oversight hearing has been scheduled jointly before the Subcommittee on Forests and Public Land Management of the Senate Committee on Energy and Natural Resources and the Subcommittee on Forests and Forest Health of the House Committee on Resources.

The hearing will take place Thursday, May 15, 1997 at 2:00 p.m. in room SD–366 of the Dirksen Senate Office Building in Washington, D.C.

The purpose of this hearing is to receive testimony on the release of the Columbia River Basin Environmental Impact Statement.

Those who wish to submit written statements should write to the Committee on Energy and Natural Resources, U.S. Senate, Washington, D.C. 20510. For further information, please call Judy Brown or Mark Rey at (202) 224–6170.

## NOTICE OF WORKSHOP

SUBCOMMITTEE ON FORESTS AND PUBLIC LAND MANAGEMENT

Mr. CRAIG. Mr. President, I would like to announce for the information of the Senate and the public that a workshop has been scheduled before the Subcommittee on Forests and Public Land Management to exchange ideas and suggestions on the proposed ''Public Land Management Responsibility and Accountability Restoration Act.'' The workshop will take place on Thursday, May 22, beginning at 2:00 p.m. in room 366 of the Dirksen Senate Office Building. The topic for this workshop will be to hear testimony regarding community-based solutions that have been tried concerning public land conflicts.

Testimony at these workshops is by invitation only. They are open to the public and the press. For further information, please write to the Subcommittee on Forests and Public Land Management, United States Senate, Washington, D.C. 20510, or call Mark Rey or Judy Brown of the Subcommittee staff at (202) 224–6170.

## AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON ARMED SERVICES

Mr. HELMS. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet at 2 p.m. on Thursday, April 24, 1997, in executive session to mark up S. 7, the National Missile Defense Act of 1997.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mr. HELMS. Mr. President, I ask unanimous consent that the Senate Committee on Commerce, Science, and Transportation be authorized to meet on April 24, 1997, at 10 a.m. on ISTEA Reauthorization/Truck Safety.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON GOVERNMENTAL AFFAIRS

Mr. HELMS. Mr. President, I ask unanimous consent on behalf of the Governmental Affairs Committee to meet on Thursday, April 24, 1997, at 12:30 p.m. for a hearing on opportunities for management reforms at the National Oceanic Atmospheric Administration.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON LABOR AND HUMAN RESOURCES

Mr. HELMS. Mr. President, I ask unanimous consent that the Committee on Labor and Human Resources be authorized to meet for a hearing on Overview of Vocational Education, during the session of the Senate on Thursday, April 24, 1997, at 10 a.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON RULES AND ADMINISTRATION

Mr. HELMS. Mr. President, I ask unanimous consent that the Committee on Rules and Administration be authorized to meet during the session of the Senate on Thursday, April 24, 1997, beginning at 9:30 a.m. until business is completed, to hold a hearing to consider revisions to Title 44.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON SMALL BUSINESS

Mr. HELMS. Mr. President, I ask unanimous consent that the Committee on Small Business be authorized to meet during the session of the Senate for an oversight hearing on ''SBA's Non-Credit Programs'' on Thursday, April 24, 1997, which will begin at 9:30 a.m. in room 428A of the Russell Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.

SELECT COMMITTEE ON INTELLIGENCE

Mr. HELMS. Mr. President, I ask unanimous consent that the Committee on Intelligence be authorized to meet during the session of the Senate on Thursday, April 24, 1997 at 2:00 p.m. to hold a closed hearing on intelligence matters.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON CLEAN AIR, WETLANDS, PRIVATE PROPERTY, AND NUCLEAR SAFETY

Mr. HELMS. Mr. President, I ask unanimous consent that the Subcommittee on Clean Air, Wetlands, Private Property, and Nuclear Safety be granted permission to conduct a hearing Thursday, April 24, 1997, at 9:30 a.m., on ozone and particulate matter standards proposed by the Environmental Protection Agency.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON EAST ASIAN AND PACIFIC AFFAIRS

Mr. HELMS. Mr. President, I ask unanimous consent that the Subcommittee on East Asian and Pacific Affairs of the Committee on Foreign Relations be authorized to meet during the session of the Senate on Thursday, April 24, 1997, at 2:00 p.m. to hold a hearing.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON SCIENCE, TECHNOLOGY, AND SPACE

Mr. HELMS. Mr. President, I ask unanimous consent that the Science, Technology and Space Subcommittee of the Senate Committee on Commerce, Science, and Transportation be authorized to meet on April 24, 1997, at 2 p.m. on reauthorization of the FY98 NASA budget.

The PRESIDING OFFICER. Without objection, it is so ordered.

## ADDITIONAL STATEMENTS

### MEDICARE

● Mr. FRIST. Mr. President, in 1995, my first year in the U.S. Senate, the Medicare Trustees told Congress that unless it took ''prompt effective, and decisive action * * * Medicare will be dead in seven years.''

Two years later, another Trustees' report has been delivered to Congress and we are even worse off. We still face the same tough choices. We must balance the budget, restore integrity to the Medicare trust fund, update the Medicare system and provide consumers with more choice—a cornerstone structural change that addresses the long-term viability of the Medicare program.

In the 104th Congress, the U.S. Congress realized that the fundamental way to capture the dynamics of change in the health care system would be to modernize Medicare by opening it to a broader array of private health plans that would compete on the basis of quality and not just cost.

President Clinton embraced this ideal as well by initiating a Medicare Choices demonstration and including provisions to expand choice, although I feel they are limited, in his February budget submission to the U.S. Congress.

Therefore, Senator ROCKEFELLER and I introduced S. 146, the Provider-Sponsored Organization Act of 1997. S. 146 expands the current Medicare risk contracting program to include PSO's, Provider Sponsored Organizations.

A PSO, very simply, is a public or private provider, or group of affiliated providers, organized to deliver a spectrum of health care services under contract to purchasers.

Our bill specifies detailed requirements for certification, quality assurance and solvency to ensure that PSO's contracting with Medicare meet standards that are comparable to or higher than those for health maintenance organizations [HMO's].

Specifically, the bill provides Federal leadership for States to fashion a streamlined PSO approval process that is consistent with Federal standards protecting Medicare beneficiaries.

Second, by providing incentives for PSO's and HMO's to evaluate patterns of care, it promotes state of the art continuous quality improvement.

Third, the bill creates a mechanism by which the Secretary of HHS would be allowed, but not required, to enter into partial risk payment arrangements with PSO's or HMO's.

Fourth, it outlines specific solvency standards for PSO's which reflect the peculiarities of their operating environment.

Now, why are PSO's, to my mind, a good place to start in opening up and modernizing Medicare to offer our seniors and individuals with disabilities more choice of private plan options?

First, and something very close to me as a physician and as one who has spent over 50,000 hours working in hospitals, PSO's will improve quality of health care. The creation of PSO's in the Medicare environment, I am absolutely convinced, will improve quality.

It really goes back to personal experience. But the fundamental reason is that PSO's are the care-givers. PSO's are the physicians, the hospitals, the facilities.

It is those physicians, those care-givers who are on the front line of health care every day. Thus, they are in the best position to control, monitor, and demand quality for that individual patient who walks in through the door.

It is my feeling that in a competitive managed care environment, PSO's will be at the table competing with insurance companies, competing with HMO's. But it is they, because they are the care-givers, that can bring to the table that concern for the individual patient, and demand quality which will have a spill-over effect in the negotiations in the managed care environment. There is an inherent PSO emphasis on quality because the people at the table are the people who are taking care of the individual patient.

The second issue around quality, is that S. 146 requires collective accountability, where quality and cost are measured by overall practice patterns across the entire PSO rather than just case-by-case utilization review.

It used to be that we did not know how to do that. In 1997, we do know how to do that. We look at system-wide measures of quality. The advantage of system-wide measures, instead of case-by-case utilization, is better use of resources, less intrusiveness in the doctor/patient relationship, and it is state of the art today. It is built into our bill.

S. 146 requires PSO's to meet new, higher quality standards and they must, as spelled out in our bill, have experience in the coordination of care. Thus, we will not see the creation of inexperienced groups coming forward.

That is important because of the so-called 50–50 rule, a standard which is inappropriately used as a surrogate measure for quality, requiring that plans participate in the commercial marketplace.

Well, today, because of the outline of higher quality standards, and because of the requirement for experience with the coordination of care, the 50–50 rule does not apply and would be waived for PSO's.

I should also say that non-PSO Medicare risk contractors, under our bill, would be eligible for waiving this quasi-quality measurement as long as they met the enhanced quality standards spelled out in our bill. Thus, S. 146 sets a new standard for quality assurance, a standard that I feel will set the pace for the rest of the industry.

Mr. President, the Provider Sponsored Organization Act returns to a basic concept that applies a lot to what we are doing in the U.S. Congress today. This bill will empower providers to become, once again, true partners in the clinical decisionmaking process. The PSO really does allow physicians, care-givers, and facilities to once again regain some control over what goes on at that doctor/patient relationship level.

In the U.S. Congress over the last year we have seen bills, like a 48-hour maternity stay bill post-birth, and a proposal for a 48-hour stay after mastectomy. I have even had proposals come forward to me for 5-day bills after heart surgery. Well, obviously the U.S. Congress can go in and try to micromanage body part by body part, but I do not think that is the direction to go.

By bringing care-givers to the table, by reenfranchising them, by allowing them to once again regain participation in the clinical decision-making process, we get out of that business.

Why? Because at the negotiating table in the managed care environment you have physicians and care-givers there speaking for the patient, not allowing just cost to drive what goes on in the managed care environment.

In addition, the PSO option will bring coordinated care to more communities. Again, this is terribly important because we see so much of managed care in urban areas and not in rural areas and not in under-served areas.

This bill very specifically has incentives built in it to encourage participation in those under-served and rural areas. It will very clearly, to my mind, bring managed care, coordinated care, networking of care to those communities where it is not an available choice today.

As you know, managed care has had great difficulty in attracting seniors. We know that about three-quarters of the employed population are enrolled in coordinated/managed care today. But in Medicare, only about 13 percent are enrolled.

Two reasons. Right now, the rigidity of our Medicare system does not allow any other entities besides a very narrowly defined HMO to participate in Medicare. We can agree or disagree whether to open that system up to a broad array of plans. Indeed, I think this first step of a PSO is the most reasonable way to go to begin to expand that choice.

In the State of Tennessee, the majority of Medicare beneficiaries have no choice. There is no HMO, except right in middle Tennessee. There are no other plans. Senior citizens have no choice whatsoever in Tennessee, except in Nashville, where they can choose one plan today.

The second reason, is that our seniors are scared their care is going to be taken away. They are scared to join managed care because they are scared that their local physician will be dropped from the network. Many fear that an HMO or managed care plan might drop their physician once they join it, and that frightens them a great deal.

It only makes sense that Medicare beneficiaries will feel much more secure about coordinated care knowing that they have the choice of a health care plan run by care-givers, run by physicians, nurses, and hospitals who are in their own local community. The Rockefeller/Frist bill will give them that security.

PSO's, as I mentioned, do apply particularly well to rural communities. Because the doctors and hospitals are already in the rural areas, serving the local population, it is easier for them, rather than some outside insurance company maybe located 200 miles away, to organize, network and provide a coordinated care option for seniors in what have been traditionally underserved rural areas.

Finally, given the fact that Medicare's own trustees have reported that the trust fund will soon be bankrupt, Medicare's rate of growth clearly must be slowed. The introduction of PSO's will advance market-based competition within Medicare, which I believe is absolutely essential to the long-term integrity of the entire Medicare Program, both part A and part B.

The Provider Sponsored Organization Act of 1997 builds on the PSO provision included in the Balanced Budget Act of 1995 [BBA]. The BBA created a legal definition of PSO's and developed a definition of ''affiliated provider.'' S. 146 goes one step further. It defines a Medicare Qualified PSO as a PSO that has the capability to contract to provide full benefit, capitated, coordinated care to beneficiaries.

Specific criteria for the direct provision of services by affiliated providers are spelled out in the bill. This ensures that all but a small fraction of contracted services are provided either under affiliation or by participating provider agreements.

It also ensures that current Medicare provider contracting rules, especially those that protect beneficiaries or consumers from financial liability in the event of a plan failure, will also apply to PSOs.

Since Medicare qualified PSOs do not enter the commercial market as a health plan in order to contract with Medicare, S. 146 provides Federal certification for the first four years, after which transition to State licensure is carried out.

In addition, this bill requires that the Secretary contract with states during that four year period to provide local monitoring of ongoing PSO performance, as well as beneficiary access to services. At the end of the four year period, State licensure would be required as long as State standards are sufficiently similar to the Federal standards, and the solvency standards are identical.

This approach over these initial four years, marries the benefits of national standards for a national program with the benefits of close monitoring at the State level by State agencies, an approach currently used by Medicare in certifying a variety of health care providers.

The issue of solvency. Last year's Balanced Budget Act mandated that the Secretary develop new solvency standards that are more appropriate to this PSO, provider-sponsored, environment.

Similarly, S. 146 recognizes that PSOs are different. They are not insurance companies, nor should they pretend to be insurance companies. PSOs are the caregivers themselves.

Thus, it is not necessary, because they are care-givers—physicians, nurses, and facilities—for them to go out and contract out or pay claims for health care services that they have to go out and essentially buy—as insurance companies have to do. Very different. This bill establishes these new solvency standards to protect Medicare beneficiaries against the risk of PSO insolvency.

The test of fiscal soundness is based on net worth and reserve requirements drawn from current Medicare law and the current National Association of Insurance Commissioners' (NAIC) ''Model HMO Act.'' Adjustments are made to reflect the operational characteristics of PSOs. For example, in measuring net worth, it ensures that health delivery assets held by the PSOs, such as the hospital building, are recognized just as they are in NAIC's Model HMO Act. Thus, fiscal soundness is assured.

Another issue on which the Rockefeller/Frist bill differs from the 1995 Balanced Budget Act is that it gives the Secretary authority to enter partial risk contracts, either with PSO's or HMO's.

The Balanced Budget Act required that PSO's take full risk with respect to Medicare benefits. While both bills would require that PSO's provide the full Medicare-defined benefit package, S. 146 adds a partial risk payment method, that is, payment for all services based on a mix of capitation and cost. This is actually very important if we want to have coordinated care go to our rural communities.

Now, why is PSO legislation necessary? First, current Medicare statute does not allow managed care plans to serve only Medicare patients. Instead, currently it requires these types of plans to participate also in the commercial market.

The Balanced Budget Act established the premise, that PSO's should be allowed to offer Medicare-only plans. Therefore, the rule that I mentioned earlier, the so-called 50–50 rule, is inappropriate under our bill for Medicare-only type plans.

Second, plans today are required to go through the State licensure process. Yet, the overwhelming majority of State licensure processes do not recognize the fact that PSO's differ from most insurers. Rather, States today expect them to look and act like insurers. But they are not, they are caregivers.

Senator ROCKEFELLER and I, in closing, did not introduce this legislation to eclipse the current Medicare risk contractors. Rather, the Provider Sponsored Organization Act compliments existing HMO options in the Medicare program and expands the choices available to seniors and individuals with disabilities.

This bill is narrow. It is focused. It really does not take on the broader issues of structural reform that must be addressed in Medicare. I would like to see much more choice than this bill, but this is the place to start.

Mr. President, Qualified Provider-Sponsored Organizations will challenge all health care organizations participating in Medicare to meet the goal of an integrated, coordinated health care system where quality, and not just cost, is put forward, where relationships of care-givers and their patients is preserved, and where physicians, nurses and hospitals come to the table. PSO's will challenge the entire system and the result will be higher quality.●

## SENATOR SAM NUNN SUPPORTS THE B–2

● Mr. INOUYE. Mr. President, there have been many supportive comments on the remarks I presented last week on the need to acquire nine additional B–2 global precision strike aircraft. There is one response, in particular, which I wish to share with my colleagues.

Former Senator Sam Nunn of Georgia served the Senate for many years. Through dedicated work and thoughtful analysis, Senator Nunn came to be regarded as a national authority on defense issues. I now ask that a letter in support of additional B–2 procurement, which Senator Nunn sent to Congressman DUNCAN HUNTER, chairman of the House Committee on National Security, Subcommittee on Military Procurement, be printed in today's RECORD. I believe that all Senators will benefit from a close and thoughtful reading of former Senator Nunn's letter.

The letter follows:

KING & SPALDING
*Washington, DC, March 10, 1997.*

HON. DUNCAN HUNTER,
*Chairman, Subcommittee on Military Procurement,*
*Committee on National Security,*
*U.S. House of Representatives, Washington, DC*

DEAR MR. CHAIRMAN: Thank you for asking me to provide testimony for your March 12, 1997, hearing on bomber force structure. As you know, I have been a strong supporter of the B–2 bomber program since its inception as the Advanced Technology Bomber in the early 1980's. I continue to believe that 21 B–2 bombers will not constitute an adequate force level to deal with many likely future contingencies and crises, and that no other military systems in existence or on the drawing boards can adequately substitute for the capabilities the B–2 offers. Therefore, I strongly endorse the Subcommittee's reconsideration of the future bomber force structure to include the issue of resuming production of the B–2 bomber. I believe the Subcommittee needs to carefully consider the following points in its deliberations.

*For the foreseeable future, two major hot spots will remain in the Middle East and on the Korean peninsula. Yet these set-piece scenarios should not be the only scenarios against which the adequacy of our forces (and our military strategy) are tested.

*Potential enemies have learned several valuable lessons from Iraq's experience during Operation Desert Storm don't give the U.S. time to deploy forces and their support to the theater, do focus on disrupting U.S. air operations, do target strategic objectives that allies will be reluctant to counterattack (Seoul, Saudi oil field, etc.) and plan to seize them rapidly, before U.S. power can be brought to bear.

*Future conflicts are likely to confront the U.S. with a race against time and the advance of enemy forces toward important strategic objectives (think how different it might have been if Saddam's troops had not stopped after taking Kuwait.)

*U.S. contingency planning, including the BUR analyses and the JCS ''Nimble Dancer'' wargames (and the widely criticized 1995 DOD Heavy Bomber Study), assumes the U.S. will enjoy two weeks of actionable warning prior to an enemy attack—valuable time during which our military plans to deploy forces from CONUS and Europe, and more important, to start the sealift bridge from CONUS to the theater.

*This sealift link is crucial to U.S. performance in 1990, the U.S. needed six months in which to build up forces levels and to establish the sealift pipeline to support those forces during high-intensity conflict. Yet, the adequacy of logistics support has never been adequately modeled in JCS wargames.

*In 1994, Iraq suddenly mobilized troops and sent them to the border with Kuwait The U.S. response capability raises serious questions. U.S. planning assumes two carriers in the Persian Gulf, yet there were none, U.S. planning assumes deployment of many hundreds of tactical aircraft to the theater in the first week, yet only about one hundred arrived, U.S. planning assumes prepositioned equipment aboard ships berthed at Diego Garcia in the Indian Ocean are important assets, yet these ships did not arrive until after the crisis was ended, U.S. planning assumes many precision munitions, yet supplies in the theater were low.

*If an important class of future contingencies will be those in which U.S. forces are trying to prevent an enemy surprise attack from seizing high-value targets, then U.S. forces will have to place a premium either on combat-ready forces stationed within the theater or on forces that can reach the theater and conduct effective operations in a timely fashion.