

(Five trillion, four hundred ninety-one billion, eight hundred forty-one million).

Five years ago, May 12, 1994, the Federal debt stood at \$4,577,406,000,000 (Four trillion, five hundred seventy-seven billion, four hundred six million).

Ten years ago, May 12, 1989, the Federal debt stood at \$2,764,990,000,000 (Two trillion, seven hundred sixty-four billion, nine hundred ninety million) which reflects a doubling of the debt—an increase of almost \$3 trillion—\$2,813,160,283,470.74 (Two trillion, eight hundred thirteen billion, one hundred sixty million, two hundred eighty-three thousand, four hundred seventy dollars and seventy-four cents) during the past 10 years.

DEATH OF HOLLY SELF DRUMMOND

Mr. THURMOND. Mr. President, South Carolina recently lost one of its most prominent citizens, Holly Self Drummond, who was known and admired by many throughout the Palmetto State.

“Miss Holly” passed away at the age of 77, and though she led a full life, her death still came too soon. Each of us who knew Holly Drummond remember her as a vibrant, outgoing, and gracious lady who was a pillar of her community and an individual who embodied all that is good about the South.

This was a woman who distinguished herself in many ways throughout her life. She was active in any number of organizations that made her community and our State better places to live. She served as a member of the South Carolina Palmetto Cabinet; the Greenwood Woman's Club; the Sasanqua Garden Club of Ninety Six; and, on the Board of Visitors of Winthrop University and Piedmont Technical College. She was also active in her local church, and of course, was a fixture at the State House where her able husband has served for many years. Her contributions truly benefited others and served as an example of civic mindedness that others strove to emulate.

Holly Drummond's passing is sadening for many reasons. My grief is deepened for this woman was a loyal supporter, and more importantly, a valued friend. I had known Holly for more years than I can remember, and her family was well known to me.

Mr. President, Holly Self Drummond's passing leaves a tremendous void not only in the town of Greenwood and the State House of South Carolina, but in the lives of the many men and women who called her “friend.” Holly Drummond will not soon be forgotten, and I am certain that all those who knew her would join me in sending condolences to her family.

DERAILING NBC'S ATOMIC TRAIN

Mr. CRAIG. Mr. President, scare tactics may boost your ratings, but they won't do much for your credibility—especially when you advertise fiction as fact. This weekend, NBC will air a miniseries that is so far from plausible it is indeed laughable. The plot for this hyped up film revolves around a horrifying nuclear accident stemming from the transportation of nuclear weapons and hazardous waste on a train from California to Idaho.

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 environ-

mental 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 develop 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 profes-

sionals 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 reimbursement 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.