Clearly, a solution is needed. For years, I have expressed my strong desire and commitment to find one. As I have said repeatedly, there is a way for us to craft legislation that could enjoy the overwhelming support of the Senate, if we put partisan differences aside and develop a true compromise that adequately compensates victims and provides financial certainty to companies and insurers.

Creating a national asbestos trust fund is an extraordinarily complex undertaking. There are a number of issues that all sides agree must be addressed: The creation of a no-fault administrative system; the equitable allocation of contributions; the establishment of reasonable medical standards; the resolution of pending claims and settlements; the creation of fair compensation values; and ensuring transparency of the system for both victims and corporate stakeholders.

Last July, the Judiciary Committee narrowly reported out a bill that was opposed by the American Insurance Association and the AFL–CIO. Since that time, there has been much work invested to try to develop a compromise and bridge the differences between the stakeholders. However, while much progress has been made, there are still several vital issues that have yet to be resolved.

During the committee markup, a compromise was reached on one of the major issues, medical criteria. Then, in the past few weeks, a compromise was reached on creation of the administrative structure within the Department of Labor. Yesterday, a new asbestos bill was introduced. This legislation incorporated some of the agreed upon compromises, and included some improvements.

However, it also takes a step backward in other areas. The new legislation dramatically altered or dropped altogether several of the key committee-adopted amendments. For example, the new bill restricts the amendment that would have restored current legal rights to victims if the fund runs out of money, adding new obstacles to access to the courts.

In addition, the new legislation failed to improve provisions that could limit recovery to only $25,000 for lung cancer patients who were exposed to asbestos at work for at least 15 years. That is in the bill. The so-called FAIR bill actually has a provision that says victims with asbestos-related lung cancer and 15 weighted years of asbestos exposure would receive only $25,000 in compensation. I literally cannot imagine how anybody could support legislation that says that is all they are entitled to. Fifteen years of weighted asbestos exposure, you have cancer, there is a connection, and your award under this bill is $25,000?

Finally, it puts the overall funding at $109 billion. Some Republicans argue investment income would boost that up to $114 billion, but this is far from certain. Even $114 billion is grossly inadequate.

Clearly, there are several fundamental areas that have not been resolved. These issues are not new. In fact, before, during, and after the committee markup, Democrats have raised some of these same concerns. For over 6 months we have been clear that $114 billion is insufficient. While we recognize that Republicans are reluctant to accept the committee-supported bill of $154 billion, we have expressed our willingness to work out a compromise.

Time is short. The majority leader has stated his interest to bring the bill to the floor immediately following the April recess. We can and should develop a solution.

But let me be clear: Securing a bipartisan compromise on asbestos is one of our top priorities. I stand ready and willing to work with my colleagues to address this important issue. But we will not support and we will do all we can to avoid passing legislation that is not fair, that does not address the problem, that will only compound the problems of those who are victims today.

I continue to believe that if we work together, we can develop effective reform legislation to provide appropriate compensation to the victims of asbestos, while providing a measure of certainty and security to American industry.

If, however, the Senate proceeds with legislation that does not reflect the middle ground, as I have said, we will have missed an opportunity to address this vital issue. I think we could all agree the stakes are too high to let it slip away.

Madam President, how much of my leader time remains?

The PRESIDING OFFICER. The Senator has used 9 minutes.

Mr. DASCHLE. Madam President, I have another matter I would like to address in the time I have remaining of my leader time, if I could.

NATIONAL PUBLIC HEALTH WEEK

Mr. DASCHLE. Madam President, I recently learned the story of a young Indian girl from South Dakota. Last year, when she began to lose weight and feel stomach pains, she traveled to a nearby Indian Health Service clinic. She was diagnosed with heartburn, and since IHS clinics often don't have the resources to treat patients unless their lives are at immediate risk, she was told to go home.

Over the course of the next several months, as her condition worsened, she returned to the clinic several times only to be turned away each time. Because she was never given a full checkup, the clinic failed to discover that her symptoms were not caused by heartburn but by stomach cancer. By the time her condition became critical, it was too late. Her cancer had spread, and there was nothing any doctor could do. Not long afterward, she died.

Perhaps the saddest aspect of this story is that it is another example of what happens each and every day. For Native Americans and other minority communities across the country, the miracles of modern medicine—and sometimes even the most basic primary care—are beyond their reach. The disparities within our health care system have reached a crisis point, and the consequences for America's minority communities are staggering.

The death rate for African American cancer patients is 30 percent higher than for whites. African Americans are also one-and-a-half times more likely to have coverage for an emergency room visit denied. Hispanic Americans are more than twice as likely as whites to die from diabetes. American Indiana are 670 percent more likely to die from alcoholism and 650 percent more likely to die from tuberculosis.

This sad litany of statistics goes on and on and it tells a story of a health care system that, for a significant and growing portion of our Nation, is simply broken.

This week is National Public Health Week. Appropriately, the American Public Health Association has chosen to focus the Nation's attention this week on the disparities in our health care system and how we can fix them.

I am grateful for its efforts. America faces few more important or complex challenges than building a world-class health care system for everyone, regardless of race, income, or geography. There are no quick fixes. The factors that have led to this two-tiered health system are complex and interrelated.

Minorities are far less likely to have health insurance or a family doctor, making regular preventive visits less likely. And many of those who do have insurance report having little or no choice in where they seek care. Minority communities are more frequently exposed to environmental risks, such as polluted industrial areas, cheap older housing with lead paint, or asbestos-laden water pipes.

For Hispanics, Native Americans, and others who do not speak English as a first language, the lack of translators and bilingual doctors makes it more difficult to communicate with doctors and nurses. The American Indian community has been forced to cope with a system suffering from decades of neglect and underfunding of the Indian Health Service.

The IHS has consistently grown at a far slower rate than the rest of the HHS budget, and at only a fraction of health care inflation. As a result, sick people are turned away every day from IHS hospitals and clinics in this country unless they are in immediate danger of losing their life or a limb.

Life or limb isn't a figure of speech at IHS clinics. It's an actual standard of care. IHS's funding crisis is not just in clinical services. Prevention efforts, facilities, personnel, mental health care, substance abuse programs, and contract support costs are all drastically underfunded, too.

I have said this on the floor many times. Our country spends an average

of $5,100 for every man, woman, and child in America. In every Federal prison, we spend an average of $3,800 for every prisoner. On every Indian reservation, we will spend $1,900 total for every man, woman, and child, one half of what we spend for Federal prisoners. So it is no wonder that people die at a rate hundreds of times greater on the reservation than they do anywhere else.

America is obligated, by law and by treaty, to provide free health care for American Indians—a commitment the U.S. Government made to the Indian people in exchange for their lands. America is not honoring that commitment.

The White House's budget this year included only $2.1 billion for IHS clinical services. That is more than 60 percent below the bare minimum needed to provide basic health care for people already in the IHS system.

The problems run still deeper. Even when both groups have roughly the same insurance coverage, the same income, the same age and the same health conditions, minorities receive less aggressive and less effective care than white Americans.

The racial and ethnic disparities in our health care system are not merely a minority issue or a health care issue. The high incidence of diabetes, asthma and other diseases among minorities as a result of this health care gap costs our Nation billions of dollars every year.

But most importantly it is a moral issue. A health care system that provides lesser treatment for minorities offends every American principle of justice and equality. We have been promised that we would address these issues at some point in the future, but we have seen no action whatsoever. We have attempted to pass the Healthcare Equality and Accountability Act of 2003, and no action has yet been taken.

This legislation would reduce health disparities and improve the quality of care for racial and ethnic minorities. The bill would expand health coverage by expanding eligibility and streamlining enrollment in Medicaid and the State Children's Health Insurance Program; it would remove language and cultural barriers by providing additional funding for cultural and language services; it would offer incentives to improve health workforce diversity; it would offer new funding to State, local, and tribal initiatives that take innovative approaches to reducing the disparities; and it would increase minority health research and data collection.

The bill would also strengthen and hold accountable the government institutions responsible for ensuring health care equity. And finally, the bill would provide adequate funding for the Indian Health Service—so that we can finally reach some adequate funding level and stop the shameful underfunding of Indian health needs.

This legislation would represent a strong first step, moving us closer to the goal of ensuring equal access to quality health care.

Last year, the majority leader said:

Inequity is a cancer that can no longer be allowed to fester in health care.

I agree completely. We know what happens when cancer is allowed to spread.

Too many Americans in minority communities have lost their lives because they are subjected to a two-tiered health care system that keeps them from getting the care they need. We cannot afford to wait any longer to confront the minority health gap in our country. Americans are asking for our leadership on a challenge that is quickly becoming a national emergency. We have an obligation to answer their call.

I yield the floor.

MEDICAL MALPRACTICE CLOTURE VOTE

Mr. BYRD. Mr. President, yesterday, for the third time in this Congress, the Senate failed to invoke cloture on the motion to proceed to a one-sided, take-it-or-leave-it medical malpractice bill.

Last year, the majority leader tried to bring up a comprehensive bill. The Senate did not invoke cloture. Rather than sit down with the other side to craft a reasonable bill that could be brought up, debated, and amended, the majority leader took the same flawed bill, applied it to only one sector of the health industry, and attempted to bring it up again, just a few weeks ago.

At that time, I voted for cloture, not because I agreed with the underlying legislation, but because I had hoped for a legitimate debate, a serious look at the issues that are part of the growing medical malpractice crisis. I recognize that there are serious problems with medical malpractice in this country, and specifically with the availability of OB/GYN services in my home State of West Virginia. I voted to end debate on the motion to proceed to that bill. But, again, cloture was not invoked.

After two unsuccessful cloture votes, one would think that, if they truly wanted to pass legislation on this important issue, the Republican leadership would sit down with their Democratic colleagues and negotiate a bill that was less partisan. But there has been no such effort. Instead, the majority continues to add physician groups here and there, trying to rack up more political points. This is not a serious effort to address a real challenge. This series of votes is not designed to advance legislation. Instead, this is choreographed political theater, played for the benefit of core supporters of the Republican party. This is not a successful strategy for advancing legislation, or for solving serious problems facing our Nation, and I can not lend my support to this charade.

I do hope that the Senate can reach a consensus on this issue. Doctors and, most importantly, patients need stability in this system and the peace of mind that comes with a reliable, high-quality health care system.

CONCLUSION OF MORNING BUSINESS

The PRESIDING OFFICER (Mr. CHAMBLISS). Morning business is now closed.

PENSION FUNDING EQUITY ACT OF 2004—CONFERENCE REPORT

The PRESIDING OFFICER. Under the previous order, the Senate will proceed to the consideration of the conference report to accompany H.R. 3108, which the clerk will report.

The legislative clerk read as follows:

The Committee of Conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill, H.R. 3108 to amend the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code of 1986 to temporarily replace the 30-year Treasury rate with a rate based on long-term corporate bonds for certain pension plan funding requirements and other provisions, and for other purposes, having met, have agreed that the House recede from its disagreement to the amendment of the Senate, and agree to the same with an amendment, signed by a majority of the conferees on the part of both Houses.

The PRESIDING OFFICER. The Senate will proceed to the consideration of the conference report.

(The conference report is printed in the proceedings of the House of the RECORD of April 1, 2004.)

The PRESIDING OFFICER. The Senator from New Hampshire.

Mr. GREGG. It is my understanding there are 4 hours equally divided; is that correct?

The PRESIDING OFFICER. That is correct.

Mr. GREGG. This is an important piece of legislation which deals with the solvency of a large number of companies and benefits that are paid to those companies' employees. The core, the essence of this bill is the fact that traditionally, companies have been required to fund their defined benefit plans in relationship to the rate of return that is accounted for on a 30-year Treasury bond. That affects how much money they must pay into these plans.

Unfortunately, for companies that have such plans, the 30-year bond no longer exists as a viable benchmark. That is because we as a government are not issuing 30-year bonds. Therefore, when people value a 30-year bond, it has become, in the last few years, an understated value. It is not reflecting what the true interest is, the true rate of return is, in the marketplace any longer.

If we continue to use the 30-year bond as a benchmark, an inflated payment is required by those companies which come under this rule.

The effect of that is a large amount of money—it is estimated to be $80 billion—would flow inaccurately or inappropriately as a result of the fact that the decision as to that payment is