EXTENSIONS OF REMARKS

COLON CANCER SCREEN FOR LIFE ACT OF 2002

HON. BENJAMIN L. CARDIN

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

Friday, February 8, 2002

Mr. CARDIN. Mr. Speaker, I rise today to introduce the Colon Cancer Screen for Life Act of 2002. Colorectal cancer is the number two cancer killer in the United States. This year, an estimated 135,400 new cases will be diagnosed and 56,700 Americans will die from the disease. My home state of Maryland ranks 7th in the nation in the number of new cases and in the number of deaths. Our nation's capital, Washington, D.C., ranks first in the nation.

Colorectal cancer disproportionately impacts the elderly. The risk of colorectal cancer begins to increases after the age of 40 and rises sharply at the ages of 50 to 55, when the risk doubles with each succeeding decade. Despite advances in surgical techniques and adjuvant therapy, there has been only a modest improvement in survival for patients who present with advanced cancers.

The good news is that colorectal cancer can be prevented, and is highly treatable when discovered early. Most cases of the disease begin an non-cancerous polyps which can be detected and removed during routine screenings—preventing the development of colorectal cancer. Screening tests also save lives even when they detect polyps that have become cancerous by catching the disease in its earliest, most curable stages. The cure rate is up to 93 percent when colorectal cancer is discovered early.

Recognizing the importance of early detection in preventing colorectal cancer deaths, Congress in 1997 enacted a Medicare colorectal cancer screening benefit. Medicare currently covers either a screening colonoscopy every ten years or a flexible sigmoidoscopy every four years for average-risk individuals. Beneficiaries identified as high risk are entitled to a colonoscopy every two years.

Despite the availability of this benefit, very few seniors are actually being screened for colorectal cancer. Since its implementation in 1998, the percentage of Medicare beneficiaries receiving either a screening or diagnostic colonoscopy has increased by only one percent.

Why aren't more seniors being screened? I believe the problem is due, in part, to rapidly declining colorectal screening reimbursement levels. By 2002, Medicare reimbursement for diagnostic colonoscopies performed in an outpatient setting will have declined 36% from initial 1998 levels. For flexible sigmoidoscopies, payment in 2002 will be 54% less. Colorectal cancer screening will not be effective if it is a ''loss leader'' for doctors.

While reimbursement has dropped across the board, cuts have been particularly harsh for screenings provided in hospital outpatient departments (HOPDs) and ambulatory surgery centers (ASCs). In 1997, a colonoscopy performed in one of these settings was reimbursed at approximately $301. Now in 2002, the rate has fallen to about $213.

The facility-specific cuts provide incentives for physicians to perform screenings in their offices, where reimbursement rates have remained between 68% and 108% higher. As you know, Medicare has established its own criteria for both ASCs and HOPDs to ensure high quality of care and patient safety. While there are office facilities where endoscopy is safely performed, physicians' offices are, for the most part, unregulated environments. The site-of-service differential could interfere with the clinical decision-making process, at the expense of patient safety.

In addition, Medicare currently pays for a consultation prior to a diagnostic colonoscopy, but not for a screening colonoscopy. Since colonoscopy involves conscious sedation, physicians generally do not perform them without a pre-procedure office visit to ascertain a patient's medical history and to educate patients as to the required preparatory steps. In fact, several states now require physicians to consult with patients prior to procedures involving conscious sedation. Because Medicare will not pay for pre-screening consultations, many physicians must provide them for free.

And, unlike screening mammography, colorectal cancer screening tests are subject to the Medicare Part B deductible, which discourages beneficiaries from seeking screening.

My colleague, Representative PHIL ENGLISH, joins me today to introduce this important legislation. This bill is supported by the American College of Gastroenterology, the American Society for Gastrointesinal Endosopy, and the American Gastroenterological Association. It would improve beneficiary utilization and help ensure the safety of colorectal cancer screening by doing three things.

First, it would increase reimbursement for colorectal cancer related procedures to ensure that physicians are able to cover the costs of providing these valuable services.

Second, our bill will provide Medicare coverage for a pre-screening office visit. If Medicare will pay for a consultation prior to diagnostic colonoscopy, it also should pay for a consultation before a screening colonoscopy.

Third, the bill would exempt colorectal cancer screening procedures from the customary Medicare deductible requirement. By reducing the financial requirements on the beneficiary, this law will encourage increased access to colorectal screening services.

The preventive benefits we authorized in 1997 were an important step toward fighting this deadly disease. But the colorectal cancer screening program is in danger of failing without our intervention. I strongly urge all my colleagues to support this critical legsilation.

PERSONAL EXPLANATION

HON. CAROLYN B. MALONEY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Friday, February 8, 2002

Mrs. MALONEY of New York. Mr. Speaker, on January 29, 2002, I was unavoidably detained and missed Rollcall vote No. 5. Rollcall vote 5 was on the motion to suspend the rules and agree to a resolution honoring the contributions of Catholic schools.

Had I been present I would have voted ''yea'' on rollcall vote 5.

EXPRESSING SENSE OF HOUSE THAT SCHEDULED TAX RELIEF SHOULD NOT BE SUSPENDED OR REPEALED

SPEECH OF

HON. SHEILA JACKSON-LEE

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, February 6, 2002

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise to oppose this resolution on the floor this morning. H. Con. Res. 312 instructs the Congress to push for more tax cuts, thereby eliminating necessary funds to help senior citizens, families, and laid-off workers.

My colleagues that stand on the other side of this have always emphasized that this Congress must put forth every effort to work together in a bipartisan way. We have worked together to pass such legislation as airline security, and H.R. 1, the ''Leave No Child Behind Act of 2001.'' But, Mr. Speaker, this resolution only separates this body along party lines. It disregards the future of our country.

We all received a copy of the President's budget on Monday. It, among other things, envisions an $80 billion deficit even while proposing an actual decline in spending for domestic programs not related to defense or homeland security. How will it be possible to adhere to President Bush's budget? The only way is by invading Social Security and Medicare and cutting program funding in such important areas as education and agriculture.

I did not support the President's tax cut last year because such a plan would have forced him to break his promise to not invade Social Security. Over the next 10 years, the President's budget would invade Social Security surpluses by approximately $1.4 trillion and invade Medicare surpluses by approximately $550 billion. Again, Mr. Speaker, this resolution disregards the future of our country. The President says that our current war on terrorism has cost $1 billion per month and is the primary reason for the deficit. We, as a nation, have experienced tremendous pain as a result of September 11. But our pain pales to the loss experienced by families of the victims. During this healing period, a time when they rely on our leadership to provide medical care,

security, and a promise for the future, we will be turning our backs if we act irresponsibly and continue with the tax relief.

The recent financial tragedy in Houston, and the alleged improprieties that led to the bankruptcy of energy giant Enron, demands that we take care of those victims who lost their entire life savings and benefits. We need to pass legislation that extends unemployment benefits to hard-working Americans that have lost their job through no fault of their own, who are without any income or health care. This would be a better use of federal funds.

Furthermore, we must act responsibly and pass a prescription drug benefit plan for our seniors on Medicare. Many of these seniors are on fixed incomes, continuously struggling to pay their rent and put food on their table. The prices of prescription drugs are outrageous and we must work toward providing access to our seniors. Federal dollars must be used to help people who need it the most. If we are to serve our country responsibly, I urge my colleagues to oppose this resolution.

H.R. 1343

HON. STEPHANIE TUBBS JONES

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Friday, February 8, 2002

Mrs. JONES of Ohio. Mr. Speaker, I rise today in support of H.R. 1343, the Local Law Enforcement Hate Crimes Prevention Act. It is time that we pass meaningful hate crimes legislation.

Over the past several years, we have witnessed a rash of violent hate crimes across America. And while no law can effectively outlaw bigotry, it can be fought by imposing stricter penalties upon those who commit hate crimes, by making the laws more inclusive, and collecting more accurate information about hate crimes.

We need to pass legislation that prohibits offenses involving actual or perceived race, color, religion, national origin, gender, sexual orientation, or disability.

Right now, in my Congressional district, there is a billboard across the street from a public library that is filled with hate for persons because of the color of their skin. Now, while I support freedom of speech, I also believe that the community can speak out against hatred. History has shown us that hate has the potential of criminal behavior.

I urge my colleagues to vote for legislation that will sustain the fabric of this Nation and lead us toward a more united America. I encourage my colleagues to vote for H.R. 1343.

IN RECOGNITION OF AFRICAN-AMERICAN NATIONAL HIV/AIDS DAY

HON. CHARLES B. RANGEL

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Friday, February 8, 2002

Mr. RANGEL. Mr. Speaker, I rise to shed light once again on a vicious scourge that has gripped the African-American community for years and continues to strangle the life of a great number of our people. Today, the CDC estimates that 284,000 of the 740,000 individuals infected with HIV are African-Americans. In other words, African-Americans make up almost 38 percent of all AIDS cases reported in this country.

Men, women and children are being infected at staggering rates. For example, nearly 47 percent of the 46,400 AIDS cases reported in 1999 (21,900 cases) were reported among African-Americans. Almost two-thirds (63 percent) of all women reported with AIDS were African-American and African-American children represent almost two-thirds (65 percent) of all reported pediatric AIDS cases. We have all heard the numbers and we all know they are astounding.

More disheartening is that despite the advances in medical therapy, many African-American patients continue to reject physician recommendations for therapy. Many patients rely totally upon nutritional programs, herbal formulas, and other empirical modalities of unproved efficacy.

Research has shed some light on the possible reasons for the lack of program participation by African-Americans infected with HIV. Results from surveys indicate that African-Americans with AIDS may believe that combination drug therapy is to costly to afford. It is true that these therapy treatments may exceed $7,000 a year but they are effective. In addition, most commercial insurance plans like Medicare and Medicaid will cover these costs. Many States included my home State of New York have programs which will provide supplemental payments for AIDS treatment (Aids Drug Assistance Program ADAP).

Also, most of the pharmaceutical companies which manufacture drugs used in the treatment of HIV/AIDS related illness have compassionate use programs for patients without insurance and who do not qualify for Medicaid. Patients usually can get assistance from physicians in enrolling for these programs and social service workers in public clinics and hospitals also will provide information and assistance for patients in need.

Given all these advances in drug treatment protocols and supportive strategies among front-line care workers, there is still a high number of African-Americans dying from the virus. Moreover, the number of individuals dying from the virus is often overshadowed by the daunting numbers that are getting infected with the virus everyday.

This suggests that we as Americans must do more to curb the increase of HIV/AIDS particularly in the African-American community. We must use a more comprehensive approach in addressing the issue.

We all know the statistics, the question is what do we do about it. I believe that a comprehensive approach to addressing the problem, which includes strategies developed with the assistance of community stakeholders, should be adopted.

The following plans should be included in this comprehensive program to fight the HIV/AIDS in the African-American community.

The Department of Health and Human Services, the Centers for Disease Control, and state health agencies must work with African-American grassroots organizations, Black churches, penal institutions, schools, clinics, hospitals, the media, and community and civic groups to ensure that the development of the planning process includes the voices all the stakeholders in the community.

Efforts should be directed to communities at greatest risk.

Plans should include access to voluntary HIV counseling, testing, and confidential notification of potentially exposed partners with voluntary counseling.

Plans should reach HIV-infected individuals and link them with care and treatment services.

Plans should incorporate comprehensive efforts that reduce sexual risk behavior. Programs that strongly emphasize abstinence, monogamy, or consistent and correct use of latex condoms among those who are sexually active should be considered. Most important, stakeholders should examine what elements in the comprehensive approach is likely to be effective in their communities.

Plans should include comprehensive efforts that reduce drug-related behavior.

Plans should use comprehensive school based programs and programs for out-of-school youth to provide HIV/AIDS prevention and intervention.

Plans should include efforts to improve prevention programs in correctional facilities.

I believe that these plans, if used as part of a comprehensive program with the assistance of community stakeholders, will make a difference in decreasing the prevalence of HIV/AIDS in the African-American community. In sum, education, testing, treatment, and counseling are keys to an HIV/AIDS free society.

PERSONAL EXPLANATION

HON. CAROLYN B. MALONEY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Friday, February 8, 2002

Mrs. MALONEY of New York. Mr. Speaker, on February 7, 2002, I was unavoidably detained and missed rollcall vote number 12. Rollroll vote 12 was on agreeing to the resolution to providing for consideration of H.R. 3394, the Cyber Security Research and Development Act.

Had I been present I would have voted ''yea'' on rollcall vote 12.