

Could this really happen, as the network originally advertised? Should you be staying up late at night to worry if your daily commute will include a rendezvous with spilled nuclear waste and Rob Lowe? Unfortunately, this movie only perpetuates Hollywood's warped depiction of all things nuclear. Because of past hype, Americans envision nuclear waste as a glowing green mass causing human and environmental meltdown on contact—not unlike the demise of the Wicked Witch of the West in the *The Wizard of Oz*. However, nothing could be farther from the truth.

If and when Hollywood comes out with another "scary" nuclear waste film, they might remember a few lessons NBC forgot. First of all, nuclear weapons are not transported by train, nor are they ever armed en route. They are moved by specially crafted 18-wheelers with the latest security and safety technologies and armed Federal agents. Even if an accident should occur, U.S. nuclear weapons are all designed to survive without detonation if jolted or engulfed in flames.

The plot of *Atomic Train* originally depicted the mutual transportation of both a nuclear weapon and nuclear waste, but NBC has changed any references to nuclear waste in the movie to "hazardous" waste. Wrong again. Federal regulations prohibit hazardous waste and nuclear waste from traveling along with nuclear weapons.

Secondly, nuclear waste is not green, glowing, or horrific to look at and great care is taken in its transportation. Spent nuclear fuel is solid, irradiated uranium oxide pellets encased in metal tubes and is non-explosive. It is transported in metal casks which will survive earthquakes, train collision and derailment, highway accident or fire.

To give credit where credit is due, the movie's trailer was right on one count—nuclear waste is transported far more frequently than most Americans realize. This is because the threat to both public and environmental health has been minimized by stringent safety protocols and close to 34 years of fine tuning. The possibility of radioactive materials harming the public en route is slim to none. Since 1965, more than 2,500 shipments of spent nuclear fuel have been transported safely throughout the U.S. without injury or environmental consequences from radioactive materials. That's a pretty good track record to go on.

Materials contaminated by radiation are also transported across the country. In fact, the first shipment of transuranic nuclear waste was safely and uneventfully transported from Idaho's own National Engineering and Environmental Laboratory (INEEL) to the Waste Isolation Pilot Plant (WIPP) in Carlsbad, New Mexico last month. It was carried in DOE certified containers and tracked by satellite during the 1,400 mile trip. The Western Governors Association worked for years to de-

velop the safest route possible and notify all emergency responders of shipment dates, routes, and even parking areas. Such shipments will become a routine matter in the years ahead.

INEEL celebrates its 50th Anniversary this year, and was the birthplace of harnessing the atom for electrical generation. Close to twenty percent of our electricity comes from nuclear energy, and remains one of the safest energy sources our country has available. Yes, nuclear waste requires special handling and precautions, but so do all of the chemical and industrial waste byproducts of our vibrant economy.

Due to the outcry over NBC's, "this could really happen," trailer, the broadcasting company has made the wise decision to pull the ads, make last minute script changes to fix some of the more blatant inaccuracies, and post a disclaimer at the beginning of the movie. Yes, this is a piece of fiction, and it is predictable that Hollywood would stray far from the truth, but it is downright irresponsible of the network to create mass hysteria to boost ratings. I can only hope that future films will promote a more intelligent plot line.

PROMOTING HEALTH IN RURAL AREAS ACT OF 1999

Mr. FRIST. Mr. President, I rise to speak in support of S.980, the "Promoting Health in Rural Areas Act of 1999," which my colleagues and I on the Senate Rural Health Caucus introduced on May 6, 1999.

There is no single issue that unites rural Americans more than access to quality health care. It is one of the most important components of good quality of life in rural areas. The ability to receive high quality health care keeps people in and attracts them to small towns. Good health care services in a community can be both a source of great pride and security and many times local hospitals are a community's largest employer.

But some of that security is being threatened. Access to health care in rural areas can be problematic. Distances are greater. Some hospitals have closed. There are fewer choices of health plans than in urban areas. The "Promoting Health in Rural Areas Act of 1999" will help to improve access for rural citizens, increase payments to providers in rural areas, and bring innovative technologies to rural areas.

Approximately 20 percent of the nation's population, or more than 50 million people, live in rural America. However, the rural population is disproportionately poor, experiences significantly higher rates of chronic illness and disability, and is aging faster than the nation as a whole. In rural areas, the elderly account for 18% of the population.

Poverty is more widespread in rural areas and in 1995 the poverty rate was 15.6% there. Poverty was especially high in minorities—affecting 35% of

rural African Americans and 31% of rural Hispanics. 22.4% of rural children live in poverty.

Health insurance coverage is also a problem. In 1996, only 53.7% of residents in rural areas had private health insurance and in 1996 about 10.5 million rural residents were uninsured. Medicare beneficiaries are more likely than the general population to reside in rural areas. Medicare spends less on rural beneficiaries than on urban beneficiaries and Medicaid covered only 45% of the rural poor. The government has a responsibility to rural communities and a responsibility to support the safety net upon which so many rural communities depend.

Before coming to the Senate, I was a heart-lung transplant surgeon. In that capacity, much of my time was spent working with rural health care providers who were caring for trauma victims eligible for organ donation. I spent many late nights flying to remote areas to harvest organs for transplantation elsewhere in the country. In this situation, I entered into their communities and worked side-by-side with rural hospitals, and their physicians, nurses, and other health professionals. These providers do an excellent job. However they work under very difficult conditions and require special attention to their particular needs.

To address the unique attributes of the health needs of the rural areas of America, I joined my colleagues in introducing this important legislation. The Promoting Health in Rural Areas Act of 1999 contains a number of provisions designed to enhance rural health.

There are provisions in the legislation to assist rural hospitals. For example, our bill reinstates the Medicare Dependent Hospital program which expired last year. This special designation directs special Medicare payments to eligible hospitals. Medicare Dependent Hospitals include rural hospitals that are not Sole Community Hospitals, have 100 or fewer beds, and at least 60% Medicare patient discharges or days. The bill also protects the Sole Community Hospitals program which aids hospitals in remote areas that serve as the sole hospital in an area.

There are also provisions to expand wage index reclassification. This means that hospitals in areas that are classified as rural can apply to use an urban wage index if they can show that their wages are similar to prevailing wages in urban areas. The provision would also direct the Health Care Financing Agency (HCFA) to establish separate wage indices for home health agencies and skilled nursing facilities so that their payments will be fairer and more accurate.

This bill would exclude Critical Access Hospitals, Medicare Dependent Hospitals, and Sole Community Hospitals from the new Medicare outpatient prospective payment system (PPS) when it is implemented. The HCFA analysis has shown that these primarily small, rural hospitals would

be disproportionately impacted by the outpatient PPS as proposed.

The bill would improve Medicare payments to rural health clinics and allow HCFA to institute a prospective payment system. Medicare currently pays Rural Health Clinics for their reasonable costs up to a per-encounter cap of \$60.40. The equivalent cap for Federally Qualified Health Center services, which was set using more recent data and a different methodology, is significantly higher (\$80.62). S. 980 updates the methodology used to calculate the per-encounter cap, which will improve payments to rural health clinics.

There are provisions in the legislation to enhance choice of health plans in rural areas. The payment formula for Medicare+Choice plans, as revised in the Balanced Budget Act of 1997 (BBA), contains substantial changes designed to lessen the variance in payments to health plans among geographic areas over time. Today, Medicare payments vary county to county by more than 350% because they had been tied to historical charges. This is not a true reflection of the cost of delivering health care and in fact penalizes rural areas with historically poor access to quality care. Therefore, S.980 adjusts the payment formulas for Medicare+Choice plans to help rural areas attract private health plans.

Attracting health professionals to rural areas, and having them remain in the those communities, has been an ongoing problem. But access to high quality medical care is improved when there is an adequate supply of practitioners who remain in the community. S. 980 improves the likelihood of attracting and retaining health care professionals in rural areas. S. 980 increases payments to practitioners serving in Health Professional Shortage Areas (HPSAs) and assists rural communities with recruiting efforts. Specifically a 10% bonus will be paid to physician assistants and nurse practitioners for outpatient services provided in these areas. Our bill also assists with recruitment of health professionals to serve rural areas. Currently a community is not allowed to recruit and hire a practitioner until the one being replaced has left. No longer would a community have to lose the practitioner, before the recruitment process could begin. In addition, tuition benefits provided as scholarships through the National Health Service Corps, would not be treated as taxable income. These changes help ensure that trained health care professionals are accessible to seniors and individuals with disabilities living in rural areas.

The bill also makes changes to assist with training of physicians in rural hospitals. S.980 would allow rural hospitals to get credit for residents who spend time training outside a hospital and in rural health clinics. It would also allow hospitals with only one residency program to add up to three residents to their limit. BBA froze the re-

imbursement for residents at 1996 levels. This was detrimental to rural areas. These changes will allow for the training of more physicians in rural areas

Mr. President, I am pleased that S. 980 would enhance telemedicine and telehealth. Under the Balanced Budget Act of 1997, Medicare has begun to pay for telemedicine consultations for patients living in rural areas that are designated as Health Professional Shortage Areas (HPSAs). The Promoting Health in Rural Areas Act would: (1) allow anything currently covered by Medicare to be reimbursed; (2) expand eligibility for telemedicine reimbursement to include all rural areas; and (3) state definitively that the referring physician need not be present at the time of the telehealth service, and clarify that any health care practitioner, acting on instructions from the referring physician or practitioner, may present the patient to the consulting physician.

In addition, the bill would formally authorize an existing group of Cabinet level and private sector members and instruct them to focus on identifying, monitoring, and coordinating federal telehealth projects. The provisions also authorize the development a grant/loan program for telemedicine activities in rural areas.

Mr. President, this bill was developed by the Senate Rural Health Caucus, of which I am a member. I am proud of the provisions directed towards rural health care providers and the benefits they will have for the citizens of rural communities.

This bill sends a strong message to rural America: Washington cares about your problems and wants to help ensure access to quality health care. This is accomplished by strengthening the Medicare program and by making the newest technology available to rural areas.

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Mr. Williams, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

REPORT OF THE ANNUAL REPORT OF THE NATIONAL INSTITUTE OF BUILDING SCIENCES FOR FISCAL YEAR 1997—MESSAGE FROM THE PRESIDENT—PM 28

The PRESIDING OFFICER laid before the Senate the following message from the President of the United

States, together with an accompanying report; which was referred to the Committee on Banking, Housing, and Urban Affairs.

To the Congress of the United States:

In accordance with the requirements of section 809 of the Housing and Community Development Act of 1974, as amended (12 U.S.C. 1701j-2(j)), I transmit herewith the annual report of the National Institute of Building Sciences for fiscal year 1997.

WILLIAM J. CLINTON.
THE WHITE HOUSE, May 13, 1999.

MESSAGES FROM THE HOUSE

At 2:08 p.m., a message from the House of Representatives, delivered by Mr. Hays, one of its reading clerks, announced that the House has passed the following bill, in which it requests the concurrence of the Senate:

H.R. 775. An act to establish procedures for civil actions brought for damages relating to the failure of any device or system to process or otherwise deal with the transition from the year 1999 to the year 2000, and for other purposes.

MEASURES REFERRED

The following bill was referred the Committee on Armed Services, pursuant to section 3(b) of Senate Resolution 400, Ninety-fourth Congress, for a period not to exceed thirty days of session:

S. 1009. A bill to authorize appropriations for fiscal year 2000 for intelligence and intelligence-related activities of the United States Government, the Community Management Account, and the Central Intelligence Agency Retirement and Disability System, and for other purposes.

MEASURES PLACED ON THE CALENDAR

The following bill was read the first and second times and placed on the calendar:

H.R. 775. An act to establish procedures for civil actions brought for damages relating to the failure of any device or system to process or otherwise deal with the transition from the year 1999 to the year 2000, and for other purposes.

EXECUTIVE REPORTS OF COMMITTEE

The following executive reports of committees were submitted:

By Mr. HELMS, for the Committee on Foreign Relations:

Treaty Doc. 105-1(A) Amended Mines Protocol (Exec. Rept. 106-2).

TEXT OF THE COMMITTEE-RECOMMENDED RESOLUTION OF ADVICE AND CONSENT

Resolved (two-thirds of the Senators present concurring therein),

SECTION 1. SENATE ADVICE AND CONSENT SUBJECT TO A RESERVATION, UNDERSTANDINGS, AND CONDITIONS.

The Senate advises and consents to the ratification of the Amended Mines Protocol (as defined in section 5 of this resolution), subject to the reservation in section 2, the