Interestingly, while the Missouri River reservoirs brought many benefits to the downstream states, navigation never developed to its original expectations. And, while no one even mentioned recreation as one of the benefits back in 1944, it exploded as an industry on the upper basin mainstem reservoirs. In fact, the Corps of Engineers' 1998 Revised Preliminary Draft Environmental Impact Statement for the Missouri River Master Water Control Manual credits recreation with $84.6 million in annual benefits while navigation creates a mere $6.9 million in annual benefits.

As you can see, we are at a crossroads today. The Corps continues to operate the reservoirs with an outdated Master Control Manual. Some of the original purposes of the Pick-Sloan Plan, like hydropower and flood control, are still valid today. However, the manual does not adequately address the conflict between navigation and recreation. Navigation takes water to support a barge channel and during times of dry years and water shortages the upper basin recreation industry suffers terribly. To keep a full navigation channel below Sioux City, Iowa, our reservoirs are drained and our boat docks left high and dry. An $84.6 million industry that offers recreational benefits to hundreds of thousands of people is held hostage by the $6.9 million barge industry.

Getting to this point in the Master Manual revision has been a long and arduous trail. Basin stakeholders have held countless meetings, thousands of hours have gone into evaluating the different options, and, in a spirit of compromise, we have agreed to allow the process to work. Too much effort has been spent to derail it now. To allow Senator Bond's provision would sound a death knell to a difficult consensus process, disregard sound biological and hydrological science, and place the whole Master Manual review process back into a political free-for-all pitting the upper-basin-states against the lower basin states. I urge you to remove Senator Bond's provision in your committee.

Sincerely,

WILLIAM J. JANKLOW.

SENATE DEMOCRATS BBA REFINEMENT AND ACCESS TO CARE PROPOSAL

Mr. DASCHLE. Mr. President, the Balanced Budget Act of 1997 made some positive changes and contributed to our current $2.2 trillion on-budget surplus.

Some of the BBA policies, however, cut providers and services far more consequentially than was ever anticipated, and that has created extraordinary problems for health care providers all over the country.

I have been hearing from providers in South Dakota about the burdens that BBA created now for almost 3 years.

Just this week, community leaders in Sturgis, SD, have been meeting to decide the fate of an important clinic we have there. The administrators in Sturgis say the cuts we made in 1997 mean that they have been losing money every year. We may actually see the clinic close as a result. That clinic is not alone. There are clinics, there are hospitals, there are providers throughout my State and throughout the country who are facing the same fiscal demise if something is not done. And their demise spells problems for the people who depend on them for care.

Last year, we made the first step. Thanks to a united Democratic effort, we put forth a bill largely endorsed by our colleagues on both sides of the aisle and passed the first installment of relief from the BBA. It was an effort to try to stave off further closings and financial harm to critical community health care facilities. We didn't go far enough. Communities are still struggling in spite of our best effort last year.

Senate Democrats believe that we cannot ignore the crisis this year either. We need to act to ensure that beneficiary access to quality health care remains, regardless of circumstances, regardless of geography, regardless of whether we are talking about a rural area or an inner city.

I want to thank Senator PATRICK MOYNIHAN, our ranking member, Senator Max BAUCUS, and so many other members of the Senate Democratic Caucus and the Finance Committee for their leadership in developing the response to this crisis that we will be introducing shortly upon our return.

The Senate Democrats, under their leadership, are now proposing a package of payment adjustments and other improvements to beneficiary access that total $80 billion over 10 years.

This $80 billion will be used to help stabilize hospitals, home health agencies, hospices, nursing homes, clinics, Medicare+Choice plans, and other providers.

Our plan pays special attention to rural providers, which serve a larger proportion of Medicare beneficiaries and are more adversely impacted by reductions in the Medicare payment.

It includes targeted relief for teaching hospitals that train our health providers and conduct cutting-edge research.

And it includes improvements to Medicaid that could mean significantly improved access to health care for a number of uninsured people.

The proposal also includes improvements that directly help beneficiaries.

Senate Democrats continue to believe that passage of an affordable, voluntary, meaningful Medicare prescription drug benefit is of highest priority.

We will continue to press for passage of a prescription drug benefit in September as we fight for the important provisions in this proposal.

I ask unanimous consent that our proposal outline be printed in the RECORD, which goes through in some detail each of the areas that we hope to address, why we hope to address them, and the reasons we are addressing them in the bill that we will be introducing immediately upon our return from the August recess.

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

SENATE DEMOCRATS' BBA REFINEMENT AND ACCESS TO CARE PROPOSAL, JULY 27, 2000

The Balanced Budget Act (BBA) of 1997 made some important changes in Medicare payment policy, improved health care coverage, and contributed to our current period of budget surpluses through significant cost savings in Medicare. CBO originally estimated Medicare spending cuts at $112 billion over 5 years. Some of the policies enacted in the BBA, however, cut payments to providers more significantly than expected—in some cases more than double the expected amount—and threaten the survival of institutions and services vital to seniors and their communities throughout the country. Senate Democrats believe that, in light of the projected $2.2 trillion on-budget surplus over the next 10 years and the problems facing vital health care services, the Congress should enact a significant package of BBA adjustments and beneficiary protections. Senate Democrats therefore propose a package of payment adjustments and access to care provisions amounting to $80 billion over 10 years.

Hospitals. A significant portion of the BBA spending reductions have impacted hospitals. According to MedPAC, ''Hospitals' financial status deteriorated significantly in 1998 and 1999,'' the years following enactment of BBA. The Senate Democrats' BBA refinement proposal addresses the most pressing problems facing hospitals by:

Adjusting inpatient payments to keep up with increases in hospital costs, an improvement that will help hospitals.

Preventing further reductions in payment rates for vital teaching hospitals—which are on the cutting edge of medical research and provide essential care to a large proportion of indigent patients. Support for medical training and research at independent children's hospitals is also included in the Democratic proposal.

Targeting additional relief to rural hospitals (Critical Access Hospitals, Medicare Dependent Hospitals, and Sole Community Hospitals) and making it easier for them to qualify for disproportionate share payments under Medicare.

Providing additional support for hospitals with a disproportionate share of indigent patients.

Home Health. The BBA his home health agencies particularly hard. Home health spending dropped 45 percent between 1997 and 1999, while the number of home health agencies declined by more than 2000 over that period. MedPAC has cautioned against implementing next year the scheduled 15% reduction in payments. The Senate Democrats' BBA refinement proposal:

Prevents further reductions in home health payments, takes into consideration the highest cost cases, and addresses the special needs of rural home health agencies.

Improves payments for medical equipment.

Rural. Rural providers serve a larger proportion of Medicare beneficiaries and are more adversely affected by reductions in Medicare payments. The proposal addresses the unique situation faced in rural areas through a number of measures, including establishing a capital loan fund to improve infrastructure of small rural facilities, providing assistance to develop technology related to new prospective payment systems, creating bonus payments for providers who serve independent hospitals, and ensuring rural facilities can continue to offer quality lab services to beneficiaries.

Hospice. Payments to hospices have not kept up with the cost of providing care because of the cost of prescription drugs, the therapies now used in end-of-life care, as well as decreasing lengths of stay. Hospice base rates have not been increased since 1989. The Senate Democrats' BBA Refinement proposal provides additional funding for hospice services to account for their increasing costs.

Nursing Homes. The BBA was expected to reduce payments to nursing homes by about $9.5 billion. The actual reduction in payments to SNFs over the period is expected to be significantly larger. A significant number of skilled nursing providers have gone into bankruptcy in the past two years. The Senate Democrats' BBA Refinement proposal:

Allows nursing home payments to keep up with increases in costs.

Further delays caps on the amount of therapy a patient can receive.

Medicare+Choice. Senate Democrats are committed to ensuring that appropriate payments are made to Medicare+Choice plans. In addition, for beneficiaries who have lost Medicare+Choice plans in their area, Senate Democrats have included provisions that strengthen fee-for-service Medicare and assist beneficiaries in the period immediately following loss of service.

Other Provisions. Access to other types of care and services are adversely affected by existing policy. The Senate Democrats' proposal will address high priority issues, including adequate payment for dialysis to assure access to quality care for end stage renal disease (ESRD) patients, training of geriatricians, and others.

Beneficiary Improvements. In addition to ensuring access to vital health care providers, the proposal includes refinements to Medicare that directly help beneficiaries. Senate Democrats continue to believe that passage of a universal, affordable, voluntary, and meaningful Medicare prescription drug benefit is of highest priority. Other improvements for beneficiaries include:

Lowering beneficiary coinsurance in hospital outpatient departments more quickly.

Removing current restrictions on payment for immunosuppressive drugs for organ transplant patients.

Allowing beneficiaries to return to the same nursing home after a hospital stay.

Medicaid and SCHIP. Improvements to the BBA as well as to immigration and welfare reform legislation that passed in 1996 could mean significantly improved access to health care for a number of uninsured people. Improvements in the proposal include:

Giving states the option to cover legal immigrant children and pregnant women.

Improving eligibility and enrollment processes in SCHIP and Medicaid.

Extending and improving the Transitional Medical Assistance program for people who leave welfare for work.

Giving states grants to develop home and community based services for beneficiaries who would otherwise be in nursing homes.

Creating a new payment system for Community Health Centers to ensure they remain a strong, viable component of our health care safety net.

Mr, DASCHLE. Mr. President, I yield the floor.

Mr. MOYNIHAN. Mr. President, I commend the distinguished Democratic Leader Senator DASCHLE on his statement and join him in supporting the Democratic BBA Refinement and Access to Care Proposal. As the Leader said, the Balanced Budget Act of 1997 (BBA) has cut Medicare spending far more than had been intended. Our Democratic proposal would spend $80 billion over 10 years to mitigate the unintended effects of the BBA on our nation's health care providers and beneficiaries.

In particular, I want to highlight that our package would prevent further reductions in payments to our Nation's teaching hospitals. The BBA, unwisely in my view, enacted a multi-year schedule of cuts in payments by Medicare to academic medical centers. These cuts would seriously impair the cutting edge research conducted by teaching hospitals, as well as impair their ability to train doctors and to serve so many of our nation's indigent.

Last year, in the Balanced Budget Refinement Act (BBRA), we mitigated the scheduled reductions in fiscal years 2000 and 2001. The package we are proposing today, would cancel any further reductions in what we call ''Indirect Medical Education payments,'' thereby restoring nearly $7 billion to our Nation's teaching hospitals.

I have stood before my colleagues on countless number of times to bring attention to the financial plight of medical schools and teaching hospitals. Yet, I regret that the fate of the 144 accredited medical schools and 1416 graduate medical education teaching institutions still remains uncertain. The proposals in our Democratic BBA refinement package will provide critically needed financing in the short-run. In the long-run, we need to restructure the financing of graduate medical education along the lines I have proposed in the Graduate Medical Education Trust Fund Act that I have introduced in the last 3 Congresses. That legislation would require the public and private sectors to provide support for graduate medical education. More on that later.

My particular interest in this topic goes back to 1994 when the Finance Committee took up the President's Health Security Act. As Chairman of the Committee I asked Paul Marks, then President of Memorial Sloan-Kettering, Cancer Center to arrange a ''seminar'' for me on health care issues. We convened on Wednesday, January 19, 1994 in the Laurance S. Rockefeller Boardroom at 10 a.m. At about a quarter past the hour I was told that the University of Minnesota might have to close its medical school.

Whereupon my education in this began. Minnesota is where the Scandinavians (Swedes) settled. They don't close medical schools; they open medical schools. What was going on? It was simple enough: managed care had reached the high plains. The good folk of Lake Wobegon had dutifully signed on, only to learn that market-based health plans do not send patients to teaching hospitals, because they cost too much. No teaching hospital; ergo no medical school.

In the Clinton Administration health security plan, they assumed health care costs would continue to rise. The Administration's solution to this was rationing—cut the number of doctors by one quarter, specialists by one-half and so on.

As I have described elsewhere, a dissenting paper dated April 26, 1993, by ''Workgroup 12'' of ''Tollgate 5,'' was written by a physician in the Veterans' Administration. Workgroup 12 was part of the 500 person Clinton health care task force. The paper began:

FOR OFFICIAL USE ONLY

Subject: Proposal to cap the total number of graduate physician (resident) entry (PGY–1) training positions in the U.S.A. to 110 percent of the annual number of graduates of U.S. medical schools.

Issue: Although this proposal has been presented in toll-gate documents as the position of Group 12, it is not supported by the majority of the members of Group 12 . . . .

Reasons not to cap the total number of U.S. residency training positions for physician graduates.

1. This proposal has been advanced by several Commissions within the last two years as a measure to control the costs of health care. While ostensibly advanced as a manpower policy, its rationale lies in economic policy. Its advocates believe that each physician in America represents a cost center. He not only receives a high personal salary, but is able to generate health care costs by ordering tests, admitting patients to hospitals and performing technical procedures. This thesis may be summarized as: To control costs, control the number of physicians.

Despite the lack of support for this proposal in the task force, the Clinton Administration moved ahead anyway with its workforce proposals. In the 1,362 page bill (S. 1775) that I introduced for the Clinton Administration, this appeared:

. . . the National Council [on Graduate Medical Education] shall ensure that, of the class of training participants entering eligible programs for academic year 1998–99 or any subsequent academic year, the percentage of such class that completes eligible programs in primary health care is not less than 55 percent (without regard to the academic year in which the members of the class complete the programs).

The Clinton Administration also proposed to limit the number of residents based on the number of graduates from American medical schools. Although there was no explicit cap in the bill that I introduced for the Clinton Administration, subsequent legislation, such as that offered by Senator Mitchell, included a cap of 110 percent.

As this was all done in secret—and buried in a 1,362 page bill—there was no national debate on this Clinton Workforce proposal. When all else fails, the press is supposed to step in. It did not. The 1993–1994 Nexis tabulation for the Times, East Coast and West Coast uncovered only 3 articles pertaining to the Clinton workforce proposal compared to thousands of articles on health reform.

Not surprisingly, the Finance Committee went in a different direction. Charles J. Fahey, on behalf of the Catholic Health Association, told us that we were witnessing the ''commodification of medicine.'' Further down the witness table we were told that a spot market had developed for bone-marrow transplants in Southern California. In other words we need not worry about rising costs, competition would depress prices. Indeed, Medicare costs actually declined in 1999.

But take note—there would be side effects. Markets do not provide public goods so teaching hospitals would be at risk. Everyone benefits from public

goods but no one has any incentive to pay. It follows that for the most part teaching hospitals have to be paid for by the public, indirectly through tax exemption or directly through expenditure.

On June 29, 1994, the Finance Committee Chairman's Mark—as we refer to these things—of the Health Security Act provided for a Graduate Medical Education and Academic Health Center Trust Fund to be financed by a 1.5 percent tax on all private health care premiums. An additional levy of .25 percent was added on to pay for medical research as proposed by Senator Hatfield. A motion to strike the 1.75 percent premium tax failed by 13 votes to 7. And we were not bashful about calling this assessment a tax, to wit:

''(a) IMPOSITION OF TAX.—There is hereby imposed—

''(1) on each taxable health insurance policy, a tax equal to 1.75 percent of the premiums received under such policy, and

''(2) on each amount received for health-related administrative services, a tax equal to 1.75 percent of the amount so received.

The bill, as reported out of the Finance Committee, set a goal of covering 95 percent of Americans through subsidies to help low-income people buy health insurance, as well as reforms in the private health insurance market. A National Health Care Commission was to make recommendations for reaching:

95 percent health insurance coverage in community rating areas that have failed to meet that target.

I might note that the Senate Finance Committee was the only committee that reported a bill that was actually taken up on the Floor. However, upon taking up the Finance Committee bill, Senate Majority Leader George Mitchell offered his own substitute health reform plan which became the focus of the ultimately fruitless Senate debate.

Future prospects, for these fine institutions, are not all that they should be. During negotiation of the Balanced Budget Refinement Act of 1999 Senator ROTH and I, with assistance from my good friend Congressman RANGEL, were able to forestall some of the scheduled deep cuts in indirect medical education payments, but, I'm afraid, only temporarily.

There were proposals about—for example by the Bipartisan Commission on the Future of Medicare, Chaired by Senator BREAUX—that would subject Graduate Medical Education payments to the appropriations process. Fifty-five of my colleagues, including Senators STEVENS and BYRD, the Chairman and Ranking Member of the Appropriations Committee, joined with me to oppose this approach.

In a February, 1999 letter, we pointed out the critical role of America's teaching hospitals in clinical research and health services research.

Teaching hospitals play a vitally important role in the nation's health care delivery system. In addition to the mission of patient care that all hospitals fulfill, teaching hospitals serve as the pre-eminent setting for the clinical education of physicians and other health professionals. . . . In order to remain the world leader in graduate medical education, we must continue to maintain Medicare's strong commitment to the nation's teaching hospitals.

I'm happy to report that in the final version of the Commission's report, they seem to have relented somewhat recommending that:

Congress should provide a separate mechanism for continued funding [of Graduate Medical Education] through either a mandatory entitlement or multi-year discretionary appropriation program.

What is needed is explicit and dedicated funding for these institutions, which will ensure that the United States continues to lead the world in this era of medical discovery. The Graduate Medical Education Trust Fund Act would require that the public sector, through the Medicare and Medicaid programs, and the private sector through an assessment on health insurance premiums, provide broad-based financial support for graduate medical education. The Clinton Administration proposed something similar as part of the Health Security Act. Funding for Graduate Medical Education would come from Medicare and from corporate and regional health alliances—but there was no way anyone could have known it as they attempted to trace the flow of money between and among these corporate and regional health alliances.

My bill would roughly double current funding levels for Graduate Medical Education and would establish a Medical Education Advisory Commission to make recommendations on the operation of the Medical Education Trust Fund, on alternative payment sources for funding graduate medical education and teaching hospitals, and on policies designed to maintain superior research and educational capacities.

After this year, I will not be there fighting in the last hours of a legislative session to preserve funding for Graduate Medical Education. The vehicle to preserve that funding, I would maintain, remains the trust fund legislation that I first introduced in June 1996.

As I said at the opening of my statement, I am pleased that the $80 billion package the Democratic Leader has announced today, would cancel scheduled cuts in ''Indirect Medical Education'' payments to our Nation's teaching hospitals, restoring about $7 billion over 10 years to those institutions. But this is only an interim step. I strongly urge that we take the next step which would be to enact my proposal for a Medical Education Trust Fund, which would ensure an adequate, stable source of funding for these vital institutions.

The PRESIDING OFFICER. Under the previous order, the Senator from Montana is recognized for 5 minutes.

MISSOURI RIVER RIDER

Mr. BAUCUS. Mr. President, I rise to join the minority leader and others who have expressed strong opposition to section 103 of the energy and water appropriations bill, which affects the management of the Missouri River.

From the debate that we've had thus far, you might think that this is pretty straightforward. Upstream states against downstream states, in a conventional battle about who gets water, how much they get, and when they get it.

I'm not going to kid anybody. That is a big part of the debate. I'm from an upstream state. We believe that we've been getting a bad deal for years. We want more balanced management of the system. That will, among other things, give more weight to the use of the water for recreation upstream, at places like Fort Peck reservoir in Montana.

Under the current river operations, there are times when the lake has been drawn down so low that boat ramps are a mile or more from the water's edge.

Our project manager at Fort Peck, Roy Snyder, who does a great job at that facility, has talked to me about how much healthier the river would be with a spring rise/split season management.

But it's not just a conventional battle over water. There's more to it. A lot more.

You wouldn't necessarily know that from the text of the provision itself. It says that none of the funds made available in the bill:

. . . may be used to revise the Missouri River Master Water Control Manual when it is made known to the Federal entity or official to which the funds are made available that such revision provides for an increase in the springtime water release program during the spring heavy rainfall and snow melt period in States that have rivers draining into the Missouri River below the Gavins Point Dam.

That's what the bill says.

Here's what it does.

Simply put, it prohibits the Secretary of the Army from obeying the law of the land. Specifically, it prohibits the Secretary from complying with the Endangered Species Act.

Let me explain. Like any other Federal agency, the Army Corps of Engineers has a legal obligation, under section 7 of the Endangered Species Act, to operate in a way that does not jeopardize the existence of any endangered species.

That's just common sense. After all, private landowners have to comply with the Endangered Species Act. Why should federal agencies get a free pass?

They shouldn't. The federal government should do its part. That's why section 7 is a fundamental part of the ESA. Without section 7, the ESA would be unfair to private landowners and, in many cases, would provide no protection for endangered species whatsoever.

Let's turn to the Missouri River. The river provides habitat for three endangered species: The pallid sturgeon, the piping plover, and the least interior tern.

Accordingly, in developing its new master manual, which will govern the