program is two-fold: (1) to develop a personalized schedule of recommended health care activities, referred to as a "personalized health care plan" for each client; and (2) to use case management methodologies as a behavioral intervention to assure client adherence to their "personalized health care plan."

To implement this strategy, the program: (1) conducts screening and enrollment for those who are self-referred, provider-referred, or recruited by staff; (2) conducts a health risk appraisal on each enrollee to assess current health maintenance status; (3) develops a personalized health care plan with each client, based on recommended primary, secondary, and tertiary health maintenance guidelines and the client's concerns and needs; (4) coordinates and provides health promotion and disease prevention programs and health screening; (5) provides clinic-based primary health care services; (6) provides multi-disciplinary case management services as appropriate, to enrolled participants; and (7) reassesses client status as dictated in the case management plan and conducts ongoing followup on all clients, case management and non-case management.

Na' Pu'uwai's service delivery plan provides for (1) direct outpatient care services of a physician and nurse; (2) case manage-

ment services of a social worker and multi-disciplinary case management team; (3) direct health education and health screening services; and (4) patient followup and outreach services.

Island of Maui

Hui No Ke Ola Pono, an association to strengthen and perpetuate life, is Maui's Native Hawaiian Health Care System, providing services that are culturally relevant to Native Hawaiians of Maui, including identification, treatment, control, and reduction of the incidence of preventable illnesses and conditions frequently occurring in the Native Hawaiian population. The services provided by Hui No Ke Ola Pono include health promotion and disease prevention; referrals for immunizations; improvement of nutrition; referrals for pregnancy and infant care; prevention and control of diabetes, high blood pressure, and middle ear infections; community outreach services; referrals to physician and nursing services; and education on traditional practitioner services.

In addition, traditional Hawaiian healers provide the following services: *ho'oponopono* (family or group counseling); *la'au lapa'au* (traditional Hawaiian herbal medicine); and *lomi lomi* (Hawaiian massage therapy).

Island of Hawai'i

Hui Malama Ola Na 'Oiwī (caring for our people) is the Native Hawaiian health care system for Native Hawaiians on the Island of Hawai'i. The program mission of Hui Malama Ola Na 'Oiwī is to assist Native Hawaiians in restoring a high quality health care system by creating and developing a non-threatening healing environment inclusive of traditional health assistance and to provide and facilitate a process of awareness and addressing the health needs, both physical and spiritual, of Native Hawaiians.

Hui Malama's objectives are to (1) promote physical, emotional, and spiritual health and well-being of Native Hawaiians on the island of Hawai'i; (2) assist and promote personal responsibility among Native Hawaiians toward making sound, informed decisions which would decrease unhealthy behaviors and reduce morbidity and mortality rates; (3) support and advocate the use of health care services that come from the traditions of the Native Hawaiian culture and of western science; and (4) work toward the establishment of primary health care centers in appropriate locations where quality primary care can be provided and where primary care services are not currently available.

The death rates of Native Hawaiians exceed the death rates for all races in the United States caused by diseases of the heart, cancer, strokes, and diabetes. Achieving good health for Native Hawaiians appears difficult, but these diseases can be controlled through early detection, proper diet and treatment, and regular exercise.

Hui Malama Ola Na 'Oiwī provides the following services:

- (1) Outreach—enrolling participants in the program, assessing their health risk factors, assisting in securing medical insurance where needed, assisting in access to a physician, providing transportation to and from the physician for those who need it, and making home visits when necessary;

(2) Health promotion and disease prevention—providing education regarding the prevention and control of diabetes, high blood pressure (hypertension), use of tobacco, alcohol and other harmful drugs, sexually transmitted diseases, stress, cancer, the importance of sound nutrition habits, regular exercise, and proper maternal and infant care practices;

(3) Primary health services—Hui Malama Ola Na ‘Oiwī assists patients in securing access to the primary health care services of a physician, a physician’s assistant, or a nurse practitioner.

APPENDIX B

CONSTITUTIONAL SOURCE OF CONGRESSIONAL AUTHORITY

The United States Supreme Court has so often addressed the scope of Congress' constitutional authority to address the conditions of the native people that it is now well-established.⁶ Although the authority has been characterized as "plenary,"⁷ the Supreme Court has addressed the broad scope of the Congress' authority.⁸ It has been held to encompass not only the native people within the original territory of the thirteen states but also lands that have been subsequently acquired.⁹

The ensuing course of dealings with the indigenous people has varied from group to group, and thus, the only general principles that apply to relations with the first inhabitants of this nation is that they were dispossessed of their lands, often but not always relocated to other lands set aside for their benefit, and that their subsistence rights to hunt, fish, and gather have been recognized under treaties and laws, but not always protected nor preserved.

Some commentators have suggested that no other group of people in America has been singled out so frequently for special treatment, unique legislation, and distinct expressions of Federal policy. Although the relationship between the United States and its native people is not a history that can be said to have followed a fixed course, it is undeniably a history that reveals the special status of the indigenous people of this land. American laws recognize that the native people do not trace their lineage to common ancestors and, from time to time, our laws have in fact discouraged the indigenous people from organizing themselves as "tribes." But this much is true—that for the most part, at any particular time in our his-

⁶The power of the general government over these remnants of a race once powerful, now weak and diminished in numbers, is necessary to their protection. As well as to the safety of those among whom they dwell. It must exist in that government, because it never has existed anywhere else, because the theater of its exercise is within the geographical limits of the United States * * * From their very weakness and helplessness, so largely due to the course of dealing of the Federal government with them, and the treaties in which it has been promised, there arises a duty of protection, and with it the power. This has always been recognized by the executive, and by congress, and by this court, whenever the question has arisen." *United States v. Kagama*, 118 U.S. 375 (1886).

⁷*Morton v. Mancari*, 427 U.S. 535 (1974).

⁸*Delaware Tribal Business Council v. Weeks*, 430 U.S. 73 (1977); *United States v. Sioux Nation*, 448 U.S. 371 (1980). The rulings of the Supreme Court make clear that neither the conferring of citizenship upon the native people, the allotment of their lands, the lifting of restrictions on alienation of native land, the dissolution of a tribe, the emancipation of individual native people, the fact that a group of natives may be only a remnant of a tribe, the lack of continuous Federal supervision over the Indians, nor the separation of individual Indians from their tribes would divest the Congress of its constitutional authority to address the conditions of the native people. *Cherokee Nation v. Hitchcock*, 187 U.S. 294 (1902); *United States v. Celestine*, 215 U.S. 278 (1909); *Tiger v. Western Inv. Co.*, 221 U.S. 286 (1911); *United States v. Nice*, 241 U.S. 591 (1916); *Chippewa Indians v. United States*, 307 U.S. 1 (1939); *Delaware Tribal Business Council v. Weeks*, 430 U.S. 73 (1977); *United States v. John*, 437 U.S. 634 (1979).

⁹*United States v. Sandoval*, 231 U.S. 28 (1913).

tory, the laws of the United States have attempted to treat the native people, regardless of their genealogical origins and their political organization, in a consistent manner.

Organization as a Tribe and the Scope of Constitutional Authority

It has been suggested that the scope of constitutional authority vested in the Congress is constrained by the manner in which the native people organize themselves. Under this theory, if the native people are not organized as tribes, then the Congress lacks the authority to enact laws and the President is without authority to establish policies affecting the native people of the United States. However, the original language proposed for inclusion in the Constitution made no reference to “tribes” but instead proposed that the Congress be vested with the authority “to regulate affairs with the Indians as well within as without the limits of the United States.”¹⁰ A further refinement suggested that the language read “and with Indians, within the Limits of any State, not subject to the laws thereof[.]”¹¹

The exchanges of correspondence between James Monroe and James Madison concerning the construction of what was to become Article I, Section 8, Clause 3 of the Constitution make no reference to Indian tribes, but they do discuss Indians.¹² Nor is the term “Indian tribe” found in any dictionaries of the late eighteenth century, although the terms “aborigines” and “tribe” are defined.”¹³

Native Hawaiians and the Meaning of “Indian”

Whether the reference was to “aborigines” or to “Indians”, the Framers of the Constitution did not import a meaning to those terms as a limitation upon the authority of Congress, but as descriptions of the native people who occupied and possessed the lands that were later to become the United States—whether those lands lay within the boundaries of the original thirteen colonies, or any subsequently acquired territories. This construction is consistent with more than two hundred Federal statutes which establish that the aboriginal inhabitants of America are a class of people known as “Native Americans” and that this class includes three groups—American Indians, Alaska Natives and Native Hawaiians.

The unique native peoples of Alaska have been recognized as “Indian” and as “tribes” for four hundred years. The Founders’ under-

¹⁰The Records of the Federal Convention of 1787, Volume II, Journal Entry of August 18, 1787, p. 321.

¹¹The Records of the Federal Convention of 1787, Volume II, Journal Entry of August 22, 1787, p. 367.

¹²In his letter to James Monroe of November 27, 1784, James Madison observes, “The federal articles give Congress, the exclusive right of managing all affairs with the Indians not members of any State, under a proviso, that the Legislative authority, of the State within its own limits be not violated. By Indian[s] not members of a State, must be meant those, I conceive who do not live within the body of the Society, or whose Persons or property form no objects of its laws. In the case of Indians of this description the only restraint on Congress is imposed by the Legislative authority of the State.” The Founders’ Constitution, Volume Two, Preamble through Article 1, Section 8, Clause 4, p. 529, James Madison to James Monroe, 27 Nov. 1784, Papers 8:156–57; See also, James Monroe to James Madison, 15 Nov. 1784, Madison Papers 8:140.

¹³The term “aborigines” is defined as “the earliest inhabitants of a country, those of whom no original is to be traced,” and the term “tribe” is defined as “a distinct body of the people as divided by family or fortune, or any other characteristic.” A Dictionary of the English Language (Samuel Johnson ed., 1755). The annotations accompanying the term “Indian” in the 1901 Oxford dictionary indicates the use of the term as far back as 1553. Oxford English Dictionary (James A.H. Murray ed., 1901).

standing of the “Eskimaux” as Indian tribes, and Congress’ recognition of its power over Alaska Natives ever since the passage of the Fourteenth Amendment and the acquisition of the Alaskan territory, help illuminate Congress’ power over, and responsibility for, all Native American peoples.

The treatment of Alaskan Eskimos is particularly instructive because the Eskimo peoples are linguistically, culturally, and ancestrally distinct from other American “Indians.” Many modern scholars do not use the word “Indian” to describe Eskimos or the word “tribe” to describe their nomadic family groups and villages. The Framers, however, recognized no such technical distinctions. In the common understanding of the time, Eskimos, like Native Hawaiians, were aboriginal peoples; they were therefore “Indians.” Their separate communities of kind and kin were “tribes.” Congress’ special power over these aboriginal peoples is beyond serious challenge.

During the Founding Era, and during the Constitutional Convention, the terms “Indian” and “tribe” were used to encompass the tremendous diversity of aboriginal peoples of the New World and the wide range of their social and political organizations. The Founding generation knew and dealt with Indian tribes living in small, familial clans and in large, confederated empires. Native Alaska villages and Native Hawaiians residing in their aboriginal lands (i.e., the small islands that comprise the State of Hawaii) are “Indian Tribes” as that phrase was used by the Founders. The Framers drafted the Constitution not to limit Congress’ power over Indians, but to make clear the supremacy of Congress’ power over Indian affairs. The Congress has exercised the power to promote the welfare of all Native American peoples, and to foster the ever-evolving means and methods of self-governance as exercised by Native people.

This history is accurately reflected in nearly two centuries of U.S. Supreme Court jurisprudence. Beginning with Chief Justice Marshall, the Supreme Court has recognized the power of the United States to provide for the welfare, and to promote the self-governance, of Indian peoples. This recognition of the right of the indigenous, native people of the United States to self-determination and self-governance is part of the structure of America’s complex multi-sovereign system of governance.

In the language and understanding of the Founders, “tribes” or “peoples” did not lose their identity as such when conquered or ruled by kings. Like other Native American people, Native Hawaiians lived for thousands of years as “tribes,” then as confederations of tribes, now as conquered tribes. All aboriginal peoples of the New World were “Indians.” That is what it meant to be an “Indian.” The Founders knew that Columbus had not landed in India or the Indies; Columbus’s navigational error had been corrected, but his malapropism had survived. And so, in the words of one of the earliest English books about America, the native people were

“Indians,” for the simple reason that “so caule wee all nations of the new founde lands.”¹⁴

The Founding generation used “tribes” to denote peoples of like kind or kin. As used in the Constitution, the word “tribe” does not refer to some specific type of government or social organization. All Native American peoples were “tribes,” whether they lived in villages or spread out in vast federations or empires. “Tribe” and “nation” were used to refer not to governments, but to groups of people recognizing a common membership or identity as such. Application of the biblical concept of “tribes” to the “Indians” reflected the understanding that the natives of the New World were not one people, but many “peoples,” “nations,” or “tribes”—terms used interchangeably well into the Nineteenth Century.¹⁵

The Founders had seen analogies to the complex tribal history of the Bible. The Founders knew the native peoples evolved, united and divided in ever shifting forms of government. The native peoples had formed “powerful confederac[ies],” tribes united under common chiefs, and federations of tribes joined with other federations.¹⁶ The colonies and the States under the Articles of Confederation had repeatedly dealt with vast federations of tribes, including the “Six Nations” in the north and the “Five Civilized Tribes” in the south.¹⁷ The Indian peoples were “tribes” not because they formed any particular organization, but because they recognized themselves as distinct peoples, with cultures, languages and societies separate from each other and from the European invaders.

As Jefferson’s “Notes on the State of Virginia” and other contemporary works show, the division of the world into “European settlers” and “Indians” was not essentially racial. The Indians were not a race, they were many peoples, thought to share diverse ancestry with peoples all over the world. The distinction between European and Native American peoples was political. The European settlers (who arrived with Royal charters) recognized the “aboriginal peoples” as separate nations—separate sovereigns with whom they would have to deal as one nation to another. Before and after the Constitution, the new settlers treated the Indian peoples as separate nations, with whom they made war, peace and treaties. The treatment of the aboriginal peoples under the Constitution was systematically and structurally distinct from the inhumane and unendurable treatment accorded to “slaves.” This distinctive nation-to-nation relationship survived the settlement of the West, the Civil War Amendments to the Constitution, and two hundred years of Congressional action and judicial construction.

History of the Origins of the Constitutional Term “Tribe”

The Articles of Confederation gave the Continental Congress power over relations with the Indians only so long as Congress’

¹⁴ Gonzalo Fernandez de Oviego y Valdez, *De la natural hystoria de las Indias* (1526), trans. by R. Eden (1955), in E. Arber, ed., *The First Three English Books on America* (Birmingham, Eng., 1885) (emphasis added).

¹⁵ Robert F. Berkhofer, Jr., *The White Man’s Indian* 16 (1979).

¹⁶ Jefferson, *Notes*, at 221.

¹⁷ See, e.g., Treaty with the Six Nations, Oct. 22, 1784 (treaty with the many tribes of Senecas, Mohawks, Onondagas, Cayugas, Oneida and Tuscarora), in C.J. Kappler, ed., *Indian Affairs: Laws and Treaties* 2:5–6; Treaty of Treaty of Fort McIntosh, Jan. 21, 1785 (treaty with the Wiandot, Delaware, Chippewa, and Ottawa “and all their tribes”), in id. at 2:6–8; Treaty of Hopewell, Nov. 28, 1785 (treaty with all the “tribes” of the Cherokee), in id. at 2:8–11.

dealings with Indians within a State did not “infringe” that State’s legislative power. This created constant friction over where the States’ power ended and Congress’ power began. The sole stated purpose of the Indian terms of the new Constitution was to eliminate any uncertainty as to Congress’ supremacy. The Framers intended to grant Congress broad, supreme authority to regulate Indian affairs. The two references to “Indians” in the Constitution generated virtually no debate at any time in the Constitutional Convention. That relations with the Indians should be one of the Federal powers appears to have been universally accepted. The Framers sought only to make clear that Congress’ power here was supreme.

The Articles had given the Continental Congress “sole and exclusive right and power” of regulating relations with Indians who were “not members of any of the states, provided that the legislative right of any state within its own limits be not infringed or violated.”¹⁸ As Madison explained, this language created two major problems. First, no one knew when or whether Indians were “members of states”; second, the grant to Congress of “sole and exclusive power,” so long as Congress did not “intrud[e] on the internal right” of States was “utterly incomprehensible.” The provision had been a source of “frequent perplexity and contention in the federal councils.”¹⁹ Capitalizing on the uncertainty, several states (Georgia, New York and North Carolina) had infringed Congress’ power by making their own arrangements with local Indians. As a result, during the Constitutional Convention and Ratification, Georgia was in armed conflict, and on the verge of war, with the powerful Creek Nation.

The only debate on the issue in the Convention focused on the need for federal supremacy over the states. Madison objected early on to the “New Jersey Plan” on the ground that it failed to bar states from encroaching on Congress’ power over “transactions with the Indians.”²⁰ In August, Madison proposed that Congress be given the power “[t]o regulate affairs with the Indians as well within as without the limits of the United States.”²¹ Madison’s proposal was submitted to the Committee on Detail without discussion. The Committee on Detail recommended that power over Indians be dealt with in the Commerce clause, which would provide Congress with power over commerce “with the Indians, within the limits of any State, not subject to the laws thereof.” The proposal provoked no debate.²² On August 31st, the Convention referred various “parts of the Constitution” (including the Commerce Clause) to a “Committee of eleven,” including Madison.²³ Without recorded discussion, the Committee recommended that the language be sim-

¹⁸ Articles of Confederation, Art. X, March 1, 1778.

¹⁹ Federalist 42, in XIV Documentary History of the Ratification of the Constitution (J. Kaminiski, ed., 1983) (“Documentary History”), XV: 431.

²⁰ Notes of James Madison, June 19, 1787, in The Records of the Federal Convention of 1787, at 3:316 (Max Farrand, rev. ed. 1966) [hereafter, “Federal Convention”] (“By the federal articles, transactions with the Indians appertain to Congress. Yet in several instances, the States have entered into treaties & wars with them”); see also, id. at 325–26.

²¹ 21 Federal Convention, at 321, 324; see also id. at 143 (Rutledge noted that “Indian affairs” should be added to Congress’ powers).

²² Id. at 367. Similarly, since Indians did not pay tax, the proposal to exclude “Indians not taxed” from the apportionment clause was accepted without discussion.

²³ Id. at 481.

plified to commerce “with the Indian tribes.”²⁴ The Convention accepted the recommendation without debate or dissent.²⁵

As noted above, the debate in the Convention focused solely on making clear the supremacy of Congress’ power. During the ratification debates, the new Constitution was defended on the ground that it gave Congress power over “Indian affairs” and “trade with the Indians.”²⁶ In the only extended discussion of the issue during ratification, Madison used the phrases “commerce with the Indian tribes” and “trade with Indians” interchangeably; Madison explained that the purpose of the new provision was to eliminate the limitation on Congress’ power over trade with the Indians living within the States.²⁷ The notion that the reference to “tribes” was a limit on Congress’ ability to deal with the native peoples is without support in history and is contrary to the only expressions of the Framers’ original intent. The Constitution gave Congress power over the Indian peoples, however and wherever it found them.

The First Federal Congress treated the Constitution as granting broad power to regulate “trade and intercourse” with “Indians,” “Indian tribes,” “nations of Indians,” and “Indian country.”²⁸ Congress understood its power to “operate immediately on the persons and interests of individual citizens.”²⁹ The actions of the new government also show that even when the Framers knew nothing about the organization of Indian peoples, they nevertheless intended to assert Federal power over those peoples. Shortly after taking office, President Washington gave instructions to Commissioners to negotiate with the Creeks. It was, as noted, the war between the Creeks and Georgia that had fostered the apparently universal conclusion that the new Federal government must be given supremacy over Indian affairs. Washington instructed the Commissioners to determine the nature of the Creek’s political divisions and governments, including “[t]he number of each division”; “[t]he number of Towns in each District”; “[t]he names, Characters and residence of the most influential Chiefs—and . . . their grades of influence.” And, most tellingly, the Commissioners were to learn “[t]he kinds of Government (if any) of the Towns, Districts, and Nation.”³⁰ Washington, like other Founders, did not know how the Creek lived and how they governed themselves. But however the Indian peoples lived, and however they governed themselves, they were still Indian peoples and they were still subject to the supreme power of the Federal government over Indian tribes.

²⁴ *Id.* at 493, 496–97, 503 (emphasis added).

²⁵ See *id.* at 495. The language appears in the final version. *Id.* at 569, 595.

²⁶ *Federalist* 40, in *Documentary History*, XV: 406. (Constitution represents “expansion on the principles which are found in the articles of confederation,” which gave Congress power over “trade with the Indians”); *Federal Farmer*, October 8, 1787, in *id.* at XIV: 24 (under the new Constitution, federal government has power over “all foreign concerns, causes arising on the seas, to commerce, imports, armies, navies, Indian affairs”); *Federal Farmer*, October 10, 1787, in *id.* at 30, 35 (federal power over “foreign concerns, commerce, impost, all causes arising on the seas, peace and war, and Indian affairs”). The *Federal Farmer* Letters are considered “one of the most significant publications of the ratification debate.” *Id.* at 14.

²⁷ Madison, *Federalist* 42, in *Documentary History* XIV: 430–31.

²⁸ “An Act to regulate trade and intercourse with the Indian tribes,” July 22, 1790, ch. 33, Sec. 4, 1 Stat. 137, in 1 *Doc. Hist. of the First Federal Congress, 1789–1791* (De Pauw, ed., 1972) (“First Federal Congress”), at 440.

²⁹ Madison, *Federalist* 40, in *Documentary History*, XV: 406.

³⁰ Washington, Instructions to the Commissioners for Southern Indians, August 29, 1789, in 2 *First Federal Congress*, at 207 (emphasis added).

President Jefferson gave similar instructions to Lewis and Clark. When they encountered unknown Indian peoples, the explorers were to learn the “names of the nations”; “their relations with other tribes or nations”; their “language, traditions, monuments”; and the “peculiarities in their laws, customs & dispositions.”³¹ Like Washington, Jefferson knew there was much he and his fellow citizens did not know about the “Indian” peoples; but he intended to find out and to assert Federal authority over whatever he found.

Fourteenth Amendment to the United States Constitution

It is inconceivable anyone thought that if Washington’s Commissioners or Lewis and Clark found a native people living without “chiefs,” like many Eskimo, or under a King like Montezuma or Kamehameha, these people would be beyond Congress’ power over Indian “tribes” or nations. Nor did the Framers of the Fourteenth Amendment intend to eliminate Congress’ special power to adopt legislation singling out and favoring Indians; they did not intend to alter the nation-to-nation relationships between the United States and the Indian peoples created by the Constitution. Indeed, the Framers of the Amendment were at pains to make certain that they preserved that structure.

“Indians” are expressly singled out for special treatment by the text of the Amendment. In order to eliminate the morally repugnant language which counted slaves as three-fifths persons, the Framers of the Fourteenth Amendment redrafted the apportionment clause. The Framers deleted the “three-fifths persons,” but retained the express exclusion of “Indians not subject to tax” (Amend. XIV, Sec. 1), because, while they intended to wipe out the badges and incidents of slavery, they intended to preserve the special relationship between the United States and the Indian people. Before and after the Amendment, Indians were not citizens of the United States, they did not have the right to vote, they did not count for purposes of apportionment, but they were subject to special legislation in furtherance of Congress’ historic trust responsibilities.

The only debate during the drafting and ratification of the Fourteenth Amendment was not about whether the special relationship with the Indian people should be preserved, but about how to make certain it was preserved. When one Senator suggested that specific reference be made excluding “Indians” from the citizenship clause, the Senator presenting the clause argued this was unnecessary. The Amendment provided citizenship only to persons “within the jurisdiction” of the United States,³² and Indian nations were treated like alien peoples not fully within the jurisdiction of the government:

in the very Constitution itself there is a provision that Congress shall have power to regulate commerce, not only with foreign nations and among the States, but also with Indian tribes. That clause, in my judgment, presents a full

³¹Thomas Jefferson, “Instructions to Captain Lewis,” June 20, 1803, in Jefferson, Writings, *supra*, at 1126, 1128.

³²Similar limiting language occurs in the Equal Protection Clause.

and complete recognition of the national character of the Indian tribes.³³

Congress debated what language to adopt in order to make certain that the special status of the Indian tribes was preserved.³⁴ There was no support for, or consideration given to, eliminating the special relationship between the United States and the Indian peoples. The uniform intent was to preserve Congress' ability to decide when Indians would be granted citizenship, when Indians would be taxed, and when Indians would be subject to special legislation.³⁵

For nearly two hundred years, the Supreme Court has recognized the political distinction the Constitution draws between "Indian tribes" and all other people. The early opinions of Chief Justice John Marshall reflect the original intent of the Framers and lay the groundwork for the Supreme Court's jurisprudence. Marshall wrote that "[t]he condition of the Indians in relation to the United States is perhaps unlike that of any other two people in existence."³⁶ With deliberate irony, he called the Indian tribes "domestic dependent nations."³⁷ The Indian peoples had surrendered "their rights to complete sovereignty,"³⁸ and yet they continued to be "nations" that governed themselves.³⁹

Marshall knew that the constitutional text reflected this pre-existing nation-to-nation relationship. The Indian Commerce Clause, U.S. Const. art. I, § 3, cl. 8, and the Treaty Clause, art. II, § 2, cl. 2, granted Congress broad power to regulate Indian affairs. These provisions permitted the United States to fulfill its obligations to the dependent Indian "nations" that were its "wards."⁴⁰ As "guardian," Congress had both the obligation and the power to enact legislation protecting the Indian nations.⁴¹

Marshall defined "Indians" broadly to include all of the "original inhabitants" or "natives" who occupied America when it was discovered by "the great nations of Europe."⁴² He also conceived of "tribes" in broad, inclusive terms. He used "tribe" and "nation" interchangeably: A "tribe or nation," he noted, "means a people distinct from others"—a "distinct community."⁴³ Like the Founders, Marshall defined an "Indian tribe" as nothing more than a commu-

³³ Cong. Globe, 39th Congress, 1st Sess. 2895.

³⁴ See, e.g., Remarks of Sen. Doolittle, Cong. Globe, 39th Cong., 1st Sess., 2895–2896 (1866) ("[Senator Howard] declares his purpose to be not to include Indians within this constitutional amendment. In purpose I agree with him. I do not intend to include them. My purpose is to exclude them").

³⁵ Congress expressed the same intent in the Civil Rights Act that same year. The Act, granting citizenship to the emancipated slaves, specifically excluded "Indians not taxed." Civil Rights Act, ch. 31, 14 Stat. 27 (1866).

³⁶ *Cherokee Nation v. Georgia*, 30 U.S. (5 Pet.) 1, 16 (1831).

³⁷ *Id.*, at 17.

³⁸ *Johnson v. McIntosh*, 21 U.S. (8 Wheat.) 543, 572–74 (1823).

³⁹ See *Worcester v. Georgia*, 31 U.S. (6 Pet.) 515, 561 (1832).

⁴⁰ *Cherokee Nation*, 30 U.S. (5 Pet.) at 17–18; *Worcester*, 31 U.S. (6 Pet.) at 558–59.

⁴¹ See *Worcester*, 31 U.S. (6 Pet.) at 560–61; accord *Cherokee Nation*, 30 U.S. (5 Pet.) at 16 ("[t]hey look to our government for protection, rely upon its kindness and its power; appeal to it for relief to their wants").

⁴² *Johnson*, 21 U.S. (8 Wheat.) at 572–74; *Worcester*, 31 U.S. (6 Pet.) at 544 (1832) (Indians are "those already in possession [of land], either as aboriginal occupants, or as occupants by virtue of a discovery made before the memory of man"). See also *Johnson*, 21 U.S. (8 Wheat.) at 575 (Indians in French Canada); *id.* at 581 (Indians in Nova Scotia); *Id.* at 584–87 (Indians in Virginia, Kentucky, the Louisiana Purchase, and Florida). Marshall noted the United States had dealt with variously organized "tribes" or "confederacies." See *id.* at 546–49.

⁴³ *Worcester*, 31 U.S. (6 Pet.) at 559, 561. See also *Cherokee Nation*, 30 U.S. (5 Pet.) at 20 ("an Indian tribe or nation within the United States"); *Johnson*, 21 U.S. (8 Wheat.) At 590 ("the tribes of Indians inhabiting this country").

nity, large or small, of descendants of the peoples who inhabited the New World before the Europeans.

Although the aboriginal “tribes” or “nations” or “peoples” were defined in part by common ancestry, their constitutional significance lay in their separate existence as “independent political communities,”⁴⁴ The “race” of Indian peoples was constitutionally irrelevant. Native peoples were “nations,”⁴⁵ and the relationship between the United States and the natives reflected a political settlement between conquered and conquering nations.

The Supreme Court has kept faith with Marshall’s conception. The Indian nations have always been defined by ancestry and political affiliation. In the native cultures, the two are inextricably intertwined. The Supreme Court’s definition is legal, and the Native American’s self-definition is historic, religious or cultural; but the two reduce to the same elements: “Indians” are (1) the descendants of aboriginal peoples who (ii) belong to some Native American “people,” “nation,” “tribe,” or “community,” as the founding generation understood those terms.⁴⁶

These interwoven qualifications reflect the Supreme Court’s consistent understanding that constitutionally-relevant Indian status, while based in part on ancestry, is a political classification.⁴⁷ It is an individual’s membership in a “political community” of Indians—even a community in the making—and not solely his or her racial identity, that brings him or her within Congress’ broad authority to regulate Indian affairs.⁴⁸

Indian Tribes and Blood Quantum

Nor does the use of blood quantum as part of the formula to determine who is and is not a Native American constitute impermissible “racial” discrimination. The Supreme Court has repeatedly made clear that Indian tribes are the political and familial heirs to “once-sovereign political communities”—not “racial groups.”⁴⁹ The Court has long recognized that a tribe’s “right to determine its own membership” is “central to its existence as an independent political community.”⁵⁰ From time immemorial, Native American communities have defined themselves at least in part by family and ancestry.⁵¹ Kinship and ancestry is part of what it means to be an “Indian.” Indians by ancestry or blood is what the Framers meant by

⁴⁴ Id., at 559.

⁴⁵ Id., at 559–60.

⁴⁶ See, e.g., *Montoya v. United States*, 180 U.S. 261, 266 (1901) (“a body of Indians of the same or a similar race, united in a community under one leadership or government, and inhabiting a particular though sometimes ill-defined territory”); *United States v. Candelaria*, 271 U.S. 432, 442 (1926); see *Oklahoma Tax Comm’n v. Sac & Fox Nation*, 508 U.S. 114, 123 (1993); *United States v. Antelope*, 430 U.S. 641, 647 n.7 (1977) (individuals “anthropologically” classified as Indians may be outside Congress’s Indian commerce power if they sever relations with tribe).

⁴⁷ *United States v. Antelope*, 430 U.S. 641, 646–47 (1977).

⁴⁸ Id., at 646.

⁴⁹ *Antelope*, 430 U.S. at 646; see *Fisher v. District Court*, 424 U.S. 382, 389 (1976); *Mancari*, 417 U.S. at 553–54; see also *Sac & Fox Nation*, 508 U.S. at 123; *United States v. Mazurie*, 419 U.S. 544, 557 (1975).

⁵⁰ *Santa Clara Pueblo v. Martinez*, 436 U.S. 49, 72 n.32 (1978); *Cherokee Inter-marriage Cases*, 203 U.S. 76, 95 (1906); *Boff v. Burney*, 168 U.S. 218, 222–23 (1897).

⁵¹ See Indian Policy Report at 108–09 (“the tribe, as a political institution, has primary responsibility to determine tribal membership for purposes of voting in tribal elections * * * and other rights arising from tribal membership. Many tribal provisions call for one-fourth degree of blood of the particular tribe but tribal provisions vary widely. A few tribes require as much as one-half degree of tribal blood * * *”); accord Felix S. Cohen, *Handbook of Federal Indian Law* 22–23 & n.27 (1982 ed.).

“Indians.” It is what Chief Justice Marshall meant by “Indians.” It is what the Framers of the Fourteenth Amendment meant by “Indians.” This central conception of “Indian” identity is woven into the Constitution and the entire body of law that has grown up in reliance on that conception.

Congressional authority to use such traditional requirements for tribal membership or benefits has never been doubted. In *United States v. John*, the Supreme Court approved Congress’ establishment of an Indian reservation for the benefit of “Chocktaw Indians of one-half or more Indian blood, resident in Mississippi.”⁵² The Court unhesitatingly applied the definition of “Indian” that appears in the Indian Reorganization Act, which has governed Indian tribes since 1934: “all other persons of one-half or more Indian blood.”⁵³ Similarly, the Alaska Native Claims Settlement Act’s use of a blood quantum formula as one factor in determining “native” status is a valid method of defining those belonging to the group eligible for statutory benefits, and the use of the blood quantum “does not detract from the political nature of the classification.”⁵⁴ The use of blood ties is integral to the nature of the political deal struck between the conquering Europeans and the native peoples, as they set out to maintain partially separate existences while inhabiting the same country.

This is not to suggest, however, that the Constitution imposes any minimum blood quantum requirement for tribal membership, and suggestions to the contrary have no legal or historical basis.

The constitutional text and historic relationship gives Congress not just the “right” to discriminate between Native Americans and others, but the responsibility to do so. As the Supreme Court has long recognized, from the relationship between these former sovereign peoples and the “superior nation” that conquered them arises “the power and the duty” of the United States to “exercis[e] a fostering care and protection over all dependent Indian communities within its borders. . . .”⁵⁵ Recently, the Supreme Court acknowledged the continued significance of this historic trust relationship.⁵⁶

Like the 556 Indian tribes currently recognized by the United States, Native Hawaiians are a group of people defined by their common descent from an ancestral class, each forming a distinct polity and having a unique historical existence. Any contemporary group whose members are defined by their lineal descendancy from a historically-defined class will necessarily share an ethnic identity with the original members of the historical class, even though intermarriage may attenuate the degree of blood quantum shared by the original historical class members. Nevertheless, a definition that is based primarily on the historical uniqueness of the original class is no more race-based than the definition of those who are

⁵²Id., 437 U.S. at 646.

⁵³Id. at 650 (quoting 25 U.S.C. Sec. 479).

⁵⁴*Alaska Chapter v. Pierce*, 694 F.2d 1162, 1168–69 n. 10 (9th Cir.1982) (noting absence of other practicable methods, like tribal rolls or proximity to reservations).

⁵⁵*Kagama*, 118 U.S. 375, 384–85 (1886) (emphasis added); See *Seminole Nation v. United States*, 316 U.S. 286, 296 (1942) (the government owes a “distinctive obligation of trust” to Indians).

⁵⁶See *Greater New Orleans Broadcasting Assn v. United States*, 527 U.S. 173, 193 (1999) (recognizing “special federal interest in protecting the welfare of Native Americans”).

members or citizens of the historic Indian tribes that greeted the first Europeans immigrants to this nation's shores.

The Supreme Court has repeatedly applied the concepts of "Indian" and "tribe" to a wide variety of Native American communities, recognizing the constant evolution of Native community life and that the questions of whether and how to treat with these changing communities are assigned by the Constitution to Congress. In *The Kansas Indians*,⁵⁷ the Court recognized that the Ohio Shawnees remained a "tribe," even though tribal property was no longer owned communally and the tribe had abandoned Indian customs "owing to the proximity of their white neighbors."⁵⁸

Fifty years later, the Supreme Court approved a similar tribal designation for the Pueblo Indians of New Mexico. After long experience under Spanish rule, the Pueblo Indians seemed little like the "savages" of James Fennimore Cooper. The Pueblo Indians lived in villages with organized municipal governments; they cultivated the soil and raised livestock; they spoke Spanish, worshiped in the Roman Catholic Church; and prior to the acquisition of New Mexico by the United States, they enjoyed full Mexican citizenship.⁵⁹ Nevertheless, the Pueblo Indians lived in "distinctly Indian communities," and Congress acted properly under the Indian Commerce Clause in determining that they were "dependent communities entitled to its aid and protection, like other Indian tribes."⁶⁰ For Native American "communities," the Court held that "the questions whether, to what extent, and for what time they shall be recognized and dealt with as dependent tribes requiring the guardianship and protection of the United States are to be determined by Congress. . . ."⁶¹

As indicated above, sixty years later, in *United States v. John*,⁶² the Supreme Court recognized Congress' authority to establish a reservation for the benefit of Choctaw Indians in Mississippi, even though (1) they were "merely a remnant of a larger group of Indians" that had moved to Oklahoma; (2) "federal supervision over them had not been continuous"; and (3) they had resided in Mississippi for more than a century and had become fully integrated into the political and social life of the State.⁶³ The Mississippi Choctaw were Indians. They had recently organized into a distinctly Indian community. The Court therefore deferred to Congress' determination that they were a "tribe for the purposes of Federal Indian law."⁶⁴

Similarly, the Supreme Court has recognized Congress' broad authority to deal with individual "Indians."⁶⁵ or large organizations

⁵⁷ 72 U.S. 737 (1866).

⁵⁸ *Id.*, 72 U.S. at 755–57.

⁵⁹ See *United States v. Joseph*, 94 U.S. (4 Otto.) 614, 616 (1877).

⁶⁰ *United States v. Sandoval*, 231 U.S. 28, 46–47 (1913); *Candelaria*, 271 U.S. at 439–40, 442–43.

⁶¹ *Sandoval*, 231 U.S. at 46; accord *Tiger v. Western Inv. Co.*, 221 U.S. 286, 315 (1911).

⁶² 437 U.S. 634 (1978).

⁶³ *Id.*, 437 U.S. at 652–53.

⁶⁴ *Id.*, at 650 n.20, 652–53.

⁶⁵ *United States v. Holliday*, 70 U.S. (3 Wall.) 407, 417 (1865) (regulation of "commerce with the Indian tribes means" regulation of "commerce with the individuals composing those tribes"); see *Morton v. Ruiz*, 415 U.S. 199, 230–38 (1974) (addressing the scope of federal Indian welfare benefits for individuals living in Indian communities); *Mancari*, 417 U.S. at 551–55.

comprised of numerous “tribes.”⁶⁶ Congress may recognize new aggregations of Native Americans, so long as such legislation is rationally related to the fulfillment of Congress’ trust obligation to the historic Indian peoples.⁶⁷ Congress’ treatment of the Alaska native people—including the establishment of unique regional corporations whose shareholders comprise numerous Native villages—has properly been upheld as within Congress’ special power over and responsibility for the Native American peoples.⁶⁸

Citizens of the Kingdom of Hawai‘i

Contrary to well-established principles of Federal-Indian law that recognize the right of a tribe to determine its own members as a fundamental aspect of the tribe’s sovereignty,⁶⁹ some have argued that the Kingdom of Hawai‘i somehow lost its “native” character because some non-Hawaiians became naturalized citizens of the Kingdom. This argument is used as the basis for asserting that Native Hawaiians cannot now be “recognized” as a native group with which the United States may maintain a special legal and political relationship.⁷⁰ However, as evident from the preceding discussion of Supreme Court rulings and precedent, this argument lacks any constitutional basis. The Supreme Court has often decided cases relating to the status of non-Indians who had become members or citizens of Indian tribes,⁷¹ but the Court has never suggested that a tribal law that provides for the membership or citizenship in the tribe of previously non-tribal members renders those tribes or their modern-day successors ineligible for recognition as having a special legal and political relationship with the United States pursuant to the Indian Commerce Clause. Similarly, opposition to the recognition of a Native Hawaiian governing entity premised upon the attenuation of the blood quantum of its citizens lacks any historical or constitutional basis.

Many contemporary tribes define their citizenship or membership based upon lineal descendancy from a tribal roll, and the Congress has from time to time established criteria for membership in certain tribes.⁷² What neither the Congress nor the Supreme Court

⁶⁶ See *Cherokee Nation v. Journeycake*, 155 U.S. 196 (1894) (Delaware Indians entitled to rights of Cherokee Nation which Delawares had joined); *United States v. Blackfeather*, 155 U.S. 218 (1894) (same for Shawnee).

⁶⁷ See *John*, 437 U.S. at 652–53; *Moe v. Confederated Salish & Kootenai Tribes*, 425 U.S. 463, 480 (1976).

⁶⁸ Although the Alaska natives’ situation is “distinctly different from that of other American Indians,” *Alaska Chapter*, 694 F.2d at 1168–69 n.101, see *Metlakatla Indian Community v. Egan*, 369 U.S. 45, 50–51 (1962), it is “well established” that Athabaskan Indians, Eskimos, and Aleuts are “dependent Indian people” within the meaning of the Constitution. *Alaska Pacific Fisheries v. United States*, 248 U.S. 78, 87–89 (1918); see also *Pence v. Kleppe*, 529 F.2d 135, 138–39 n.5 (9th Cir. 1976) (“Indian” means “the aborigines of America” and includes Eskimos and Aleuts in Alaska); *United States v. Native Village of Unalakleet*, 411 F.2d 1255, 1256–57 (Ct. Cl. 1969) (“Eskimos and Aleuts are Alaskan aborigines” and, therefore, “Indians”).

⁶⁹ *Santa Clara Pueblo v. Martinez*, 436 U.S. 49, 72 n.32 (1978).

⁷⁰ See, e.g., Stuart Minor Benjamin, *Equal Protection and the Special relationship: The Case of Native Hawaiians*, 106 Yale L.J. 537, 607–8 & n.287 (1996) (discussing this argument, while noting that “[i]nclusion of some Westerners would not necessarily defeat a claim of tribal status” as the Supreme Court has never directly addressed the question, and noting that “some Indian tribes included Westerners. . . .”).

⁷¹ See, e.g., *United States v. Rogers*, 45 U.S. (4 How.) 567 (1846); *Boff v. Burney*, 168 U.S. 218 (1897); *Daniel Red Bird v. United States*, 203 U.S. 76 (1906).

⁷² Public Law No. 129, §§ 1–4, 34 Stat. 137, 137–38 (April 26, 1906) (setting forth enrollment criteria for members of the Choctaw, Chickasaw, Cherokee, Creek and Seminole Tribes of Oklahoma).

has done is to suggest that the Constitution imposes a blood quantum limitation or requirement on tribal citizenship.

The Significance of "Federal Recognition"

It is important to recognize that the legal distinctions that have been drawn in contemporary times between Indian tribes that are "acknowledged" by the Department of the Interior⁷³ or "recognized" by the Congress—tribes that have a direct government-to-government relationship with the United States and are thereby eligible for various Federal benefits—and Native American groups that are not so recognized and have no such government-to-government relationship, is a relatively recent phenomenon. "[A] close scrutiny of the various executive orders, Congressional legislation, departmental policies, Solicitor's opinions, and judicial decisions since 1783 . . . discloses an astonishing oblivion of the need for an express declaration or statement regarding which Indian tribes were to be recognized, until the enactment of the Wheeler-Howard (Indian Reorganization) Act of 1934,"⁷⁴ thirteen years after the enactment of the Hawaiian Homes Commission Act. In fact, there was no systematic procedure by which a Native American group could petition the United States for recognition until 1978, when regulations were promulgated to implement the Federal Acknowledgment process.⁷⁵

An administrative process for the acknowledgment of Native groups by the United States that was established almost twenty years after Hawaiians admission to the Union could not have informed the provisions of the Hawaiian Homes Commission Act nor the Hawai'i Admission Act and it is thus not surprising that the language of those Acts do not conform neatly with categorizations that had yet to be developed.

Although the authority of Congress to formally "recognize" tribes through legislation is unquestioned, the Department of the Interior's regulations associated with the administrative process for the acknowledgment of tribes pursuant to 25 CFR Part 83 exclude Native Hawaiians from that process, and thus legislation is the only mechanism available to Native Hawaiians.⁷⁶ The present legislation thus establishes no precedent applicable to groups eligible to apply for recognition under the existing administrative framework.



⁷³ See 25 CFR Part 83.

⁷⁴ William W. Quinn, Jr., *Federal Acknowledgment of American Indian Tribes: The Historical Development of a Legal Concept*, 34 Am. J. Leg. Hist. 331, 332 (1990) (citing 48 Stat. 984 (1934) (codified as amended at 25 U.S.C. §§ 461 et seq.)); see generally, William W. Quinn, Jr., *Federal Acknowledgment of American Indian Tribes: Authority, Judicial Interposition, and 25 CFR § 83*, 17 Am. Indian L. Rev. 37 (1992); L.R. Weatherhead, *What is an "Indian Tribe"?—The Question of Tribal Existence*, 8 Am. Indian L. Rev. 1 (1980).

⁷⁵ 25 CFR, Part 83, Quinn 1992, at 40–41.

⁷⁶ See 25 CFR §§ 83.1, 83.3 (administrative process available only to groups within the "continental United States," defined as the "contiguous 48 states and Alaska"). Native Hawaiians have twice sought unsuccessfully to challenge their exclusion from this process. *Price v. State of Hawaii*, 764 F.2d 623 (9th Cir. 1985); *Kahawaiolaa v. Norton*, 222 F. Supp. 2d 1213 (D. Haw. 2002).