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### FOLDER TITLE:

Medicare- New Preventive Benefits [1]

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### RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
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# National Association for the Advancement of Colored People

1000 U Street, N.W., Suite 100 – (202) 667-1700 – Washington, D.C. 20001

## DISTRICT OF COLUMBIA BRANCH

March 27, 1997

The Honorable William Thomas, Chairman  
Health Subcommittee  
House Ways and Means Committee  
U.S. House of Representatives  
1102 Longworth HOB  
Washington, D.C. 20515

Dear Mr. Chairman:

I would like to commend you for convening a hearing on the issue of Medicare coverage for preventive benefits. The legislation you have introduced, the Medicare Preventive Benefits Improvement Act, H.R. 15, is a good first step towards addressing the health concerns of African Americans, who suffer disproportionately from diseases such as breast cancer, prostate cancer, and colorectal cancer. While I support the overall effort to enact preventive benefits legislation represented by H.R. 15, I believe that significant changes need to be made to address the colorectal cancer screening provisions of this legislation, which I believe are inadequate for screening the African American population.

You and I would agree that preventive screening is the key to detecting colorectal cancer in its earliest stage, so colorectal cancer can be treated and removed before it becomes fatal. It is my understanding that over the years you have supported several bills that provide Medicare coverage for colorectal cancer screening, and I applaud your efforts.

However, I am very concerned about the impact of H.R. 15 on the African American community. As it stands now, African Americans who develop colorectal cancer have a fifty percent greater mortality rate than the general population. In addition, medical studies have shown that African Americans disproportionately develop cancer in the right side of the colon, which means that African Americans need access to screening procedures that can view the entire colon. Legislation that provides for screening with only fecal occult blood tests and flexible sigmoidoscopy is inadequate to meet the screening needs of African Americans. In addition, the high-cost and risk associated with colonoscopy also make this procedure an inadequate solution for screening African Americans for colorectal cancer. African American patients and their doctors should be given a choice of all available options.

As mentioned, the issue of choice is crucial for African American patients and their doctors when deciding which procedures to use for colorectal cancer screening. The Medicare Preventive Benefits Improvement Act (H.R. 15), does not provide Medicare coverage for all commonly used colorectal cancer screening procedures, and therefore, limits the choices of doctors and patients. This legislation would have a devastating effect on screening for African Americans, who would be denied access to one of the most cost-effective procedures for screening the entire colon, the barium enema. This lack of access to such an important screening procedure will needlessly cost thousands of lives.

Colorectal cancer screening is an important issue for all Americans, not only African Americans. Patients and doctors, whether they are African American or not, should decide which screening procedures are appropriate -- not the federal government.

I urge you to support the provisions included in bi-partisan legislation introduced by Congressman Alcee Hastings and co-sponsored by members of the Congressional Black Caucus which provides Medicare coverage for colorectal cancer screening using all commonly used procedures including fecal occult blood tests (FOBT), flexible sigmoidoscopy, colonoscopy, and the barium enema. Congressman Hastings' legislation, the Colorectal Cancer Screening Act, provides the same Medicare coverage for FOBT, flexible sigmoidoscopy, and colonoscopy as H.R. 15, but also corrects a significant omission in H.R. 15 by including the barium enema. I believe that Congressman Hastings' provisions should be included in H.R. 15 to give all Americans a complete choice of colorectal cancer screening procedures.

Once again, thank you for your work to support and promote Medicare coverage for preventive benefits. As a supporter of Medicare coverage for preventive services, I also thank you in advance for pursuing the passage of inclusive colorectal cancer screening legislation which is not biased against African Americans.

Please include these remarks in the record of your March 13, 1997 Health Subcommittee hearing.

Sincerely,

  
Rev. Morris L. Shearin, President  
Washington D.C. NAACP

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# COMMENTARY

## PREVENTIVE STEPS

# Blacks Need Better Access to Screening Tests for Cancer

RICHMOND.

**A** recent symposium on "Race and Health Care as We Approach the Twenty-First Century" at Virginia Commonwealth University was the first of what will be annual topical discussions on matters of utmost concern to all of us. I was privileged, in my post at the Center for Public Policy, to convene the two-day meeting. Participants included scholars who have achieved national acclaim for providing solutions to the problems; they represented a broad spectrum of women, minorities, academicians, practitioners, and others. The participants discussed not only the unique challenges faced by African Americans in health care, but also the obstacles they face in gaining access to adequate screening for certain kinds of cancer.



**L. DOUGLAS WILDER**

adequate screening for certain kinds of cancer.

At a time when the President and Congress are considering measures to provide preventive screening to the Medicare population for certain cancers, it is essential that we consider the differences in how cancer manifests itself in African Americans, and what this means to appropriate screening.

The challenge is particularly acute for prostate and colorectal cancers. The data on these diseases are clear and simple: While the nation's focus has been on the 40,000 deaths each year from AIDS and the more than 44,000 deaths each year from breast cancer in the United States, it is important to recognize that colorectal cancer will claim more than

50,000, and prostate cancer more than 42,000, Americans in 1997. For African Americans, the statistics are particularly frightening, as African Americans are struck more frequently than, and differently from, other Americans. And surprise, surprise, there are no genetic or hereditary deficiencies that account for this.

FOR PROSTATE cancer, African American males have the highest incidence in the world — 66 percent higher than white men, with a mortality rate more than two times higher. If detected while localized, the five-year survival rate for prostate cancer is 99 percent. For colorectal cancer, the mortality rate among African Americans continues to rise, even as the American Cancer Society reports declines in colorectal cancer among other segments of the population.

African Americans who get colorectal cancer are 50 percent more likely to die of the disease than others in this country. In addition, the disease affects African Americans differently from the way it affects white Americans: The National Cancer Institute's Black/White Cancer Survival Study found that African Americans have a greater tendency to get colorectal cancer in the right colon — the portion not reached by sigmoidoscopy — than other Americans, explaining, at least in part, the higher mortality rate from the disease. These data illustrate the special importance of regular prostate and colorectal screening for African Americans to detect these cancers at the earliest stages and, to the extent possible, correct the disparity in the incidence of the disease.

What can be done to meet the challenge of reducing the mortality rate for these cancers among all segments of the Medicare population? I am pleased to see that Medicare coverage for preventive screening benefits is one area where President Clinton and Repub-

lican congressional leaders appear to agree. President Clinton has recognized the importance of preventive screening, and his FY 1998 budget proposes to extend Medicare coverage to include screening for prostate and colorectal cancer, as well as other preventive benefits. In addition, a group led by Republican Congressmen Bill Thomas and Mike Bilirakis, who head the two key Health Subcommittees in the House of Representatives, has introduced legislation to provide similar benefits under Medicare. Similar efforts are underway in the U.S. Senate as well. With bipartisan support, these important screenings will be available to all elderly Americans served by Medicare.

THE EXTENSION of Medicare coverage to include these new benefits makes screening of the entire colon — with colonoscopy or barium enema — possible for early detection of colorectal cancer. Key members of the U.S. Congress have adopted an approach that provides appropriate choice for patients in the Medicare population, including the African American population and other Medicare recipients who prefer a comprehensive screening option. Congressman Norman Sisisky of Virginia, himself a colorectal cancer survivor, has taken a leading role in advocating regular preventive screening and has indicated that his "mission in the 105th Congress [is] to enact Medicare coverage for colorectal cancer screening."

Congressman Sisisky has supported the excellent work of Congressman Alcee Hastings and Senator John Breaux, who in the 104th Congress introduced legislation in the House and Senate to provide Medicare coverage for colorectal cancer screening and who are likely to do so again in the 105th Congress. Their approach has also been supported by a number of members of the Congressional Black Caucus, including the

distinguished Ranking Member of the Ways and Means Committee, Congressman Charles Rangel. Caucus members know and understand the special needs of the African American population and are personally committed to providing appropriate screening options to accommodate those needs.

Legislation alone will not be enough to persuade Americans — including African Americans — to undergo preventive screening. A broad public education campaign is needed to foster serious discussion about the benefits of these screening procedures for all Americans. I hope part of this campaign will provide African Americans with information about the special impact of these cancers on our population, and about our special screening needs. I am pleased that the American Gastroenterology Association recently published recommendations for regular colorectal cancer screening, which recommended procedures appropriate for the African American population. I understand the American Cancer Society will also be issuing its recommendations for preventive colorectal cancer screening.

IT IS vitally important that preventive screening be covered by Medicare and that all Americans — including African Americans — have access to affordable, appropriate screening methodologies. Now is the time to act. I challenge President Clinton and the Republican-led Congress to make good on their promise to the American people that the next two years will be ones of action rather than delay and partisanship.

In this instance, the lives of tens of thousands of elderly Americans could be saved and their quality of life improved if President Clinton and the Congress have the courage to meet the people's challenge to work together for the common good.

■ L. Douglas Wilder is a former Governor of Virginia.



THE VICE PRESIDENT  
WASHINGTON

April 1, 1997

The Honorable L. Douglas Wilder  
Distinguished Professor  
Virginia Commonwealth University  
Richmond, VA 23284-2028

Dear Doug:

Recently, I read of the "Race and Health Care as We Approach the 21<sup>st</sup> Century" symposium that you led earlier this year. I would like to join U.S. Representative Norman Sisisky in applauding your efforts to bring attention to the public health policy challenges facing the African-American community.

In particular, you are to be commended for exploring at your symposium the issue of colorectal cancer screening. Preventive screening is critical for all Americans, especially African-Americans who suffer disproportionately from this disease. Your efforts to highlight the importance of screening can literally save the lives of thousands of people.

Again, I want to congratulate you on your symposium and offer my best wishes for your future success. Tipper and I look forward to seeing you soon.

Sincerely,

Al Gore

STATEMENT

The Honorable L. Douglas Wilder  
Distinguished Professor  
Virginia Commonwealth University  
Center for Public Policy

before

The House Committee on Ways and Means  
Subcommittee on Health  
"Improving Medicare's Preventive Benefits"

March 13, 1997

Mr. Chairman, I am pleased to submit this statement on a subject of great interest to me: improving Medicare's preventive benefits, especially screening for colorectal and prostate cancers, two of the most deadly cancers. Colorectal cancer will claim more than 50,000 and prostate cancer more than 42,000 Americans in 1997. As the Congress considers H.R. 15 and other measures to provide preventive benefits under Medicare, it is vitally important that we consider the differences in how these and other cancers manifest themselves in African Americans, and ensure that this population has access to appropriate screening.

This subject is particularly timely. In January, in conjunction with Virginia Commonwealth University, I held a Symposium entitled "Race and Health Care as We Approach the 21st Century," which focused not only on the unique challenges African Americans face in health care, but also on the obstacles this population faces in gaining access to adequate screening for certain kinds of cancer. Among the distinguished participants was the past president of the American Cancer Society who participated in a discussion about the particular needs of African Americans with regard to some of the screenings included in your legislation.

Mr. Chairman, you are probably unaware that African Americans are struck with certain cancers more frequently -- and differently -- than other Americans, yet no genetic or hereditary reasons have been identified which account for this. The challenge is particularly acute for prostate and colorectal cancers, where the statistics are astonishing. *African American males have the highest incidence of prostate cancer in the world -- 66 percent higher than white men, with a mortality rate more than two times higher.* Access to adequate screening can dramatically improve these statistics. As you may know, if detected while localized, the 5-year survival rate for prostate cancer is 99 percent.

For colorectal cancer, the mortality rate among African Americans continues to rise, even as the American Cancer Society reports declines in colorectal cancer among other segments of the population. *African Americans who get colorectal cancer are 50 percent more likely to die of the disease than others in this country.* In addition, the disease affects African Americans

differently than it affects white Americans: the National Cancer Institute's Black/White Cancer Survival Study found that African Americans have a greater tendency to get colorectal cancer in the right colon -- the portion not reached by sigmoidoscopy -- than other Americans, explaining, at least in part, this higher mortality rate from the disease. These data illustrate the special importance of regular prostate and colorectal cancer screening for African Americans to detect these cancers at the earliest stages and, to the extent possible, correct the disparity in the incidence of the disease.

If enacted, H.R. 15 would take an important step in providing adequate screening for all Americans, including African Americans. However, I am deeply disturbed by one aspect of your bill, which is inadequate for screening African Americans. Because colon cancer manifests itself more frequently in the right colon of African Americans, it is vitally important that the entire colon be screened for the disease to ensure early detection of the disease. Indeed, it is important that all Americans have the option of screening the entire colon because as many as 50% of colon cancers occur in the right colon. Flexible sigmoidoscopy therefore may be inadequate for a broader segment of the population.

H.R. 15's approach for those at average risk would provide screening only with flexible sigmoidoscopy, which screens only the left colon. Indeed, the bill provides a total colon exam for average risk individuals only if the Secretary of Health and Human Services ("HHS") certifies the barium enema -- a common procedure used today for colon cancer screening -- is appropriate. The bill directs the Secretary of HHS to complete this review within two years from enactment, which means that -- at best -- this approach delays reimbursement for barium enema for at least that amount of time. More realistically, this approach probably delays coverage for many years, as HHS usually misses even statutorily-mandated guidelines. In the meantime, **hundreds and perhaps thousands of African Americans** -- and quite possibly members of other racial and ethnic groups -- **will die** due to inadequate screening for colorectal cancer. Even those who are screened will be denied reimbursement for the appropriate procedure.

President Clinton and key Members of the U.S. Congress, both Republican and Democratic, have adopted an approach that provides appropriate choices for patients in the Medicare population, including the African American population and other Medicare recipients, who prefer a comprehensive screening option. My good friend Congressman Norm Sisisky, of Virginia, himself a colorectal cancer survivor, has taken a leading role in advocating regular preventive screening and has indicated that his "mission in the 105th Congress [is] to enact Medicare coverage for colorectal cancer screening." Congressman Sisisky has supported the excellent work of Congressman Alcee Hastings, of Florida, Congresswoman Louise Slaughter, of New York, and Senator John Breaux, of Louisiana, who in the 104th Congress introduced legislation in the House and Senate to provide Medicare coverage for colorectal cancer screening and who are likely to do so again in the 105th Congress. Their approach has also been supported by a number of members of the Congressional Black Caucus, including the distinguished Ranking Member of the Ways and Means Committee, Rep. Charles Rangel (D-NY), who know and understand the special needs of the African American population and are personally committed to providing

appropriate screening options to accommodate those needs. I urgently ask that you reconsider your position and agree to substitute their approach to colorectal cancer screening.

I recognize that legislation alone will not be enough to convince Americans, including African Americans, to undergo preventive screening. A broad public education campaign is needed to foster serious discussion about the benefits of these screening procedures for all Americans. I will do all I can to ensure that part of this campaign will be providing African Americans throughout the United States and in your Congressional District with information about the special impact of these cancers on our population, and on our special screening needs. I am pleased that the American Gastroenterology Association recently published recommendations for regular colorectal cancer screening, which recommended procedures appropriate for the African American population. I understand the American Cancer Society will also be issuing similar recommendations for preventive colorectal cancer screening.

It is vitally important that preventive screening be covered by Medicare and that all Americans -- *including African Americans* -- have access to affordable, appropriate screening procedures. I commend the Chairman for his leadership and, with the changes I have urgently recommended, urge enactment of this important legislation. Now is the time to act. The lives of tens of thousands of elderly Americans could be saved and their quality of life improved if the Congress and President Clinton have the courage to meet the people's challenge to work together for the common good.

Testimony of the  
Honorable Norman Sisisky  
Subcommittee on Health  
House Committee on Ways and Means  
Hearing on Medicare Preventative Benefits  
March 13, 1997

Mr. Chairman, I would like to thank you and the Members of the Subcommittee for the opportunity to testify before you today on the issue of Medicare preventative benefits and the bill H.R. 15, the "Medicare Preventative Benefit Improvement Act of 1997."

I want to commend you Mr. Chairman, and Representative Cardin, for your leadership on this important legislation, and for making this legislation a bipartisan initiative. It is particularly important that partisan differences and the intense focus on controlling costs in the Medicare program not divert this Committee and the Congress from making needed improvements in the program. Indeed, at a time when there are fewer Medicare dollars available, it is critical that Medicare funds be spent in the most cost-effective manner possible. I think that the committee understands that we can save lives and control costs, and this legislation is an important step in that direction. I look forward to working with you to see the enactment of Medicare preventative benefits in the 105th Congress.

My testimony today addresses the provisions in this legislation that would establish Medicare coverage for colorectal cancer screening. This is an issue which I have an intense personal interest because I was struck with colorectal cancer less than two years ago. I am one of the fortunate ones whose cancer was detected in a routine screening. Many are not so fortunate, but today I am finished with my treatments and I feel great.

Mr. Chairman, there are moments in everyone's life that they will never forget. One such moment came for me when my doctor called me into his office and told me that I had colorectal cancer. I did not know at the time but I was one of more than 150,000 Americans who would hear that message during the year. What I did know is that I and my family were about to face a challenge unlike any other we had experienced.

As I learned more about the disease of colorectal cancer and my own situation, I made two commitments. First, I committed to myself and my family that I would do whatever I could to beat this disease. No matter what was required -- surgery, radiation, chemotherapy, or other procedure or treatment -- I was going to fight as hard as I could to be a cancer survivor. I was determined then, and am determined today, that I will not be among the 45,000 Americans who die each year from colorectal cancer.

Second, I committed that, as a Member of Congress, I would do whatever I could to help people beat his disease. As I learned more about this disease, it became apparent that the most significant hope for reducing the number of Americans who get colorectal cancer, and reducing the mortality rate from the disease, is colorectal cancer screening. Because colorectal cancer generally develops over a five to ten year period, a comprehensive screening program beginning

at age 50 has the potential to save thousands of lives that would otherwise be lost to this disease.

The place to start a national colorectal screening program is with the Medicare population. If we can establish colorectal cancer screening as an essential test for the Medicare population, there is reason to hope that private insurers, HMOs, and other health care payors will follow our lead and begin to provide coverage for screening individuals between the ages of 50 and 65. Mr. Chairman, I am greatly encouraged by the efforts of you, and Representative Cardin, in producing legislation that would establish a colorectal cancer screening program within Medicare.

While I appreciate the leadership you have shown on this issue, Mr. Chairman, I must today voice a concern with H.R. 15 as it is currently written. The problem I have is that H.R. 15 fails to cover one of the most cost-effective colorectal cancer screening procedures currently available, the barium enema screening procedure. The barium enema is recommended for colorectal screening by such organizations as the American Cancer Society, the American College of Gastroenterology, the American Gastroenterological Association, the American College of Physicians, the Blue Cross/Blue Shield Association of America, the Academy of Family Physicians, and the American College of Radiology. Further, it was determined by the Office of Technology Assessment that the barium screening was one of the two most cost-effective procedures for screening individuals at average-risk for colorectal cancer, and was found to be the most cost-effective for screening individuals at high-risk for colorectal cancer in a study by Dr. David Eddy. A soon to be released "evidence report" by the Agency for Health Care Policy and Research also concluded that there is evidence to support the use of the barium test as a screening procedure for individuals at average and high-risk for colorectal cancer.

The barium enema is particularly important to African Americans who, according to a number of recent studies, are more commonly struck by colorectal cancer in a portion of the colon that is not reached by sigmoidoscopy. It is my understanding that under H.R. 15, sigmoidoscopy is the only procedure covered by Medicare recipients who are at average-risk for colorectal cancer. Mr Chairman, I'm not a doctor. I came to understand many of these issues through my treatment as a patient. As a cancer patient and a Member of Congress, I do not believe that we can tolerate the fact that the mortality rate for African Americans who get colorectal cancer is 50% higher than for all other Americans with colorectal cancer. I believe that H.R. 15 needs to address this situation and establish a colorectal cancer screening program within Medicare that is adequate to detect the disease where it most commonly occurs in African Americans. This way, we can be sure that we are providing the most comprehensive screening package available for every American.

The former Governor of Virginia, the Honorable Douglas Wilder, recently held a Symposium at Virginia Commonwealth University on "Race and Health Care As We Approach the 21st Century" at which there was an extensive discussion of how this country has failed to meet the needs of African Americans. I have enclosed with my testimony a written statement by Governor Wilder, and ask that it be included in the appropriate section of the hearing record.

It is my further understanding of H.R. 15 that the bill includes a provision that directs the

Secretary of Health and Human Services to study the barium enema and determine, within two years, whether Medicare coverage should be extended to this procedure as well as those specified in the bill. Mr. Chairman, I do not believe that there is any reason why the barium test should be treated differently than the other tests that are specified in the bill. Mr. Chairman, the barium test has to be included. Believe me, I have had this procedure and there is nothing pleasant about it. If you have had it, you know that there is no doctor, anywhere, who would require a patient to get screened by this procedure if they did not absolutely need to. If the bill excludes Medicare coverage of the barium enema, it will deny patients and their doctors the option on using this procedure. I really think that is wrong.

I am aware that there is at least one medical specialty association which has put forward a number of arguments as to why this procedure should be excluded or delayed under Medicare. Mr. Chairman, I urge you and the Members of the Subcommittee to read the reports I have cited in my testimony and review the overwhelming evidence to the contrary if you have any doubts. I urge you to read in particular the reports which have been published within the past six weeks -- including the report that is endorsed by one medical specialty association that has opposed coverage of the barium test. All of these reports and recommendations include the option of using the barium enema to screen for colorectal cancer -- H.R. 15 should provide that option as well. We must make sure that this legislation is based on the best medical techniques that exist to protect patients from colorectal cancer and help them fight this killer.

In conclusion, I would like to leave the Members of the Subcommittee with one thought. It is time for the Medicare program to include coverage of screening for colorectal cancer. I could afford to have these tests done. Many people cannot, especially those who live in lower economic circumstances. A comprehensive colorectal cancer screening program can save tens of thousands of lives, and it can reduce the pain and suffering that comes with this disease. I speak from personal experience on this matter, and I hope we can all work together in the bipartisan spirit with which you developed this legislation to see this program enacted into law.

Thank you again for the opportunity to testify before the Subcommittee. I would be pleased to answer any questions you may have.



For More Information Contact:  
Robert Smith at (404) 329-7610 or  
Nancy Bennett at (202) 546-4011 ext. 123

## **AMERICAN CANCER SOCIETY STATEMENT OF SUPPORT FOR MEDICARE PREVENTIVE CARE**

The American Cancer Society commends members of the Health and Environment Subcommittee for their leadership in expanding Medicare coverage for preventive services, including cancer screening. Early detection, while it does not prevent cancer from occurring, can extend life, reduce treatment and the accompanying health care costs, and improve the quality of life for patients with cancer. The Society estimates that of the cancers diagnosed in 1996, about 100,000 more people would have survived if their cancer had been detected in a localized stage and treated promptly.

As part of today's hearing, the Committee will consider appropriate screening for breast cancer and colorectal cancer, among other issues. The American Cancer Society strongly supports annual mammography screening for women age 40 and older. The scientific evidence shows that beginning a program of annual mammography at age 40 will give women the best chance of detecting cancer early, when there is a higher opportunity for long-term survival.

In addition, the National Board of the American Cancer Society recently approved new colorectal guidelines which provide clear guidance to practitioners and their patients for the early detection of colorectal polyps and cancer at various levels of risk. These guidelines include the following:

- For average risk individuals (65-75% of cases), the American Cancer Society recommends annual fecal occult blood test plus flexible sigmoidoscopy every five years; or colonoscopy every 10 years or double contrast barium enema every five to ten years. Testing should begin at age 50.
- For moderate risk individuals (20-30% of cases) the American Cancer Society recommends colonoscopy or a total colon exam, which includes either colonoscopy, or double contrast barium enema, depending on family history and the size of the polyps. Testing interval and age to begin depend on initial diagnosis and family history.
- For high risk individuals (5-8% of cases) with a history of familial adenomatous polyps, the Society recommends early surveillance with endoscopy, counseling to consider genetic testing, and referral to a specialty center. Testing should begin at puberty. For high risk individuals with a family history of hereditary non-polyposis colon cancer, the Society recommends colonoscopy and counseling to consider genetic testing. Testing should begin at age 21.

for the Early Detection of Colorectal Polyps and Cancer at Various Levels of Risk<sup>1</sup>

Risk category	Recommendation <sup>2</sup>	Age to begin	Interval
<b>AVERAGE RISK</b>			
All people ages 50 and over not in the categories below	One of the following: Fecal occult blood testing plus flexible sigmoidoscopy <sup>3</sup> ; OR Total colon exam (TCE) <sup>4</sup> .	Age 50	FOBT every year, and flexible sigmoidoscopy every 5 years
		Age 50	Colonoscopy every 10 years, or DCBE every 5-10 years
<b>MODERATE RISK</b>			
People with single, small (< one cm) adenomatous polyps	Colonoscopy	At time of initial polyp diagnosis	TCE within 3 years after initial polyp removal; if normal, as per average risk recommendations (above)
People with large (one cm or larger) or multiple adenomatous polyps of any size	Colonoscopy	At time of initial polyp diagnosis	TCE within 3 years after initial polyp removal; if normal, TCE <sup>5</sup> every 5 years
Personal history of curative-intent resection of colorectal cancer	TCE <sup>5</sup>	Within 1 year after resection	If normal--TCE in 3 years; if still normal, TCE <sup>5</sup> every 5 years
Colorectal cancer, or adenomatous polyps, in first degree relative before age 60, or in two or more first degree relatives of any ages	TCE	Age 40, or 10 years before the youngest case in the family, whichever is earlier	Every 5 years
Colorectal cancer in other relatives (not included above)	As per average risk recommendations (above)		
<b>HIGH RISK</b>			
Family history of familial adenomatous polyposis	Early surveillance with endoscopy, counseling to consider genetic testing, and referral to a specialty center	Puberty	See text
Family history of hereditary non-polyposis colon cancer	Colonoscopy and counseling to consider genetic testing	Age 21	If genetic test is positive, or if the patient has not had genetic testing, every 2 years until age 40, then every year.
Inflammatory bowel disease	Colonoscopies with biopsies for dysplasia	8 years after the start of pancolitis; 12-15 years after the start of left-sided colitis	Every 1-2 years

<sup>1</sup> Approximately 65-75% of cases are from average risk individuals; approximately 20-30% are from moderate risk individuals; and 5-8% of cases are from high risk individuals.

<sup>2</sup> Digital rectal examination should be done at the time of each sigmoidoscopy, colonoscopy, or double contrast barium enema.

<sup>3</sup> Annual FOBT has been shown to reduce mortality from colorectal cancer, so it is preferable to no screening. However, the ACS recommends that annual FOBT be accompanied by flexible sigmoidoscopy to further reduce the risk of colorectal cancer mortality.

<sup>4</sup> Total colon examination includes either colonoscopy, or double contrast barium enema (DCBE). The choice of procedure should depend on the medical status of the patient and the relative quality of the medical examinations available in a specific community. Flexible sigmoidoscopy should be performed in those instances where the recto-sigmoid colon is not well visualized by DCBE. DCBE should be performed when the entire colon has not been adequately evaluated by colonoscopy.

<sup>5</sup> This assumes a peri-operative TCE was done.

MAMMOGRAPHY.

THE WHITE HOUSE  
WASHINGTON

March 26, 1997

**MAMMOGRAM ANNOUNCEMENT**

**DATE:** March 27, 1997  
**LOCATION:** Oval Office  
**BRIEFING TIME:** 11:30 am - 12:00 pm  
**EVENT TIME:** 12:00 pm - 12:30 pm  
**FROM:** Bruce Reed

**I. PURPOSE**

You will be announcing several new steps to encourage women to undergo regular mammograms beginning at age 40 as recommended by the National Cancer Institute in a morning press conference. This will highlight your continued commitment to making mammograms more readily available to women of all ages and the Administration's ongoing efforts to prevent, detect and treat breast cancer more effectively.

**II. BACKGROUND**

At 10:30am on Thursday, the Presidentially appointed National Cancer Advisory Board will announce that they are now recommending mammograms every one or two years for women in their forties. At this event, Richard Klausner, the Director of the National Cancer Institute, will also announce that he is accepting their recommendations. Since 1993, the National Cancer Institute has not recommended regular mammograms for women in their forties; the decision had been left up to women and their doctors.

This decision by the National Cancer Institute means there is now consensus in the medical community on regular mammogram screening. However, the American Cancer Society recommends screening every year and the National Cancer Institute is recommending them every one or two years. In practice the National Cancer Institute informs us that there will be little to no difference between the recommendations.

You will be responding to these new recommendations by announcing the following steps that will expand coverage of mammograms to women in their forties and to provide clearer educational information to women on this issue:

- MEDICARE LEGISLATION - You will announce that as you forward the health portion of the balanced budget to Congress on Thursday, the Medicare provisions will be amended to include annual mammograms for women age 40 and over.

(This expansion will be added to reforms already in your budget that improve the mammography benefit by eliminating the copayment.)

- MEDICAID

You will be announcing that the Health Care Financing Administration (HCFA) is sending a letter to state Medicaid directors to urge states to provide annual mammography screening to Medicaid beneficiaries over age 40, and to assure them that HCFA will provide federal matching payments for these screenings.

- FEDERAL EMPLOYEES

You will announce that starting January 1, 1988, the Office of Personnel Management will require all federal health benefits plans to comply with the National Cancer Advisory Board's recommendations on mammogram screenings.

- PUBLIC INFORMATION CAMPAIGN

You will announce that the Administration is launching a public education campaign to provide information to women about breast cancer screening. Secretary Shalala will announce in her remarks that the 1-800-4-CANCER hotline will begin immediately to provide information consistent with the recommendations of the National Cancer Institute.

- CHALLENGE TO PRIVATE SECTOR HEALTH PLANS

You will call on the private sector health plans to follow the federal government lead to require federal health plans to provide coverage consistent with the National Cancer Institute's recommendations.

### III. PARTICIPANTS

Briefing Participants:

Secretary Shalala  
Erskine Bowles  
Rahm Emanuel  
Bruce Reed  
Chris Jennings  
Kitty Higgins  
Betsy Myers  
Terry Edmonds  
Mike McCurry

Event Participants:

Secretary Shalala

There will be no invited guests to this event.

#### **IV. PRESS PLAN**

Pool Press.

#### **V. SEQUENCE OF EVENTS**

- You will enter the Oval Office, accompanied by Secretary Shalala, and walk directly to the podium.
- You will make remarks and then introduce Secretary Shalala.
- Secretary Shalala will make remarks.
- The Pool will ask questions, and then you will depart.

#### **VI. REMARKS**

Remarks Provided by Terry Edmonds in Speechwriting.

**PRESIDENT WILLIAM J. CLINTON  
MAMMOGRAPHY ANNOUNCEMENT  
THE WHITE HOUSE  
MARCH 27, 1997**

Good afternoon. Secretary Shalala has just briefed me on the National Cancer Institute's new recommendations on mammography. These recommendations, based on the latest and best medical evidence, give clear, consistent guidance to women in our national fight against breast cancer. Breast cancer is the most commonly diagnosed cancer among women. It affects one in eight women in their lifetimes. My own mother fell victim to this terrible disease. We may not yet have a cure for breast cancer -- but we do know that early detection and early treatment are our most potent weapons against this dread disease. And we know that mammography can save lives.

That is why it is so important to send a clear, consistent message to women and their families about when to start getting mammograms and how often to repeat them.

After careful study of the science, the National Cancer Advisory Board has now concluded that women between the ages of 40 and 49 should get a mammogram examination for breast cancer every one or two years in consultation with their doctors. The National Cancer Institute has accepted these recommendations. Now women in their 40s will have clear guidance based on the best science and action to match it. Today, I am taking action to bring Medicare, Medicaid and federal employee health plans in line with the National Cancer Institute's recommendations.

First, in the Medicare budget I am sending to Congress today, I am making annual screening mammography exams, beginning at age 40, a covered expense, without co-insurance or deductibles. Second, Secretary Shalala is sending a letter to state Medicaid Directors urging them to also cover an annual mammogram beginning at age 40, and assuring them that the federal government will pay its matching share. And today, I am directing the Office of Personnel Management to require all federal health benefits plans to comply with the National Cancer Advisory Board's recommendations on mammogram screenings beginning next year.

The federal government is doing its part to make sure women have both coverage and access to this potentially life-saving test. I want to challenge private health plans to join us. They too should cover regular screening mammograms for women 40 and over.

Finally, we all know that there has been much discussion on this issue and a lot of confusion. That is why we are launching a major public education campaign to make sure every woman and every health professional in America is aware of these new recommendations.

This is a major step forward in our fight against breast cancer. In addition to Secretary Shalala, I want to thank National Cancer Advisory Board chairperson, Dr. Barbara Rimer

[RHYMER] and all the members of the Board, along with NCI Director, Dr. Richard Klausner for the fine job you did in producing these recommendations. I also want to thank the First Lady, who could not be here today because of her historic visit to Africa. Hillary has devoted countless hours to educating women about the importance of mammography. She has particularly tried to educate older women to take advantage of Medicare coverage of mammograms because we know that too few of them do.

Now, I'd like to turn it over to Secretary Shalala.

# SHALALA

Thank you Mr. President for your leadership – and for once again showing your deep and personal commitment to lifting the ugly shadow of breast cancer that hangs over every American woman.

One of the biggest fears women have about breast cancer is the fear of not knowing what to do, or when to do it.

But today years of confusion have been replaced by a clear and consistent scientific recommendation for women between 40 and 49.

We can now tell them talk to your doctor because regular mammograms can save your life.

To get the word out, we are developing written materials, and using our 1-800-4-CANCER number to reach out to insurance companies, medical associations, advocacy groups and women themselves.

The guidance we offer today to women in their forties is a step forward.

But it is only one piece of our overall strategy to fight breast cancer and win.

We know that around 80 percent of breast cancers occur in women over 50; and that regular mammography reduces their risk of death by at least one-third.

And we know that breast cancer is the second leading cause of cancer death among American women.

But, thanks to the President, behind this pain and loss lies hope and real progress.

Under the President's leadership, we have almost doubled funding for breast cancer research, treatment and prevention to more than \$500 million dollars since 1993.

And we're working hard to improve access to quality mammograms.

That's why we're reaching out to women in all 50 states – especially low income women and women of color – to make sure they know about and have access to mammograms.

That's why the First Lady has led a mammography awareness campaign aimed at women over 65 – those women most at risk.

And that's why under the Mammography Quality Standards Act, American women can now have greater confidence in the safety and accuracy of their mammograms.

We should all be proud of the fact that mortality rates for breast cancer are falling – not nearly enough – but they are finally going down.

And we should all be proud that with this announcement today, we have replaced confusion with clarity and moved another step closer to the day when our grandchildren will have to turn to the history books to learn about a disease called breast cancer.

Working together, we can – and will – make it happen.

Thank you.

## PRESIDENT CLINTON ANNOUNCES MAMMOGRAPHY ACTIONS

March 27, 1997

Today President Clinton will announce actions to encourage women to begin receiving regular mammograms in their forties in response to the National Cancer Institute's (NCI) recommendation that women should begin undergoing regular mammography screening at forty. The President is taking action to bring Medicare, Medicaid, and federal employee health plans in line with the NCI's new recommendations, and is calling on private health plans to do the same.

With the NCI's recommendation, women now have clear and consistent science-based advice that they should begin regular mammography screening in their forties. The Clinton Administration has strived to make high quality mammograms more readily available to women of all ages and to improve efforts to prevent, detect, and treat breast cancer, which currently affects 1 in 8 American women in their lifetime.

The President announced the following actions today in response to the NCI's recommendation:

- **Medicare.** President Clinton is proposing that Medicare cover annual screening mammograms for women beginning at age forty without coinsurance and deductibles. Currently, Medicare does not cover annual screening mammograms for women in their forties, and covered mammograms can be subject to coinsurance and deductibles. The proposed changes are included in the President's overall Medicare and Medicaid budget proposals, which the Administration is sending to Congress today.
- **Medicaid.** The President announced that the Health Care Financing Administration at HHS is sending a letter today to every State Medicaid director to encourage them to cover annual mammography screening beginning at age 40 and to make clear that the federal government will provide federal matching payments for these services. States currently have the option of covering mammography screening, but not all States cover annual mammography screening beginning at age 40.
- **Federal Employee Health Plans.** President Clinton is directing the Office of Personnel Management to require all federal employee health plans to cover annual mammograms beginning at age 40. Current Federal Employee Health Benefits program policy only covers one mammogram screening every two years for women in their forties. The new policy will take effect in January 1998, the start of the FEHB's next contract year.
- **Challenge to Private-Sector Health Plans.** President Clinton called on private-sector health plans to follow his lead in making the federal health plans consistent with the NCI's recommendations by covering annual screening mammograms beginning at age 40.
- **Public Education Campaign.** The Administration announced that it will lead a national public education campaign to provide women with clear information about when they should begin regular mammography screening. The NCI will also work with health organizations and associations to communicate the latest and most accurate information. Information will be available through the NCI's toll-free Cancer Information Service at 1-800-4-CANCER and on the web at <http://rex.nci.nih.gov>.

## A Strong Record on Breast Cancer

The Clinton Administration has worked hard to combat breast cancer, the second leading cause of death from cancer for women. This year over 180,000 women will be newly diagnosed with breast cancer and more than 40,000 will die of this disease. The Clinton Administration has responded to the significant threat posed by breast cancer with increased efforts in research, prevention and treatment. The following are examples of new initiatives undertaken since 1993:

- **Nearly Doubling Breast Cancer Research, Prevention, and Treatment.** Since the Clinton Administration has taken office, funding for breast cancer research, prevention and treatment at HHS has nearly doubled, from about \$276 million in FY 1993 to an estimated \$513 million in FY 1997.
- **Signed the Kassebaum-Kennedy Legislation into Law, Ending Pre-existing Condition Exclusions.** As a result of this law, no American will live in fear of being denied coverage just because they have a pre-existing condition such as breast cancer. The new law is particularly helpful for the millions of cancer victims who will no longer face the dilemma of hesitating to go to a new and better job for fear of losing their health insurance.
- **Medicare Mammography Campaign.** The Clinton Administration has made it a priority to educate older women about the importance of detecting breast cancer early and to inform them about Medicare coverage of mammography services. Both the President and the First Lady have appeared in TV public service announcements encouraging older women to get mammography screenings. Breast cancer is more prevalent in older age groups and the risk of breast cancer increases with age. About 80% of breast cancers occur in women age 50 or older. Yet, only 65% of women age 50-64 have had a mammogram in the past two years, and only 54% of women age 65 and older have a mammogram every two years. [National Health Interview Survey, NCHS]
- **Mammography Quality Standards.** In 1992, the FDA proposed regulations to implement the Mammography Quality Standards Act (MQSA). The rules ensure that the roughly 10,000 mammography facilities nationwide accredited by the FDA meet high quality standards for equipment and personnel.
- **National Breast and Cervical Cancer Early Detection Program.** The Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program offers free or low-cost mammography screening to uninsured, low-income, elderly, and minority women. Since the program's inception, it has provided screening tests to almost one million medically underserved women. In October 1996, the program went nationwide, with funding for all 50 states.
- **Developed National Action Plan on Breast Cancer.** The Clinton Administration established a National Action Plan on Breast Cancer (NAPBC), which supports innovative research and outreach projects on breast cancer, with a special emphasis on the development of public-private partnerships. In 1996, President Clinton announced the new NAPBC web site (<http://www.napbc.org>) to provide answers to frequently asked questions about breast cancer, information on breast cancer clinical trials and research, breast cancer organizations and advocacy groups, educational conferences and meetings, publications, and other resources.
- **Research on Using Imaging Technologies from the Defense, Space, and Intelligence Communities to Detect Cancer Earlier and with Greater Accuracy.** The Department of Health and Human Services has been working with the Department of Defense, the CIA, NASA, and other public and private entities to explore ways in which imaging technologies from other fields may be applied to the early detection of breast cancer.

## **THE COLORECTAL CANCER SCREENING ACT OF 1997**

### **Why is this bill necessary?**

Colorectal cancer is the second most deadly cancer based on annual deaths - 54,000 Americans will die from colorectal cancer in 1997. Colorectal cancer afflicts men and women of all races, and yet death from this disease can be reduced significantly by early detection.

### **What would this bill do?**

The Colorectal Cancer Screening Act of 1997 would make colorectal cancer screening available to Medicare beneficiaries improving the chance for early diagnosis. The type and frequency of screening are compatible with the recommendations of two large physician groups, the American College of Physicians and the American Academy of Family Practice. The type of screening process mandated in this bill depends on the patient's risk factors for colon cancer. Patients at higher risk (e.g., those with an immediate family member with colon cancer), receive more aggressive screening than patients with a normal risk for colon cancer.

Several screening tests for colorectal cancer are currently available. Some tests are very simple and can be performed by any doctor, while others (barium enema and colonoscopy) are technically more difficult and require special equipment and facilities. Furthermore, some of the tests evaluate only part of the colon. Although early detection would reduce the number of deaths, the best method for early detection has not been determined. This bill would mandate that screening begin immediately, but the Secretary of HHS is required to study and determine which test is best and most cost effective within two years. HHS will also study the needs of African-Americans who are at high risk for colon cancer and who have a higher mortality rate.

Diagnosing and treating colon cancer early will save Medicare the costs of expensive operations and hospitalizations for patients with advanced disease. Furthermore, this bill authorizes the experts in colon cancer to determine the best, most cost-effective screening techniques while making this important service available immediately to Medicare beneficiaries.

### **What are the benefits of this bill?**

- Early diagnosis of one of the most deadly cancers
- All screening techniques are included
- Screening program adjusted for beneficiaries risk factors for colon cancer
- Colon cancer experts (not Congress) will determine the best, most effective screening techniques
- Reduction in expensive operations and hospitalizations for advanced colon cancer

105TH CONGRESS  
1ST SESSION

**S.** \_\_\_\_\_

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IN THE SENATE OF THE UNITED STATES

Mr. BREAUX introduced the following bill; which was read twice and referred to the Committee on \_\_\_\_\_

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**A BILL**

To amend title XVIII of the Social Security Act to improve preventive benefits under the Medicare program.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Colorectal Cancer  
5 Screening Act of 1997".

6 **SEC. 2. MEDICARE COVERAGE OF COLORECTAL SCREEN-**  
7 **ING SERVICES.**

8 (a) COVERAGE.—

9 (1) IN GENERAL.—Section 1861 of the Social  
10 Security Act (42 U.S.C. 1395x) is amended—

11 (A) in subsection (s)(2)—

1 (i) by striking "and" at the end of  
2 subparagraphs (N) and (O); and

3 (ii) by inserting after subparagraph  
4 (O) the following:

5 "(P) colorectal cancer screening tests (as de-  
6 fined in subsection (oo)); and"; and

7 (B) by adding at the end the following:

8 "Colorectal Cancer Screening Tests

9 "(oo)(1) The term 'colorectal cancer screening test'  
10 means, unless determined otherwise pursuant to section  
11 2(a)(2) of the Colorectal Cancer Screening Act of 1997,  
12 any of the following procedures furnished to an individual  
13 for the purpose of early detection of colorectal cancer:

14 "(A) Screening fecal-occult blood test.

15 "(B) Screening flexible sigmoidoscopy.

16 "(C) Screening barium enema.

17 "(D) In the case of an individual at high risk  
18 for colorectal cancer, screening colonoscopy or  
19 screening barium enema.

20 "(E) For years beginning after 2002, such  
21 other procedures as the Secretary finds appropriate  
22 for the purpose of early detection of colorectal can-  
23 cer, taking into account changes in technology and  
24 standards of medical practice, availability, effective-  
25 ness, costs, the particular screening needs of racial

1 and ethnic minorities in the United States and such  
2 other factors as the Secretary considers appropriate.

3 “(2) In paragraph (1)(D), an ‘individual at high risk  
4 for colorectal cancer’ is an individual who, because of fam-  
5 ily history, prior experience of cancer or precursor neo-  
6 plastic polyps, a history of chronic digestive disease condi-  
7 tion (including inflammatory bowel disease, Crohn’s Dis-  
8 ease, or ulcerative colitis), the presence of any appropriate  
9 recognized gene markers for colorectal cancer, or other  
10 predisposing factors, faces a high risk for colorectal can-  
11 cer.”.

12 (2) REVIEW OF COVERAGE OF COLORECTAL  
13 CANCER SCREENING TESTS.—

14 (A) IN GENERAL.—Not later than 2 years  
15 after the date of enactment of this Act (and pe-  
16 riodically thereafter), the Secretary of Health  
17 and Human Services (in this paragraph re-  
18 ferred to as the “Secretary”) shall review—

19 (i) the standards of medical practice  
20 with regard to colorectal cancer screening  
21 tests (as defined in section 1861(o) of the  
22 Social Security Act (42 U.S.C. 1395x(o)))  
23 (as added by paragraph (1) of this sec-  
24 tion);

1 (ii) the availability, effectiveness,  
2 costs, and cost-effectiveness of colorectal  
3 cancer screening tests covered under the  
4 medicare program under title XVIII of the  
5 Social Security Act (42 U.S.C. 1395 et  
6 seq.) at the time of such review;

7 (iii) the particular screening needs of  
8 racial and ethnic minorities in the United  
9 States; and

10 (iv) such other factors as the Sec-  
11 retary considers appropriate with regard to  
12 the coverage of colorectal cancer screening  
13 tests under the medicare program.

14 (B) DETERMINATION.—If the Secretary  
15 determines it appropriate based on the review  
16 conducted pursuant to subparagraph (A), the  
17 Secretary shall issue and publish a determina-  
18 tion that one or more colorectal cancer screen-  
19 ing tests described in section 1861(oo) of the  
20 Social Security Act (42 U.S.C. 1395x(oo)) (as  
21 added by paragraph (1) of this section) shall no  
22 longer be covered under that section.

23 (b) FREQUENCY AND PAYMENT LIMITS.—

1 (1) IN GENERAL.—Section 1834 of the Social  
2 Security Act (42 U.S.C. 1395m) is amended by in-  
3 serting after subsection (c) the following:

4 “(d) FREQUENCY AND PAYMENT LIMITS FOR  
5 COLORECTAL CANCER SCREENING TESTS.—

6 “(1) SCREENING FECAL-OCCULT BLOOD  
7 TESTS.—

8 “(A) PAYMENT LIMIT.—In establishing fee  
9 schedules under section 1833(h) with respect to  
10 colorectal cancer screening tests consisting of  
11 screening fecal-occult blood tests, except as pro-  
12 vided by the Secretary under paragraph (5)(A),  
13 the payment amount established for tests per-  
14 formed—

15 “(i) in 1998 shall not exceed \$5; and

16 “(ii) in a subsequent year, shall not  
17 exceed the limit on the payment amount  
18 established under this subsection for such  
19 tests for the preceding year, adjusted by  
20 the applicable adjustment under section  
21 1833(h) for tests performed in such year.

22 “(B) FREQUENCY LIMIT.—Subject to revi-  
23 sion by the Secretary under paragraph (5)(B),  
24 no payment may be made under this part for

1 colorectal cancer screening test consisting of a  
2 screening fecal-occult blood test—

3 “(i) if the individual is under 50 years  
4 of age; or

5 “(ii) if the test is performed within  
6 the 11 months after a previous screening  
7 fecal-occult blood test.

8 “(2) SCREENING FOR INDIVIDUALS NOT AT  
9 HIGH RISK.—Subject to revision by the Secretary  
10 under paragraph (5)(B), no payment may be made  
11 under this part for a colorectal cancer screening test  
12 consisting of a screening flexible sigmoidoscopy or  
13 screening barium enema—

14 “(i) if the individual is under 50 years  
15 of age; or

16 “(ii) if the procedure is performed  
17 within the 47 months after a previous  
18 screening flexible sigmoidoscopy or screen-  
19 ing barium enema.

20 “(3) SCREENING FOR INDIVIDUALS AT HIGH  
21 RISK FOR COLORECTAL CANCER.—Subject to revi-  
22 sion by the Secretary under paragraph (5)(B), no  
23 payment may be made under this part for a  
24 colorectal cancer screening test consisting of a  
25 screening colonoscopy or screening barium enema for

1 individuals at high risk for colorectal cancer if the  
2 procedure is performed within the 23 months after  
3 a previous screening colonoscopy or screening bar-  
4 ium enema.

5       “(4) PAYMENT AMOUNTS FOR CERTAIN  
6 COLORECTAL CANCER SCREENING TESTS.—The Sec-  
7 retary shall establish payment amounts under sec-  
8 tion 1848 with respect each colorectal cancer screen-  
9 ing tests described in subparagraphs (B), (C), and  
10 (D) of section 1861(oo)(1) that are consistent with  
11 payment amounts under such section for similar or  
12 related services, except that such payment amount  
13 shall be established without regard to section  
14 1848(a)(2)(A).

15       “(5) REDUCTIONS IN PAYMENT LIMIT AND RE-  
16 VISION OF FREQUENCY.—

17       “(A) REDUCTIONS IN PAYMENT LIMIT FOR  
18 SCREENING FECAL-OCCULT BLOOD TESTS.—  
19 The Secretary shall review from time to time  
20 the appropriateness of the amount of the pay-  
21 ment limit established for screening fecal-occult  
22 blood tests under paragraph (1)(A). The Sec-  
23 retary may, with respect to tests performed in  
24 a year after 2000, reduce the amount of such  
25 limit as it applies nationally or in any area to

1 the amount that the Secretary estimates is re-  
2 quired to assure that such tests of an appro-  
3 priate quality are readily and conveniently  
4 available during the year.

5 “(B) REVISION OF FREQUENCY.—

6 “(i) REVIEW.—The Secretary shall re-  
7 view periodically the appropriate frequency  
8 for performing colorectal cancer screening  
9 tests based on age and such other factors  
10 as the Secretary believes to be pertinent.

11 “(ii) REVISION OF FREQUENCY.—The  
12 Secretary, taking into consideration the re-  
13 view made under clause (i), may revise  
14 from time to time the frequency with  
15 which such tests may be paid for under  
16 this subsection, but no such revision shall  
17 apply to tests performed before January 1,  
18 2001.

19 “(6) LIMITING CHARGES OF NONPARTICIPATING  
20 PHYSICIANS.—

21 “(A) IN GENERAL.—In the case of a  
22 colorectal cancer screening test consisting of a  
23 screening flexible sigmoidoscopy or screening  
24 barium enema, or a screening colonoscopy or  
25 screening barium enema provided to an individ-

1           ual at high risk for colorectal cancer for which  
2           payment may be made under this part, if a  
3           nonparticipating physician provides the proce-  
4           dure to an individual enrolled under this part,  
5           the physician may not charge the individual  
6           more than the limiting charge (as defined in  
7           section 1848(g)(2)).

8           “(B) ENFORCEMENT.—If a physician or  
9           supplier knowingly and willfully imposes a  
10          charge in violation of subparagraph (A), the  
11          Secretary may apply sanctions against such  
12          physician or supplier in accordance with section  
13          1842(j)(2).”

14          (c) CONFORMING AMENDMENTS.—

15           (1) Paragraphs (1)(D) and (2)(D) of section  
16          1833(a) of the Social Security Act (42 U.S.C.  
17          1395l(a)) are each amended by inserting “or section  
18          1834(d)(1)” after “subsection (h)(1)”.

19           (2) Section 1833(h)(1)(A) of the Social Secu-  
20          rity Act (42 U.S.C. 1395l(h)(1)(A)) is amended by  
21          striking “The Secretary” and inserting “Subject to  
22          paragraphs (1) and (5)(A) of section 1834(d), the  
23          Secretary”.

24           (3) Clauses (i) and (ii) of section 1848(a)(2)(A)  
25          of the Social Security Act (42 U.S.C. 1395w-

1 4(a)(2)(A)) are each amended by inserting after "a  
2 service" the following: "(other than a colorectal can-  
3 cer screening test consisting of a screening  
4 colonoscopy or screening barium enema provided to  
5 an individual at high risk for colorectal cancer or a  
6 screening flexible sigmoidoscopy or screening barium  
7 enema)".

8 (4) Section 1862(a) of the Social Security Act  
9 (42 U.S.C. 1395y(a)) is amended—

10 (A) in paragraph (1)—

11 (i) in subparagraph (E), by striking  
12 "and" at the end;

13 (ii) in subparagraph (F), by striking  
14 the semicolon at the end and inserting "  
15 and"; and

16 (iii) by adding at the end the follow-  
17 ing:

18 "(G) in the case of colorectal cancer screening  
19 tests, which are performed more frequently than is  
20 covered under section 1834(d);"; and

21 (B) in paragraph (7), by striking "para-  
22 graph (1)(B) or under paragraph (1)(F)" and  
23 inserting "subparagraph (B), (F), or (G) of  
24 paragraph (1)".

1 **SEC. 3. EFFECTIVE DATE.**

- 2       The amendments made by section 2 shall apply to  
3 items and services furnished on or after January 1, 1998.

## Questions and Answers: Mammography Screening for Women

### **Why is this decision important?**

This year, over 180,000 American women will be newly diagnosed with breast cancer, and more than 40,000 will die of this disease. It is the second leading cause of death from cancer for women, and the most common cause of death from any cause in women aged 40-44.

Early detection of breast cancer is crucial for successful treatment, and regular mammography screening is our best tool now for early detection. But the question that has been difficult to resolve is when women should begin regular screening mammography. Until recently, in the judgment of the NCI, clinical studies did not satisfactorily support evidence of benefit for women in their 40s. Now, more recent evidence from clinical trials and current evidence that regular mammograms reduce the death rate from breast cancer by about 17 percent in the 40-49 age group, the National Cancer Advisory Board and the NCI are recommending that women in their 40s should be screened every one to two years with mammography.

The importance of this decision is that women now have a clear and consistent answer to the question of when they should begin regular mammogram screening – and we have improved our capacity to detect and treat this disease. Two leading cancer organizations, the American Cancer Society in the private sector and the National Cancer Institute, part of the National Institutes of Health, are delivering a common message about how women can help reduce the chance of breast cancer – and that message is based on the best scientific evidence currently available.

Now it's up to women and their health care providers to act on this recommendation, and it's up to all of us to help support that action by making these findings universally known and by providing access to these life-saving services.

### **Was the NCAB or NCI under pressure from the White House to recommend mammography for women in their 40s?**

No. The National Cancer Advisory Board is a presidentially appointed committee that advises and consults with the director of the National Cancer Institute and the Secretary of Health and Human Services. It has advised NCI on the mammography issue for years, and planned its current review more than a year ago. In this review, the Board considered the updated findings from breast cancer screening studies. These new data showed that regular screening mammography of women in their 40s reduces deaths from breast cancer by about 17 percent.

**Doesn't the new recommendation support the contention that the only reason that NCI withdrew its recommendation in 1993 was to hold down the cost of the Health Security Act?**

No. In December 1993, NCI announced that it would no longer recommend that screening for mammography begin at age 40 because of a lack of scientific evidence. The decision was based on a lack of clear scientific evidence for a reduction in deaths among women in that age group, and the realization of the risks of screening. Today's decision is based on new scientific evidence now available to NCI.

**Women have been the focus of many of your recent events, are you "repaying" women for their votes in the 1996 election?**

No. Over 180,000 American women will be newly diagnosed with breast cancer, <sup>this year</sup> and more than 40,000 will die of this disease. This is a terrifying disease for women and the Clinton Administration is working hard to provide women with the most effective tools in the fight against breast cancer.

**Isn't mammography for all women in their 40s a very expensive proposition for the number of lives to be saved?**

This is a terrifying disease for women. It is a leading killer, and it can have devastating effects even for those who do not die from it.

Mammography is a real and effective step that women can take to help detect this disease early. Early detection not only improves their chances for life, but also for effective treatment that is the least disfiguring.

If we can indeed reduce the death rate from breast cancer by 17 percent among women 40-49, we should do that. If we can help women get effective treatment at the earliest ~~women~~, we should do that. It's worth the cost.

**Isn't the NCI recommendation still different from the ACS recommendation?**

Both organizations are giving the same answer to the basic question: "When should women begin mammography screening?" Both organizations have now recommended mammography screening of women in their 40s. <sup>regular</sup>

As for the interval between screening mammograms, the NCI and ACS recommendations are compatible. While NCI recommends screening either every one or two years, and the ACS recommends annual mammograms, both recommendations allow annual screening if a woman wishes to have it and advise women to discuss the pros and cons with their doctor.

**On what basis should a woman and her doctor decide the frequency of mammography?  
What factors should decide?**

In deciding how frequently to be screened, a woman and her health care provider should consider her risk factors. Some factors a woman must consider include whether or not she has a personal or family history of breast cancer; whether she has signs or symptoms of menopause; and whether or not she has a personal history of benign breast disease, such as atypical hyperplasia. NCI will develop educational materials to help women and health professionals do this.

**What is going to be done to educate the public about mammography screening?**

NCI is developing a national public education program to provide women with understandable information on when women should begin regular mammography screening, and concerning an individual's risk of getting breast cancer. In addition to developing a wide variety of new information materials (print, radio and TV, and electronic) for women and for health professionals, NCI will work with the national media to develop coherent and accurate information.

NCI will also work with health professional organizations and associations, as well as other federal agencies, to communicate the latest and most accurate information. As always, this information will be available through the NCI's toll-free Cancer Information Service at 1-800-4-CANCER, and through other groups including the American Cancer Society and the National Alliance of Breast Cancer Organizations.

**What portion of women in their 40s have regular mammography today?**

Of women ages 40-49, 60 percent received a mammogram in the past two years, according to 1993 figures from the National Center for Health Statistics.

**Do most private insurers cover mammography screening?**

According to the Health Insurance Association of America, about 79 percent of all employer health plans covered mammography screening in 1991. Most states (40) have legislation concerning insurance reimbursement for routine screening mammograms for women in their 40s, according to the State Cancer Legislative Database. The provisions of the laws vary from state to state, but most require that health plans cover all or part of the costs for women in their 40s.

**How much do Medicare and Medicaid spend on mammography now?**

Estimated Medicare spending for mammography is about \$270 million this year; and for Medicaid, about \$10 million.

**How many women will benefit from the additional Medicare coverage, and how much will it cost?**

There are about 380,000 women in their 40s who will have Medicare coverage in 1998, rising to over 400,000 in the next five years. The cost of the added annual mammography benefit for this group is estimated to be about \$2.7 million over five years.

**How many women will benefit from additional coverage in Medicaid?**

Since coverage policies are made by the states, we cannot estimate the extent of new benefits that will be provided. However, our letter to state Medicaid directors will urge states to make mammography screening available to women in their 40s on an annual basis.

**In yesterday's Journal of the American Medical Association (JAMA), the Cancer Genetics Studies Consortium recommended annual mammograms for women between ages 25 and 35 who are born with mutations in the BRCA1 and BRCA2 genes -- two identified breast cancer susceptibility genes. What do you think about this recommendation and will you extend Medicare and Medicaid coverage for these women too?**

No. At this time we do not know enough about the links between genetics and cancer to make this decision. We will continue the important research into the genetic basis of breast cancer, for which President Clinton recently announced \$30 million in new funding for a collaborative initiative between the Department of Defense and the National Institutes of Health.

As we have always recommended, in deciding when and how frequently to be screened, a woman and her health care provider should consider her risk factors and determine when to begin mammography screening.

**You're challenging the private sector to provide expanded benefits to insurers and health plans across the country. How and when will you do this for federal government employees?**

The President believes that there should be no double standard. He will ensure that the federal government complies with this challenge as quickly as possible. As such, the President is ensuring that Medicare, Medicaid and the health plans covering federal employees amend their policies to reflect today's NCAB recommendation.

**How much will this cost to apply the NCAB recommendation to cover mammograms in their forties to the Federal Employees Health Benefit (FEHB) program?**

The new policies for FEHB will become effective in January, 1998. At this time, we do not have the necessary information to know the final cost. Our projected cost of this change will be available soon. However, we do know that it will be extremely modest.

**Will this policy increase premiums for federal government employees?**

We have no indication that this policy will notably increase premiums for federal government employees. This is an extremely low cost, high return benefit change.

**Doesn't the new NCI recommendation conflict with the U.S. Preventive Services Task Force?**

In its 1996 recommendation, the Task Force (an independent advisory group supported through HHS) found insufficient evidence to recommend for or against routine mammography for women in their 40s. This recommendation did not take into account recently announced results of important clinical studies, which have been considered by the National Cancer Advisory Board. It is expected that the Task Force will be reconvened later this year or early in 1998, and at that time they will begin reviewing the most recent evidence and if appropriate making any modifications to their recommendations accordingly.

**What is the current status of the use of mammography, and what are the trends?**

According to data collected in 1993, about 60 percent of women aged 40 and over had a mammogram in the previous two years. (60 percent for 40-49, 65 percent for 50-64, 54 percent for those 65 and over). The number of women over 40 who had a mammogram in the previous two years more than doubled between 1987 and 1993, from about 29 percent to 60 percent.

(Source: 1993 National Health Interview Survey, NCHS)

**FAX**

File

~~602~~ CJ - colorado forum  
Date 4/14/97

Number of pages including cover sheet 15

TO: Katie Button  
Office of the First Lady

FROM: MC Genova  
Colorado Forum  
511 16th Street, Suite 210  
Denver, CO 80202

Phone  
Fax Phone 202-456-6244

Phone 303-825-1211  
Fax Phone 303-592-1136

CC:

REMARKS:  Urgent  For your review  Reply ASAP  Please Comment

[Empty remarks box]



February 17, 1997

The Honorable Hillary Rodham Clinton  
The White House  
2nd Floor, West Wing  
1600 Pennsylvania Avenue, N.W.  
Washington, D.C. 20500

Dear Hillary,

I can hardly believe that it's been nearly a year since the members of the Colorado Forum had a conversation with you regarding welfare reform and the visits each of our members made to a welfare family. We are planning our annual excursion to Washington again this year and have scheduled the evening of April 29 and all day April 30 for our meetings with a variety of government officials. Of course, the members of the Forum would love to have an opportunity to talk with you again.

We continue to try to find solutions to the concerns that welfare reform has raised: how to create the proper incentives for the business community to provide jobs to individuals coming off the welfare rolls and particularly, what to do about the children who need quality day care when their parents (mothers) go to work. Forum members have been wrestling with these issues and would love to hear your perspective. We know that you have listened carefully, all across this country, to people who have good ideas and have tested solutions in their communities. We want to hear what you know, sort out those ideas for Colorado, and see if we can make something exciting happen.

In addition, the Forum has been looking at how we might be able to create a public/private health care plan for uninsured children in Colorado. The issue of uninsured children appears to be a solvable problem. In our state, there are approximately 150,000 children who don't have access to the health care system. We want to think about this in a creative way and again, would love to hear what you think.

We all came away from our last meeting with you feeling that the knowledge you have gained as you study these issues from a grass roots level needs to be tapped.

I would be very grateful if you had a few minutes to spend with the Colorado Forum to talk about these conundrums; and . . . it would be wonderful to see you again.

I will call your office in a week or so to see if it might be possible to get on your calendar for a few minutes when we are in Washington. Thank you so much for any consideration you might be able to give us.

Warmly,



Gail H. Klapper  
Member/Director

cc: Melanne Verveer

**TENTATIVE AGENDA**  
**COLORADO FORUM WASHINGTON TRIP ITINERARY**  
**TUESDAY, APRIL 29 - WEDNESDAY, APRIL 30, 1997**

**TUESDAY, APRIL 29, 1997**

*Group Flight:*

10:30 a.m. TO WASHINGTON D.C. UA #296

3:35 p.m. Arrive Dulles Airport

5:00 p.m.

**WEDNESDAY, APRIL 30, 1997**

9:00-10:00 a.m. **U.S. Senators - Colorado Delegation**  
**Senator Ben Nighthorse Campbell**  
**Senator Wayne Allard**

**Subjects: Rocky Flats, ISTEA Reauthorization, Colorado's**  
**Uninsured Children, Animas La-Plata**

10:30-11:30 a.m. **Robert E. Rubin, Secretary of the Treasury**  
**David A. Lipton, Assistant Secretary for International Affairs**  
**Joshua Gotbaum, Assistant Secretary of the Treasury for**  
**Economic Policy**  
**Michael S. Barr, Special Assistant to the Secretary**  
**Matthew A. Gorman, Director, Office of Business Liaison**  
**Department of the Treasury**  
**Secretary's Conference Room**  
**Subjects: Tax Policy, G-8, Welfare-to-Work, Banking**

12:15-1:30 p.m. **Cokie Roberts**  
**Lunch at ANA Hotel**  
**2401 M Street**  
**Potomac Room**

The group will split up for the following meetings:

2:00-2:45 p.m.      **Energy Secretary Federico Peña**  
Department of Energy  
Subject: Rocky Flats

2:15      **Senator Pete Domenici**  
(R-New Mexico)  
Subject: Rocky Flats Funding

3:00-4:45 p.m.      **Acting Administrator Jane Garvey**  
Federal Highway Administration  
Subject: ISTEA Reauthorization

3:15      **Representative Jim Oberstar**  
(DFL-Minnesota)  
Subject: ISTEA Reauthorization

The group will come together for this meeting:

4:00-5:00 p.m.      **U.S. House Representatives - Colorado Delegation**  
Representative Diana Degette  
Representative Joel Hefley  
Representative Scott McInnis  
Representative Dan Schaefer  
Representative Bob Schaffer  
Representative David Skaggs

5:00 p.m.              **Meet Bus to Dulles**  
Cabs to ANA

6:35 p.m.              **Depart to Denver**                                      **UA #1051**

**Meetings requested, but not yet confirmed:**

**First Lady Hillary Clinton**  
**President Clinton**  
**Senator Ed Kennedy/Senator Orrin Hatch**

**COLORADO FORUM/DENVER METRO CHAMBER  
1997 WASHINGTON TRIP**

**Colorado Forum Members**

**Ms. Patricia A. Cahill**  
President & CEO  
Catholic Health Initiatives  
Denver, Colorado

**Mr. Kenneth Charlton (also Denver Chamber Board member)**  
Chairman & CEO  
Banc One Colorado Corporation  
Denver, Colorado

**Mr. Steve Coffin (also Denver Chamber Board member)**  
Vice President of Governmental  
and Public Affairs  
Colorado Interstate Gas Company  
Colorado Springs, Colorado

**Mr. Thomas T. Farley**  
Senior Partner  
Petersen & Fonda, P.C.  
Pueblo, Colorado

**Mr. Samuel Gary**  
Chairman of the Board  
The Gary-Williams Company  
Chairman of the Board  
The Piton Foundation  
Denver, Colorado

**Mr. Randall C. Hampton**  
Director of Tax  
Ernst & Young LLP.  
Denver, Colorado

**Mr. S.R. (Rollie) Heath, Jr. (also Denver Chamber Board member)**  
Chairman & CEO  
Ponderosa Industries Inc.  
Denver, Colorado

**Mr. D. D. "Del" Hock (also Denver Chamber Board member)**  
Chairman & CEO, Retired  
Public Service Company of Colorado  
Denver, Colorado

**Mr. Eugene L. Hohensee**  
Senior Corporate and Transactional Partner  
Arnold & Porter  
Denver, Colorado

**Mr. Bret Kelly**  
Chairman of the Board  
Steel City Agencies, Inc.  
Pueblo, Colorado

**Ms. Gail H. Klapper** (also Chair-Elect Denver Chamber)  
Member/Director  
The Colorado Forum  
Managing Attorney  
The Klapper Firm  
Denver, Colorado

**Mr. Raymond P. Kogovsek**  
President  
Kogovsek & Associates  
Pueblo, Colorado

**Mr. Fred V. Kroeger**  
Chairman of the Board  
Kroeger's Inc.  
Durango, Colorado

**Mr. Frank "Sam" E. Maynes**  
Attorney at Law  
Maynes, Bradford, Shipps & Sheftel  
Durango, Colorado

**Mr. Will F. Nicholson, Jr.**  
Chairman of the Board  
Rocky Mountain BankCard  
Denver, Colorado

**Mr. Edmond F. "Buddy" Noel, Jr.**  
Member, Attorney  
Sherman & Howard  
Denver, Colorado

**Mr. B. Stephens Parker**  
President  
Burns National Bank  
Durango, Colorado

**Ms. Kathryn A. Paul**  
Division President  
Kaiser Permanente  
Rocky Mountain Division  
Denver, Colorado

**Mr. Leonard M. Perlmutter**  
President  
LAP, Inc.  
Denver, Colorado

**Mr. John M. Philp (also Denver Chamber Board member)**  
Director - Public/Governmental Affairs  
United Airlines  
Denver, Colorado

**Mr. Herrick S. Roth**  
President  
Herrick S. Roth Associates Inc.  
Denver, Colorado

**Mr. John Scully (Chair - Denver Metro Chamber)**  
Colorado Vice President  
US WEST Communications  
Denver, Colorado

**Mr. Harris D. Sherman**  
Senior and Managing Partner  
Arnold & Porter  
Denver, Colorado

**Mr. George W. Sparks**  
General Manager  
Hewlett-Packard Company  
Solutions Services Division  
Loveland, Colorado

**Mr. Charles E. Steinbrueck (also Denver Metro Chamber Board)**  
President & CEO  
Grease Monkey International, Inc.  
Denver, Colorado

**Mr. Lee White**  
Senior Vice-President  
George K. Baum & Co.  
Denver, Colorado

**Mr. Ronald W. Williams**  
President & CEO  
The Gary-Williams Company  
Denver, Colorado

**Mr. Dave Wollard (Past Chair - Denver Metro Chamber)**  
President & Chief Operating Officer, Retired  
Banc One Colorado Corporation  
Denver, Colorado

Denver Metro Chamber of Commerce

**Mr. John Lay**  
President  
Denver Metro Chamber of Commerce  
Denver, Colorado

**Mr. Douglas L. Jones**  
President  
The Jones Realty Group  
Denver, Colorado

**Spouses:**

**Millie Hock  
Genia Miller Parker  
Marjorie Roth  
Christopher Hurley**

**Staff:**

**Maryclaire Genova  
Polly Jessen  
Dana Klapper**

# Withdrawal/Redaction Marker

## Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. list	Colorado Forum 1997 Trip to Washington Social Security numbers redacted (1 page)	4/14/97	P6/b(6)

**This marker identifies the original location of the withdrawn item listed above.  
For a complete list of items withdrawn from this folder, see the  
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**COLLECTION:**

Clinton Presidential Records  
Domestic Policy Council  
Chris Jennings (Subject File)  
OA/Box Number: 23748 Box 19

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**FOLDER TITLE:**

Medicare- New Preventive Benefits [1]

gf40

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**RESTRICTION CODES**

Presidential Records Act - [44 U.S.C. 2204(a)]

Freedom of Information Act - [5 U.S.C. 552(b)]

P1 National Security Classified Information [(a)(1) of the PRA]  
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]  
P3 Release would violate a Federal statute [(a)(3) of the PRA]  
P4 Release would disclose trade secrets or confidential commercial or  
financial information [(a)(4) of the PRA]  
P5 Release would disclose confidential advise between the President  
and his advisors, or between such advisors [(a)(5) of the PRA]  
P6 Release would constitute a clearly unwarranted invasion of  
personal privacy [(a)(6) of the PRA]

b(1) National security classified information [(b)(1) of the FOIA]  
b(2) Release would disclose internal personnel rules and practices of  
an agency [(b)(2) of the FOIA]  
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]  
b(4) Release would disclose trade secrets or confidential or financial  
information [(b)(4) of the FOIA]  
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purposes [(b)(7) of the FOIA]  
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financial institutions [(b)(8) of the FOIA]  
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concerning wells [(b)(9) of the FOIA]

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PRM. Personal record misfile defined in accordance with 44 U.S.C.  
2201(3).

RR. Document will be reviewed upon request.

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1	Patricia A. Cahill		
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4	Thomas T. Farley		
5	Samuel Gary		
6	Maryclaire Genova		
7	Randall C. Hampton		
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35	Lee White		
36	Ronald W. Williams		
37	Dave Wollard		

P6/b(6)



## OUR VISION

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### THE IDEA

In 1978, a diverse group of Colorado chief executive officers and leading professionals convened the first meeting of THE COLORADO FORUM. The goal of this founding group was to create an informed, objective voice on critical public policy issues. Today, the FORUM has 55 members representing disparate regions of the state and speaking from various points on the political spectrum. From a common base of accurate and current information, THE COLORADO FORUM seeks to promote consensus in the community on enlightened public policy.

Membership in THE COLORADO FORUM is purposely limited to encourage open discussion and direct participation by the members. Consortia from Western and Southern Colorado together with representation from Northern Colorado and the metro area enhance the diversity in the FORUM and provide a breadth of interests and expertise.

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### AN HONEST BROKER

THE COLORADO FORUM is not a political action committee nor is it a trade organization. Members pride themselves on their ability to step outside their personal business interests to ascertain what is best for Colorado. Purposely free of bureaucratic constraints, the FORUM is an unincorporated organization without officers and directors.

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### THE TASK

Through detailed analysis, consensus building and persistence, THE COLORADO FORUM seeks to be a positive influence on selected public policy issues.

### THE PROCESS

To encourage candor and facilitate innovative solutions, THE COLORADO FORUM works exclusively "off the record" with all of the various interests focused on an issue until consensus has been reached. This unusual process allows FORUM members to seek common ground in the community in critical public policy areas. Through mediation among adversarial points of view, THE COLORADO FORUM encourages public policy decisions which will enhance the quality of life in Colorado. Our goal is to follow an issue to completion - sometimes working for years to get the job done. Recent examples of the FORUM's involvement are reflected in the building of the new Denver International Airport and the establishment of Colorado's Early Childhood Education program.

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### CONNECTION TO FEDERAL DECISION MAKERS

Each year the members of THE COLORADO FORUM take a trip to Washington D.C. to discuss the issues they have identified for action with Federal policy makers. FORUM members recognize the significant impact of federal action on state and local concerns. Consequently, the FORUM is committed to maintaining a connection to Federal officials as they focus on issues of interest to Colorado citizens.





## OUR FOCUS

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### ISSUE: WELFARE REFORM

As the Federal Government took dramatic steps to change the Welfare system in this country, THE COLORADO FORUM began to look at how welfare works in Colorado and the affect of federal legislation on state policy. Each FORUM member visited with a family on welfare in that family's home in an effort to better understand what is working and what needs to be changed in the program currently in place. In addition, FORUM members talked with case workers, state policy makers and legislators as part of the learning process. As a result, The FORUM has become an advocate for changes in the state's welfare system that encourage self sufficiency, while acknowledging the need for more flexibility, expanded child care capacity and additional jobs.

### ISSUE: HEALTH CARE FOR COLORADO'S CHILDREN

THE COLORADO FORUM has focused its attention on the uninsured children in the state. Encouraged by the relatively low cost of insuring children and the too large, but nevertheless manageable number of children who are currently uninsured, The FORUM is working to bring the public and private sectors together to address this problem.





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**ISSUE: CLEAN UP OF ROCKY FLATS**

One of Colorado's best kept secrets and one of its most dramatic threats is the Rocky Flats facility which is uniquely situated in close proximity to nearly three million Colorado residents. Although Rocky Flats is no longer producing nuclear material, the effort to clean up the plant and reduce the danger of exposure to our communities is daunting. COLORADO FORUM members have visited Rocky Flats and worked to understand clean up options. The FORUM has formed coalitions among business leaders, affected communities, and vested interests in an effort to reach consensus on an expedited cleanup schedule and coordinate advocacy to accomplish that task.

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**ISSUE: IMPROVE COLORADO'S TRANSPORTATION INFRASTRUCTURE**

THE COLORADO FORUM has played a pivotal role in the statewide effort to identify and quantify Colorado's long term transportation infrastructure needs and to develop a consensus across the state for a package of projects and additional funding to begin to solve our congestion problems. FORUM members made transportation infrastructure improvements a priority, and assumed leadership roles in the Blue Ribbon Panel on Transportation and its successor organization, the Colorado Transportation Network (CTN). The FORUM worked with government officials, business organizations and environmental interests to put together a combination of state funds and ballot initiatives to raise sufficient revenue to begin to address the identified funding shortfall for highway improvements, transit and transportation related projects.



B U R O U G H D E N
C O N S E N S U S

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## ISSUE: WATER

Colorado water policy has been on THE COLORADO FORUM's agenda since 1980. The FORUM began its involvement with Colorado's water problems by initiating a report that dealt with Colorado's relationship to other states and their use of Colorado River water. This report has become an important tool for policy makers interested in Colorado's water resources and development.

From early 1985, THE COLORADO FORUM has been the principal non-water management voice before the Executive branch of the federal government and Congress favoring approval of the Animas-La Plata Water Project, a federal reclamation project in Southwestern Colorado. The FORUM helped forge the Ute Indian Tribe's Water Rights Treaty in conjunction with the Animas-La Plata Project. In October, 1988 the treaty was approved by Congress, and in November of that year President Reagan signed and authorized the measure.

The FORUM continues to be involved in this project to resolve Indian water rights disputes in Southern Colorado. Environmental concerns have recently complicated the project's ability to move forward.

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## PROJECTS ADDRESSED IN PAST YEARS

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### DENVER INTERNATIONAL AIRPORT

THE COLORADO FORUM was actively involved for over ten years in an effort to encourage the building of Denver International Airport. Recently, FORUM members have focused on the efficient operation of that facility, working with city and federal officials, the airlines, and private sector interests to resolve baggage handling, noise and airport runway configuration issues.

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### EDUCATION

#### EARLY CHILDHOOD

The FORUM has been a strong advocate for early childhood education and encouraged the successful passage of legislation to initiate and then expand the Colorado Preschool Program

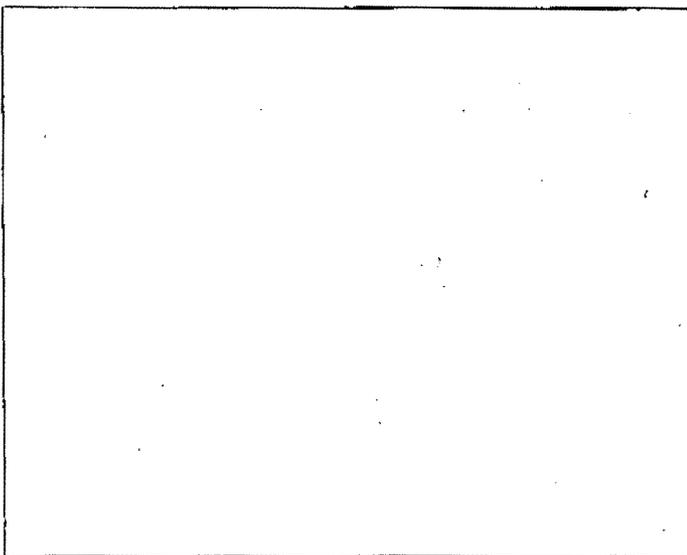
#### HIGHER EDUCATION

The FORUM helped to develop a strong, united coalition in favor of increased funding for state-supported higher education infrastructure needs. This resulted in successful implementation of infrastructure improvements over a three year period.

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### CAMPAIGN FINANCE REFORM

FORUM members were concerned with the rapidly escalating cost of political campaigns. They convened a large group of diverse interest groups and worked to achieve consensus on legislation and a ballot initiative. The result was a campaign finance reform measure passed by the General Assembly as well as a ballot initiative passed by the people.



MEMORANDUM

Chris  
CR

TO: Cynthia Rice  
Office of Domestic Policy  
The White House

MANATT  
PHELPS  
PHILLIPS  
ATTORNEYS AT LAW

FROM: Sage Rhodes

DATE: May 7, 1997 FILE NO.: 12095-030

SUBJECT: Colorectal Cancer Screening

File CJ Colorectal  
Screening

Bob Blair asked me to provide you with the attached information, which he hopes you will be willing to forward on to Chris Jennings and Nancy Ann Min, on the issue of colorectal cancer screening. As you may be aware, Senator Breaux has reintroduced his colorectal cancer screening bill (S. 690). Of perhaps greater significance, the American Cancer Society has issued new screening recommendations that clearly recommend the barium examination for screening average -- and high -- risk groups. Clinical Practice Guidelines issued in February by the 16-member panel initially established by the Agency for Health Care Policy and Research include the same recommendations, and this approach has been endorsed by DC Chapter of the NAACP because of the importance of providing the option of full colon screening for African Americans, who have a much greater tendency to get colorectal cancer in the portion of the colon beyond the reach of sigmoidoscopy.

I have included:

- The American Cancer Society Recommendations on Colorectal Cancer Screening, which is consistent with colorectal cancer screening with barium examination, the approach taken by the Breaux bill.
- A copy of the Colorectal Cancer Screening Guidelines published in the February issue of *Gastroenterology*, which recommend colorectal cancer screening consistent with barium examination, the approach taken by the Breaux bill.
- A copy of a letter from the DC NAACP in support of colorectal cancer screening with barium examination, the approach taken by the Breaux bill.
- An Article by former Governor Wilder on the importance of colorectal cancer screening and in support of colorectal cancer screening with barium examination, the approach taken by the Breaux bill.
- A letter from Vice President Al Gore recognizing Governor Wilder's Symposium on Race and Health Care As We Approach the 21st Century, which focused on colorectal cancer screening and called for colorectal cancer screening with barium examination, the approach taken by the Breaux bill.

MANATT, PHELPS & PHILLIPS, LLP

1501 M Street N.W., Suite 700 Washington, D.C. 20005 -1702 · 202-463-4300 · FAX 202-463-4394

Los Angeles · Washington, D.C. · Nashville

Sarah Lyons  
Legislative Assistant  
Senator John Breaux  
May 7, 1997  
Page 2

- A statement by former Governor L. Douglas Wilder before the House Ways and Means Subcommittee on Health in support of colorectal cancer screening with barium examination, the approach taken by the Breaux bill.
- A statement by the Congressman Norm Sisisky (D-VA) before the House Ways and Means Subcommittee on Health in support of colorectal cancer screening with barium examination, the approach taken by the Breaux bill.
- A copy of the Breaux bill.

Bob and David Klaus send along their best regards and hope you will review this information with interest and forward it to Chris and Nancy Ann. Thanks.