as we have gone through these negotiations.

S. 2290 includes revised funding provisions. The new bill establishes a fund that can pay $114 billion in claims, with an additional $10 billion in contingent funding available from defendant companies. Money required to go to the fund from defendants and insurers is assured over a period of 27 years. Defendant participants, for example, guarantee their funding obligations through a grant of authority to the administrator of the fund to impose a surcharge in any year where monies received fall short of the annual requirements. S. 2290 also provides up to $300 million annually in hardship and inequity adjustments that may be granted by the administrator among defendant participants. Money from insurers is front loaded for the early years of the fund where the most stress on the system is expected. Enforcement provisions have been strengthened to help the administrator go after recalcitrant participants.

The new FAIR Act increases compensation going to claimants. Based on the funding now available under S. 2290, claims values have been increased in several disease categories. S. 2290 also now provides for reimbursement for out-of-pocket costs of physical examinations by claimants' physicians as well as costs for x-rays and pulmonary function testing at the lowest level of diseased-inflicted claimants or Level I claimants.

S. 2290 establishes a new streamlined administrative structure. Rather than administering claims in the U.S. Court of Federal Claims, as was the case when S. 1125 came out of the Judiciary Committee, the new bill creates a new executive Office of Asbestos Disease Compensation within the Department of Labor, which has 90 years of experience in administering similar compensation programs, to process claims as well as manage the fund. The new administrative structure will be more streamlined, more efficient, less adversarial, and less burdensome on claimants. The program can be effectively run at a fraction of the cost. The application process is faster, is more user friendly, and is fairer to claimants. To further ease the burden on claimants, S. 2290 also establishes a claimant-assistance program. The administrator of the new office will be appointed by the President with the advice and consent of the Senate.

S. 2290 ensures a quick start to processing and paying claims. S. 2290 includes a number of new provisions that ensure the fund will be set up and that processing and payment of claims occurs as quickly as possible. Placement of the claims-handling office within the Department of Labor will utilize DOL's existing infrastructure and experienced personnel to facilitate startup. S. 2290 requires implementation of interim regulations and procedures within 90 days after the bill is enacted to allow the office to begin accepting and processing claims in short order. Our new bill grants interim authority to an existing Assistant Secretary of the Department of Labor until the new administrator is appointed to avoid potential delays associated with the appointment process.

Lastly, S. 2290 provides for upfront funding, as early as 90 days after date of enactment, from fund participants, as well as increased borrowing authority, to ensure adequate initial funding will be available to fully meet demand. These new provisions are meant to insure that claimants will have speedy access to the fund while stopping any court actions in their tracks; this is to prevent any further, scarce resources from being siphoned away from the truly sick to the unimpaired claimants.

The new FAIR Act ensures that any risk of insufficient funds does not fall on claimants. S. 2290 establishes a fund that can pay $114 billion in claims, with an additional $10 billion in contingent funding available from defendant participants. It also provides the administrator with more management flexibility and increased borrowing authority to be able to address any short-term funding issues.

Under the terms of the new bill, if after 7 years it is determined that the fund will have insufficient resources to pay off 100 percent of all claims, the administrator is empowered to take actions to sunset the fund. In this event, S. 2290 fully protects the rights of claimants by creating a federal cause of action, so claimants will be able to pursue their claims in the U.S. District Court where they live or where they were exposed to asbestos.

In closing, it is important to note that asbestos victims, American businesses, workers, retirees, shareholders, and the U.S. economy cannot afford to wait any longer for asbestos litigation reform. Consideration of the FAIR Act on the floor will allow what I'm sure will be a spirited debate and consideration of any reasonable amendments to our new proposal. That being said, we need move forward with the debate on the FAIR Act and enact S. 2290 now. I ask that my colleagues join me in voting to move forward on this important bill.

NOW CAN WE TALK ABOUT HEALTH CARE

Mr. DASCHLE. Madam President, yesterday's New York Times Magazine contained a very insightful article written by our colleague from New York, Senator CLINTON. This article, entitled ''Now Can We Talk About Health Care?,'' is truly a call to action.

Senator CLINTON could not be more right when she points out that if we were starting from scratch in designing a health care system, ''none of us, from dyed-in-the-wool liberals to rock-solid conservatives, would fashion the kind of health care system America has inherited.'' She pointedly asks why we should carry this flawed system and its problems into the future. It is a rhetorical question, of course, but the answer, unfortunately, is that we are doing just that.

Last year, 43.6 million Americans were without health coverage—an increase of over 2 million from the year before. About 74,800 people in my State of South Dakota—12 percent of the population—are without health insurance. But statistics alone do not communicate the anguish felt by so many people in our country regarding an issue as personal as their health care.

Senator CLINTON correctly notes that things will only get worse. Her article explains that the very manner in which we finance care is ''so seriously flawed that if we fail to fix it, we face a fiscal disaster that will not only deny quality care to the uninsured and underinsured but also undermine the capacity of the system to care for even the well insured.'' This a sobering warning.

It does not have to be this way. The United States is the only major industrialized nation that fails to provide guaranteed health care to all its citizens. And, in many countries—Canada, the United Kingdom, Japan, France, and Sweden to name a few—they do it while spending less per capita than we do in the United States. Yet in each of those countries, citizens have greater life expectancies and lower rates of child mortality than we have in the United States.

We must act. The nonpartisan Institute of Medicine recently recommended that by 2010, everyone in the United States should be insured. That is no small task, and it won't come free. But, as Senator CLINTON points out, it will save us money in other ways. People will get the preventive care they need and deserve, and this will save us the cost of treating conditions and diseases that have progressed. And, certainly, it is a moral imperative when we are talking about people's health.

We must invest in our public health infrastructure, in preventive care, and in covering the care people need. We can save money by increasing our reliance on information technology with appropriate privacy protections. And we can use every tool we have—including genetic testing—to prevent and contain disease. We can encourage these tests by enacting the Genetic Information Nondiscrimination Act, a bipartisan bill that has already passed the Senate but awaits action in the House. We can reduce health disparities by passing the Healthcare Equality and Accountability Act, a bill I introduced with each of the House minority caucuses last year. And we can address the problem of the uninsured in a serious manner rather than proposing tax credits that will do little to help those most in need or pushing consumer-driven plans that shift cost and risk onto the individual.

I commend Senator CLINTON on her thoughtful article. It is something we

all should read. Health care should not be a partisan issue. It is a necessity. Whether someone receives the health care they need should not depend on whether they are fortunate enough to access and afford adequate health insurance under our current system. I ask unanimous consent that Senator CLINTON's article be printed in the RECORD.

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

[From the New York Times, Apr. 18, 2004]

NOW CAN WE TALK ABOUT HEALTH CARE?

(By Hillary Rodham Clinton)

I know that you're thinking. Hillary Clinton and health care? Been there. Didn't do that!

No, it's not 1994; it's 2004. And believe it or not, we have more problems today than we had back then. Issues like soaring health costs and millions of uninsured have yet to fix themselves. And now we are confronting a new set of challenges associated with the arrival of the information age, the technological revolution and modern life.

Think for a moment about recent advances in genetic testing. Knowing you are prone to cancer or heart disease or Lou Gehrig's disease may give you a fighting chance. But just try, with that information in hand, to get health insurance in a system without strong protections against discrimination for pre-existing or generic conditions. Each vaunted scientific breakthrough brings with it new challenges to our health system. But it's not only medicine that is changing. So, too, are the economy, our personal behaviors and our environment. Unless Americans across the political spectrum come together to change our health care system, that system, already buckling under the pressures of today, will collapse with the problems of tomorrow.

Twenty-first-century problems, like genetic mapping, an aging population and globalization, are combining with old problems like skyrocketing costs and skyrocketing numbers of uninsured, to overwhelm the 20th-century system we have inherited.

The way we finance care is so seriously flawed that if we fail to fix it, we face a fiscal disaster that will not only deny quality health care to the uninsured and underinsured but also undermine the capacity of the system to care for even the well insured. For example, if a hospital's trauma center is closed or so crowded that it cannot take any more patients, your insurance card won't help much if you're the one in the freeway accident.

Let's face it—if we were to start from scratch, none of us, from dyed-in-the-wool liberals to rock-solid conservatives, would fashion the kind of health care system America has inherited. So why should we carry the problems of this system into the future?

21ST-CENTURY PROBLEMS

At the dawn of the last century, America was coping with the effects of the industrial revolution—crowded living conditions, dangerous workplaces, inadequate sanitation and infrastructure in cities and pollution and infectious diseases like typhoid fever and cholera that exacted a huge toll on the oldest and youngest in society.

Since then, a century's worth of advances yielded remarkable results. Antibiotics were developed. Anesthesia was improved. Public health programs like mosquito control and childhood immunizations succeeded in reducing or even eradicating diseases like malaria and polio in this country. Congress passed legislation regulating the quality of food and drugs and assuring that safety and science guided medical developments. Workplace and product-safety standards resulted in fewer deaths and injuries from accidents. Effective campaigns cut tobacco use and alcohol abuse. Employers began providing some workers with health care coverage, primarily for hospitalization costs. And to aid some of those left out, President Lyndon B. Johnson persuaded Congress to establish Medicare and Medicaid to address the poorest, sickest, oldest and highest-risk patients in our society. As a result of these accumulated gains, life expectancy grew from 47 years in 1900 to 77 years for those born in 2000.

As astounding as those changes were, we are likely to see even more revolutionary changes in the next 100 years. Advances in medicine coincide with advances in computers and communications. The American workplace is changing in response to global pressures. But even positive advances may come with a negative underside. Our affluence contributes to an increasingly sedentary lifestyle that, combined with a diet filled with sugar and fat-rich foods, undermines our ability to fend off chronic diseases like diabetes. And research is proving that the pollutants and contaminants in our environment cause disease and mortality.

It is overwhelming just thinking about the problems, never mind dealing with them. But we have to begin applying American ingenuity and resolve or watch the best health care system in the world deteriorate.

MEDICAL ADVANCES

The pace of scientific development in medicine is so rapid that the next hundred years is likely to be called the Century of the Life Sciences. We have mapped the human genome and seen the birth of the burgeoning field of genomics, offering the opportunity to pinpoint and modify the genes responsible for a whole host of conditions. Scientists are exploring whether nanotechnology can target drugs to diseased tissues or implant sensors to detect disease in its earliest forms. We can look forward to ''designer drugs'' tailored to individual genetic profiles. But the advances we herald carry challenges and costs.

Think about the potential for inequities in drug research. Today, pharmaceutical and biotech companies have little incentive to research and develop treatments for individuals with rare diseases. Never heard of progeria? That's the point. This fatal syndrome, also called premature-aging disease, affects one in four million newborns a year. It's rare enough that there is no profit in developing a cure. This is known as the ''orphan drug'' problem. Genetic profiles and individualized therapies have the potential to increase the problem of orphaned drugs by further fragmenting the market. Even manufacturers of drugs for conditions like high blood pressure might focus their efforts on people with common genetic profiles. Depending on your genes, you could be out of luck.

The increasing understanding and use of genomics may also undermine the insurance system. Health insurance, like other insurance, exists to protect against unpredictable, costly events. It is based on risk. As genetic information allows us to predict illness with greater certainty, it threatens to turn the most susceptible patients into the most vulnerable. Many of us will become uninsurable, like the two young sisters with a congenital disease I met in Cleveland. Their father went from insurance company to insurance company trying to get coverage, until one insurance agent looked at him and said, ''We don't insure burning houses.''

Many have worked to get laws on the books to protect people from genetic discrimination, but we have yet to pass legislation that addresses job security and health coverage. The challenges do not stop there. Health insurance will have to change fundamentally to cope with predictable, knowable risks. Will health insurance companies offer coverage tailored to a person's future health prospects? Right now, if you have asthma, or even just allergies, insurers in the individual market can exclude your respiratory system from your health insurance policy. Will all health plans stop offering benefits that relate to genetic diseases?

The ability to predict illness may overwhelm more than just the insurance system; it may overwhelm the patient and the provider. Studies in The Journal of the American Medical Association found that nearly 6 out of 10 patients at risk for breast and ovarian cancer declined a genetic test, and a similar fraction of those at risk for colon cancer also declined testing. Why? One reason is probably to avoid higher insurance premiums. But the decision to undergo genetic testing is a complex one that involves many issues. Positive test results often indicate increased risk but no certainty that a disease will occur. Negative results also come without guarantees. The development of genetic profiles and individual therapies will exponentially increase the amount of information a physician is expected to manage. Instead of remembering one or two drugs for any condition, a physician will have to analyze all the different genetic, demographic and behavioral variables to generate optimal treatment for a patient.

Medical advances have the potential to overwhelm the health care system top to bottom. At the very least, the pace of technological progress is so rapid that our antiquated health care system is ill equipped to deliver the fruits of that progress. But these advances are not occurring in isolation from other factors affecting both how we finance health care and how much care we need and expect.

GLOBALIZATION

The globalization of our economy has changed everything from how we work as individuals to what we produce as a nation to how quickly diseases can spread. American companies—and workers—compete not only with one another but all over the world. It is called competitive advantage, but it can put American businesses and workers at a disadvantage.

The United States' closest economic rivals have mandatory national health care systems rather than the voluntary employer-based model we have. Automakers in the United States and Canada pay taxes to help finance public health care. But in the United States, automakers also pay about $1,300 per midsize car produced for private employee health insurance. Automakers in Canada come out ahead, according to recent news reports, even after paying higher taxes.

At the same time, American companies are outsourcing jobs to countries where the price of labor does not include health coverage, which costs Americans jobs and puts pressure on employers who continue to cover their employees at home.

And many new jobs, especially those in the service sector and part-time jobs, don't include comprehensive health benefits. More uninsured and underinsured workers impose major strains on a health system that relies on employer-based insurance. In addition, the failure of government to help contain health costs for employers has led to a fraying of the implicit social contract in which a good job came with affordable coverage.

Gone are the days when a young person would start in the mail room and stay with the company until retirement. Employee

mobility is now the rule rather than the exception. Those who pay for health care—insurance companies and employers—increasingly deal with employees who change jobs every few years. This has the effect of not only increasing the numbers of uninsured but also of decreasing the incentive for employers to underwrite access to preventive care.

At the same time, war, poverty, environmental degradation and increased world travel for business and pleasure mean greater migration of people across borders. And with people go diseases. The likes of SARS can travel quickly from Hong Kong to Toronto, and news of a strange flu in Asia worries us in New York. Welcome to the world without borders.

The Pulitzer Prize-winning science writer Laurie Garrett has described it as ''payback for decades of shunning the desperate health needs of the poor world.'' No matter the blame, the need to act now to address issues of global health is no longer just a moral imperative; it is self-interest.

LIFESTYLE AND DEMOGRAPHIC CHANGES

One hundred years ago, who could have predicted that living longer would be a problem?

In three decades, the number of Medicare beneficiaries will double. By the year 2050, one in five Americans will be 65 or older. We will have to find a way to finance the growing demand not only for health care but also for long-term care, which is now largely left out of Medicare.

Our society's affluence is only half of the story. Widening disparities in wealth and in health care too often cleave along ethnic lines. Today, a Hispanic child with asthma is far less likely than a non-Hispanic white child to get needed medication. African-Americans are systematically less likely to get state-of-the-art cardiac care. As our country becomes more and more diverse, these disparities become more obvious and more intolerable.

Our changing lifestyles also contribute to behavior-induced health problems. We can shop online, order in fast food, drive to our errands. Entertainment—movies, TV, video games and music—is one click away. The physical activity required to get through the day has decreased, while the pace and stress of daily life has quickened, affecting mental health. Persistent poverty, risky behaviors like substance abuse and unprotected sex and pollution from cars and power plants all add to the country's health problems. As Judith Stern of the University of California at Davis so aptly put it, genetics may load the gun, but environment pulls the trigger.

OLD PROBLEMS PERSIST

If all we had to do was face these tremendous changes, that would be daunting enough. But many of the systemic problems we have struggled with for decades—like high costs and the uninsured—are simply getting worse.

In 1993, the critics predicted that if the Clinton administration's universal health care coverage plan became law, costs would go through the roof. ''Hospitals will have to close,'' they said, ''Families will lose their choice of doctors. Bureaucrats will deny medically necessary care.''

They were half-right. All that has happened. They were just wrong about the reason.

In 1993, there were 37 million uninsured Americans. In the late 90's, the situation improved slightly, largely because of the improved economy and the passage of the Children's Health Insurance Program. But now some 43.6 million Americans are uninsured, and the vast majority of them are in working families.

While employer-sponsored insurance remains a major source of coverage for workers, it is becoming less accessible and affordable for spouses, dependents and retirees. In 1993, 46 percent of companies with 500 or more employees offered some type of retiree health benefit. That declined to 29 percent in 2001. When you think about the new economy and worker mobility, it's no wonder employees are dropping retiree health benefits. You can only wonder how many yet-to-retire workers are next.

Even those Americans not among the ranks of the uninsured increasingly find themselves underinsured. In 2003, two-thirds of companies with 200 or more employees dealt with increasing costs by increasing the share that their employees had to pay and dropping coverage for particular services. With rising deductibles and co-pays, even if you have insurance, you may not be able to afford the care you need, and some benefits, like mental health services, may not be covered at all.

The problem of the insured and underinsured affects everyone. A recent Institute of Medicine study estimates that 18,000 25- to 64-year old adults die every year as a result of lack of coverage. But even if you are insured, if you have a heart attack, and the ambulance that picks you up has to go three hospitals away because the nearby emergency rooms are full, you will have suffered from our inadequate system of coverage.

If, as a nation, we were saving money by denying insurance to some people, you could at least say there's some logic to it—no matter how cruel. But that's not the case. Despite the lack of universal coverage in our country, we still spend much more than countries that provide health care to all their citizens. We are No. 1 in the world in health care spending. On a per capita basis, health spending in the United States is 50 percent higher than the second-highest-spending country: Switzerland. Our health costs now constitute 14.9 percent of our gross domestic product and are growing at an alarming rate: by 2013, per capita health care spending is projected to increase to 18.4 percent of G.D.P.

What drives skyrocketing spending? The cost of prescription drugs rose almost twice as fast as spending on all health services, 40 percent in just the last few years.

Hospital costs have been rising as well, in large measure because more than one in four health care dollars go to administration. In 1999, that meant $300 billion per year went to pay for administrative bureaucracy; accountants and bookkeepers, who collect bills, negotiate with insurance companies and squeeze every possible reimbursement out of public programs like Medicare and Medicaid. Asthma and other pulmonary disorders linked to pollution contribute significantly to these costs, according to the health economist Ken Thorpe. Diabetes, high blood pressure and mental illness are also among the conditions that keep these costs rising.

If we spend so much, even after administrative costs, why does the United States rank behind 47 other countries in life expectancy and 42nd in infant mortality?

A lot of the money Americans spend is wasted on care that doesn't improve health. A recent study by Dartmouth researchers argues that close to a third of the $1.6 trillion we now spend on health care goes to care that is duplicative, fails to improve patient health or may even make it worse. A study in Santa Barbara, Calif., found that one out of every five lab tests and X-rays were conducted solely because previous test results were unavailable. A recent study found that for two-thirds of the patients who received a $15,000 surgery to prevent stroke, there was no compelling evidence that the surgery worked.

In situations in which the benefits of intervention are clear, many patients are not receiving that care. For example, few hospitalized patients at risk for bacterial pneumonia get the vaccine against it during their hospital stays. A recent study in The New England Journal of Medicine by Elizabeth McGlynn found that, overall, Americans are getting the care they should only 55 percent of the time.

As a whole, our ailing health care system is plagued with underuse, overuse and misuse. In a fundamental way, we pay far more less than citizens in other advanced economies get.

HOW WE DELIVER CARE

There is no ''one size fits all'' solution to our health care problems, but there are common-sense solutions that call for aggressive, creative and effective strategies as bold in their approach as they are practical in their effect.

First, the way we deliver health care must change. For too long our model of health care delivery has been based on the provider, the payer, anyone but the patient. Think about the fact that our medical records are still owned by a physician or a hospital, in bits and pieces, with no reasonable way to connect the dots of our conditions and our care over the years.

If we as individuals are responsible for keeping our own passports, 401(k) and tax files, educational histories and virtually every other document of our lives, then surely we can be responsible for keeping, or at least sharing custody of, our medical records. Studies have shown that when patients have a greater stake in their own care, they make better choices.

We should adopt the model of a ''personal health record'' controlled by the patient, who could use it not only to access the latest reliable health information on the Internet but also to record weight and blood sugar and to receive daily reminders to take asthma or cholesterol medication. Moreover, our current system revolves around ''cases'' rather than patients. Reimbursements are based on ''episodes of treatment'' rather than on a broader consideration of a patient's well-being. Thus it rewards the treatment of discrete diseases and injuries rather than keeping the patient alive and healthy. While we assure adequate privacy protections, we need care to focus on the patient.

Our system rewards clinicians for providing more services but not for keeping patients healthier. The structure of the health care system should shift toward rewarding doctors and health plans that treat patients with their long-term health needs in mind and rewarding patients who make sensible decisions about maintaining their own health.

HARNESSING MODERNIZATION

As paradoxical as it is that advances in medical technology could potentially break our antiquated system, advances in other technologies may hold the answer to saving it. Using a 20th-century health care system to deal with 21st-century problems is nowhere more true than in the failure to use information technology.

Ten years ago, the Internet was used primarily by academics and the military. Now it is possible to imagine all of a person's health files stored securely on a computer file—test results, lab records, X-rays—accessible from any doctor's office. It is easy to imagine, yet our medical system is not there.

The average emergency-room doctor or nurse has minutes to gather information on a patient, from past records and from interviewing the patient or relatives. In the age

of P.D.A.'s, why are these professionals forced to rely on a patient's memory?

Information technology can also be used to disseminate research. A government study recently documented that it takes 17 years from the time of a new medical discovery to the time clinicians actually incorporate that discovery into their practice at the bedside. Why not 17 seconds?

Why rely solely on the doctor's brain to store that information? Computers could crunch the variables on a particular patient's medical history, constantly update the algorithms with the latest scientific evidence and put that information at the clinician's fingertips at the point of care.

Americans may not be getting the care they should 45 percent of the time, but the tools exist to narrow that gap. Research shows that when physicians receive computerized reminders, statistics improve exponentially. Reminders can take the form of an alert in the electronic health record that the hospitalized patient has not had a pneumonia vaccine or as computerized questions to remind a doctor of the conditions that must be fulfilled before surgery is considered appropriate.

Newt Gingrich and I have disagreed on many issues, including health care, but I agree with some of the proposals he outlines in his book ''Saving Lives and Saving Money,'' which support taking advantage of technological changes to create a more modern and efficient health care system. I have introduced legislation that promotes the use of information technology to update our health care system and organize it around the best interests of patients. Improvements in technology will end the paper chase, limit errors and reduce the number of malpractice suits.

I strongly believe that savings from information technology should not just be diffused throughout the system, never to be recaptured, but should be used to make substantial progress toward real universal coverage. By better using technology, we can lower health care costs throughout the system and thereby lower the exorbitant premiums that are placing a financial squeeze on businesses, individuals and the government. At the same time, some of those savings should be used to make substantial progress toward real universal coverage. (I may have just lost Newt Gingrich.)

TAKING THE BROADER VIEW: PUBLIC HEALTH AND PREVENTION

While we focus on empowering the individual through technology, we also have to recognize the larger factors that affect our health—from the environment to public health.

If asthma and other pulmonary disorders are the main drivers of increased health spending, that argues strongly that we should rethink how social and environmental factors impact our collective health. Consider that over the last century we have extended life expectancy by 30 years but that only 8 of those years can be credited to medical intervention. The rest of our gains stem from the construction of water and sewer systems, draining mosquito-infested swamps and addressing spoilage, quality and nutrition in our food supply. Yet we continue to underinvest in these important systematic measures—resulting in expensive health consequences like the explosion of asthma among children living in New York City or the harmful levels of lead found among children drinking water from the District of Columbia water system.

Our neglect of public health also contributes to spiraling health costs. We tend to address health care—as a nation and as individuals—after the sickness has taken hold, rather than addressing the cause through public health. Public health programs can help stop preventable disease and control dangerous behaviors. Take obesity, for example. Individuals should understand that they put their lives at risk with unhealthy behavior. But let's face it—we live in a fast-food nation, and we need to take steps, like restoring physical-education programs in schools, that support the individual's ability to master his or her own health. Studies conducted by the Centers for Disease Control and Prevention have identified ''Programs That Work,'' which should be financed. It comes down to individual responsibility reinforced by national policy.

The public health system also needs to be brought up to date. The current public health tools were developed when the major threats to health were infectious diseases like malaria and tuberculosis. But now chronic diseases are the No. 1 killer in our country. We need to be concerned not just about pathogens but also about carcinogens.

Over the last three years, I have introduced legislation to increase investment in tracking and correlating environmental and health conditions. I have met with people from Long Island to Fallon, Nev., who want answers about cancer clusters in their communities. The data we have seen about lead and mercury contamination in our food and water suggest that the effects they have on the fetus and children may have contributed to the increasing number of children in special education with attention and learning disorders. We need more research to determine once and for all if increasing pollution in our communities and increasing rates of learning-related disabilities are cause and effect.

We should also be looking at sprawl—talking about the way we design our neighborhoods and schools and about our shrinking supply of safe, usable outdoor space—and how that contributes to asthma, stress and obesity. We should follow the example of the European Union and start testing the chemicals we use every day and not wait until we have a rash of birth defects or cancers on our hands before taking action. And we should look at factors in our society that lead to youth violence, substance abuse, depression and suicide and ultimately require insurance and treatment for mental health.

After Sept. 11, mental health was a significant factor in the health toll on our nation's first responders. And yet our mental health delivery system is underfinanced and unprepared.

Finally, as a society, we need greater emphasis on preventive care, an investment in people and their health that saves us money, because when families can't get preventive care, they often end up in the emergency room—getting the most expensive care possible.

EXPANDING COVERAGE

All that we have learned in the last decade confirms that our goal should continue to be what every other industrialized nation has achieved—health care that's always there for every citizen.

For the first time, this year a nonpartisan group dedicated to improving the nation's health, the Institute of Medicine, recommended that by 2010 everyone in the United States should have health insurance. Such a system would promote better overall health for individuals, families, communities and our nation by providing financial access for everyone to necessary, appropriate and effective health services.

It will, as I have been known to say, take the whole village to finance an affordable and accountable health system. Employers and individuals would share in its financing, and individuals would have to assume more responsibility for improving their own health and lifestyles. Private insurers and public programs would work together, playing complementary roles in ensuring that all Americans have the health care they need. Our society is already spending $35 billion a year to treat people who have no health insurance, and our economy loses $65 billion to $130 billion in productivity and other costs. We are already spending what it would cost if we reallocated those resources and required responsibility.

In the post 9/11 world, there is one more reason for universal coverage. The anthrax and ricin episodes, and the continuing threat posed by biological, chemical and radiological weapons, should make us painfully aware of the shortcomings of our fragmented system of health care. Can you imagine the aftermath of a bioterrorism attack, with thousands of people flooding emergency rooms and bureaucrats demanding proof of insurance coverage from each and every one? Those without coverage might not see a doctor until they had infected others.

Insurance should be about sharing risk and responsibility—pooling resources and risk to protect ourselves from the devastating cost of illness and injury. It should not be about further dividing us. Competition should reward health plans for quality and cost savings, not for how many bad risks they can exclude—especially as we enter the genomic age, when all of us could have uninsurable risks written into our genes.

So achieving comprehensive health care reform is no simple feat, as I learned a decade ago. None of these ideas mean anything if the political will to ensure that they happen doesn't exist.

Some people believe that the only solution to our present cost explosion is to shift the cost and risk onto individuals in what is called ''consumer driven'' health care. Each consumer would have an individual health care account and would monitor his or her own spending. But instead of putting consumers in the driver's seat, it actually leaves consumers at the mercy of a broken market. This system shifts the costs, the risks and the burdens of disease onto the individuals who have the misfortune of being sick. Think about the times you have been sick or injured—were you able under those circumstances to negotiate for the best price or shop for the best care? And instead of giving individuals, providers and payers incentives for better care, this cost-shifting approach actually causes individuals to delay or skip needed services, resulting in worse health and more expensive health needs later on.

Meanwhile, proposals like those for individual health insurance tax credits, without reforms for the individual insurance market, leave individuals in the lurch as well. We know that asthmatics can have their entire respiratory systems excluded from coverage. Individual insurance companies can increase your premium or limit coverage for factors like age, previous medical history or even flat feet. Those in the individual market cannot pool their risk with colleagues or other members of the group. The coverage you can get and the price you pay for it will reflect individual risk, and you simply don't receive many of the benefits of what we consider traditional insurance when people pool risks. So the proposal to give individuals tax credits to buy coverage in the individual market, without any rules of fair play, won't provide much help for Americans who need health care. In the same way, the recent Medicare bill, which seeks to privatize Medicare benefits, long a government guarantee, threatens to leave the ''bad risks'' without any affordable coverage. With the new genetic information at our disposal, that could

mean any one of us could one day be denied health insurance.

When many of those who opposed the Health Security Act look back, they are still proud of their achievement in blocking our reform plan. The focus of that proposal was to cover everybody by enabling the healthier to pool the ''risk'' with others. The plan was to redirect what we currently pay for uninsured care into expanding health coverage.

We could make cosmetic changes to the system we currently have, but that would simply take what is already a Rube Goldberg contraption and make it larger and even more unwieldy. We could go the route many have advocated, putting the burden almost entirely on individuals, thereby creating a veritable nationwide health care casino in which you win or lose should illness strike you or someone in your family. Or we could decide to develop a new social contract for a new century premised on joint responsibility to prevent disease and provide those who need care access to it. This would not let us as individuals off the hook. In fact, joint responsibility demands accountability from patients, employers, payers and society as a whole.

What will we say about ourselves 10 years from today? If we finally act to reform what we know needs to change, we may take credit in building a health care system that covers everyone and improves the quality of all our lives. But if we continue to dither and disagree, divided by ideology and frozen into inaction by competing special interests, then we will share in the blame for the collapse of health care in America, where rising costs break the back of our economy and leave too many people without the medical attention they need.

The nexus of globalization, the revolution in medical technology and the seismic pressures imposed by the contradictions in our current health care system will force radical changes whether we choose them or not. We can do nothing, we can take incremental steps—or we can implement wide-ranging reform.

To me, the case for action is clear. And as we work to develop long-term solutions, we can take steps now to help address the immediate problems we face. As Senator John Kerry has proposed, we should cover everyone living in poverty, and all children; allow people to buy into the federal employee health benefits program; and also help employers by reinsuring high-cost claims while assuming more of the costs from hard-pressed state and local governments.

We can pass real privacy legislation that will ensure that Americans continue to feel secure in the trust they place in others for their most intimate medical information. And we can realize the promise of savings through information technology and disease management by passing quality health legislation now.

If we do not fix the problems of the present, we are doomed to live with the consequences in the future. As someone who tried to promote comprehensive health care reform a decade ago and decided to push for incremental changes in the years since, I still believe America needs sensible, wide-ranging reform that leads to quality health care coverage available to all Americans at an affordable cost.

The present system is unsustainable. The only question is whether we will master the change or it will master us.

HONORING OUR ARMED FORCES

PFC CHANCE PHELPS, USMC

Mr. THOMAS. Madam President, I rise today to express our Nation's deepest thanks and gratitude to a special young man and his family. During this past recess, I attended funeral services in Dubois, WY for Marine PFC Chance Phelps. On April 9, 2004, Private First Class Phelps died in the line of duty while serving his country in the war on terrorism. He was shot and killed while fighting insurgents in the town of Ramadi, Iraq, west of Baghdad.

Private First Class Phelps was a member of the 3rd Battalion, 11th Marine Regiment, 1st Marine Division. He spent the early years of his life in Dubois, WY before moving to Colorado. He enjoyed the outdoors, hunting and fishing, and was an outstanding athlete. He was good natured, and loved his family and his country. Private First Class Chance had a profound sense of duty that led him to join the United States Marine Corps. He felt deeply compelled to serve and defend his country following the terrorist attacks of September 11.

It is because of people like Chance Phelps that we continue to live safe and secure. America's men and women who answer the call of service and wear our Nation's uniform deserve respect and recognition for the enormous burden that they willingly bear. Our people put everything on the line everyday, and because of these folks, our Nation remains free and strong in the face of danger.

The motto of the Marine Corps is ''Semper Fidelis.'' It means ''Always Faithful.'' Through his selfless and courageous sacrifice, PFC Chance Phelps lived up to these words with great honor.

Private First Class Phelps is survived by his mother Gretchen, his father John, his sister Kelley, and his brothers of the United States Marine Corps. We say goodbye to a son, a brother, a Marine, and an American. Our Nation pays its deepest respect to PFC Chance Phelps for his courage, his love of country and his sacrifice, so that we may remain free. He was a hero in life and he remains a hero in death. All of Wyoming, and indeed the entire Nation are proud of him.

So, one Marine to another, Private First Class Phelps, Semper Fi.

SP4 DENNIS MORGAN

Mr. JOHNSON. Madam President, I rise today to pay tribute to SP4 Dennis Morgan, a member of the South Dakota National Guard, who died on April 15, 2004, while serving in Operation Iraqi Freedom.

Specialist Morgan was a member of the 153rd Engineer Batallion, which is based in Wagner, SD. He was helping clear mines and explosives when a roadside bomb went off, killing him.

Answering America's call to the military, Specialist Morgan joined the National Guard immediately after graduating from Winner High School in 2000. He joined, along with his best friend from high school, Michael Lee. Their bond was special and they did everything together. Michael's father, Melvin, said of Dennis, ''He was often at our place, working on cars with Michael, and here for dinners.''

After high school, Morgan moved back to his original hometown of Valentine, NE, where he sometimes worked as an auto mechanic. Shortly before leaving for Iraq, he married his girlfriend, Cathy.

Specialist Morgan is the first member of the South Dakota National Guard to be killed in combat since World War II. Company A, which includes members from Wagner and Winner, was assigned to the 1st Marine Expedition Headquarters. Their Company is responsible for defusing roadside explosives. ''They were very proud of their mission, and they still are, because those explosive devices are what are killing everybody,'' said Roger Anderson, information officer was the South Dakota Army National Guard.

Specialist Morgan served our country and died as a hero, fighting for it. He served as a model of loyalty and dedication in the preservation of freedom. The thoughts and prayers of my family, as well as our country's, are with his family during this time of mourning. Our thoughts continue to be with all those families who have children, spouses, fathers, and other loved ones serving overseas.

Specialist Morgan led a full life, committed to his family, his Nation, and his community. It was his incredible dedication to helping others that will serve as his greatest legacy. Our Nation is a far better place because of Specialist Morgan's contributions, and, while his family, friends, and Nation will miss him very much, the best way to honor his life is to remember his commitment to service and his family.

I join with all South Dakotans in expressing my sympathies to the friends and family of Specialist Morgan, I know that he will always be missed, but his service to our Nation will never be forgotten.

PFC DERYK L. HALLAL

Mr. BAYH. Madam President, I rise today with a heavy heart and deep sense of gratitude to honor the life of a brave young man from Indianapolis, IN. PFC Deryk L. Hallal, 24 years old, died in the al-Anbar province, just west of Baghdad on April 6, 2004. He was struck by gunfire during an attack.

Deryk graduated from North Central High School in 1998 and studied computer programming at the Professional Careers Institute before joining the Marines last year, just months after the conflict in Iraq began. He was a rifleman assigned to the 2nd Battalion, 4th Marine Regiment, based at Camp Pendleton, CA. According to his mother, he was fulfilling the duty he felt compelled to do after the events of September 11. With his entire life before him, Deryk chose to risk everything to fight for the values Americans hold close to our hearts, in a land halfway around the world.

Deryk was the 27th Hoosier soldier to be killed while serving his country in Operation Iraqi Freedom. This brave