agents. As of April 2008, there are 72 select agents, meaning the agents pose a severe threat to public or animal health and safety. Thirteen of these agents are found naturally in the United States. There are 325 entities and 9,918 individuals registered with the CDC to work with select agents and toxins, and 75 entities and 4,336 individuals registered with APHIS.

We take four key actions in S. 3127 to strengthen the Select Agent Program.

First, our legislation reauthorizes the program through 2013 and calls for a comprehensive evaluation of the program. The review, to be conducted by the National Academy of Sciences, will look at the effects of the program on international scientific collaboration and domestic scientific advances. Historically, the United States has been an international leader in biosecurity. In fact, Canada recently proposed legislation to tighten safety and access to pathogens and toxins of concern for bioterrorism. Canada's new legislation, released in April 2008, would establish a mandatory licensing system to track human pathogens, similar to our Select Agent Program. It also ensures compliance with the country's Laboratory Biosafety Guidelines across the country.

Second, the bill ensures a comprehensive list of select agents. Currently, CDC and APHIS develop a list of agents and toxins to which the program regulations apply. However, we believe some additional factors should be considered in revising the list. For example, scientific developments now make it possible to create agents from scratch or to modify them and make them more deadly. Highly infectious viruses or bacteria that are otherwise difficult to obtain can now be created by scientists using ''synthetic genomics''. In addition, we now have more information from the Department of Homeland Security, DHS, about the threat posed by certain bioterrorism agents.

In 2002, U.S. researchers assembled the first synthetic virus using the genome sequence for polio. Later, in 2005 scientists reconstructed the 1918 pandemic influenza virus. Then in January 2008, a ''safe'' form of Ebola was created synthetically. While this ''safe'' Ebola can be used for legitimate research to develop drugs and vaccines to protect against it, a scientist could also change it back to its lethal form. Also, earlier this year, advancements in technology yielded the first synthetic bacterial genome.

We must consider these scientific advances, including genetically modified organisms and agents created synthetically, if we are to address all agents of concern. In addition, DHS's recent biological risk assessments provide new information for our assessment of biological threats. This information should also be considered when determining which agents and toxins should be regulated.

Next, the bill encourages sharing information with State officials to enable more effective emergency State planning. State health officials are currently not made aware of which agents are being studied within their State. This leaves medical responders, public health personnel, and animal health officials unprepared for a potential release, whether accidental or intentional.

Lastly, S. 3127 clarifies the statutory definition of smallpox. The Intelligence and Terrorism Prevention Act of 2004 criminalized the use of variola virus, the agent that causes smallpox. The statutory definition of the virus includes agents that are 85 percent identical to the causative strain. Researchers are worried this could be interpreted to also include the strain used to develop the smallpox vaccine, as well as less harmful naturally occurring viruses. This sort of ambiguity could be detrimental to necessary medical countermeasure research and development. Our bill requires the Attorney General to issue guidance clarifying the interpretation of this definition.

In addition, in this legislation we take three key actions to evaluate and enhance the safety and oversight of high containment laboratories.

First, our bill evaluates existing oversight of BSL 3 and 4, or high containment, labs. The bill requires an assessment of whether current guidance on infrastructure, commissioning, operation, and maintenance of these labs is adequate. As I mentioned, the number of these labs is increasing around the globe. As these new facilities age, we need to make sure they are appropriately maintained. It is essential that laboratory workers and the public know these facilities are as safe as possible. If the guidance we currently have in place is not adequate, then we need to know how to improve it.

Second, the bill improves training for laboratory workers. As the number of laboratories and personnel increases, we must ensure workers are appropriately trained and lab accidents to not increase. Accidents and injuries in the lab, such as chemical burns and flask explosions, may result from improper use of equipment. Our bill develops a set of minimum standards for training laboratory personnel in biosafety and biosecurity, and encourages HHS and USDA to disseminate these training standards for voluntary use in other countries.

Finally, the bill establishes a voluntary Biological Laboratory Incident Reporting System. This system will encourage personnel to report biosafety and biosecurity incidents of concern and thereby allow us to learn from one another. Similar to the Aviation Safety Reporting System, which gathers information on aviation accidents, this system will help identify trends in biosafety and biosecurity incidents of concern and develop new protocols for safety and security improvements. Lab exposures to pathogens not on the select agent list will also be captured through this type of voluntary reporting system.

In closing, I encourage my Senate colleagues to join Senator KENNEDY and me as we work to improve our Nation's biosecurity and biosafety systems by passing S. 3127, the Select Agent and Biosafety Improvement Act of 2008. I thank the many researchers, scientists, and State health officials from across the country who shared with me and my staff their ideas, experiences, and recommendations. In this time of exciting scientific advances, we must ensure our laws and prevention programs are updated to reflect current conditions. In addition, we must remain vigilant in our efforts to protect the American people from bioterrorism. The Select Agent Program is an important part of ensuring the Nation's safety and security and I look forward to working with my colleagues to reauthorize and improve the program.

HEALTH CARE

Mr. LAUTENBERG. Mr. President, I ask unanimous consent to have printed in the RECORD a letter dated May 15, 2008, to Majority Leader REID, Speaker PELOSI, Minority Leader MCCONNELL and Minority Leader BOEHNER.

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

MAY 15, 2008.

Hon. HARRY REID,
U.S. Senate,
Washington, DC.
Hon. NANCY PELOSI,
House of Representatives,
Washington, DC.
Hon. MITCH MCCONNELL,
U.S. Senate,
Washington, DC.
Hon. JOHN BOEHNER,
House of Representatives,
Washington, DC.

DEAR MAJORITY LEADER REID, SPEAKER PELOSI, MINORITY LEADER MCCONNELL AND MINORITY LEADER BOEHNER: As representatives of non-partisan organizations committed to improving health care for all children, we are writing to share our deep concern regarding the impact of the directive to states that was issued by the HHS Centers for Medicare and Medicaid Services (CMS) on August 17, 2007. In particular, we are concerned that scores of children who are currently enrolled in the State Children's Health Insurance Program (SCHIP) will lose coverage as a result of this policy change. Unfortunately, the letter CMS sent to states on May 7, 2008, which seeks to clarify the directive's requirements, does not change the policy outlined in the August 17 directive and, sadly, does nothing to mitigate its impact. States still must overcome serious hurdles before they can provide SCHIP coverage to uninsured children in working families and children—even those who lose a parent or whose parents become unemployed—will be subject to a one-year waiting period before they will be eligible for coverage under SCHIP. We urge Congress to enact legislation that would impose a moratorium on the implementation of this directive.

As organizations committed to ensuring that all of our nation's children have access to affordable health care coverage, we strongly believe that no child in America

who is currently covered under SCHIP or Medicaid should lose their health coverage or access to care as a result of this administrative directive. We share your commitment to ensuring that federal health coverage programs make our nation's lowest income children the foremost priority, however, the CMS directive runs directly contrary to our common goal of covering America's poorest children first. The August 17 directive already is jeopardizing access to health care for low-income children in at least 23 states. Moreover, recent reports by the Government Accountability Office (GAO) and the Congressional Research Service (CRS) affirm that the directive goes beyond what is permissible under current law. Unfortunately, CMS' May 7, 2008 letter to states did not address these serious concerns. In light of the directive's impact on state efforts to provide coverage for uninsured children and the recent GAO and CRS findings, we urge the House and Senate to take immediate action to halt the implementation of the August 17 directive and restore states' ability to determine how best to cover their children.

With more than nine million American children lacking any form of health insurance and nearly two-thirds of that number already eligible for Medicaid or SCHIP, we must do all we can to reduce coverage barriers, not add additional ones. This directive already is having a chilling effect on states, stalling efforts in several states that were poised to enact policy changes to improve coverage of uninsured children. Halting the implementation of this directive is essential if we are to tackle the coverage crisis facing our nation's most vulnerable children. No child in America should lose their health coverage as a result of philosophical differences in Washington, D.C. Our nation must do better for our children.

We know you agree that our children are our nation's most precious resource and that investments in health care for kids reap benefits that last a lifetime. We welcome the opportunity to discuss these issues with you and to work with you to be sure that all of our nation's children have access to the health care services and coverage they need.

Sincerely,

First Focus; American Association of School Administrators; LEAnet; National Association of Community Health Centers; PICO National Network; The 2010 Cover All Kids Initiative; AARP; Action for Children North Carolina; Alliance for Excellent Education; American Academy of HIV Medicine; American Academy of Nursing; American Academy of Pediatrics; American Academy of Pediatrics, Pennsylvania Chapter; American Academy of Pediatrics Utah; and American Association of People with Disabilities.

American College of Obstetricians and Gynecologists; American Dental Education Association; American Humane Association; American Medical Women's Association; American Music Therapy Association; American Network of Community Options and Resources, ANCOR; American Nurses Association; American Psychiatric Association; American Public Health Association; Anchorage School District, AK; Anchorage's Promise, AK; Association for Community Affiliated Plans; Association of Clinicians for the Underserved, ACU; Association of Women's Health, Obstetric & Neonatal Nurses, AWHONN; and Autism Society of America.

Bayonne Jewish Community Center, NJ; Bayonne YMCA, NJ; Bazelon Center for Mental Health Law; Bedford Youth & Family Services, MA; The Black Children's Institute of Tennessee; California State Association of Counties; Catholic Charities of the Archdiocese of Newark; Catholic Charities USA; Catholic Healthcare West; Center for Public Policy Priorities, TX; Center for Medicare Advocacy, Inc.; Child and Adolescent Health Measurement Initiative; Child and Family Policy Center, Des Moines, IA; Children and Adults with Attention Deficit/Hyper Activity Disorder; and Child Welfare League of America.

Children First for Oregon; Children Now, Sacramento/Oakland, CA; Children's Aid Society; Children's Dental Health Project; The Children's Health Fund; The Children's Partnership; Clinical Social Work Association; Colorado Children's Campaign, Denver, CO; Colorado Community Health Network; Colorado Organization on Adolescent Pregnancy, Parenting, and Prevention; Community Action Partnership; Community Health Care Association of New York State; Connecticut Association for Human Services; Connecticut Legal Services, Inc.; and Consumer Health Coalition.

Corona-Norco United Way, CA; County Commissioners' Association of Ohio; County Commissioners Association of Pennsylvania; County Welfare Directors Association of California; Cystic Fibrosis Foundation; DePelchin Children's Center, Houston, TX; Disability Rights Education and Defense Fund; Easter Seals; Educational Arts Team; Families USA; Family Voices; Family Voices-NJ; FAMIS Outreach Project, Radford, VA; FRESC: Good Jobs Strong Communities; and Greater Hartford Legal Aid, Inc., CT.

Healthy York Network, York, PA; Health Care For All Massachusetts; HIV Medicine Association; Hudson Perinatal Consortium, Inc., Jersey City, NJ; Immunization Action Coalition; Indiana Primary Health Care Association; Intermoutain Pediatric Society; Iowa/Nebraska Primary Care Association; Jersey City Library Literacy Program; Legal Assistance Resource Center of CT; Legislative Coalition for People with Disabilities (Utah); Maine Children's Alliance; Maryland Women's Coalition for Health Care Reform; Maternal and Child Health Access, Los Angeles, CA; and Maternity Care Coalition, Philadelphia, PA.

Mental Health America; Medicaid Health Plans of America; Mental Health/Mental Retardation Program Administrators of Pennsylvania; Methodist Healthcare Ministries, San Antonio, TX; Miami-Dade County; Michigan County Social Services Association; Michigan's Children; Montview Boulevard Presbyterian Church Health Care Task Force, Denver, CO; Mountain Youth Resources; National Association for the Education of Young Children; National Association of Children's Hospitals; National Association of Counties; National Association of County Behavioral Health and Developmental Disability Directors; National Association of County Human Services Administrators; and National Association of Pediatric Nurse Practitioners.

National Association of School Psychologists; National Association of Social Workers; National Association of State Directors of Special Education; National Council for Community Behavioral Healthcare; National Council of Jewish Women; National Council of Urban Indian Health; National Down Syndrome Congress; National Federation of Families for Children's Mental Health; National Health Law Program, NHeLP; National Hispanic Health Foundation; National Hispanic Medical Association; National Partnership for Women & Families; National Women's Law Center; New Haven Legal Assistance Association; and New Mexico Alliance for School-Based Health Care.

New Mexico Voices for Children; NH Healthy Kids Corp; Organization of Chinese Americans, OCA; Ohio Child Support Enforcement Agency Directors' Association; Ohio Job and Family Services Directors' Association; OPTIONS for Independence; Oregon Action; Pennsylvania Association of County Human Services Administrators; Pennsylvania Partnerships for Children; Prevent Blindness America; Public Children Services Association of Ohio; Public Health-Seattle & King County, WA; Rhode Island KIDS COUNT; Rural Health Association of Tennessee; and Salt Lake County Mayor.

Salt Lake Community Action Program; Sargent Shriver National Center on Poverty Law; SC Appleseed Legal Justice Center, Columbia, SC; Service Employees International Union; Southeastern Network of Youth and Family Services, Bonita Springs, FL; Statewide Parent Advocacy Network of New Jersey; Tennessee Commission on Children and Youth; Tennessee Health Care Campaign; Tennessee Justice Center; Tennessee Primary Care Association; Texas Association of Public and Nonprofit Hospitals; Texas Network of Youth Services; The Arc of the United States; The Arc of Utah; and TII CANN—Title II Community AIDS National Network.

United Cerebral Palsy; United Neighborhood Health Services, Inc.; United Spinal Association; United Way of America; United Ways of California; United Way of Greater High Point; United Way of Hudson County; United Ways of Louisiana; United Way of Pennsylvania; United Ways of Texas; Utah Covering Kids & Families Coalition; Visiting Homemaker Services of Hudson County; Voices for America's Children; Voices for Children, NE; Voices for Ohio's Children; Voices for Utah Children; Washington Health Foundation; and Washington Physicians for Social Responsibility.

MACKINAC ISLAND STATE PARK

Mr. LEVIN. Mr. President, I am pleased that the Senate is acting on the House Concurrent Resolution, H. Con. Res. 325, which was introduced by Congressman STUPAK and recognizes the celebration of the 50th anniversary of the Mackinac Island State Park Commission's Historical Preservation and Museum Program. This anniversary, which will take place on June 15, 2008, honors the work of the Commission to protect, preserve, and communicate the rich history and natural wonders of Mackinac Island.

Located in the heart of the Great Lakes, between Michigan's Upper and Lower Peninsulas, Mackinac Island is an important part of this Nation's history. In colonial years, the island provided strategic fur-trading posts for French, British, and American settlements. During the Civil War, Britain's Fort Mackinac was established on this island and the fort was also used during the War of 1812. In 1817, the village of Mackinac was incorporated and served as the seat for the territorial county of Michilimackinac, which covered much of what is now Michigan. It also functioned as the seat of Mackinac County from 1849 through 1882. The island was considered a sacred place to Native Americans and functioned as a tribal gathering place and burial site. Today, the island is a popular tourism destination where people can relax, enjoy nature, and learn about history.

Since its inception in 1895, the Mackinac Island State Park Commission has been actively engaged in a variety of