

Mr. MOYNIHAN, Mr. SESSIONS, Mr. DEWINE, Mr. HELMS, Mr. THURMOND, Mr. SCHUMER, and Mr. INOUE):

S. Res. 323. A resolution to designating Monday, June 19, 2000, as National Eat-Dinner-With-Your-Children Day; considered and agreed to.

By Mr. DURBIN (for himself, Mr. GORTON, Mr. ROBB, Mr. GRAMS, and Mr. VOINOVICH):

S. Con. Res. 122. Concurrent resolution recognizing the 60th anniversary of the United States nonrecognition policy of the Soviet takeover of Estonia, Latvia, and Lithuania, and calling for positive steps to promote a peaceful and democratic future for the Baltic region; to the Committee on Foreign Relations.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. HELMS (for himself, Mr. LOTT, Mr. WARNER, Mr. HATCH, Mr. GRAMS, and Mr. SHELBY):

S. 2726. A bill to protect United States military personnel and other elected and appointed officials of the United States Government against criminal prosecution by an international criminal court to which the United States is not a party; to the Committee on Foreign Relations.

AMERICAN SERVICEMEMBERS' PROTECTION ACT OF 2000

Mr. HELMS. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 2726

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "American Servicemembers' Protection Act of 2000".

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) On July 17, 1998, the United Nations Diplomatic Conference of Plenipotentiaries on the Establishment of an International Criminal Court, meeting in Rome, Italy, adopted the "Rome Statute of the International Criminal Court." The vote on adoption of the Statute was 120 in favor to 7 against, with 21 countries abstaining. The United States voted against final adoption of the Rome Statute.

(2) As of May 30, 2000, 96 countries had signed the Rome Statute and 10 had ratified it. Pursuant to Article 126 of the Rome Statute, the Statute will enter into force on the first day of the month after the 60th day following the date that the 60th country deposits an instrument ratifying the Statute.

(3) Since adoption of the Rome Statute, a Preparatory Commission for the International Criminal Court has continued to meet regularly to draft documents to implement the Rome Statute, including Rules of Procedure and Evidence, definitions of Elements of Crimes, and a definition of the Crime of Aggression.

(4) During testimony before the Congress, the lead United States negotiator, Ambassador David Scheffer stated that the United States could not sign the Rome Statute because certain critical negotiating objectives of the United States had not been achieved. As a result, he stated: "We are left with consequences that do not serve the cause of international justice."

(5) Ambassador Scheffer went on to tell the Congress that: "Multinational peacekeeping forces operating in a country that has joined the treaty can be exposed to the Court's jurisdiction even if the country of the individual peacekeeper has not joined the treaty. Thus, the treaty purports to establish an arrangement whereby United States armed forces operating overseas could be conceivably prosecuted by the international court even if the United States has not agreed to be bound by the treaty. Not only is this contrary to the most fundamental principles of treaty law, it could inhibit the ability of the United States to use its military to meet alliance obligations and participate in multinational operations, including humanitarian interventions to save civilian lives. Other contributors to peacekeeping operations will be similarly exposed."

(6) Any Americans prosecuted by the International Criminal Court will, under the Rome Statute, be denied many of the procedural protections to which all Americans are entitled under the Bill of Rights to the United States Constitution, including, among others, the right to trial by jury, the right not to be compelled to provide self-incriminating testimony, and the right to confront and cross-examine all witnesses for the prosecution.

(7) American servicemen and women deserve the full protection of the United States Constitution when they are deployed around the world to protect the vital national interests of the United States. The United States Government has an obligation to protect American servicemen and women, to the maximum extent possible, against criminal prosecutions carried out by United Nations officials under procedures that deny them their constitutional rights.

(8) In addition to exposing American servicemen and women to the risk of international criminal prosecution, the Rome Statute creates a risk that the President and other senior elected and appointed officials of the United States Government may be prosecuted by the International Criminal Court. Particularly if the Preparatory Commission agrees on a definition of the Crime of Aggression, senior United States officials may be at risk of criminal prosecution for national security decisions involving such matters as responding to acts of terrorism, preventing the proliferation of weapons of mass destruction, and deterring aggression. No less than American servicemen and women, senior officials of the United States Government deserve the full protection of the United States Constitution with respect to official actions taken by them to protect the national interests of the United States.

SEC. 3. TERMINATION OF PROHIBITIONS OF THIS ACT.

The prohibitions and requirements of sections 4, 5, 6, and 7 shall cease to apply, and the authority of section 8 shall terminate, if the United States becomes a party to the International Criminal Court pursuant to a treaty made under article II, section 2, clause 2 of the Constitution of the United States.

SEC. 4. PROHIBITION ON COOPERATION WITH THE INTERNATIONAL CRIMINAL COURT.

(a) CONSTRUCTION.—The provisions of this section apply only to cooperation with the International Criminal Court and shall not be construed to apply to cooperation with an ad hoc international criminal tribunal established by the United Nations Security Council before or after the date of the enactment of this Act to investigate and prosecute war crimes committed in a specific country or during a specific conflict.

(b) PROHIBITION ON RESPONDING TO REQUESTS FOR COOPERATION.—No agency or en-

tity of the United States Government or of any State or local government, including any court, may cooperate with the International Criminal Court in response to a request for cooperation submitted by the International Criminal Court pursuant to Part 9 of the Rome Statute.

(c) PROHIBITION ON SPECIFIC FORMS OF COOPERATION.—No agency or entity of the United States Government or of any State or local government, including any court, may undertake any action described in the following articles of the Rome Statute with the purpose or intent of cooperating with, or otherwise providing support or assistance to, the International Criminal Court:

(1) Article 89 (relating to arrest, extradition, and transit of suspects).

(2) Article 92 (relating to provisional arrest of suspects).

(3) Article 93 (relating to seizure of property, asset forfeiture, execution of searches and seizures, service of warrants and other judicial process, taking of evidence, and similar matters).

(d) RESTRICTION ON ASSISTANCE PURSUANT TO MUTUAL LEGAL ASSISTANCE TREATIES.—The United States shall exercise its rights to limit the use of assistance provided under all treaties and executive agreements for mutual legal assistance in criminal matters, multilateral conventions with legal assistance provisions, and extradition treaties, to which the United States is a party, and in connection with the execution or issuance of any letter rogatory, to prevent the transfer to, or other use by, the International Criminal Court of any assistance provided by the United States under such treaties and letters rogatory.

(e) PROHIBITION ON INVESTIGATIVE ACTIVITIES OF AGENTS.—No agent of the International Criminal Court may conduct, in the United States or any territory subject to the jurisdiction of the United States, any investigative activity relating to a preliminary inquiry, investigation, prosecution, or other proceeding at the International Criminal Court.

SEC. 5. RESTRICTION ON UNITED STATES PARTICIPATION IN CERTAIN UNITED NATIONS PEACEKEEPING OPERATIONS.

(a) POLICY.—Effective beginning on the date that the Rome Statute enters into force pursuant to Article 126 of the Rome Statute, the President should use the voice and vote of the United States in the United Nations Security Council to ensure that each resolution of the Security Council authorizing a peacekeeping operation pursuant to chapter VI or VII of the charter of the United Nations permanently exempts United States military personnel participating in such peacekeeping operation from criminal prosecution by the International Criminal Court for actions undertaken by such personnel in connection with the operation.

(b) RESTRICTION.—United States military personnel may not participate in a peacekeeping operation authorized by the United Nations Security Council pursuant to chapter VI or VII of the charter of the United Nations on or after the date that the Rome Statute enters into effect pursuant to Article 126 of the Rome Statute, unless the President has submitted to the appropriate congressional committees a certification described in subsection (c) with respect to such peacekeeping operation.

(c) CERTIFICATION.—The certification referred to in subsection (b) is a certification by the President that United States military personnel are able to participate in a peacekeeping operation without risk of criminal prosecution by the International Criminal Court because—

(1) in authorizing the peacekeeping operation, the United Nations Security Council

permanently exempted United States military personnel participating in the operation from criminal prosecution by the International Criminal Court for actions undertaken by them in connection with the operation;

(2) each country in which United States military personnel participating in the peacekeeping operation will be present is either not a party to the International Criminal Court or has entered into an agreement in accordance with Article 98 of the Rome Statute preventing the International Criminal Court from proceeding against United States personnel present in that country; or

(3) the President has taken other appropriate steps to guarantee that United States military personnel participating in the peacekeeping operation will not be prosecuted by the International Criminal Court for actions undertaken by such personnel in connection with the operation.

SEC. 6. PROHIBITION ON DIRECT OR INDIRECT TRANSFER OF CERTAIN CLASSIFIED NATIONAL SECURITY INFORMATION TO THE INTERNATIONAL CRIMINAL COURT.

(a) **DIRECT TRANSFER.**—Not later than the date on which the Rome Statute enters into force, the President shall ensure that appropriate procedures are in place to prevent the transfer of classified national security information to the International Criminal Court.

(b) **INDIRECT TRANSFER.**—Not later than the date on which the Rome Statute enters into force, the President shall ensure that appropriate procedures are in place to prevent the transfer of classified national security information relevant to matters under consideration by the International Criminal Court to the United Nations and to the government of any country that is a party to the International Criminal Court unless the United Nations or that government, as the case may be, has provided written assurances that such information will not be made available to the International Criminal Court.

SEC. 7. PROHIBITION OF UNITED STATES MILITARY ASSISTANCE TO PARTIES TO THE INTERNATIONAL CRIMINAL COURT.

(a) **PROHIBITION OF MILITARY ASSISTANCE.**—Subject to subsections (b), (c), and (d), no United States military assistance may be provided to the government of a country that is a party to the International Criminal Court.

(b) **WAIVER.**—The President may waive the prohibition of subsection (a) with respect to a particular country if the President determines and reports to the appropriate congressional committees that such country has entered into an agreement with the United States pursuant to Article 98 of the Rome Statute preventing the International Criminal Court from proceeding against United States personnel present in such country.

(c) **SPECIAL AUTHORITIES.**—The prohibition of subsection (a) shall be subject to the special authorities of section 614 of the Foreign Assistance Act of 1961 and the applicable conditions and limitations under such section.

(d) **EXEMPTION.**—The prohibition of subsection (a) shall not apply to the government of any country that is—

(1) a NATO member country, or

(2) a major non-NATO ally (including, inter alia, Australia, Egypt, Israel, Japan, the Republic of Korea, and New Zealand).

SEC. 8. AUTHORITY TO FREE UNITED STATES MILITARY PERSONNEL AND CERTAIN OTHER PERSONS HELD CAPTIVE BY OR ON BEHALF OF THE INTERNATIONAL CRIMINAL COURT.

(a) **AUTHORITY.**—The President is authorized to use all means necessary and appropriate to bring about the release from cap-

tivity of any person described in subsection (b) who is being detained or imprisoned against that person's will by or on behalf of the International Criminal Court.

(b) **PERSONS AUTHORIZED TO BE FREED.**—The authority of subsection (a) shall extend to the following persons:

(1) United States military personnel, elected or appointed officials of the United States Government, and other persons employed by or working on behalf of the United States Government.

(2) Military personnel, elected or appointed officials, and other persons employed by or working on behalf of the government of a NATO member country or major non-NATO ally (including, inter alia, Australia, Egypt, Israel, Japan, the Republic of Korea, and New Zealand) that is not a party to the International Criminal Court, upon the request of such government.

(3) Individuals detained or imprisoned for official actions taken while the individual was a person described in paragraph (1) or (2), and in the case of such individuals described in paragraph (2), upon the request of such government.

(c) **CONSTRUCTION.**—Subsection (a) shall not be construed to authorize the payment of bribes or the provision of other incentives to induce the release from captivity of a person described in subsection (b).

SEC. 9. STATUS OF FORCES AGREEMENTS.

(a) **REPORT ON STATUS OF FORCES AGREEMENTS.**—Not later than 6 months after the date of the enactment of this Act, the President shall transmit to the appropriate congressional committees a report evaluating the degree to which each existing status of forces agreement with a foreign government, or other similar international agreement, protects United States military and other personnel from extradition to the International Criminal Court under Article 98 of the Rome Statute.

(b) **PLAN FOR ACHIEVING ENHANCED PROTECTION OF UNITED STATES MILITARY PERSONNEL.**—Not later than 1 year after the date of the enactment of this Act, the President shall transmit to the appropriate congressional committees a plan for amending existing status of forces agreements, or negotiating new international agreements, in order to achieve the maximum protection available under Article 98 of the Rome Statute for United States military and other personnel in those countries where maximum protection under Article 98 has not already been achieved.

(c) **SUBMISSION IN CLASSIFIED FORM.**—The report under subsection (a), and the plan under subsection (b), or appropriate parts thereof, may be submitted in classified form.

SEC. 10. ALLIANCE COMMAND ARRANGEMENTS.

(a) **REPORT ON ALLIANCE COMMAND ARRANGEMENTS.**—Not later than 6 months after the date of the enactment of this Act, the President shall transmit to the appropriate congressional committees a report with respect to each military alliance to which the United States is party—

(1) describing the degree to which United States military personnel may, in the context of military operations undertaken by or pursuant to that alliance, be placed under the command or operational control of foreign military officers subject to the jurisdiction of the international criminal court because they are nationals of a party to the international criminal court, and

(2) evaluating the degree to which United States military personnel engaged in military operations undertaken by or pursuant to that alliance may be exposed to greater risks as a result of being placed under the command or operational control of foreign military officers subject to the jurisdiction of the international criminal court.

(b) **PLAN FOR ACHIEVING ENHANCED PROTECTION OF UNITED STATES MILITARY PERSONNEL.**—Not later than one year after the date of the enactment of this Act, the President shall transmit to the appropriate congressional committees a plan for modifying command and operational control arrangements within military alliances to which the United States is a party to reduce any risks to United States military personnel identified pursuant to subsection (a)(2).

(c) **SUBMISSION IN CLASSIFIED FORM.**—The report under subsection (a), and the plan under subsection (b), or appropriate parts thereof, may be submitted in classified form.

SEC. 11. WITHHOLDINGS.

Funds withheld from the United States share of assessments to the United Nations or any other international organization pursuant to section 705 of the Admiral James W. Nance and Meg Donovan Foreign Relations Authorization Act, Fiscal Years 2000 and 2001 (as enacted by section 1000(a)(7) of Public Law 106-113; 113 Stat. 1501A-460), are authorized to be transferred to the Embassy Security, Construction and Maintenance Account of the Department of State.

SEC. 12. DEFINITIONS.

As used in this Act and in sections 705 and 706 of the Admiral James W. Nance and Meg Donovan Foreign Relations Authorization Act, Fiscal Years 2000 and 2001, the following terms have the following meanings:

(1) **APPROPRIATE CONGRESSIONAL COMMITTEES.**—The term “appropriate congressional committees” means the Committee on International Relations of the House of Representatives and the Committee on Foreign Relations of the Senate.

(2) **CLASSIFIED NATIONAL SECURITY INFORMATION.**—The term “classified national security information” means information that is classified or classifiable under Executive Order 12958 or a successor executive order.

(3) **EXTRADITION.**—The terms “extradition” and “extradite” include both “extradition” and “surrender” as those terms are defined in Article 102 of the Rome Statute.

(4) **INTERNATIONAL CRIMINAL COURT.**—The term “International Criminal Court” means the court established by the Rome Statute.

(5) **MAJOR NON-NATO ALLY.**—The term “major non-NATO ally” means a country that has been so designated in accordance with section 517 of the Foreign Assistance Act of 1961.

(6) **PARTY TO THE INTERNATIONAL CRIMINAL COURT.**—The term “party to the International Criminal Court” means a government that has deposited an instrument of ratification, acceptance, approval, or accession to the Rome Statute, and has not withdrawn from the Rome Statute pursuant to Article 127 thereof.

(7) **PEACEKEEPING OPERATION AUTHORIZED BY THE UNITED NATIONS SECURITY COUNCIL PURSUANT TO CHAPTER VI OF VII OF THE CHARTER OF THE UNITED NATIONS.**—The term “peacekeeping operation authorized by the United Nations Security Council pursuant to chapter VI of VII of the charter of the United Nations” means any military operation to maintain or restore international peace and security that—

(A) is authorized by the United Nations Security Council pursuant to chapter VI or VII of the charter of the United Nations, and

(B) is paid for from assessed contributions of United Nations members that are made available for peacekeeping activities.

(8) **ROME STATUTE.**—The term “Rome Statute” means the Rome Statute of the International Criminal Court, adopted by the United Nations Diplomatic Conference of Plenipotentiaries on the Establishment of an International Criminal Court on July 17, 1998.

(9) SUPPORT.—The term “support” means assistance of any kind, including material support, services, intelligence sharing, law enforcement cooperation, the training or detail of personnel, and the arrest or detention of individuals.

(10) UNITED STATES MILITARY ASSISTANCE.—The term “United States military assistance” means—

(A) assistance provided under chapters 2 through 6 of part II of the Foreign Assistance Act of 1961 (22 U.S.C. 2311 et seq.);

(B) defense articles or defense services furnished with the financial assistance of the United States Government, including through loans and guarantees; or

(C) military training or education activities provided by any agency or entity of the United States Government.

Such term does not include activities reportable under title V of the National Security Act of 1947 (50 U.S.C. 413 et seq.).

By Mr. KENNEDY (for himself, Mr. BRYAN, Ms. MIKULSKI, and Mr. WELLSTONE):

S. 2727. A bill to improve the health of older Americans and persons with disabilities, and for other purposes; to the Committee on Finance.

MEDICARE HEALTH IMPROVEMENT ACT OF 2000

Mr. KENNEDY. Mr. President, today we are introducing legislation to improve the health of Medicare beneficiaries and the health of the Medicare program itself. Under Medicare, the health and quality of life for millions of older adults and people with disabilities have significantly improved. The rate of chronic disability among adults over 65 continues to decline, but we can do better. A recent report by the World Health Organization showed that the U.S. falls behind 23 other nations in “healthy life expectancy.” On average, Americans can expect only 70 healthy years, compared to Japanese citizens who can anticipate 74½ years of life without disability. Chronic disability robs too many older Americans of active and productive years, and adds \$26 billion annually in health care costs as people over 65 lose their ability to live independently.

In the next 30 years, the viability of Medicare will be challenged as the baby boom generation ages. Nearly one fifth of the population will be 65 and older by 2025, which means that a larger number of beneficiaries will be supported by a smaller number of workers. The current debate over the future of Medicare often revolves around benefit cuts or tax increases. But an obvious alternative that should be part of the debate is to reduce the demand for Medicare by improving the health of senior citizens. Unfortunately, Medicare today contains few incentives to encourage beneficiaries and providers to take health promotion and disease prevention seriously. This bill will help older adults and individuals with disabilities to improve their health. It will also educate health providers about the best practices for treatment of Medicare patients.

Older adults are generally health conscious and are interested in taking steps to maintain their health and

independence. Poor lifestyle factors—which include lack of exercise, poor diet, at-risk behaviors, smoking, and alcohol abuse—account for 70% of the physical decline and disease that occur with aging. Experts agree that the potential for better health through health promotion and disease prevention is great. Too often, however, older Americans lack the accurate information that would help them take advantage of these opportunities. This bill will ensure that Medicare beneficiaries are better informed about the lifestyle changes they can make to improve their health, and the preventive health services they can use to prevent disease.

To encourage more beneficiaries to use the preventive services that Medicare currently offers, our legislation will eliminate cost-sharing for these services. Prevention saves lives and saves money. The incidence of cancer in adults over 65 is approximately eleven times higher than in persons under 65. Most cancers can be treated and many can be cured if detected early. But cancer screening tests are significantly underused by Medicare beneficiaries. Thirty-eight percent of women over 65 who have survived breast cancer (and remain at risk) do not receive an annual mammogram. Our bill will waive cost-sharing for mammography, screening pelvic exams, colorectal cancer screening, prostate cancer screening, bone mass measurement, hepatitis B vaccine and its administration, and diabetes self-management training.

Despite the great potential of preventive services to improve the quality of life for older Americans, few clinical guidelines focus on preventive care for this population. Our bill calls for a task force to conduct studies to determine which preventive services in primary care are most valuable to senior citizens. A separate demonstration project will determine effective means to reduce smoking by Medicare beneficiaries. Cessation of smoking can reduce the risk of lung cancer, heart disease, and stroke. In 1997, smoking-related expenditures were estimated to cost the Medicare program a total of \$20.5 billion.

There are substantial defects in the quality of care provided to Medicare beneficiaries. Medical research has established that early use of a beta blocker after a heart attack reduces the risk of mortality and rehospitalization. Yet 51 percent of older adults fail to receive this treatment when it is indicated. In fact, patients at the highest risk of death in the hospital are least likely to receive a beta blocker.

Every senior citizen deserves quality health care. The gaps between the best medical practice and actual practice must be narrowed. Our bill asks the Department of Health and Human Services to determine which areas in the treatment of Medicare beneficiaries do not meet the highest professional standards, and to determine

the best practices in those areas. Steps will then be taken to inform health care professionals about these standards for treatment.

The opportunities for better health care and budget savings are great, if care can be delivered to beneficiaries with high-cost chronic conditions in a more coordinated and effective way. Our legislation authorizes demonstration projects to develop innovative approaches to increase the quality of care and reduce costs for Medicare beneficiaries in skilled nursing facilities. Similar demonstration projects are authorized for beneficiaries with serious or chronic illness who do not reside in nursing facilities.

In ways like this, we do more—much more—to preserve and strengthen Medicare, and achieve substantial long-term savings as well. I look forward to working closely with my colleagues on both sides of the aisle to achieve this important goal. I ask unanimous consent that the bill, the bill summary, and the relevant fact sheet be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

S. 2727

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the “Medicare Health Improvement Act of 2000”.

(b) TABLE OF CONTENTS.—The table of contents is as follows:

Sec. 1. Short title; table of contents.

Sec. 2. Definitions.

TITLE I—HCFA MISSION STATEMENT

Sec. 101. Establishment of HCFA mission statement with regard to the medicare program.

TITLE II—ENABLING OLDER AMERICANS AND PERSONS WITH DISABILITIES TO IMPROVE THEIR HEALTH STATUS

Sec. 201. Waiver of all preventive services cost sharing under the medicare program.

Sec. 202. Information campaign on preventive health care for older Americans and individuals with disabilities.

Sec. 203. Development of health status self-assessment tool for medicare beneficiaries.

TITLE III—IMPROVING THE QUALITY OF CARE PROVIDED TO OLDER AMERICANS AND PERSONS WITH DISABILITIES

Sec. 301. Information campaign for the best practices for the treatment of conditions of medicare beneficiaries.

Sec. 302. Program to promote the use of best practices for the treatment of conditions of medicare beneficiaries and to reduce hospital and physician visits that result from improper drug use.

Sec. 303. Studies on preventive interventions in primary care for older Americans.

Sec. 304. Smoking cessation demonstration project.

TITLE IV—DEMONSTRATION PROJECTS TO IMPROVE THE CARE OF RESIDENTS OF SKILLED NURSING FACILITIES AND PERSONS WITH SERIOUS ILLNESSES

Sec. 401. Demonstration projects to provide effective care for skilled nursing facility residents.

Sec. 402. Demonstration projects to improve the care of persons with serious illnesses.

TITLE V—WHITE HOUSE CONFERENCE ON IMPROVING THE HEALTH OF OLDER AMERICANS

Sec. 501. White House Conference on Improving the Health of Older Americans.

SEC. 2. DEFINITIONS.

In this Act:

(1) **COMMISSIONER.**—The term “Commissioner” means the Commissioner of Social Security.

(2) **MEDICARE BENEFICIARIES.**—The term “medicare beneficiaries” means individuals who are entitled to benefits under part A or enrolled under part B of the medicare program, including individuals enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization under part C of such program.

(3) **MEDICARE PROGRAM.**—The term “medicare program” means the health insurance program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(4) **SECRETARY.**—The term “Secretary” means the Secretary of Health and Human Services.

TITLE I—HCFA MISSION STATEMENT

SEC. 101. ESTABLISHMENT OF HCFA MISSION STATEMENT WITH REGARD TO THE MEDICARE PROGRAM.

Part A of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting before section 1801 the following:

“HCFA MISSION STATEMENT

“SEC. 1800. In administering the health insurance program established under this title, it is the mission of the Health Care Financing Administration to—

“(1) effectively and efficiently administer a program of health insurance coverage for individuals who are entitled to benefits under part A or enrolled under part B of this title, including individuals enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization under part C of this title, in accordance with the requirements of this title;

“(2) assure that health care provided to such individuals is of the highest quality; and

“(3) carry out programs in cooperation with other Government agencies and the private sector to promote health, prevent disease, and assure the highest possible functional level for such individuals.”.

TITLE II—ENABLING OLDER AMERICANS AND PERSONS WITH DISABILITIES TO IMPROVE THEIR HEALTH STATUS

SEC. 201. WAIVER OF ALL PREVENTIVE SERVICES COST SHARING UNDER THE MEDICARE PROGRAM.

(a) **WAIVER OF COINSURANCE AND DEDUCTIBLES.**—

(1) **IN GENERAL.**—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following:

“(m) **WAIVER OF COINSURANCE AND DEDUCTIBLE FOR PREVENTIVE SERVICES.**—

“(1) **COINSURANCE.**—

“(A) **IN GENERAL.**—Notwithstanding any other provision of this part—

“(i) the Secretary shall waive any coinsurance applicable to services described in subparagraph (B); and

“(ii) with respect to payment for such services, any reference to a percent that is less

than 100 percent shall be deemed to be a reference to 100 percent.

“(B) **SERVICES DESCRIBED.**—The services described in this subparagraph are the following services:

“(i) Screening mammography (as defined in section 1861(jj)).

“(ii) Screening pelvic exam (as defined in section 1861(nn)(2)).

“(iii) Hepatitis B vaccine and its administration (under section 1861(s)(10)(B)).

“(iv) Colorectal cancer screening test (as defined in section 1861(pp)).

“(v) Bone mass measurement (as defined in section 1861(rr)).

“(vi) Prostate cancer screening test (as defined in section 1861(oo)).

“(vii) Diabetes outpatient self-management training services (as defined in section 1861(qq)).

“(2) **DEDUCTIBLE.**—

“(A) **IN GENERAL.**—Notwithstanding any other provision of this part, the deductible described in section 1833(b) shall not apply with respect to services described in subparagraph (B).

“(B) **SERVICES DESCRIBED.**—The services described in this subparagraph are the following services:

“(i) Hepatitis B vaccine and its administration (under section 1861(s)(10)(B)).

“(ii) Colorectal cancer screening test (as defined in section 1861(pp)).

“(iii) Bone mass measurement (as defined in section 1861(rr)).

“(iv) Prostate cancer screening test (as defined in section 1861(oo)).

“(v) Diabetes outpatient self-management training services (as defined in section 1861(qq)).”.

(2) **CONFORMING AMENDMENT.**—Section 1833(a) of the Social Security Act (42 U.S.C. 1395l(a)) is amended by striking “section 1876” and inserting “sections 1834 and 1876” in the matter preceding paragraph (1).

(b) **EFFECTIVE DATE.**—The amendments made by this section shall apply to services furnished on or after December 31, 2001.

SEC. 202. INFORMATION CAMPAIGN ON PREVENTIVE HEALTH CARE FOR OLDER AMERICANS AND INDIVIDUALS WITH DISABILITIES.

(a) **IN GENERAL.**—The Secretary and the Commissioner shall jointly conduct an information campaign, in consultation with the heads of other Government agencies and States and the private sector, for individuals who have attained age 50 and individuals with disabilities to promote—

(1) the use of preventive health services among such individuals, including services that are available to medicare beneficiaries and are covered by the medicare program;

(2) the proper use of prescription and over-the-counter drugs in order to reduce the number of hospital stays and physician visits among such individuals that are a result of the improper use of such drugs; and

(3) the steps (including exercise, maintenance of a proper diet, and utilization of accident prevention techniques) that such individuals may take in order to promote and safeguard their health.

(b) **USE OF SERVICES.**—The information campaign described in subsection (a) shall stress the benefits of—

(1) using the services described in subsection (a)(1);

(2) following the proper directions for using prescription and over-the-counter drugs as described in subsection (a)(2); and

(3) utilizing the steps described in subsection (a)(3).

(c) **ELEMENTS OF CAMPAIGN.**—In conducting the information campaign described in subsection (a), the Secretary and the Commissioner (as applicable) shall—

(1) expand the section in the Medicare and You handbook on preventive benefits to in-

clude a more detailed description of the importance of using preventive health services and the benefits offered under the medicare program;

(2) instruct fiscal intermediaries and carriers under the medicare program to include preventive benefits messages on the Medicare Summary Notice statement and the Explanation of Medicare Benefits;

(3) regularly include preventive benefits messages on the medicare part B benefits statement;

(4) combine public service announcements and a print media campaign to raise awareness of the value of using preventive health services;

(5) distribute brochures and other information on health promotion and disease prevention activities through—

(A) State health insurance assistance programs;

(B) area agencies on aging;

(C) Social Security Administration field offices; and

(D) any other appropriate entities, as determined by the Secretary and the Commissioner; and

(6) include information on the importance of using preventive health services—

(A) on the cost of living adjustment (COLA) notice, which is sent to individuals who receive disability benefits under titles II and XVI of the Social Security Act (42 U.S.C. 401 et seq.; 1381 et seq.);

(B) on the social security account statements distributed pursuant to section 1143 of the Social Security Act (42 U.S.C. 1320b-13); and

(C) in brochures on retirement and survivors' benefits that are produced by the Commissioner.

(d) **TARGETED POPULATIONS.**—To the extent appropriate, aspects of the information campaign described in subsection (a) may be targeted to specific subpopulations of medicare beneficiaries.

(e) **GRANTS AND CONTRACTS.**—

(1) **IN GENERAL.**—The Secretary and the Commissioner shall provide grants to, and enter into contracts with, eligible entities to assist with carrying out the purposes of this section.

(2) **ELIGIBLE ENTITY DEFINED.**—In this subsection, the term “eligible entity” means—

(A) any community organization working with medicare beneficiaries;

(B) any organization representing medicare beneficiaries;

(C) area agencies on aging; and

(D) any other appropriate entities, as determined by the Secretary and the Commissioner.

SEC. 203. DEVELOPMENT OF HEALTH STATUS SELF-ASSESSMENT TOOL FOR MEDICARE BENEFICIARIES.

(a) **DEVELOPMENT.**—The Secretary, in conjunction with the Director of the National Institutes of Health, the Director of the Centers for Disease Control and Prevention (CDC), the Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Administrator of the Agency for Healthcare Research and Quality (AHRQ), shall develop a health status self-assessment tool that includes assessment of mental health status, alcohol use, and substance use, and assists medicare beneficiaries in identifying important health information, risk factors, or significant symptoms that should be acted upon or discussed with the beneficiary's health care provider.

(b) **DISTRIBUTION.**—The Secretary shall establish procedures for the distribution of the self-assessment form developed under subsection (a) and may contract with the eligible entities described in section 202(e)(2) to distribute and promote the use of such forms.

(c) TRAINING.—The Secretary shall establish a training program for the staff of State health insurance assistance programs that will enable such staff to assist medicare beneficiaries in completing the self-assessment form developed under subsection (a).

TITLE III—IMPROVING THE QUALITY OF CARE PROVIDED TO OLDER AMERICANS AND PERSONS WITH DISABILITIES

SEC. 301. INFORMATION CAMPAIGN FOR THE BEST PRACTICES FOR THE TREATMENT OF CONDITIONS OF MEDICARE BENEFICIARIES.

(a) STUDY.—The Secretary, in consultation with the Administrator for Health Care Policy and Research, the Director of the National Institutes of Health, and such other professional societies and experts as the Secretary considers appropriate, shall—

(1) conduct a study to determine areas where treatment of medicare beneficiaries falls short of the highest professional standards; and

(2) determine the best practices in the areas described in paragraph (1).

(b) INFORMATION CAMPAIGN.—The Secretary shall provide for an information campaign to inform medicare beneficiaries about the results of the study conducted under subsection (a).

SEC. 302. PROGRAM TO PROMOTE THE USE OF BEST PRACTICES FOR THE TREATMENT OF CONDITIONS OF MEDICARE BENEFICIARIES AND TO REDUCE HOSPITAL AND PHYSICIAN VISITS THAT RESULT FROM IMPROPER DRUG USE.

(a) IN GENERAL.—The Secretary, in conjunction with the Administrator of the Health Resources and Service Administration and such other agencies and professional societies as the Secretary deems appropriate, shall establish a program to—

(1) improve treatment of medicare beneficiaries based on the results of the study conducted under section 301(a) and other relevant information; and

(2) reduce the number of hospital stays and physician visits among medicare beneficiaries that are a result of the improper use of prescription and over-the-counter drugs.

(b) ELEMENTS OF PROGRAM.—The program described in subsection (a) shall include—

(1) an information campaign for health professionals;

(2) coordination of the part of the program established under subsection (a) that is designed to achieve the purpose described in paragraph (2) of that subsection with the information campaign conducted under section 202; and

(3) any other activity the Secretary considers appropriate to carry out the purposes described in subsection (a).

(c) DEMONSTRATIONS AND GRANTS.—In establishing the program under subsection (a), the Secretary may conduct demonstration projects and award grants to eligible entities (as defined in subsection (d)).

(d) ELIGIBLE ENTITY DEFINED.—In this section, the term “eligible entity” means an entity that is an academic health center, a professional medical society, or such other entity as the Secretary considers appropriate to carry out the purposes of this section.

(e) REPORT TO CONGRESS.—Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Secretary shall annually report to Congress on the program conducted under this section.

SEC. 303. STUDIES ON PREVENTIVE INTERVENTIONS IN PRIMARY CARE FOR OLDER AMERICANS.

(a) STUDIES.—The Secretary, acting through the United States Preventive Services Task Force, shall conduct a series of studies designed to identify preventive interventions that can be delivered in the pri-

mary care setting that are most valuable to older Americans.

(b) MISSION STATEMENT.—The mission statement of the United States Preventive Services Task Force is amended to include the evaluation of services that are of particular relevance to older Americans.

(c) REPORT.—Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Secretary shall submit a report to Congress on the conclusions of the studies conducted under subsection (a), together with recommendations for such legislation and administrative actions as the Secretary considers appropriate.

SEC. 304. SMOKING CESSATION DEMONSTRATION PROJECT.

(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Care Financing Administration, shall conduct a demonstration project to—

(1) evaluate the most successful and cost-effective means of providing smoking cessation services to medicare beneficiaries; and

(2) test incentive systems for physicians, other health care professionals, and medicare beneficiaries to optimize rates of successful smoking cessation among medicare beneficiaries.

(b) LATEST SCIENTIFIC EVIDENCE.—The Secretary shall use the latest scientific evidence regarding smoking cessation strategies and guidelines in conducting the demonstration project under this section.

(c) PAYMENT.—Payment to an individual or an entity for a service provided under the demonstration project shall be equal to the lesser of—

(1) the actual charge for providing the service to a medicare beneficiary; or

(2) the amount determined by a fee schedule established by the Secretary for the purposes of this section for such service.

(d) WAIVER AUTHORITY.—

(1) IN GENERAL.—The Secretary may waive such requirements of the medicare program as may be necessary for the purposes of carrying out the demonstration project conducted under this section.

(2) NON-MEDICARE PROVIDERS.—Individuals and entities that do not provide items and services under the medicare program shall be permitted to participate in the demonstration project conducted under this section.

(e) REPORT TO CONGRESS.—Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Secretary shall report to Congress on the demonstration project conducted under this section.

TITLE IV—DEMONSTRATION PROJECTS TO IMPROVE THE CARE OF RESIDENTS OF SKILLED NURSING FACILITIES AND PERSONS WITH SERIOUS ILLNESSES

SEC. 401. DEMONSTRATION PROJECTS TO PROVIDE EFFECTIVE CARE FOR SKILLED NURSING FACILITY RESIDENTS.

(a) IN GENERAL.—The Secretary shall conduct demonstration projects that are designed to provide medicare beneficiaries who are residents of skilled nursing facilities (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395i-3(a)) with higher quality and more cost-effective services in order to avoid unnecessary hospitalizations of such residents.

(b) REQUIREMENTS.—

(1) IN GENERAL.—The demonstration projects conducted under this section shall include the following:

(A) Programs of case management.

(B) Programs of disease management.

(C) Such other programs as the Secretary determines are likely to increase the quality of, and reduce the cost of, the care provided to such residents.

(2) AUTHORIZED TECHNIQUES.—The demonstration projects conducted under this section may utilize—

(A) contracts with centers of excellence or other entities or individuals with special expertise in providing quality services to residents of skilled nursing facilities;

(B) innovative payment techniques, including capitation payments, for all or selected services provided under such projects and incentive payments to reward favorable cost and quality outcomes;

(C) provision of services not normally covered under the medicare program, if the provision of such services would result in the more cost-effective provision of, or higher quality of, services covered under such program; or

(D) reduced cost-sharing requirements for medicare beneficiaries participating in such projects.

(c) WAIVER AUTHORITY.—The Secretary may waive such requirements of the medicare program as may be necessary for the purposes of carrying out the demonstration projects conducted under this section other than requirements relating to providing medicare beneficiaries with freedom of choice of provider under section 1802 of the Social Security Act (42 U.S.C.1395a) or any other provision of law.

(d) REPORT TO CONGRESS.—Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Secretary shall report to Congress on the demonstration projects conducted under this section.

SEC. 402. DEMONSTRATION PROJECTS TO IMPROVE THE CARE OF PERSONS WITH SERIOUS ILLNESSES.

(a) EXPANSION OF MEDICARE COORDINATED CARE DEMONSTRATION PROJECT.—Section 4016 of the Balanced Budget Act (Public Law 105-33; 111 Stat. 343) is amended—

(1) by striking subsection (a)(2) and inserting the following:

“(2) TARGET INDIVIDUAL DEFINED.—In this section, the term “target individual” means an individual that is enrolled under the fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.; 1395j et seq.) and—

“(A) has a chronic illness, as defined and identified by the Secretary; or

“(B) has a serious illness, as so defined and identified.”;

(2) in subsection (b)(2), by striking “Not” and inserting “With respect to demonstration projects for items and services provided to target individuals described in subsection (a)(2)(A), not”;

(3) by adding at the end the following:

“(f) REQUIREMENTS.—

“(1) IN GENERAL.—The demonstration projects conducted under this section shall include—

“(A) programs of case management;

“(B) programs of disease management; and

“(C) such other programs as the Secretary determines are likely to increase the quality of, and reduce the cost of, the care provided to target individuals.

“(2) AUTHORIZED TECHNIQUES.—The demonstration projects conducted under this section may include—

“(A) contracts with centers of excellence or other entities or individuals with special expertise in providing quality services to target individuals;

“(B) innovative payment techniques, including capitation payments, for all or selected services provided under such projects and incentive payments to reward favorable cost and quality outcomes;

“(C) provision of services not normally covered under title XVIII of the Social Security Act (42 U.S.C 1395 et seq.), if the provision of such services would result in the more cost-effective provision of, or higher quality of, services covered under that title; or

“(D) reduced cost-sharing requirements for target individuals participating in such projects.”.

(b) **EFFECTIVE DATE.**—The amendments made by this section shall take effect on the date of enactment of this Act.

TITLE V—WHITE HOUSE CONFERENCE ON IMPROVING THE HEALTH OF OLDER AMERICANS

SEC. 501. WHITE HOUSE CONFERENCE ON IMPROVING THE HEALTH OF OLDER AMERICANS.

(a) **IN GENERAL.**—Not later than December 31, 2002, the President shall convene a White House Conference on Improving the Health of Older Americans.

(b) **GOAL OF CONFERENCE.**—The goal of the Conference shall be to—

(1) develop a consensus on a program to enable older Americans to protect and improve their own health;

(2) develop procedures to ensure that—
(A) older Americans are provided with the highest standard of health care available, with an emphasis on assuring that standard practice is also the best practice; and

(B) the needs of older Americans are more effectively met through the benefits provided under the medicare program; and

(3) outline a research and demonstration agenda to further the goals described in paragraphs (1) and (2).

(c) **CONFERENCE PARTICIPANTS.**—

(1) **PARTICIPANTS.**—In order to carry out the purposes of this section, the Conference shall bring together—

(A) representatives of older Americans and those who care for older Americans;

(B) researchers and research institutions with an expertise in issues related to older Americans;

(C) health professionals and members of professional societies with expertise in caring for older Americans; and

(D) other appropriate parties.

(2) **SELECTION OF DELEGATES.**—The participants shall be selected without regard to political affiliation or past partisan activity and shall, to the best of the President's ability, be representative of the spectrum of thought in the field of geriatric health care.

MEDICARE HEALTH IMPROVEMENT ACT OF 2000—SUMMARY

The viability of Medicare is increasingly threatened as the nation's population ages and as large numbers of beneficiaries are supported by fewer workers. The current debate over the future of Medicare often revolves around benefit cuts or tax increases. But an alternative that should be part of the debate is to improve the health of beneficiaries and reduce the demand for Medicare. Unfortunately, Medicare contains few incentives to encourage beneficiaries and providers to take health promotion and disease prevention seriously. This bill will help older Americans and individuals with disabilities to improve their health and will educate health care providers in the best practices to achieve these goals.

TITLE I: HCFA MISSION STATEMENT

The purpose of this title is to establish a mission statement for the Health Care Financing Administration, the agency in the Department of Health and Human Services that administers Medicare. The mission of HCFA would be to: (1) effectively and efficiently administer health insurance coverage; (2) assure that the health care provided to Medicare beneficiaries is of the highest quality; (3) carry out health promotion and disease prevention activities; (4) and assure the highest possible level of functioning for beneficiaries.

TITLE II: ENABLING OLDER AMERICANS AND PERSONS WITH DISABILITIES TO IMPROVE THEIR HEALTH

Cost-sharing is waived for the following preventive services currently covered by Medicare—screening mammography, screening pelvic exam, hepatitis B vaccine and its administration, colorectal cancer screening, bone mass measurement, prostate cancer screening, and diabetes outpatient self-management training services.

An information campaign for individuals over age 50 and individuals with disability will be conducted jointly by the Secretary of Health and Human Services and the Commissioner of Social Security to promote the use of preventive health services, including services not covered by Medicare. The campaign will also encourage the proper use of prescription and over-the-counter medications, and the use of measures such as exercise, proper diet, and accident prevention to safeguard health.

A health status self-assessment program will be developed to help Medicare beneficiaries identify health information, risk factors, and symptoms that they should act on or discuss with their health provider.

TITLE III: IMPROVING THE QUALITY OF CARE FOR OLDER AMERICANS AND PERSONS WITH DISABILITIES

HHS, in consultation with other agencies, will conduct a study to determine areas in the treatment of Medicare beneficiaries that do not meet the highest professional standards. The study will also determine the best practices for treatment in these areas and inform Medicare beneficiaries about the study results.

A program will be established to inform health professionals of the best practices for treatment, and to reduce hospital stays and outpatient visits attributable to improper use of medications.

A task force will conduct studies to determine which preventive services in primary care are most valuable to older Americans.

A smoking cessation demonstration project will determine how to reduce smoking most effectively among Medicare beneficiaries.

TITLE IV: DEMONSTRATION PROJECTS TO IMPROVE THE CARE OF SKILLED NURSING RESIDENTS AND PERSONS WITH SERIOUS ILLNESSES

HHS will conduct demonstration projects on case management and disease management to increase the quality and reduce the cost of care for Medicare beneficiaries in nursing facilities. The projects will encourage contracts with Centers of Excellence, and will be authorized to use innovative payment techniques, explore services not normally covered by Medicare, and experiment with reduced cost-sharing requirements for beneficiaries. Similar demonstration projects will be conducted to improve the care of beneficiaries with serious or chronic illness who are not in nursing facilities.

TITLE IV: WHITE HOUSE CONFERENCE ON IMPROVING THE HEALTH OF OLDER AMERICANS

This title requests the President to convene a White House Conference on Improving the Health of Older Americans. The goals of the Conference will be to develop ways to enable older Americans to improve their health, and to develop procedures to ensure that they receive the highest quality of care, including the development of a research and demonstration agenda to advance these goals.

COST

The Congressional Budget Office estimates that the cost of this program will be \$1.6 billion over 5 years and \$5 billion over 10 years.

MEDICARE HEALTH IMPROVEMENT ACT OF 2000—FACT SHEET

The health and quality of life for millions of adults age 65 or older and people with disabilities have significantly improved under Medicare. From 1982 to 1994, chronic disability among Americans over 65 declined by 1.3% annually, and has continued to decline through 1999. Nevertheless, a recent report by the World Health Organization revealed that the U.S. lags behind Europe, Australia, Canada, Israel and Japan in “healthy life expectancy.” Americans have a life expectancy of 76.7 years of which 70 will be without disability, in comparison to Japanese citizens who can anticipate 74.5 healthy years. Chronic disability robs older Americans of active and productive years. It adds \$26 billion annually in health care costs for those over 65 who lose their ability to live independently over the course of a year.

In the next 30 years, the viability of Medicare will be challenged as the baby boom generation ages. The percentage of the population 65 and older is expected to increase from 13% to 19% in 2025, resulting in larger numbers of beneficiaries who will be supported by fewer workers. If the prevalence of chronic disability can be further reduced and healthy life expectancy increased, the aging population will enjoy a longer period of independence and general well-being while using fewer medical services.

Medicare was enacted in 1965 to ensure acute medical care for older adults and persons with disabilities. As the field of medicine and the demographics of the American population have changed, the purpose of Medicare has evolved to include health promotion and disease prevention activities.

Older Americans and persons with disabilities can contribute significantly to improving their health.

Medicare offers multiple preventive services, but current cost-sharing requirements often deter people from using these services. Additional measures such as exercise, proper diet, accident prevention and appropriate use of medications, can enable beneficiaries to prevent or delay the onset of disability. According to Healthy People 2010, “More than any other age group, older adults are seeking health information and are willing to make changes to maintain their health and independence.” Medicare can do more to inform people about health promotion and disease prevention to help them improve their health.

Lifestyle problems account for approximately 70% of the physical decline and disease that occur with aging. The over-65 population is increasingly knowledgeable about medical issues and can be motivated to make behavioral changes to improve their health.

Deaths from heart disease and stroke rise significantly over age 65, accounting for more than 40% of all deaths among persons aged 65 to 74, and almost 60% of deaths in persons age 85 and older. Medication and dietary changes have been shown to reduce risk factors for heart disease and stroke, such as high blood pressure and high cholesterol. Other lifestyle changes—including increased physical activity, maintaining healthy weight and cessation of smoking—can also be effective.

Osteoporosis leads to 300,000 hip fractures each year and 50,000 deaths from complications. 50% of fracture victims lost their ability to walk independently. The direct and indirect costs of osteoporosis are estimated to be \$13.8 billion annually.

Only 13% of people ages 65 to 74 engage in vigorous physical activity that promotes cardiorespiratory fitness and prevents osteoporosis. Only 11% engage in strengthening exercises and only 22% engage in

stretching exercises. For those ages 75 older, the rates are 6%, 8%, and 21% respectively. Yet these activities help older adults maintain their functional independence and quality of life.

The incidence of cancer in adults ages 65 and older is approximately 11 times higher than that for persons under 65. Most cancers can be treated and many can be cured if detected early, but cancer screening tests are underutilized by Medicare beneficiaries. In 1998, only 42.7% of older women obtained a Pap smear. One study showed that only 62% of breast cancer survivors over 65 and at risk for recurrence, obtained an annual mammogram.

Good health largely depends on taking responsibility for one's own health. Studies support a role for educational programs that provide relevant information and guidelines to enable medical consumers to determine when professional care is required.

Medicare beneficiaries are entitled to treatment that meets the highest professional standards.

Medicare effectively pays the bills for covered health services, but it is less successful in assuring that older adults and persons with disabilities actually receive the quality health care they need and deserve. Less than optimal health care is extremely costly to Medicare.

Approximately 17,000 individuals aged 65 or older die of influenza or influenza-related pneumonia each year. But in 1997, only 63% of non-institutionalized older adults received the influenza vaccine, and only 43% received the pneumococcal vaccine. For every 10,000 persons over 65 who receive the pneumococcal vaccine, approximately \$1.4 million in health care costs are saved.

On average, older adults use 4.5 prescription medication at the same time and are at higher risk of misuse or drug-drug interactions. Hospitalization from drug reactions or interactions is six times higher for older adults than for the general population.

Aspirin is an effective therapy that can reduce the risk of death and disability from coronary artery disease, including heart attacks and strokes. Yet this inexpensive medication is inadequately used, especially in community settings. General practitioners (11%), family doctors (18%), and internists (20%) are less likely to recommend the use of aspirin than are cardiologists (37%). Aspirin is especially underused in patients over 80 years old, even though this population is likely to receive the greatest benefit.

Early use of a beta-blocker reduces the rates of mortality and rehospitalization after acute myocardial infarction. Yet 51% of older adults who are eligible for such therapy do not receive a beta blocker after a heart attack. In fact, patients at highest risk for death in the hospital were the least likely to receive beta blockers.

Mental illness is not a part of normal aging. Depression affects up to 20% of older adults in the community and up to 37% of older primary care patients, but often goes unrecognized and untreated. Both major and minor depression are associated with high use of health care services and poor quality of life. Untreated, depression can worsen symptoms of other illness, produce disability, and result in suicide. The incidence of suicide is highest in the elderly population. Up to 75% of older suicide victims are seen by their primary care provider in the month prior to suicide, but are not treated or referred for treatment of their depression.

Physicians diagnose only 30% of older adults who have an alcohol problem. The effects of alcohol can be greater in older patients, due to changes in body mass and metabolism. Drinking is linked with falls,

motor vehicle accidents, and is often a factor in suicide and marital violence. Alcohol interacts with many medications and impairs judgment and cognition. The long-term abuse of alcohol increases the risk for high blood pressure, arrhythmias, cardiomyopathy and stroke, as well as certain cancers.

Smoking-related expenditures were 9.4% of Medicare expenditures in 1993 and were estimated to cost Medicare \$20.5 billion in 1997. Cessation of smoking slows the rate of decline of lung function, in addition to reducing the risk of heart disease and stroke.

Improving the health of older adults and persons with disabilities will also improve the health of Medicare.

Improving the health of older adults and persons with disabilities is essential for its own sake, and is also one of the most important ways to improve the health of Medicare, even as enrollment increases.

Chronically disabled adults over 65 have health costs that are seven times those of healthy individuals. Reduction in the rate of chronic disability could maintain the current disabled retiree to worker ratio through 2030, despite a dramatic change in the overall retiree to worker ratio, with potentially immense savings to Medicare.

Savings achieved by improving the health of Medicare beneficiaries outweigh any costs associated with increased longevity.

SUMMARY

Establishes a mission statement for the Health Care Financing Administration, with new emphasis on health promotion and diseases prevention.

Waives cost-sharing for preventive services currently offered by Medicare, such as screening mammography, screening pelvic exam, colorectal screening, bone mass measurement and diabetes self-management training.

Provides an information campaign to promote the use of preventive health services.

Authorizes the development of a health self-assessment tool that includes assessment of mental health.

Promotes the use of best practices for treatment of Medicare beneficiaries.

Establishes a demonstration project for smoking cessation.

Provides demonstration projects to improve the care of residents in skilled nursing facilities and persons with serious illnesses who are not in nursing facilities.

Requests a White House conference on improving the health of older Americans.

The cost of these specific measures is estimated to be \$1.6 billion over 5 years and \$5 billion over 10 years, but these costs are likely to be offset by reductions in Medicare costs as the measures become effective in improving the health of senior citizens.

By Mr. CONRAD (for himself and Mr. SMITH of Oregon):

S. 2729. A bill to amend the Internal Revenue Code of 1986 and the Surface Mining Control and Reclamation Act of 1977 to restore stability and equity to the financing of the United Mine Workers of America Combines Benefit Fund by eliminating the liability of reachback operations, to provide additional sources of revenue to the Fund, and for other purposes; to the Committee on Finance.

COMBINED FUND STABILITY AND FAIRNESS ACT

Mr. CONRAD. Mr. President, I rise to introduce, along with my colleague, Senator GORDON SMITH of Oregon, legislation that we call the Combined Fund Stability and Fairness Act.

The Coal Act of 1992 represents an unbreakable commitment to retired miners, their spouses, and their dependents. But it is clear today that if we do not address the shortcomings of the 1992 Act, we will fall short of keeping that promise.

Simply put, the Combined Benefit Fund needs to be put on a firm financial footing so that the miners and their family members—who depend on the health benefits the Fund provides—can stop worrying about when their benefits might be cut.

The Coal Act of 1992 cast a wide net in identifying companies that would be obligated to pay into the fund. Not only were companies then in the coal mining business included, but the Act also brought in companies that were no longer in the bituminous coal mining business as well as successor companies. Nearly eight years later, we know that Congress overreached.

Two years ago, the Supreme Court in *Eastern Enterprises versus Apfel*, held that the so-called “super reachback” companies should not have been included among Combined Benefit Fund contributors in the first place.

The logic of the Court's decision in *Eastern* appears just as applicable to the reachback companies. They should not have been included either.

The bill the Senator from Oregon and I are introducing today is not a bailout for the reachback companies. In fact, the reachbacks will not receive one penny under this legislation. It provides relief to the reachbacks on a prospective basis only.

There are a limited number of companies that will receive payments under this bill. One group—what we refer to as the “final judgment” companies—are companies in the same situation as *Eastern Enterprises*. However, they had been unsuccessful in litigation decided before the *Eastern* decision, and were barred from recovery by the doctrine of *res judicata*. The other group—the “stranded interim” companies—are companies that were assessed following the enactment of the 1992 Act but were never assigned any beneficiaries.

The total of the refunds to be paid to these two groups of companies amounts to about \$28 million. That is the only money under this bill that would not go retired miners and their dependents.

I think this is a fundamental question of fairness and equity. Those companies ought to be treated the same way as those companies that were relieved of the obligation because of the *Eastern* decision. That is just basic fairness.

To help ensure the solvency of the Combined Benefit Fund into the future, the legislation would extend the Abandoned Mine Reclamation Fee program beyond its current expiration date of 2004 through 2010. The interest earned on the Abandoned Mine Lands Fund would be made available to the Combined Benefit Fund. This is similar to

the approach Congress took with respect to the AML fund in the 1992 Act.

It is important to stress that the AML fees would be lowered substantially from current levels. The rate on surface-mined coal would drop from 35 cents per ton to 20 cents per ton; the rate on underground-mined coal would drop from 15 cents per ton to 5 cents per ton; and the rate on lignite coal would drop from 10 cents per ton to 5 cents per ton.

The legislation also authorizes the transfer of \$38 million in general fund revenues every year to cover any shortfall in the fund.

The combination of the AML Fund interest money, the premium adjustment mechanism, and the annual general fund transfers will ensure that all Combined Benefit Fund obligations will be fully met.

The fundamental purpose of the Combined Fund Stability and Fairness Act is to provide a secure, sound and fair financial foundation for the benefits miners have been promised. It is my hope that Congress will not delay in addressing this issue. Too many people are depending on us.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 2729

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; AMENDMENTS OF 1986 CODE.

(a) **SHORT TITLE.**—This Act may be cited as the “Combined Fund Stability and Fairness Act”.

(b) **AMENDMENT OF 1986 CODE.**—Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

TITLE I—REACHBACK PROVISIONS

SEC. 101. REFORM OF REACHBACK PROVISIONS OF COAL INDUSTRY HEALTH BENEFIT SYSTEM.

(a) **AGREEMENTS COVERED BY HEALTH BENEFIT SYSTEM.**—

(1) **IN GENERAL.**—Section 9701(b)(1) (defining coal wage agreement) is amended to read as follows:

“(1) **COAL AGREEMENTS.**—

“(A) **1988 AGREEMENT.**—The term ‘1988 agreement’ means the collective bargaining agreement between the settlers which became effective on February 1, 1988.

“(B) **COAL WAGE AGREEMENT.**—The term ‘coal wage agreement’ means the 1988 agreement and any predecessor to the 1988 agreement.”

(2) **CONFORMING AMENDMENT.**—Section 9701(b) (relating to agreements) is amended by striking paragraph (3).

(b) **DEFINITIONS APPLICABLE TO OPERATORS.**—

(1) **SIGNATORY OPERATOR.**—Section 9701(c)(1) (defining signatory operator) is amended to read as follows:

“(1) **SIGNATORY OPERATOR.**—The term ‘signatory operator’ means a 1988 agreement operator.”

(2) **1988 AGREEMENT OPERATOR.**—Section 9701(c)(3) (defining 1988 agreement operator) is amended to read as follows:

“(3) **1988 AGREEMENT OPERATOR.**—The term ‘1988 agreement operator’ means—

“(A) an operator which was a signatory to the 1988 agreement, or

“(B) a person in business which, during the term of the 1988 agreement, was a signatory to an agreement (other than the National Coal Mine Construction Agreement or the Coal Haulers’ Agreement) containing pension and health care contribution and benefit provisions which are the same as those contained in the 1988 agreement. Such term shall not include any operator who was assessed, and paid the full amount of, contractual withdrawal liability to the 1950 UMWA Benefit Plan, the 1974 UMWA Benefit Plan, or the Combined Fund.”

(3) **CONFORMING AMENDMENTS.**—

(A) Section 9711(a) is amended by striking “maintained pursuant to a 1978 or subsequent coal wage agreement”.

(B) Section 9711(b)(1) is amended by striking “pursuant to a 1978 or subsequent coal wage agreement”.

(c) **MODIFICATIONS TO REFLECT REACHBACK REFORMS.**—

(1) **BOARD OF TRUSTEES OF COMBINED FUND.**—

(A) **IN GENERAL.**—Section 9702(b)(1) is amended—

(i) by striking “one individual who represents” in subparagraph (A) and inserting “two individuals who represent”;

(ii) by striking subparagraph (B) and redesignating subparagraphs (C) and (D) as subparagraphs (B) and (C), respectively, and

(iii) by striking “(A), (B), and (C)” in subparagraph (C) (as so redesignated) and inserting “(A) and (B)”.

(B) **CONFORMING AMENDMENT.**—Section 9702(b)(3) is amended to read as follows:

“(3) **SPECIAL RULE.**—If the BCOA ceases to exist, any trustee or successor under paragraph (1)(A) shall be designated by the 3 employers who were members of the BCOA on the enactment date and who have been assigned the greatest number of eligible beneficiaries under section 9706.”

(C) **TRANSITION RULE.**—Any trustee serving on the date of the enactment of this Act who was appointed to serve under section 9702(b)(1)(B) of the Internal Revenue Code of 1986 (as in effect before the amendments made by this paragraph) shall continue to serve until a successor is appointed under section 9702(b)(1)(A) of such Code (as in effect after such amendments).

(2) **ASSIGNMENT OF BENEFICIARIES.**—Section 9706 (relating to assignment of eligible beneficiaries) is amended by adding at the end the following:

“(h) **ASSIGNMENT AS OF OCTOBER 1, 2000.**—

“(1) **IN GENERAL.**—Effective October 1, 2000, the Commissioner of Social Security shall—

“(A) revoke all assignments to persons other than 1988 agreement operators for purposes of assessing premiums for periods after September 30, 2000,

“(B) make no further assignments to persons other than 1988 agreement operators, and

“(C) terminate all unpaid liabilities of persons other than 1988 agreement operators with respect to eligible beneficiaries whose assignment to such persons is pending on October 1, 2000.

“(2) **REASSIGNMENT UPON PURCHASE.**—This subsection shall not be construed to prohibit the reassignment under subsection (b)(2) of an eligible beneficiary.”

(3) **LIABILITY FOR 1992 PLAN.**—

(A) **IN GENERAL.**—Section 9712(d) (relating to guarantee of benefits) is amended by striking paragraph (3) and by redesignating

paragraphs (4), (5), and (6) as paragraphs (3), (4), and (5), respectively.

(B) **CONFORMING AMENDMENT.**—Section 9712(d)(3) (as redesignated under subparagraph (A)) is amended by striking “or last signatory operator described in paragraph (3)”.

(C) **EFFECTIVE DATE.**—The amendments made by this paragraph shall apply to premiums assessed for periods after September 30, 2000, except that a person other than a 1988 agreement operator shall not be liable for any unpaid premium under section 9712(d) of the Internal Revenue Code of 1986 as of such date if liability for such premium had not been assessed or was being contested on such date.

TITLE II—FINANCING PROVISIONS

Subtitle A—Premiums

SEC. 201. REDUCTION IN ANNUAL PREMIUMS TO COAL MINERS COMBINED FUND IF SURPLUS EXISTS.

(a) **IN GENERAL.**—Part II of subchapter B of chapter 99 (relating to financing of Combined Benefit Fund) is amended by inserting after section 9704 the following new section:

“SEC. 9704A. REDUCTIONS IN HEALTH BENEFIT PREMIUM IF SURPLUS EXISTS.

“(a) **GENERAL RULE.**—If this section applies to any plan year, the per beneficiary premium used for purposes of computing the health benefit premium under section 9704(b) for the plan year shall be the reduced per beneficiary premium determined under subsection (c).

“(b) **YEARS TO WHICH SECTION APPLIES.**—

“(1) **IN GENERAL.**—This section applies to any plan year beginning after September 30, 2000, if the trustees determine that the Combined Fund has an excess reserve for the plan year.

“(2) **EXCESS RESERVE.**—For purposes of this section—

“(A) **IN GENERAL.**—The term ‘excess reserve’ means, with respect to any plan year, the excess (if any) of—

“(i) the projected net assets as of the close of the test period for the plan year, over

“(ii) the projected 3-month asset reserve as of such time.

“(B) **PROJECTED NET ASSETS.**—For purposes of subparagraph (A)(i), the projected net assets shall be the amount of the net assets which the trustees determine will be available at the end of the test period for projected fund benefits. Such determination shall be made in the same manner used by the Combined Fund to calculate net assets available for projected fund benefits in the Statement of Net Assets (Deficits) Available for Fund Benefits for purposes of the monthly financial statements of the Combined Fund for the plan year beginning October 1, 1999.

“(C) **PROJECTED 3-MONTH ASSET RESERVE.**—For purposes of subparagraph (A)(ii), the projected 3-month asset reserve is an amount equal to 25 percent of the projected expenses (including administrative expenses) from the health benefit premium account and unassigned beneficiaries premium account for the plan year immediately following the test period. The determination of such amount shall be based on the 10-year forecast of the projected net assets and cash balance of the Combined Fund prepared annually by an actuary retained by the Combined Fund.

“(D) **TEST PERIOD.**—For purposes of this section, the term ‘test period’ means, with respect to any plan year, the plan year and the following plan year.

“(c) **REDUCED PER BENEFICIARY PREMIUM.**—For purposes of this section, the reduced per beneficiary premium for any plan year to which this section applies is the per beneficiary premium determined under section 9704(b)(2) without regard to this section, reduced (but not below zero) by—

“(1) the excess reserve for the plan year, divided by

“(2) the total number of eligible beneficiaries which are assigned to assigned operators under section 9706 as of the close of the preceding plan year.

“(d) TERMINATION OF PREMIUM REDUCTION.—If, on any day during a plan year to which this section applies, the Combined Fund has net assets available for projected fund benefits (determined in the same manner as projected net assets under subsection (b)(2)(B)) in an amount less than the projected 3-month asset reserve determined under subsection (b)(2)(C) for the plan year—

“(1) this section shall not apply to months in the plan year beginning after such day, and

“(2) the monthly installment under section 9704(g)(1) for such months shall be equal to the amount which would have been determined if the health benefits premium under section 9704(b) had not been reduced under this section for the plan year.”

(b) CONFORMING AMENDMENTS.—

(1) Section 9704(a) (relating to annual premiums) is amended by striking “Each” and inserting “Subject to section 9704A, each”.

(2) The table of sections for part II of subchapter B of chapter 99 is amended by inserting after the item relating to section 9704 the following new item:

“Sec. 9704A. Reductions in health benefit premium if surplus exists.”

(c) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years of the Combined Fund beginning after September 30, 2000.

SEC. 202. ELECTION TO PREFUND REQUIRED CONTRIBUTIONS.

(a) COMBINED FUND.—Section 9704(g) (relating to payment of premiums) is amended by redesignating paragraph (2) as paragraph (3) and by inserting after paragraph (1) the following:

“(2) ELECTION TO PREFUND.—

“(A) IN GENERAL.—An assigned operator shall be entitled to prefund its obligations to the Combined Fund by depositing into an irrevocable trust dedicated solely to the payment of such obligations an amount which the board of trustees determines, on the basis of reasonable actuarial assumptions, to be equal to the present value of the operator's present and future obligations to the Combined Fund.

“(B) EFFECTS ON LIABILITY.—If an assigned operator prefunds its obligations under this paragraph—

“(i) the assigned operator (and any successor) shall continue to remain liable for such obligations if the amount deposited is insufficient, but

“(ii) any related person to such operator (or successor) shall be relieved of any liability for such obligations.”

(b) 1992 FUND.—Section 9712(d) (relating to guarantee of benefits), as amended by section 101, is amended by adding at the end the following:

“(6) ELECTION TO PREFUND.—

“(A) IN GENERAL.—A 1988 last signatory operator shall be entitled to prefund its obligations to the 1992 UMWA Benefit Plan by depositing into an irrevocable trust dedicated solely to the payment of such obligations an amount which the board of trustees determines, on the basis of reasonable actuarial assumptions, to be equal to the present value of the operator's present and future obligations to such plan.

“(B) EFFECTS ON LIABILITY.—If a 1988 last signatory operator prefunds its obligations under this paragraph—

“(i) the operator (and any successor) shall continue to remain liable for such obligations if the amount deposited is insufficient, but

“(ii) any related person to such operator (or successor) shall be relieved of any liability for such obligations.”

SEC. 203. FIRST YEAR PAYMENTS OF 1988 OPERATORS.

So much of section 9704(i)(1)(D) as precedes clause (ii) is amended to read as follows:

“(D) PREMIUM REDUCTIONS AND REFUNDS.—

“(i) 1st YEAR PAYMENTS.—In the case of a 1988 agreement operator making payments under subparagraph (A)—

“(I) the premium of such operator under subsection (a) shall be reduced by the amount paid under subparagraph (A) by such operator for the plan year beginning February 1, 1993, or

“(II) if the amount so paid exceeds the operator's liability under subsection (a), the excess shall be refunded to the operator.”

Subtitle B—Transfers From Abandoned Mine Reclamation Fund

SEC. 211. TRANSFER OF INTEREST FROM ABANDONED MINE RECLAMATION FUND TO COMBINED FUND.

(a) IN GENERAL.—Section 402(h)(2) of the Surface Mining Control and Reclamation Act of 1977 (30 U.S.C. 1232(h)(2)) is amended to read as follows:

“(2)(A) Except as provided in subparagraph (B), the Secretary shall transfer from the fund to the United Mine Workers of America Combined Benefit Fund established under section 9702 of the Internal Revenue Code of 1986 for any fiscal year the amount of interest which the Secretary estimates will be earned and paid to the fund during the fiscal year.

“(B) The Secretary shall increase the amount transferred under subparagraph (A) for fiscal year 2001 by the excess of—

“(i) the total amount of interest earned and paid to the fund after September 30, 1992, and before October 1, 2000, over

“(ii) the total amount transferred to the Combined Fund under this subsection for fiscal years beginning before October 1, 2000.”

(b) CONFORMING AMENDMENTS.—Section 204(h) of such Act (30 U.S.C. 1232(h)) is amended by striking paragraph (3) and by redesignating paragraph (4) as paragraph (3).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to fiscal years beginning after September 30, 2000.

SEC. 212. MODIFICATIONS OF ABANDONED MINE RECLAMATION FEE PROGRAM.

(a) REDUCTIONS IN RECLAMATION FEES.—Section 402(a) of the Surface Mining Control and Reclamation Act of 1977 (30 U.S.C. 1232(a)) is amended—

(1) by striking “35 cents” and inserting “20 cents”;

(2) by striking “15 cents” and inserting “5 cents”;

(3) by striking “10 cents” and inserting “5 cents”.

(b) EXTENSION OF FEE PROGRAM.—Section 402(b) of such Act (30 U.S.C. 1232(b)) is amended by striking “2004” and inserting “2010”.

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to fiscal years beginning after September 30, 2000.

SEC. 213. USE OF FUNDS TRANSFERRED FROM ABANDONED MINE RECLAMATION FUND.

(a) IN GENERAL.—Section 9705(b)(2) of the Internal Revenue Code of 1986 (relating to use of funds) is amended to read as follows:

“(2) USE OF FUNDS.—The amount transferred under paragraph (1) for any fiscal year shall be used—

“(A) first, to refund to an assigned operator (and any related person to such operator) an amount equal to the sum of—

“(i) any amount paid by such operator or person to the Combined Fund (and not previously refunded) solely by reason of the op-

erator having been a signatory to a pre-1974 coal wage agreement, plus

“(ii) interest on the amount under clause (i) at the overpayment rate established under section 6621 for the period from the payment of such amount to the refund under this subparagraph,

“(B) second, to make any refund required under section 9704(i)(1)(D)(i)(II),

“(C) third, to proportionately reduce the unassigned beneficiary premium under section 9704(a)(3) of each assigned operator for the plan year in which transferred, and

“(D) last, to pay the amount of any other obligation occurring in the Combined Fund.”

(b) EFFECTIVE DATE.—The amendment made by this subsection shall apply to fiscal years beginning after September 30, 2000.

Subtitle C—Authorization

SEC. 221. AUTHORIZATION OF TRANSFER OF FUNDS TO COMBINED BENEFIT FUND.

Section 9705 (relating to transfers to the Combined Benefit Fund) is amended by adding at the end the following:

“(C) AUTHORIZATION OF APPROPRIATIONS.—

“(1) IN GENERAL.—There is authorized to be appropriated \$38,000,000 for each fiscal year beginning after September 30, 2000.

“(2) USE OF FUNDS.—Any amounts transferred to the Combined Fund under paragraph (1) shall be available, without fiscal year limitation, to cover any shortfall in any premium account established under section 9704(e).

“(3) TRANSFERS.—

“(A) IN GENERAL.—The Secretary shall transfer amounts appropriated under paragraph (1) on October 1 of each fiscal year.

“(B) EXCESS AMOUNTS.—If the Secretary, after examining the audit of the Combined Fund by the Comptroller General of the United States, determines that the amount transferred for any fiscal year exceeds the amount required to cover shortfalls for that year, the Secretary shall notify the Committees on Appropriations of the House of Representatives and the Senate and the authorization of appropriations for the first fiscal year after the determination shall be reduced by the amount of the excess.”

SEC. 222. ANNUAL AUDIT.

Section 9702 (relating to establishment of the Combined Fund) is amended by adding at the end the following:

“(d) ANNUAL AUDIT.—

“(1) AUDIT.—The Comptroller General of the United States shall conduct an annual audit of the Combined Fund. Such audit shall include—

“(A) a review of the progress the Combined Fund is making toward a managed care system as required under this subchapter, and

“(B) a review of the use of, and necessity for, amounts transferred to the Combined Fund under section 9705(c).

“(2) REPORT.—The Comptroller General shall report the results of any audit under paragraph (1) to the Secretary of the Treasury and to the appropriate committees of Congress, including its recommendations (if any) as to any administrative savings which may be achieved without reducing the effective level of benefits under section 9703.”

By Mr. FRIST for himself and Mr. KENNEDY:

S. 2731. A bill to amend title III of the Public Health Service Act to enhance the Nation's capacity to address public health threats and emergencies; to the Committee on Health, Education and Pensions.

PUBLIC HEALTH THREATS AND EMERGENCIES
ACT OF 2000

Mr. FRIST. Mr. President, I am pleased today to introduce the “Public

Health Threats and Emergencies Act of 2000" with my colleague, Senator, KENNEDY, to improve our public health infrastructure and to address the growing threats of antimicrobial resistance and bioterrorism.

Over the last two years, we have held three hearings and forums on these topics, and I also commissioned a GAO report on antimicrobial resistance. The outcome of all this research is clear; we need to improve our public health infrastructure to be able to respond in a timely and effective manner to these and other threats.

For too long, we have not provided adequate funding to maintain and improve the core capacities of our nation's public health infrastructure. As the GAO report found, many State and local public health agencies lack even the most basic equipment such as FAX machines or answering machines to assist their workload and improve communications.

We face a myriad of public health threats everyday, and besides improving our core public health capacity, this act aim addresses two problems in particular: antimicrobial resistance and bioterrorism.

Antimicrobial resistance is a pressing public health problem. As a heart and lung transplant surgeon, I know all too well that the most common cause of death after transplantation of a heart or lung is not rejection, but infection. One hundred percent of transplantation patients contract infections following surgery. Infection is the most common complication following surgery, the leading cause for rehospitalization, and the most expensive aspect of treatment post-transplantation. Antibiotics are a mainstay of treatment, yet we are increasingly seeing resistant bacteria which are not killed by most first-line antimicrobials.

In fact, the New England Journal of Medicine has reported that certain Staphylococci, which are a common cause of post-surgical and hospital acquired infections, are showing intermediate resistance to vancomycin, an antibiotic of the last resort. Just recently in mid-April, the FDA approved the first entirely new type antibiotic in 35 years.

How did we reach this point? For most of human history, infections were the scourge of man's existence causing debilitating disease and often death. Antibiotics, when initially discovered more than 50 years ago, were heralded as miracle drugs and quickly became our most lethal weapon in the crusade against disease-causing bacteria. Antibiotics were widely dispensed and, in the 1970's premature optimism lead us to declare the war on infections won.

Unfortunately, we discovered that bacteria are cagey, tenacious organisms that swiftly developed resistance to antibiotics and adapted to drug-rich environments. In addition, the art of medicine evolved, creating new opportunities for bacteria to cause infection

from invasive procedures using catheters to organ transplant recipients who are treated with immunosuppressive agents to prevent rejection. As a result, we are both seeing more invasive, life-threatening infections that require concurrent treatment with several antibiotics to control and infections that were on the decline, such as Tuberculosis, re-emerging in an antimicrobial resistant form.

While infections have plagued man's existence for most of human history, throughout civilization, bioweapons have been strategically deployed during critical military battles. For example, in 1344, the Mongols hurled corpses infected with bubonic plague over the city walls of Caffa (now Feodosia, Ukraine). During World War I, the Germans hoped to gain an advantage by infecting their enemies horses and livestock with anthrax.

Bioterrorism is a significant threat to our country. As a nation we are presently more vulnerable to bioweapons than other more traditional means of warfare. Bioweapons pose considerable challenges that are different from those of standard terrorist devices, including chemical weapons.

The mere term "bioweapon" invokes visions of immense human pain and suffering and mass casualties. Pound for pound, ounce for ounce, bioagents represent one of the most lethal weapons of mass destruction known. Moreover, victims of a covert bioterrorist attack do not necessarily develop symptoms upon exposure to the bioagent. Development of symptoms may be delayed days long after the bioweapon is dispersed.

As a result, exposed individuals will most likely show up in emergency rooms, physician offices, or clinics, with nondescript symptoms or ones that mimic the common cold or flu. In all likelihood, physicians and other health care providers will not attribute these symptoms to a bioweapon. If the bioagent is communicable, such as small pox, many more people may be infected in the interim, including our health care workers. As Stephanie Bailey, the Director of Health for Metropolitan Nashville and Davidson County pointed out in our hearing on bioterrorism, "many localities are on their own for the first 24 to 48 hours after an attack before Federal assistance can arrive and be operational. This is the critical time for preventing mass casualties."

If experts are correct in their belief that a major bioterrorist attack is a virtual certainty, that it is no longer a question of "if" but rather "when." In fact, my home town of Nashville last year joined an ever-increasing number of cities to receive and respond to a package that was suspected of containing anthrax. Thankfully, this was a hoax.

To address these concerns about our public health infrastructure and improve our preparedness for the threats of antimicrobial resistance and bioter-

rorism, I have joined with Senator KENNEDY to provide greater resources and coordination to address these issues.

The Public Health Threats and Emergencies Act, which we introduce today, will provide needed guidance, resources, and coordination to increase the core capacities of the nation's public health infrastructure. This Act will also improve the coordination and increase the resources available to address the threats of bioterrorism and antimicrobial resistance.

Strengthening capacities to ensure that the public health infrastructure is adequate to respond to carry out core functions and respond to emerging threats and emergencies, the Public Health Threats and Emergencies Act authorizes: the establishment of voluntary performance goals for public health systems; grants to public health agencies to conduct assessments and build core capacities to achieve these goals; and funding to rebuild and remodel the facilities of the Center for Disease Control and Prevention.

To strengthen public health capacities to combat antimicrobial resistance, the Act authorizes: a task force to coordinate Federal programs related to antimicrobial resistance and to improve public education on antimicrobial resistance; the National Institutes of Health (NIH) to support research into the development of new therapeutics against and improved diagnostics for resistant pathogens; and grants for activities to improve specific capacities to detect, monitor, and combat antimicrobial resistance.

To strengthen public health capacities to prevent and respond to bioterrorism, the Act authorizes: two interdepartmental task forces to address joint issues of research needs and the public health and medical consequences of bioterrorism; NIH and CDC research on the epidemiology of bioweapons and the development of new vaccines or therapeutics for bioweapons; and grants to public health agencies and hospitals and care facilities to detect, diagnose, and respond to bioterrorism.

Mr. President, this Act is necessary. We must take steps now to improve our basic capacities to address all public health threats, including antimicrobial resistance and bioterrorism. I am hopeful this legislation provides State and local public health agencies the resources to improve their abilities so that we better protect the health and well-being of our Nation's citizens.

I want to thank Senator KENNEDY for joining me in this effort and for the work of his staff. I would also like to thank Dr. Stephanie Bailey, the Director of Health for Metropolitan Nashville and Davidson County for her assistance and input on this important piece of legislation.

Mr. KENNEDY. Mr. President, several months ago, my distinguished colleague, Senator BILL FRIST, and I began to develop legislation needed to enhance the nation's protections

against the triple threat to health posed by new and resurgent infectious diseases, by "superbugs" resistant to antibiotics, and by terrorist attacks with biological weapons. Today, Senator FRIST and I are introducing the Public Health Threats and Emergencies Act of 2000. I commend Senator FRIST for his leadership and commitment on this important legislation.

The bill that we are introducing today will provide the nation with additional weapons to win the battle against the deadly perils of infectious disease, antimicrobial resistance and bioterrorism. The Public Health Threats and Emergencies Act of 2000 will revitalize the nation's ability to monitor and fight outbreaks of infectious disease, control the spread of germs resistant to antibiotics, and protect the nation more effectively against bioterrorism.

Today we face a world where deadly contagious diseases that erupt in one part of the world can be transported across the globe with the speed of a jet aircraft. The recent outbreak of West Nile Fever in the New York area is an ominous warning of future dangers. Diseases such as cholera, typhoid and pneumonia that we have fought for generations still claim millions of lives across the world and will pose increasing dangers to this country in years to come. New plagues like Ebola virus, Lassa Fever and others now unknown to science may one day invade our shores.

Less exotic, but also deadly, are the simpler infections that for almost a century we have been able to treat with antibiotics, but that are now becoming resistant even to our most advanced medicines. Drugs that once had the power to cure dangerous infections are now often useless—because "superbugs" have now become resistant to all but the most powerful and expensive medications. Strains of tuberculosis that are resistant to antimicrobial drugs are prevalent around the world, and are a growing danger in our inner cities and among the homeless. If action is not urgently taken, we may soon return to the days when a simple case of food poisoning could prove deadly and a mere cut could become severely infected and cost a limb.

The growing financial burden of antimicrobial resistance on the health care system is staggering. Treating a patient with TB usually costs \$12,000. But when a patient has drug-resistant TB, that figure soars to \$180,000. The National Foundation for Infectious Diseases estimates that the total cost of antimicrobial resistance to the U.S. health care system is as high as \$4 billion every year—and this figure will only rise as resistant infections become more common.

But the most potentially deadly of these threats is bioterrorism. We are a nation at risk. Biological weapons are the massive new threats of the twenty-first century. The Office of Emergency Preparedness estimates that 40 million

Americans could die if a terrorist released smallpox into the American population. Anthrax could kill 10 million. Other deadly pathogens known to have been developed in biological warfare labs around the world could kill millions.

Our proposal will strengthen the nation's public health agencies, which provide the first line of defense against bioterrorism and many other threats to the public health. Our legislation authorizes the Secretary of Health and Human Services to respond swiftly and effectively to a public health emergency, and provides the Secretary with needed resources to mount a strong defense against whatever danger imperils the nation's health.

The bill calls upon the Secretary of Health and Human Services to establish a national monitoring plan for dangerous infections resistant to antibiotics, and to work closely with state and local public health agencies to ensure that this peril is contained.

It is also essential to educate patients and medical providers in the appropriate use of antibiotics. Too often, patients demand antibiotics and doctors provide them for illnesses which do not require and do not respond to these drugs. Our legislation calls upon the federal government to lead a national campaign to educate patients and health providers in the appropriate use of antibiotics.

The threat of bioterrorism demands particular attention, because of its potential for massive death and destruction. Currently, dozens of federal agencies share responsibility for domestic preparedness against bioterrorist attacks. This bill will enhance the nation's preparedness by improving coordination among federal agencies responsible for all aspects of a bioterrorist attack. Better coordination will allow us to develop the public health countermeasures needed to defend against bioterrorism, such as stockpiles of essential supplies and effective disaster planning.

Since the infectious organisms likely to be used in a bioterrorist attack are rarely encountered in normal medical practice, many doctors or laboratory specialists are likely to be unable to diagnose persons with these diseases rapidly and accurately. Recognizing a bioterrorist attack quickly is a major part of containing it. This bill will improve the preparedness of public health institutions, health providers, and emergency personnel to detect, diagnose, and respond to bioterrorist attacks through improved training and public education.

One of the highest duties of Congress is to protect the nation against all threats, foreign and domestic. Deadly infectious diseases, new "superbugs" resistant to antibiotics, and bioterrorism clearly menace the nation. We must resist these threats as vigorously as we would fight an invading army. The Frist-Kennedy bill is intended to provide the weapons we need to win this battle.

ADDITIONAL COSPONSORS

S. 663

At the request of Mr. SPECTER, the name of the Senator from Virginia (Mr. WARNER) was added as a cosponsor of S. 663, a bill to impose certain limitations on the receipt of out-of-State municipal solid waste, to authorize State and local controls over the flow of municipal solid waste, and for other purposes.

S. 872

At the request of Mr. VOINOVICH, the name of the Senator from Virginia (Mr. WARNER) was added as a cosponsor of S. 872, a bill to impose certain limits on the receipt of out-of-State municipal solid waste, to authorize State and local controls over the flow of municipal solid waste, and for other purposes.

S. 901

At the request of Mr. BINGAMAN, the name of the Senator from California (Mrs. FEINSTEIN) was added as a cosponsor of S. 901, a bill to provide disadvantaged children with access to dental services.

S. 1128

At the request of Mrs. MURRAY, her name was added as a cosponsor of S. 1128, a bill to amend the Internal Revenue Code of 1986 to repeal the Federal estate and gift taxes and the tax on generation-skipping transfers, to provide for a carryover basis at death, and to establish a partial capital gains exclusion for inherited assets.

At the request of Mr. KYL, the name of the Senator from Mississippi (Mr. COCHRAN) was added as a cosponsor of S. 1128, supra.

S. 1487

At the request of Mr. AKAKA, the name of the Senator from Nebraska (Mr. HAGEL) was added as a cosponsor of S. 1487, a bill to provide for excellence in economic education, and for other purposes.

S. 1522

At the request of Mr. AKAKA, the name of the Senator from New Hampshire (Mr. SMITH) was added as a cosponsor of S. 1522, a bill to amend the Animal Welfare Act to ensure that all dogs and cats used by research facilities are obtained legally.

S. 2084

At the request of Mr. LUGAR, the name of the Senator from Michigan (Mr. ABRAHAM) was added as a cosponsor of S. 2084, a bill to amend the Internal Revenue Code of 1986 to increase the amount of the charitable deduction allowable for contributions of food inventory, and for other purposes.

S. 2123

At the request of Ms. LANDRIEU, the name of the Senator from Connecticut (Mr. DODD) was added as a cosponsor of S. 2123, a bill to provide Outer Continental Shelf Impact assistance to State and local governments, to amend the Land and Water Conservation Fund Act of 1965, the Urban Park and Recreation Recovery Act of 1978, and the