

**H.R. 1740, THE BREAST CANCER EDUCATION
AND AWARENESS REQUIRES LEARNING YOUNG
ACT OF 2009; H.R. 1691, THE BREAST CANCER
PATIENT PROTECTION ACT OF 2009; H.R. 2279,
THE ELIMINATING DISPARITIES IN BREAST
CANCER TREATMENT ACT OF 2009; AND H.R.
995, THE MAMMOGRAM AND MRI AVAIL-
ABILITY ACT OF 2009**

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON ENERGY AND
COMMERCE
HOUSE OF REPRESENTATIVES
ONE HUNDRED ELEVENTH CONGRESS
FIRST SESSION

OCTOBER 7, 2009

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WEDNESDAY, OCTOBER 7, 2009

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The Subcommittee met, pursuant to call, at 11:47 a.m., in Room 2123 of the Rayburn House Office Building, Hon. Frank Pallone, Jr. [Chairman of the Subcommittee] presiding.

Members present: Representatives Pallone, Dingell, DeGette, Schakowsky, Baldwin, Matheson, Harman, Barrow, Christensen, Castor, Sarbanes, Space, Sutton, Braley, Deal, Whitfield, Shimkus, Blunt, Pitts, Wilkins Myrick, Burgess, Blackburn, Gingrey and Barton (ex officio).

Staff present: Sarah Despres, Counsel; Anne Morris, Professional Staff; Elana Leventhal, Policy Advisor; Alvin Banks, Special Assistant; Allison Corr, Special Assistant; Aarti Shah, Counsel; and Chad Grant, Legislative Analyst.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. We will start the hearing, and I do apologize for the delay.

Today the Subcommittee is meeting to review four bills relating to breast cancer: H.R. 995, the Mammogram and MRI Availability Act of 2009, sponsored by Congressman Nadler of New York; H.R. 1691, the Breast Cancer Patient Protection Act of 2009, sponsored by Ms. DeLauro of Connecticut; H.R. 1740, the Breast Cancer Education and Awareness Requires Learning Young Act of 2009 by Congresswoman Wasserman Schultz from Florida; and H.R. 2279, the Eliminating Disparities in Breast Cancer Treatment Act of 2009 sponsored by our own Member, Congresswoman Castor also from Florida. And I want to thank all the sponsors of these bills

for the hard work on raising awareness about these very important issues, and I should also point out that they have been spending some time over the last 6 months trying to have this Subcommittee have this hearing and the reason for the delay was of course we were dealing with health care reform.

Now, aside from the non-melanoma skin cancer, breast cancer is the most commonly diagnosed cancer in women. The NIH estimates that over 190,000 new cases of breast cancer will be diagnosed in women in 2009, and though we have seen breast cancer death rates decline since 1990, still approximately 40,000 women will succumb to the disease this year. And that is the work of advocacy groups and the key sponsors of the bills today is so crucially important. We have made great strides in detecting and treating breast cancer but there is still much more to be done and much more to learn.

Although all of these bills address concerns related to breast cancer, they all focus on different aspects of the disease from screening and early detection to treatment and quality improvement, and all they all raise very important issues with respect to how breast cancer patients or any other patients for that matter are being treated in the medical environment we live in today. Not every American has access to good preventive services. Not every American has the good fortune to have an insurance plan that covers the medical care they need, and that is why we are working hard trying to pass health reform legislation that will improve access to quality and affordable health care for every American. If enacted, health care reform legislation will dramatically improve our efforts in the battle against breast cancer.

Particularly important are the insurance reforms. In drafting America's Affordable Health Choices Act, we took the same tack as Ms. DeLauro did in taking decision-making authority out of the hands of health insurers and putting it back in the hands of patients and their doctors where it belongs. In addition, the subsidies offered in the exchange and expansion of the Medicaid program under health care reform will cover childless adults and mean that many low- and middle-income women who might not have access to health insurance today will be covered in the future for the first time, and that means they will be able to access a doctor and receive treatment when they need it.

A key component to winning the battle against breast cancer is effective and appropriate screening, which both Ms. Wasserman Schultz and Mr. Nadler's bill seek to address. Early detection of breast cancer has long been acknowledged as an effective way to improve outcomes. In fact, studies have shown that the 5-year survival rate in women who have received timely treatment due to early detection is at 98 percent, and that is why the U.S. Preventative Services Taskforce has recommended that all women over the age of 40 have a mammography screening every 1 or 2 years. Now, I agree with my colleagues that early detection and prevention is key to survival, and that is why in health reform we bolster the very important work that the U.S. Preventative Services Taskforce does by providing increased funding so that they can analyze more studies and make more prevention recommendations. The evidence-based recommendations that receive the highest ratings from the taskforce such as mammography screenings will be covered by all

insurance carriers participating in the health insurance exchange and by Medicaid, and while Medicare already covers these services under health reform, beneficiaries would no longer face cost-sharing requirements to receive them.

In addition in health reform, we must also improve the quality of care that is provided in this country as Ms. Castor is seeking to do with her bill. Tens of thousands of Americans die to preventable medical errors every year. Billions of dollars are wasted on low-quality care. We as a Nation must do better. Improving quality is a concept we picked up in health reform as well. We require the Secretary to establish national priorities for quality improvement and we also create a center for quality improvement. This center will develop and encourage the use of best practices for quality assurance and will provide implementation grants to those who are already doing innovative work to improve the quality of care. Using breast cancer as an example, we can and must do better to ensure that all Americans receive the highest quality care and that we collect data that will help us continuously improve as more information becomes known about the medical system and specific diseases.

I want to thank all of our witnesses. I know we are going to start after opening statements with the Members' panel. I would say I guess it is clear from my opening statement that in many cases some of the things in these bills hopefully will be addressed in the larger health care reform bill but I don't mean to suggest that that takes away from the need for us to have this hearing today or to move forward with these bills. It may very well be that some things are included and some are not, and so this is a legislative hearing and the intention would be to move these bills, but we also have to see what is included in the health care reform as well.

[The prepared statement of Mr. Pallone follows:]

**Chairman Frank Pallone, Jr.
Health Subcommittee Hearing
HR 1740, the Breast Cancer Education and Awareness
Requires Learning Young Act of 2009;
HR 1691, the Breast Cancer Patient Protection Act of 2009;
HR 2279, the Eliminating Disparities in Breast Cancer
Treatment Act of 2009;
HR 995, the Mammogram and MRI Availability Act of 2009
Opening Statement**

October 7, 2009

Good morning. Today the Subcommittee is meeting to review four bills relating to breast cancer: HR 995, the Mammogram and MRI Availability Act of 2009 (Nadler); HR 1691, the Breast Cancer Patient Protection Act of 2009 (DeLauro); HR 1740, the Breast Cancer Education and Awareness Requires Learning Young Act of 2009 (Wasserman Schultz); and HR 2279, the Eliminating Disparities in Breast Cancer Treatment Act of 2009 (Castor). I would like to thank all of the sponsors of these bills for their hard work on raising awareness about these very important issues.

Aside from non-melanoma skin cancer, breast cancer is the most commonly diagnosed cancer in women. The NIH estimates that over 190,000 new cases of breast cancer will be diagnosed in women in 2009. And though we have seen breast cancer death rates decline since 1990, still approximately 40,000 women will succumb to the disease this year.

This is why the work of advocacy groups and the key sponsors of the bills today, is so crucially important. We have made great strides in detecting and treating breast cancer but there is still much more to be done, and much more to learn.

While all of these bills address concerns related to breast cancer, they all focus on different aspects of the disease from screening and early detection to treatment and quality improvement. And they all raise very important issues with respect to how breast cancer patients, or any other patients for that matter, are being treated in the medical environment we live in

today. Not every American has access to good preventive services; not every American has the good fortune to have an insurance plan that covers the medical care they need.

That's why we are hard at work trying to pass health reform legislation that will improve access to quality and affordable health care for every American. If enacted, health reform legislation will dramatically improve our efforts in the battle against breast cancer.

Particularly important are the insurance reforms. In drafting America's Affordable Health Choices Act, we took the same tact as Ms. DeLauro did in taking decision making authority out of the hands of health insurers and putting it back in the hands of patients and their doctors, where it belongs.

In addition, the subsidies offered in the Exchange and expansion of the Medicaid program to cover childless adults will mean that many low and middle income women who might not

have access to health insurance today will be covered in the future thanks to health reform. That means they will be able to access a doctor and receive treatment when they need it.

A key component to winning the battle against breast cancer is effective and appropriate screening, which both Ms. Wasserman Schultz' and Mr. Nadler's bills seek to address. Early detection of breast cancer has long been acknowledged as an effective way to improve outcomes. In fact, studies have shown that the 5-year survival rate in women who have received timely treatment due to early detection is at 98%. This is why the US Preventive Services Taskforce has recommended that all women over the age of 40 have a mammography screening every one or two years.

I agree with my colleagues. Early detection and prevention is key to survival. That's why in health reform we bolster the very important work that the US Preventative Services Task Force does by providing increased funding so that they can analyze more

studies and make more prevention recommendations. The evidence-based recommendations that receive the highest ratings from the task force, such as mammography screenings, will be covered by all insurance carriers participating in the Health Insurance Exchange and by Medicaid. And while Medicare already covers these services, under health reform, beneficiaries would no longer face cost-sharing requirements to receive them.

In addition, we must also improve the quality of care that is provided in this country as Ms. Castor is seeking to do with her bill. Tens of thousands of Americans die due to preventable medical errors every year. Billions of dollars are wasted on low quality care. We as a nation must do better.

Improving quality is a concept we picked up in Health Reform as well. We require the Secretary to establish national priorities for quality improvement and we also create a Center for Quality improvement. The center will develop and encourage the

use of best practices for quality assurance and will provide implementation grants to those who are already doing innovative work to improve the quality of care. Using breast cancer as an example, we can and must do better to ensure that all Americans receive the highest quality care and that we collect data that will help us continuously improve as more information becomes known about the medical system and specific diseases.

I would like to thank all of our witnesses for being here today, I look forward to your testimony. I now recognize our Ranking Member, Mr. Deal for five minutes for the purpose of making an openings statement.

Mr. PALLONE. So thank you, and with that I would yield to our ranking member, Mr. Deal.

OPENING STATEMENT OF HON. NATHAN DEAL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. DEAL. Thank you, Chairman Pallone. Thank you for holding the hearing and thanks to our colleagues for appearing before us today and all the other distinguished witnesses whose testimony we will certainly look forward to hearing.

All of us, I think, understand the importance of the topic that is before us today. Many of us have cosponsored many of the legislative agenda items that are before the Committee. I for one have cosponsored H.R. 1740 because I think it is important for early diagnosis and treatment of breast cancer as well as the continued effort to educate young women about this particular disease. Now, we have dealt with a variety of issues over the years and most recently highlighted by testimony from Ranking Member Barton about a constituent who in the midst of dealing with breast cancer had her policy canceled. The House has dealt with that when we passed H.R. 758 by an overwhelming vote of 421 to 2, so we have begun the process, I think, of dealing with many of the issues surrounding the treatment and diagnosis of breast cancer.

But as we continue to deal with how we can best combat this disease, I believe that as stewards of the taxpayers' dollars that we must make sure that these dollars are being most in the most appropriate way, particularly those that are with the NIH and CDC. We must assure that these limited resources are appropriately expended to fight all diseases including breast cancer, and I have particular concerns about some of the expenditures in both NIH and CDC that would appear to be far beyond the normal pale of what people regard as important research for those two agencies to be supervising.

So I look forward to the testimony and I welcome our colleagues on the first panel. I yield back.

Mr. PALLONE. Thank you, Mr. Deal.

Let me mention to everybody, that is just a recess. We are not voting, just so you know.

I recognize the gentlewoman from Colorado, Ms. DeGette.

Ms. DEGETTE. Thank you very much, Mr. Chairman, and out of respect for our intrepid and courageous witnesses in our first panel, I will waive my opening statement and submit my very excellent statement that everyone will be able to read in the record. Thank you.

Mr. PALLONE. Thank you.

Next is the gentleman from Missouri, Mr. Blunt.

Mr. BLUNT. Thank you, Mr. Chairman. I do have a statement. I will submit it for the record as well. I am pleased we are having this hearing. I am pleased to be a cosponsor of H.R. 1740, the EARLY Act, with my good friend, Ms. Wasserman Schultz, and look forward to the hearing.

[The prepared statement of Mr. Blunt follows:]

**BLUNT STATEMENT FOR E&C HEALTH SUBCOMMITTEE HEARING
OCTOBER 7, 2009**

Mr. Chairman,

Thank you for holding this hearing regarding breast cancer legislation. This is timely as we encourage awareness of this disease and those who have been affected by it. The vital research and funding that have already been devoted to this disease has resulted in high survival rates for those afflicted, which is good news. As advocates for this disease know though, there is more that can be done and that is why I am pleased to be a co-sponsor of H.R. 1740, the EARLY Act, introduced by my colleague Representative Wasserman Schultz. It's important that we encourage education and awareness among young women, so they can hopefully avoid ever dealing with this disease at a late stage. I would hope that any legislation enacted would provide more tools for patients, doctors, and researchers as we continue to work to fight this disease and search for a cure. I look forward to working with you Mr. Chairman, with Mr. Deal, as well as my colleagues in the full committee as we move forward on this critical issue.

Mr. PALLONE. Thank you.
The gentlewoman from California, Ms. Harman.

OPENING STATEMENT OF HON. JANE HARMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. HARMAN. Thank you, Mr. Chairman. I will be brief but I want to salute our colleagues but especially our colleague, Debbie Wasserman Schultz, for her courage, her passion and her example. Many of us wore pink today in solidarity with her. We are strong supporters of her bill. Hopefully we will find a way now that it is in acceptable form to Committee staff to include it in the health care bill with the robust public option that we are going to pass on the House Floor one of these days.

Just briefly, I have a brother who is an oncologist. I couldn't have been prouder when he was given the Healer of the Year award by Marin County, California, for his work on breast cancer. Breast cancer attacks oldies, grandmas like me, but it also attacks beautiful young women like Debbie Wasserman Schultz and hopefully not my daughters, who are a bit younger than she is, and hopefully not my granddaughter, who is a lot younger than she is. So this is something we all have experience with. All of us know people who have breast cancer. Hopefully they all will be survivors and most of us are very responsive to the Susan G. Komen and other efforts to raise awareness.

I just want to say that these bills are all good. I am rousingly enthusiastic about Debbie Wasserman Schultz's bill and in that context I would like to ask unanimous consent to insert in the record a statement by the United Jewish Communities in support of that bill.

[The information follows:]



October 7, 2009

Dear Members of Congress:

We, the following volunteer and professional leaders (listed below) of UJC/The Jewish Federations of North America, our thousands of social service agencies, and the broader Jewish community strongly support the **EARLY Act**, Breast Cancer Education and Awareness Requires Learning Young Act, and ask for its immediate consideration before the United States Congress.

Ashkenazi Jewish women are more likely to have a mutation for the BRCA1 or BRCA2 gene, thus making our population three to seven times more likely to develop breast cancer. Breast cancer is the leading cause of cancer deaths in young women under the age of 40. The EARLY Act will increase the awareness among young women under the age of 40 of the threats posed by breast cancer, steps to reduce the risks, and early detection techniques; increase the awareness of the distinct risk factors and treatments including infertility and recurring malignancies specific to young women under 40; and offers support for young women diagnosed with breast cancer.

Thank you in advance for your support of this life saving legislation. If you should have any questions about the EARLY Act or other issues facing Congress, please contact Amy Aarons Rosen, Senior Associate, UJC/The Jewish Federations of North America at amy.rosen@ujc.org or 202.735.5871.

Sincerely,

United Jewish Communities/The Jewish Federations of North America and
753 Jewish Communal Leaders (attached)

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92.	Michele	Solomon	San Carlos	CA
93.	Cheryl	Swanko	Carmel	NY
94.	Matt	Katz	San Carlos	CA
95.	Ruth	Perez	San Mateo	CA
96.	Bruce	Maciver	Alexandria	VA
97.	Joanne	Rosenberg	Tucson	AZ
98.	Idit	Jacques	Columbus	OH
99.	Simone	Hyams	Tucson	AZ
100.	Debra	Shapiro	Brooklyn	NY
101.	Judith	Rosenberg	Knoxville	TN
102.	Michele	Glassberg	New York	NY
103.	Shayna	Kreisler	Brooklyn	NY
104.	Emily	Trotz	Memphis	TN
105.	Sharon	Lite	Tucson	AZ
106.	Janet	Gidney	Phoenix	AZ
107.	Jamie	Frankos	Foster City	CA
108.	Patricia	Uhimann	Prairie Village	KS
109.	Marianne	Bloomberg	Farmington Hills	MI
110.	Merle	Grandberg	Chestnut Hill	MA
111.	Roberta	Gornish	St. Louis	MO
112.	Cora	Ginsberg	Chappaqua	NY
113.	Eleanor	Elbaum	Providence	RI
114.	Rachel	Halupowski	Portland	OR
115.	Dan	Guyer	Huntington Woods	MI
116.	Janet	Aarons	Birmingham	AL
117.	Pepi	Dunay	Boca Raton	FL
118.	Lyn	Saberg	Fort Lauderdale	FL
119.	Lori	Lightman	Tucson	AZ
120.	Lynn	Harris Gossen	St. Louis	MO
121.	Renee	Pitt	Orlando	FL
122.	Shelly	Christensen	Plymouth	MN
123.	Maya	Segal	Culver City	CA
124.	Jackie	Burman	Washington	DC
125.	Caren	Seligman	Birmingham	AL
126.	Jeff	Rosenblum	St. Louis	MO
127.	Susan	Sorrel	Millwood	NY
128.	Amy	Garland	St. Louis	MO
129.	Diane	Azorsky	Leawood	KS
130.	Gail	Weinberg	Overland Park	KS
131.	Howard	Charish	Paramus	NJ
132.	Ezra	Shanken	Denver	CO
133.	Doris	Jacobson	Anaheim	CA

134.	Marilyn	Marks	Orlando	FL
135.	Joy	Rosen	Wimauma	FL
136.	Andrea	Fisher	Omaha	NE
137.	Bev	Tannenbaum	Odessa	FL
138.	Deborah	Smith	Naples	FL
139.	Carol	Jaffe	Tampa	FL
140.	Maurice	Shevin	Birmingham	AL
141.	Barbara	Orenstein	Rochester	NY
142.	Cindy	Spahn	Tampa	FL
143.	Beth	Manlin	Saint Louis	MO
144.	Leslie	Sidell	Denver	CO
145.	L	Goldberg	Smithtown	NY
146.	Brooke	Pariser	Ocean Shores	WA
147.	Benjamin	Pariser	Ocean Shores	WA
148.	Michelle	Hoberman	Omaha	NE
149.	Janet	Wasserberger	Tampa	FL
150.	Margaret	Allon	Denver	CO
151.	Paulina	Subbotovsky	Torrance	CA
152.	Marc	Newman	Scottsdale	AZ
153.	Donna	Feinberg	Villanova	PA
154.	Susan	Kuhn	Tampa	FL
155.	Susan	Kessler	Tampa	FL
156.	Neal	Rosen	Wimauma	FL
157.	Harriet	Kaufmann	Englewood	CO
158.	Sheryl	Goodman	Englewood	CO
159.	Ashley	Wax	Bellevue	WA
160.	Abby	Hahn	St. Louis	MO
161.	Bella	Pavlov	Los Angeles	CA
162.	Steve	Rosenblum	St Louis	MO
163.	Sara	Scher	Tampa	FL
164.	Jill	Rosen	Ambler	PA
165.	Lisa	Fischer	East Brunswick	NJ
166.	Jody Kaufman	Loewenstein	Milwaukee	WI
167.	Terrie	Sherman	Tucson	AZ
168.	Lisa	Mintz	Denver	CO
169.	Margery	Weinberg	Monroe Township	NJ
170.	Debby	Saadi	St Louis Park	MN
171.	Debby	Saadi	St Louis Park	MN
172.	Mariann	Greene	Boynton Beach	FL
173.	Ellen	Gray	Denver	CO
174.	Joan	Bohm	Chesterfield	MO
175.	/Andrea	Markowitz	Wimauma	FL
176.	Joan	Benstock	Belleair Beach	FL
177.	Abby	Belafsky	Voorhees	NJ

178.	Norman	Kaplon	Portland	OR
179.	Alise	Boxer	Denver	CO
180.	Elaine	Bloom	Miami Beach	FL
181.	Judy	Zirofsky	Wimauma	FL
182.	Ruth	Malman	Denver	CO
183.	Patty	Halfon	Denver	CO
184.	Randie	Harmelin	Wynnewood	PA
185.	Megan	Wiston	Lake Worth	FL
186.	Rhoda	Karpay	Tampa	FL
187.	Joel	Karpay	Tampa	FL
188.	Andrea	Stein	Denver	CO
189.	Gail	Zucker	Seattle	WA
190.	Renee	Reckler	Greenwood Village	CO
191.	Ronna	Paul	Northbrook	IL
192.	Lynn	Karpay	Potomac	MD
193.	Elin	Robbins-Geman	Denver	CO
194.	Gail	Brady	New City	NY
195.	Duncan	Stuart	Baltimore	MD
196.	Elaine	Pittell	Hollywood	FL
197.	Marilyn	Hyman	Greenwood Village	CO
198.	Marlene	Scherk	San Diego	CA
199.	Tamar	Earnest	Allentown	PA
200.	Carolyn	Sanger	Tucson	AZ
201.	T.	Smieja	Ridgecrest	CA
202.	Abby	Selman-Pait	Orlando	FL
203.	Harriet	Miller	Kingston	NY
204.	Sharon	Rosenblum	Saint Louis	MO
205.	Amy	Morris	Greenwood Village	CO
206.	Laurie	Morris	Greenwood Village	CO
207.	Barbara	Rissman	Woodstock	NY
208.	Barbara	Shapiro	Tucson	AZ
209.	Karen	Heintz	San Antonio	TX
210.	Shea	Friedland	Washington	DC
211.	Sandra	Heintz	Morristown	NJ
212.	Rosalind	Kalmans	Houston	TX
213.	Mary	Tessler	Scottsdale	AZ
214.	Diane	Slakter	Tampa	FL
215.	Wendy	Nekritz	Denver	CO
216.	Debbie	Diamond	Portland	OR
217.	Anne	German	Providence	RI
218.	Marla	Kaftan	Birmingham	MI
219.	Ann	Rudolph	Tampa	FL
220.	Susan	Nekritz	Northbrook	IL
221.	Ellen	Levitt	Nashville	TN

222.	Nora	Schrutt	Denver	CO
223.	Andee	Scioli	Omaha	NE
224.	Judy	Goldstein	San Antonio	TX
225.	Deborah	Elmgren	Portland	OR
226.	Inna	Smilansky	Rochester Hills	MI
227.	Joi	Morris	Santa Monica	CA
228.	Fay	Roos	Tucson	AZ
229.	Linda	Mintz	Annapolis	MD
230.	Mari	Forbush	Crystal	MN
231.	Susie	Moss	Greenwood Village	CO
232.	Diane	Naar	Bridgewater	NJ
233.	Deborah	Peskin	Longmeadow	MA
234.	Lillian	Swickle	Bridgewater	NJ
235.	Nancy	Lee	Far Hills	NJ
236.	Sharon	Kaufman	Houston	TX
237.	Pamela	Brooks	Cypress	TX
238.	Sharon Alterman	Alterman	Franklin	MI
239.	Sheryl	Zeger	Bedminster	NJ
240.	Jennifer	Mandel	Gaithersburg	MD
241.	Debbie	Stark	Denver	CO
242.	Merilyn	Burke	Tampa	FL
243.	Margie	Okrent	San Antonio	TX
244.	Lisa	Hunsicker	Littleton	CO
245.	Debbie	Rosenblum	Denver	CO
246.	Stacy	Gerowitz	Beverly Hills	CA
247.	Peppy	Margolis	Three Bridges	NJ
248.	Arthur	Roswell	Bridgewater	NJ
249.	B	Anthony	Los Angeles	CA
250.	Stephanie	Milzer	Denver	CO
251.	Mona	Holtz	Bridgewater	NJ
252.	Ellen	Meyers	Worcester	MA
253.	Christine	Yee	San Francisco	CA
254.	Michelle	Segal	Morristown	NJ
255.	Lisa	Schulte	Bridgewater	NJ
256.	Roxanne	Cohen	San Carlos	CA
257.	Renie	Carniol	Whippany	NJ
258.	Dorothy	Weller	Bridgewater	NJ
259.	Sarah	Meytin	Gaithersburg	MD
260.	Rossana	Rossetto	San Francisco	CA
261.	Linda	Rice	New York	NY
262.	Caren	Gallaher	Knoxville	TN
263.	Michele	Stuart	Stamford	CT
264.	Leslie	Tramer	San Antonio	TX
265.	Shirlee	B;Londer	Palm Beach	FL

			Gardens	
266.	Gail	Stewart	West Bloomfield	MI
267.	Sheila	Trugman	Worcester	MA
268.	Annette	Radick	Bedminster	NJ
269.	Jon	Tramer	San Antonio	TX
270.	Steven	Gerson	Marietta	GA
271.	Harriet	Leitner	Irvington	NY
272.	Susan	Hurvitz	State College	PA
273.	Eva	Ritt	Winter Park	FL
274.	Barbara	Kessler	Tarpon Springs	FL
275.	Deborah	Burica	Plymouth	MN
276.	Ellen	Coper	Potomac	MD
277.	Jerry	Starr	Maplewood	NJ
278.	Matt	Abrams Gerber	New York	NY
279.	Laurie	Fox	Los Angeles	CA
280.	Yael	Eshel	Glendale	AZ
281.	Sharon	Freiman	Chevy Chase	MD
282.	Karen	Shaw	Pacific Palisades	CA
283.	Lori	Fireman	Columbus	OH
284.	Susan	Seidler	Prairie Village	KS
285.	Shirley	Shrago Siff	Palm Beach	FL
286.	Eileen	Feldgus	Tucson	AZ
287.	Jodi	Greenwald	Charlotte	NC
288.	Susan	Beiles	Staten Island	NY
289.	Stacey	Werner	Chevy Chase	MD
290.	Nancy	Kleinfeldt	Huntington Woods	MI
291.	Denise	Cohen	Watchung	NJ
292.	Violet	Balto	Baton Rouge	LA
293.	Linda	Dombrowsky	Wyckoff	NJ
294.	Amanda	Bernstein	Emerson	NJ
295.	Dalia	Zatlin	San Mateo	CA
296.	Francie	Harris	Washington	DC
297.	Danielle	Weinstein	New York	NY
298.	Rhoda	Kaplun	Allentown	PA
299.	Marilyn	Zutty	Boca Raton	FL
300.	Bob	Michael	Morton	IL
301.	Randy	Fenton	Tucson	AZ
302.	Sherry	Kellner	Warren	NJ
303.	Jane	Zutty	Hollywood	FL
304.	Marsha	Silverman	Bronx	NY
305.	Lauren	Goodman	New Orleans	LA
306.	K.	Spiegel	Los Angeles	CA
307.	Deborah	Goldenberg	Dayton	OH
308.	Mary	Trachtenberg	Oklahoma City	OK

309.	Nina	Stillman	Plymouth	MN
310.	Michael	Neil	Yardley	PA
311.	Shirley	Ross	Long Beach	CA
312.	Denise	Wilde	New York	NY
313.	Susan	Katz	East Peoria	IL
314.	Brian	Katz	New Orleans	LA
315.	Lori	Klinghoffer	Short Hills	NJ
316.	Robin	Rochlin	Paramus	NJ
317.	Nelle	Miller	Sarasota	FL
318.	Jody	Weisberg	Raleigh	NC
319.	Barbara	Adelman	Minnetonka	MN
320.	Sarah	Raphaely	New York	NY
321.	Sara	Olshin	Teaneck	NJ
322.	Cora	Ginsberg	Chappaqua	NY
323.	Paula	Saginaw	North Caldwell	NJ
324.	Ann	Jacobson	Naples	FL
325.	Susan	Hazan	Tucson	AZ
326.	Anne	Jacobson	Boca Raton	FL
327.	Linda	Goldstein	Bellaire	TX
328.	Am	Goldkrand	Savannah	GA
329.	David	Willens	Naples	FL
330.	Sara	Rosenbaum	Richmond	VA
331.	Marcia	Chapman	Wayne	NJ
332.	Amy	Glazer	Woodcliff Lake	NJ
333.	Eileen	Dombrowsky	West Caldwell	NJ
334.	Sandy	Cohen	Dallas	TX
335.	Fern	Feder	Tucson	AZ
336.	Sari	Gross	Wayne	NJ
337.	Sandra	Lachter	Tucson	AZ
338.	Norma	Sanchez	Wimauma	FL
339.	Blanche	Silver	Teaneck	NJ
340.	Susan	Benkel	Woodcliff Lake	NJ
341.	Elizabeth	Askowitz	New Rochelle	NY
342.	Rachel	Jacobs	Menlo Park	CA
343.	Melinda	Doner	Englewood	OH
344.	Helen	Astmann	Paramus	NJ
345.	Sara	Leslie	Menlo Park	CA
346.	Joy	Shorr	Hillsdale	NJ
347.	Diane	Karp	Newport Beach	CA
348.	Irene	Lofland	Denver	CO
349.	Barbara	Hochman	Teaneck	NJ
350.	Carol	Wilson	Allentown	PA
351.	Barbara	Orenstein	Rochester	NY
352.	Nancy	Rosenberg	Rochester	NY

353.	Beth	Binder	Highland Park	IL
354.	Susie	Sorkin	San Carlos	CA
355.	Helen	Goodman	Rochester	NY
356.	Gladys	Wolsky	Rochester	NY
357.	Lori	Fritz	Minnetonka	MN
358.	Judy	Gavsier	Minneapolis	MN
359.	Ruth	Fried	Rochester	NY
360.	Judith	Bulin	Pittsford	NY
361.	Judy	Schwartz	Rochester	NY
362.	Merrick	Makowka	Denver	CO
363.	Cathy	Harris	Rochester	NY
364.	Beth	Seeley	Penfield	NY
365.	Joy	Maikus	Glencoe	IL
366.	Toby	Kriss	Long Grove	IL
367.	Lisa	Rosenkranz	Glencoe	IL
368.	Dvora	Spiewak	Teaneck	NJ
369.	Randi	Piaker	West Hartford	CT
370.	Dana	Gordon	Highland Park	IL
371.	Barbara	Koch	Chicago	IL
372.	Vanessa	Friedman	Kentfield	CA
373.	Susan	Farber	Niskayuna	NY
374.	Joyce	Spielberger	Birmingham	AL
375.	Lisa	Chanil	River Vale	NJ
376.	Jennifer	Brown	Glencoe	IL
377.	Jean	Smith	Rowley	MA
378.	Gail	Fernhoff	Hillsdale	NJ
379.	Gabrielle	Kleinmann	Woodstock	NY
380.	Randi	Singman	Ny	NY
381.	Emily	Hanlen	New York	NY
382.	Lisa	Jadis	Warren	NJ
383.	Devra	Shutan	Highland Park	IL
384.	Barbara	Slutsky	Highland Park	IL
385.	Barbara	Resnick	Lincolnwood	IL
386.	Debbie	Waxelbaum	Scottsdale	AZ
387.	Leslie	Linevsky	Weston	FL
388.	Tamara	Sugar	Skokie	IL
389.	Rebecca	Citron	Englewood	NJ
390.	Gail	Norry	Rydal	PA
391.	Donna	Field	Highland Park	IL
392.	Marlene	Apkon	Ashland	MA
393.	Helene	Weinberg	Naples	FL
394.	Marilyn	Eisenberg	Skokie	IL
395.	Debby	Waranch	Naples	FL
396.	Carl	Zielonka	Tampa	FL

397.	Elissa	Goldstein	Naples	FL
398.	Donna	Goldblatt	Naples	FL
399.	Susan	Reese	Highland Park	IL
400.	Marjorie	Diamond	Lafayette	CA
401.	Ellen	Sanderson	Framingham	MA
402.	Susan	Levenberg	Schereville	IN
403.	Jamie	Bradshaw	Anthem	AZ
404.	Sherman	Minkoff	Scottsdale	AZ
405.	Karen	Lustig	Pittsford	NY
406.	Myrna	Shaw	Highland Park	IL
407.	Elaine	Levinson	Indianapolis	IN
408.	Randee	Simborg	Chicago	IL
409.	Laurie	Segall	Denver	CO
410.	Jennifer	Salcedo	Houston	TX
411.	Ilana	Bernstein	West Hartford	CT
412.	Stephanie	Brown	Berkeley	CA
413.	Bonnie	Nickol	Little Rock	AR
414.	Susan	Rosen	Palm Beach Gardens	FL
415.	Blaire	Mossman	Scottsdale	AZ
416.	Susan	Golden	Akron	OH
417.	Irene	Moff	Foster City	CA
418.	Jane	Friedman	Cincinnati	OH
419.	Mona	Kolko	Pittsford	NY
420.	Marilyn	Zutty	Boca Raton	FL
421.	Judith W.	Kaplan	Pittsford	NY
422.	Marianne	Friedman	Piedmont	CA
423.	Roberta	Borg	Rochester	NY
424.	Paul	Moss	White Bear Lake	MN
425.	Jane	Zutty	Hollywood	FL
426.	Elihu	Cohen	North Syracuse	NY
427.	Sue	G Ordon	Dallas	TX
428.	Abigail	Rasnick	Rochester	NY
429.	Roberta	Feldman	Rochester	NY
430.	Jodi	Atkin	Rochester	NY
431.	Barbara	Horowitz	West Bloomfield	MI
432.	Monica	Fischman	Southfield	MI
433.	Elaine	Block-Victor	W. Bloomfield	MI
434.	Jennifer	Oxford	Orefield	PA
435.	Susan	Kellman	West Bloomfield	MI
436.	Carol	Seidberg	Phoenix	AZ
437.	Kenneth	Seidberg	Phoenix	AZ
438.	Michelle	Kleiman	Bloomfield Hills	MI
439.	Joyce	Herman	Penfield	NY

440.	Becky	Lauten	Easton	PA
441.	Dayna	Libow	Scottsdale	AZ
442.	Patrice	Phillips	West Bloomfield	MI
443.	Susan	Citrin	Birmingham	MI
444.	Susan	Rothenberg	Rochester	NY
445.	Anita	Gutkin	Scottsdale	AZ
446.	Penny	Blumenstein	Palm Beach	FL
447.	Lindsay	Perlman	Burbank	CA
448.	Julie	Pappas	Glencoe	IL
449.	Joanne	Duckler	Glencoe	IL
450.	Julie	Maeir	Skokie	IL
451.	Beth	Machlin	Glencoe	IL
452.	Randie	Levin	Bloomfield Hills	MI
453.	Lila	Silverman	Bloomfield Hills	MI
454.	Kelly	Borre	Northbrook	IL
455.	Sydelle	Sonkin	Palm Beach Gardens	FL
456.	Daphne	Futerman	Rochester	NY
457.	Linda	Hayman	Bloomfield Hills	MI
458.	Joan	Sereboff	Naples	FL
459.	Janice	Weinstein	Birmingham	AL
460.	Sherry	Baskin	Mayfield	OH
461.	Marianne	Bankier	Northbrook	IL
462.	Regina	Brenner	Allentown	PA
463.	Wendy	Laskin	Phoenix	AZ
464.	Mark	Schwartz	Scottsdale	AZ
465.	Susan	Levinson	Greenbrae	CA
466.	Robin	Blank	Scottsdale	AZ
467.	Linda	Ruda	Rochester	NY
468.	Ellen	Levine	Castro Valley	CA
469.	Lisa	Stein	Scottsdale	AZ
470.	Andi	Minkoff	Scottsdale	AZ
471.	Stephen	Kahn	Scottsdale	AZ
472.	Nora	Perlmutter	Scottsdale	AZ
473.	Frances	Falk	Phoenix	AZ
474.	Adina	Hirsch	Arlington	VA
475.	Paula	Dubnow	Phoenix	AZ
476.	Renee	Hammel	Cary	NC
477.	Jason	Secore	Scottsdale	AZ
478.	Michele	Kahn	Scottsdale	AZ
479.	Steven	Perlmutter	Scottsdale	AZ
480.	Ellnor	Greenfield	Chandler	AZ
481.	J	Marcus	Scottsdale	AZ
482.	Lauren	Zaslow	Phoenix	AZ

483.	Paul	Smelkinson	Tucson	AZ
484.	Elaine	Smelkinson	Tucson	AZ
485.	Amy	Leveton	Scottsdale	AZ
486.	Judy	Ackerman	Scottsdale	AZ
487.	Sharona	Silverman	Scottsdale	AZ
488.	Allyson	Laks	Phoenix	AZ
489.	Eilen	Silverman	Scottsdale	AZ
490.	Rita	Melamed	Tempe	AZ
491.	Myron	Weissman	Beachwood	OH
492.	Fran	Weissman	Beachwood	OH
493.	Kenneth	Mossman	Scottsdale	AZ
494.	Jordan	Greenbaum	Atlanta	GA
495.	Julie	Kupsov	Farmington Hills	Mi
496.	Sharon	Weil	Portland	OR
497.	Jennifer	Weprin	Portland	OR
498.	Dana	Hunt	Portland	OR
499.	Lorel	Lazard	Scottsdale	AZ
500.	Alicia	Hunt	Oregon City	OR
501.	Linda	Singer	Portland	OR
502.	Kim	Rosenberg	Portland	OR
503.	Julie	Diamond	Portland	OR
504.	Marilyn	Abend	Lake Oswego	OR
505.	Barbara	Weprin	Dayton	OH
506.	Bryan	Kort	Phoenix	AZ
507.	Barbara	Mark-Dreyfuss	Scottsdale	AZ
508.	Hope	Grunow	Phoenix	AZ
509.	Beth	Kupsov	Royal Palm Beach	FL
510.	Anita	Gutkin	Scottsdale	AZ
511.	Dawn	Cohen	Phoenix	AZ
512.	Ilene	Raker	Phoenix	AZ
513.	Suzanne	Kostelac	Henderson	NV
514.	Julie	Marks	Scottsdale	AZ
515.	Rana	Schwartz	Scottsdale	AZ
516.	Hilary	Barthold	Portland	OR
517.	Barbara	Cohen	Portland	OR
518.	Hila	Smith	Chandler	AZ
519.	Shoshana	Ross	Tempe	AZ
520.	Jo Ann	Timbanard	Paradise Valley	AZ
521.	Michael	Barinbaum	Scottsdale	AZ
522.	Lynn	Barinbaum	Scottsdale	AZ
523.	Halina	Abner	Phoenix	AZ
524.	Linda	Moskowitz	Phoenix	AZ
525.	Jenee	Evans	Weston	FL
526.	Ilene	Gross	Phoeniz	AZ

527.	Amy	Blauer	Portland	OR
528.	Marianne	Chervitz	Chesterfield	MO
529.	Jason	Perlman	Girard	OH
530.	Charlotte	Tevet	Portland	OR
531.	Faye	Samuels	Portland	OR
532.	Gloria	Fine	West Palm Beach	FL
533.	Ruth	Weinstein	Wilmington	DE
534.	Sarah	Comerchero	Scottsdale	AZ
535.	Ida Rae	Cahana	Portland	OR
536.	Jill	Hartmann	San Diego	CA
537.	Michael	Kranitz	Niagara Falls	NY
538.	Leah	Bernstein	Los Altos	CA
539.	Stacy	Kirschner	Peoria	AZ
540.	Adele	Smith	Phoenix	AZ
541.	Jen	Feldman	Portland	OR
542.	Rina	Moscovitz	New York	NY
543.	Sara	Schneider	Phoenix	AZ
544.	Roseann	Gerson	Marietta	GA
545.	Evan	Rosen	Arlington	VA
546.	David	Harris	Los Angeles	CA
547.	Jan	Ehrich	Wescosville	PA
548.	Rachel	Wolf	Greensboro	NC
549.	Cathy	Mc Alynn	Great Neck	NY
550.	Sandy	Lewis	Scottsdale	AZ
551.	Jordan	Schulman	Olney	MD
552.	Carol	Tobin	Denver	CO
553.	Sharon	Gaines	Cranston	RI
554.	Rebecca	Missel	Morristown	NJ
555.	Elsa	Goldberg	Tucson	AZ
556.	William	Daroff	Potomac	MD
557.	Beth	Haiet Meyer	South Orange	NJ
558.	Gerrie	Bamira	South River	NJ
559.	Jacob	Toporek	Edison	NJ
560.	Jo	Staffin	Longwood	FL
561.	Carole	Rose	Macungie	PA
562.	Karen	Ellsweig	Zionsville	PA
563.	Grace	Gouze	Monroe Twp.	NJ
564.	Rona	Greenberg	Monroe Township	NJ
565.	Julie	Chapman	Englewood	CO
566.	Irit	Eizips	Cupertino	CA
567.	Elise	Meshel	Olney	MD
568.	Nancy	Cohen	Easton	PA
569.	Michael	Gotta	Deerfield Beach	FL
570.	Rosemary	Barlow	San Rafael	CA

615.	Yael	Irom	Los Angeles	CA
616.	Allison	Jacobs	Jacksonville	FL
617.	Lindsey	Geller	Indianapolis	IN
618.	Leslie	Ungar	Wadsworth	OH
619.	Toby	Kriss	Long Grove	IL
620.	Marlene	Pilger	Huntley	IL
621.	Ronald	Lederman	Akron	OH
622.	Deborah	Kintzing	Greensboro	NC
623.	Ron	Isaacs	Bridgewater	NJ
624.	Rhea-Beth	Markowitz	Martinez	GA
625.	Nancy	Siwak	St. Louis	MO
626.	Mindy	Ferber	Evanston	IL
627.	Gerald	Weissman	Bridgewater	NJ
628.	Lisa	Fishman	Farmington	CT
629.	Debra	Grant	South Bend	IN
630.	Ann	Hamburger	Columbia	MD
631.	Maureen	Dell	Ellicott City	MD
632.	Nikki	Hamburger	Central Falls	RI
633.	Judy	Maas	Chicago	IL
634.	Ellen	Rank	Syosset	NY
635.	Tammy	Gersman	Akron	OH
636.	Bernice	Waldman	West Hartford	CT
637.	William	Daroff	Washington	DC
638.	Audrey	Hellinger	Chicago	IL
639.	Judy	Smith	Deerfield	IL
640.	Marcie	Harrison	Chicago	IL
641.	Devorah	Heyman	Des Plaines	IL
642.	Joan	Hakimi	Skokie	IL
643.	Barbara	Cohn	Chicago	IL
644.	Steven	Nathan	Augusta	GA
645.	Judith	Deheeger	Winnetka	IL
646.	Elaine	Dunst	Bridgewater	NJ
647.	Barbara	Gordon	Chicago	IL
648.	Susan	Bosse	St. Louis	MO
649.	Pj	Brichta	Wilmette	IL
650.	Joshua	Force	New Orleans	LA
651.	Anna	Shabtay	Culver City	CA
652.	Susan	Sirota	Riverwoods	IL
653.	Lori	Tessel	Los Angeles	CA
654.	Andrea	Solow	Chicago	IL
655.	Stephanie	Gross	St. Louis	MO
656.	Angela	Flotken	Clayton	MO
657.	Michele	Sackheim	Highland Park	IL
658.	Gail	Norry	Rydal	PA

571.	Ellen	Silver	Deer Mountain	UT
572.	Sandra	Horwitz	Long Beach	CA
573.	Marlyn	Mcclaskey	San Rafael	CA
574.	Sandy	Lenger	Milltown	NJ
575.	Adam	Solender	Savannah	GA
576.	Joanne	Cohen	Jacksonville	FL
577.	Joyce	Garver Keller	Columbus	OH
578.	Joyce	Garver Keller	Columbus	OH
579.	Leslie	Epstein Pearson	New York	NY
580.	Esther	Winthrop		
581.	Judy	Halper		
582.	Beth	Mann		
583.	Beth	Zive		
584.	Julie	Goodman	Orange County	CA
585.	Arnold	Goodman	Orange County	CA
586.	Dana	Gordon	Highland Park	IL
587.	Ronna	Leibach	Buffalo Grove	IL
588.	Shirley	Ross	Long Beach	CA
589.	Mona	Kolko	Pittsford	NY
590.	Erica	Cohen	Highland Park	IL
591.	Lori	Klinghoffer	Short Hills	NJ
592.	Cora	Ginsberg	Chappaqua	NY
593.	Leah	Ronen	Evans	GA
594.	Lauren	Rickoff	Davie	FL
595.	Kim	Shwachman	Northbrook	IL
596.	Diane	Naar	Bridgewater	NJ
597.	Karen	Kesner	Deerfield	IL
598.	Renee	Silberman	Lincolnwood	IL
599.	Judy	Craven	Deerfield	IL
600.	Arlene	Schiff	Lenox	MA
601.	Yvonne	Distenfeld	Rockville	MD
602.	Julie	Maeir	Skokie	IL
603.	Allison	Berns	Sylvania	OH
604.	Lynn	Harris Gossen	St. Louis	MO
605.	Helen	Horwitz	Richmond	VA
606.	Leonard	Knauer	Martinsville	NJ
607.	Dori	Knauer	Martinsville	NJ
608.	Wendy	Wolf	Saint Louis	MO
609.	Shayna	Martinoff	Sunny Isles Beach	FL
610.	Jayne	Langsam	St. Louis	MO
611.	Marjorie	Zessar	Chicago	IL
612.	Todd	Rockoff	Akron	OH
613.	Shelly	Kupfer	Chevy Chase	MD
614.	Jodi	Berman	Los Angeles	CA

659.	Susan	Stern	Scarsdale	NY
660.	Renee	Chelm	Novelty	OH
661.	Rachel	Oiknine	St. Louis	MO
662.	Kara	Wagner Sherer	Chicago	IL
663.	Iris	Schneider	Sleepy Hollow	NY
664.	Hilary	Greenberg	Highland Park	IL
665.	David K.	Koch	Akron	OH
666.	Arlene	Lewis	Northfield	IL
667.	Lisa	Rosenkranz	Glencoe	IL
668.	Randee	Jacobs	St.Louis	MO
669.	Laurence	Sebert	New York	NY
670.	Debbie	Katcoff	Augusta	GA
671.	Della	Leavitt	Chicago	IL
672.	Betty	Adler	Palo Alto	CA
673.	Jennifer	Dechtman	Denver	CO
674.	Jonathan	Kaplan	Baton Rouge	LA
675.	Patricia C	Crane	Copley	OH
676.	James	Arvesen	Lebanon	NJ
677.	Lisa	Rubinstein	Northbrook	IL
678.	Jill	Rosen	Ambler	PA
679.	Dan	Backer	Weston	MA
680.	Andrea	Dechtman	New York	NY
681.	Ellen	Chute	W. Bloomfield	MI
682.	Kelly	Goldberg	Corona	CA
683.	Emily	Korobkin	Farmington Hills	MI
684.	Evelyn	Breuer	Farmington Hills	MI
685.	L	Klein	W Bloomfield	MI
686.	Beverly	King	Livonia	MI
687.	Sarit	Flascher	Farmington Hills	MI
688.	Yuliya	Gaydayenko	Rochester Hills	MI
689.	Alexandra	Lempert	Toledo	OH
690.	Becky	Eizen	Southfield	MI
691.	Wendy	Abrams	Deerfield	IL
692.	Motiashia	Austin	Detroit	MI
693.	Shelley	Elias	Chicago	IL
694.	Joan	Chapuseaux	Plymouth	MI
695.	Karen	Bango	West Bloomfield	MI
696.	Elaine	Polevoy	West Bloomfield	MI
697.	Elizabeth	Orman	Farmington Hills	MI
698.	Deborah	Goldenberg	Dayton	OH
699.	Ethan	Blustein	Ann Arbor	MI
700.	Susan	Faitler	Oak Park	MI
701.	Sarah	Bleich	Royal Oak	MI
702.	Jennifer	Smith	Creve Coeur	MO

703.	Leslie	Stewart	Greenwood Village	CO
704.	Eileen	Guttman	Beachwood	OH
705.	Anita	Karnibad	Savannah	GA
706.	Susan	Goutkovitch	West Bloomfield,	MI
707.	Anita	Fishman	South Bend	IN
708.	Tom	Beck	Central	NJ
709.	Judi	Finkelstein	San Rafael	CA
710.	Erella	Reichman	West Bloomfield	MI
711.	Debby	Horowitz	Southbury	CT
712.	Julie	Ohana	West Bloomfield	MI
713.	Beth	Adelman	Dayton	OH
714.	Risa	Berris	Farmington Hills	MI
715.	Perry	Ohren	West Bloomfield	MI
716.	Nancy	Lee	Far Hills	NJ
717.	Cindy	Kaplan	Highland Park	IL
718.	Lenore	Dechtman	Aurora	CO
719.	Robert	Grossman	Hillsborough	NJ
720.	Suzanne	Leach	Farmington Hills	MI
721.	Lisa Beth	Meisel	Tenafly	NJ
722.	Cheri	Dekofsky	Agoura Hills	CA
723.	Alice	Ludmer	Saint Louis	MO
724.	Elena	Dell'Aglio	Flint	MI
725.	Susan	Reese	Highland Park	IL
726.	Beth	Eiseneberg	San Diego	CA
727.	Linda	Netzky-Berkson	Seattle	WA
728.	Suzanne	Saposnik	Chicago	IL
729.	Devra	Shutan	Highland Park	IL
730.	Penny	Breslow	Savannah	GA
731.	Andrea	Fox	Glencoe	IL
732.	Elizabeth	Rubenstein	St. Louis	MO
733.	Annette	Radick	Bedminster	NJ
734.	B. Paula	Resnick	Lincolnwood	IL
735.	Linda	Mintz	South Bend	IN
736.	Linda	Ferguson	Richmond	VA
737.	Susan	Leshner	Chicago	IL
738.	Alan	Kirschbaum	Oxnard	CA
739.	Ellen	Levitt	Nashville	TN
740.	Judith	Galler	Ventnor	NJ
741.	Ted	Maas	Elmhurst	IL
742.	Beverly	Staples	Glen Allen	VA
743.	Barbara	Linn	Evanston	IL
744.	Tammi	Thurm	Greensboro	NC
745.	Katie	Mendel	Denver	CO
746.	Susan	Pinsker	Greensboro	NC

747.	Eva	Corets	Clyde Hill	WA
748.	Laura	Simon	Beachwood, OH	OH
749.	Andrea	Nitzkin	Farmington Hills	MI
750.	Amy	Rzepka	Solon	OH
751.	Pam	Marks	Solon	OH
752.	Pam	Seubert	Chicago	IL
753.	Lesley	Greenberg	Glenn Allen	VA



House Committee on Energy and Commerce's Subcommittee on Health
October 7, 2009

Statement in Support of the Breast Cancer Education and Awareness Requires Learning Young Act from William C. Daroff, vice president for public policy and director of UJC/The Jewish Federations of North America's Washington office:

Chairman Pallone, Ranking Member Deal and members of the Subcommittee,

Thank you for the opportunity to express our strong support for the Breast Cancer Education and Awareness Requires Learning Young Act to the Subcommittee on Health of the United States House of Representatives Committee on Energy and Commerce this morning. We applaud Representative Wasserman Schultz for introducing this bill and thank the Subcommittee for holding today's hearing.

On behalf of our mothers, daughters, and sisters, UJC/The Jewish Federations of North America join Representative Wasserman Schultz in her efforts to ensure that no woman should unnecessarily suffer from breast cancer simply because she was unaware of or did not understand the early indicators of the disease.

UJC/The Jewish Federations of North America represents 157 Jewish Federations and 400 smaller Jewish communities across the country. As the public policy voice of the Jewish community, as well as one of the nation's largest social service providers, we are keenly aware of the impact breast cancer has on families as well as the demands placed on those who provide care and support during one's difficult battle with this disease.

Breast cancer is unfortunately far too common in the Jewish community. In fact, one in 40 Jewish women of Ashkenazi or eastern European descent carries an alteration to the BRCA1 or BRCA2 genes. These genes regulate cell growth and are needed to prevent cancer from developing. Carriers of this alteration are three to seven times more likely to develop breast cancer before the age of 50. These numbers are too staggering to ignore.

It is with this unique perspective that we strongly endorse passage of the EARLY Act. We are joined by 750 individuals and over 50 local, state and national organizations who have signed an online petition sponsored by UJC/The Federations of North America in support of Representative Wasserman Schultz's bill.

We believe the EARLY Act will help women learn and better understand the early warning signs of breast cancer so they can seek professional treatment sooner. Please approve this bill expeditiously.

Thank you again, Mr. Chairman, for the opportunity to discuss this very important piece of legislation.

For further information, please contact Amy Rosen, UJC's Senior Legislative Associate at amy.rosen@ujc.org or 202-736-5871.



October 7, 2009

United States Congress
Washington, DC 20515

Dear Members of Congress:

On behalf of UJC/The Jewish Federations of North America and the following federations and beneficiary agencies, we strongly support the **EARLY Act**, Breast Cancer Education and Awareness Requires Learning Young Act (H.R.1740/S. 994) and ask for its immediate consideration before the United States Congress.

Ashkenazi Jewish women are more likely to have a mutation for the BRCA1 or BRCA2 gene, thus making our population three to seven times more likely to develop breast cancer. Breast cancer is the leading cause of cancer deaths in young women under the age of 40. The EARLY Act will increase the awareness by young women under the age of 40 of the threats posed by breast cancer, steps to reduce the risks and early detection techniques; increase the awareness of the distinct risk factors and treatments including infertility and recurring malignancies specific to young women under 40; and offers supports for young women diagnosed with breast cancer.

Thank you in advance for your support of this life saving legislation. If you should have any questions about this legislation or other issues facing Congress, please contact UJC/The Jewish Federations of North America at 202.785.5900.

Sincerely,

United Jewish Communities/The Jewish Federations of North America
Association of Jewish Family & Children's Agencies
International Association of Jewish Vocational Services
Jewish Council for Public Affairs

Local & State Organizations

Brownstein Jewish Family Service (Southbury, Connecticut)
CJE SeniorLife (Metropolitan Chicago, Illinois)
Durham-Chapel Hill Jewish Federation
Jewish Board of Family and Children's Services (New York, New York)
Jewish Community Board of Akron Jewish Community Relations Council
Jewish Community Federation of Cleveland
Jewish Community Foundation of Greater Kansas City
Jewish Community Relations Committee of the Birmingham Jewish Federation
Jewish Community Relations Council of the Greater Miami Jewish Federation

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VICE CHAIRS
Marilyn Blumer
Diane Feinberg
Cheryl Fishbein
Rani Garfinkle
Julie Lipsitz-Singer
Esther Polland
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Jewish Community Relations Council of Minnesota and the Dakotas
 Jewish Family & Children's Service of Greater Boston
 Jewish Family & Children's Service of Minneapolis
 Jewish Family & Children's Services of the East Bay
 Jewish Family Service (Cincinnati, Ohio)
 Jewish Family Service (Salt Lake City, Utah)
 Jewish Family Service (Seattle, Washington)
 Jewish Family Service of Atlantic & Cape May Counties
 Jewish Family Service of Central New Jersey
 Jewish Family Service of Los Angeles
 Jewish Family Service of the Desert
 Jewish Family Service of Metropolitan Detroit
 Jewish Family Service of MetroWest (MetroWest, New Jersey)
 Jewish Family Service of Rhode Island
 Jewish Family Service of Somerset, Hunterdon, and Warren Counties
 Jewish Family Service of St. Paul
 Jewish Federation of Broward County
 Jewish Family Service of Buffalo & Erie County
 Jewish Federation of Central Massachusetts
 Jewish Federation of Collier County
 Jewish Federation of Greater Philadelphia
 Jewish Federation of Metropolitan Chicago
 Jewish Federation of Orange County
 Jewish Federation of Peoria
 Jewish Federation of Reading, Pennsylvania
 Jewish Federation of Rhode Island
 Jewish Federation of Silicon Valley
 Jewish Federation of Somerset, Hunterdon & Warren
 Jewish Federation of St. Joseph Valley
 Jewish Federation of Ventura County
 Minneapolis Jewish Federation
 New Jersey State Association of Jewish Federations
 Ohio Jewish Communities
 Sabes Jewish Community Center, Minneapolis
 The Columbus Jewish Federation, Jewish Community Relations Council
 The Jewish Community Center of Greater St. Paul Area
 The Jewish Federation of Greater Kansas City
 UJA Federation of Greenwich
 UJA-Federation of New York
 UJA Federation of Northern New Jersey
 United Jewish Fund & Council of St. Paul
 Women's Division of the Jacksonville Jewish Federation

Mr. PALLONE. Without objection, so ordered. I guess I didn't get the memo to wear the pink. I see Jerry did. But I was given a pink bat in lieu of a gavel today, so maybe we will use that.

Ms. HARMAN. Well, Jerry Nadler represents two of my kids on the west side of New York, one of whom is female, so it is a good thing that he has high awareness of this. I just want to add a couple of facts. One, advances in cancer research and treatments have greatly improved survival rates. In the 1960s, a woman diagnosed with breast cancer had only a 63 percent chance of living longer than 5 years. Now it is 89 percent. Hispanic and African-American women have a lower survival rate than the rest of the population, so clearly we have a lot of work to do on reducing racial disparities.

And finally, next Friday, October 16, is National Mammography Day. It is a day when radiologists provide free or discounted screening mammograms, and hopefully the women in my district and all those can hear us at this hearing will take advantage of this. Breast cancer is a terrible opponent but it is a beatable one. I yield back, Mr. Chairman.

Mr. PALLONE. Thank you.

Next is the gentleman from Georgia, Mr. Gingrey.

OPENING STATEMENT OF HON. PHIL GINGREY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. GINGREY. Mr. Chairman, thank you. I did have an opening statement I would like to give.

Deaths from breast cancer among women have dropped more than 2 percent each year since 1990 due in large part to the intervention of improved treatments and early detection of the disease. A study published in 2008 found the United States has the highest rate of survival for breast and prostate cancers in the world. These statistics are just a small example of the quality that makes our health care system a leader throughout the world. Unfortunately, being the best is not the entire story. While our health care system is a benefit to many with breast cancer, the disease is still the second most common cancer that women are forced to deal with in the United States. It is estimated that 192,000 new cases of invasive breast cancer are expected to be diagnosed this year and roughly 40,000 women are expected to die from the disease in 2009, 40,000. These are sobering statistics that beg our thoughtful consideration.

Therefore, I would like to commend the efforts of our panelists and all those who strive each and every year to bring attention and awareness to a disease that has impacted many of our friends and colleagues, some of whom are sitting here with us today as we well know. I applaud their efforts to raise the awareness and early detection of breast cancer among our Nation's patients, and I look forward to hearing their testimony today.

However, we must also take a step back and look at the legislation before us in the context of the overall reform plan reported from this Committee at the end of July. From what I surmise, two of the bills before us today address federal requirements on insurance plans that would in essence I think, become moot because of H.R. 3200. If H.R. 3200 were to become law, this Congress would not be deciding what benefits insurance companies must contain or what measures should be used to ensure non-citizens cannot use

taxpayer dollars to purchase health insurance. Those would be the purview of a political appointee with little regard for the will of the people.

After the outpouring of concern and constructive criticism for the President's plan during the August recess, I had hoped to come back to these hallowed walls and found a new Congress open and willing to work in a bipartisan fashion for the benefit of our constituents. Today as we sit here with the specter of H.R. 3200 hanging over our heads, it is looking more and more that that hope to be a false one. Mr. Chairman, it seems the lessons of August have not been learned by some of my colleagues on the other side of the aisle. I yield back my time.

Mr. PALLONE. Thank you, Mr. Gingrey.

Next is our chairman, Mr. Dingell.

OPENING STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. DINGELL. Mr. Chairman, I thank you. Good morning.

I would first like to thank you for holding this hearing. It is an important one and it is an opportunity to learn more about the four breast cancer bills before us today. Breast cancer is the second most common type of cancer amongst women in the United States so it is important for us to continue a vigorous examination of how to best prevent and treat this disease. In 2009, an estimated 192,370 new cases of invasive breast cancer will be diagnosed among women, and approximately 40,107 of these women are expected to die from the disease. An additional 1,920 cases of breast cancer are expected to occur amongst men. In my home State of Michigan alone, there will be an estimated 6,480 new cases this year and 1,350 deaths. It is estimated that about \$8.1 billion is spent in this Nation every year for the treatment of breast cancer. While real strides are being made against the disease, the 5-year survival rate is 98 percent when detected early but too many women continue to lose the battle against breast cancer for want of proper treatment and proper early diagnosis.

H.R. 995 would require a group health plan that provides diagnostic mammography for women over 40 to also cover an annual screening mammography and an MRI for high-risk women. The National Cancer Institute has recommended that women 40 and over should have a mammogram once every 1 or 2 years. Doctors and patients should make the decision whether to have a mammogram based on risk factors, not the cost.

Another bill under consideration is H.R. 1691, the Breast Cancer Patient Protection Act, of which I am a sponsor. H.R. 1691 would ensure that women undergoing mastectomies would be guaranteed 48 hours of hospital care unless the provider and the patient determine a shorter stay is appropriate. This is again aimed at dealing with the problem of drive-through mastectomies and other things of that character as provided by the health insurance providers of this country. The legislation would also protect physicians who provide quality care for breast cancer patients from retaliation by health maintenance organizations and other insurance companies seeking to maximize profits at the expense of patient care. This bill

is of great importance to me because a member of my staff in Michigan was a victim of these unscrupulous insurance company practices when she was sent home after a mastectomy in considerable pain with no support to manage her condition. She ultimately succumbed to her cancer but the heartless way in which her insurance company treated her was an outrage. Guaranteeing that treatment decisions are made by the provider in consultation with the patient, taking into account the patient's unique medical needs, is the cornerstone of good, successful and, believe it or not, inexpensive or the least expensive medical care.

H.R. 1740 would direct the CDC to develop and implement a national education campaign about the threat that breast cancer poses to young women of all ethnic and cultural backgrounds and the particular heightened risks of certain groups of our women. It is important that we examine the ways to educate our young women and medical professionals about breast cancer in young women.

The final bill considered today, H.R. 2279, would address the disparities in breast cancer diagnosis and treatment by requiring providers to report their practices to encourage doctors to offer adequate care to all irrespective of race, income, age or health insurance status.

Together these bills will protect women from drive-through mastectomies as well as advanced breast cancer protection and treatment amongst high-risk communities, young populations and minorities. This hearing coincides with National Breast Cancer Awareness Month and will shine light on issues of great importance to women and their families. I look forward to the testimony of today's witnesses and I commend you for the hearing, and I thank you, Mr. Chairman.

Mr. PALLONE. Thank you, Chairman Dingell.

Next is one of the sponsors of the bill—oh, I am sorry. Next is the gentleman from Texas, Mr. Burgess.

Mr. BURGESS. Mr. Chairman, in the interest of time, and I know we have got votes, I will submit my statement for the record.

[The prepared statement of Mr. Burgess follows:]

**Opening Statement
Congressman Michael Burgess, M.D.
“Breast cancer hearing”
Subcommittee on Health
October 7, 2009**

Thank you Mr. Chairman.

Our fight against cancer knows no ideological or partisan lines.

Cancer is a disease that all Americans fear and often one that hits close to home. Cancer strikes roughly half of all men and one-third of all women in the United States.

Everyone on this panel has had cancer touch their lives in some way through family, friends, even in their own lives.

While we have learned that cancer is a complex disease, with still no cure, our efforts geared at prevention, early detection, and treatment have made significant gains.

When I was practicing medicine, cancer was largely a death sentence. But thanks to advances in imaging and new pharmaceuticals, close to two-thirds of patients are now living five years or more after diagnosis.

Another impressive statistic - death rates from breast cancer have dropped 25 percent in the last several years. What we have been able to accomplish in just a few years in regard to breast cancer is simply astonishing.

Yet, 13,000 Texans are expected to be diagnosed with breast cancer this year.

But in this race we cannot slow down just because we have picked up ground. Now is the time to sprint to the finish line in our efforts to eliminate all cancer suffering and death, and our success with breast cancer can serve in many respects as a guide.

But still, there are certainly improvements that can be made and we will be discussing several bills in this regard.

I'm a doctor so I certainly don't pretend to understand why insurance companies do some of the things they do.

Why would you deny a mammogram to a high risk individual? Trust me, if a woman is getting a mammogram it is because she and her doctor know it is a prudent thing to do. The cancer a mammogram could detect at an early stage isn't just the difference between life and death, it is the difference between potentially non-disruptive treatment and extremely invasive surgery.

An ounce of prevention saves lives and saves health care dollars in the long run.

The same rings true with hospital stays following a mastectomy, breast reconstruction or lymph node dissection. No patient wants to stay in the hospital longer than they have to and no doctor wants to keep them there. If this committee is so concerned about avoidable readmissions, one of the simplest things we can do is allow the doctor to decide when discharge post-surgery is appropriate.

Furthermore, if there are companies out there that don't realize this and are designing lousy policies, patients need to be protected from their lack of foresight one way or another.

I am open to having a discussion on fixing these items, and I hope my colleagues who are here to testify are not just paying lip service to these very important issues.

The provisions of these bills could easily have been included in HR 3200. When it comes to coverage of services under health insurance plans, if treatment for cancer is an essential service per the Health Benefits Plan Commissioner, I would think these issues would be moot.

Finally, I think we need to have these conversations in the context of the world as we know it today, or how it might look if Congress adopts HR 3200, or maybe – if we are lucky – something more reasonable.

That said, I look forward to the testimony and figuring out the best policy to further advance our nation's fight against breast cancer.

Mr. PALLONE. Thank you, Dr. Burgess.

Next is one of our prime sponsors of the legislation, the gentlewoman from Florida, Ms. Castor.

OPENING STATEMENT OF HON. KATHY CASTOR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Ms. CASTOR. Chairman Pallone, thank you very much for convening this timely hearing on breast cancer legislation during National Breast Cancer Awareness Month.

Breast cancer is still a brutal killer in America but we are going to continue to fight and we are going to make progress, and we are going to make progress due in large part to the leaders who are here today, to my colleagues here on the Health Subcommittee but to these brave Members of Congress that represent hundreds of thousands of people and many, many women who have struggled with breast cancer. Congresswoman Rosa DeLauro, Congresswoman Jerry Nadler and my good friend from Florida, Congresswoman Debbie Wasserman Schultz. Congresswoman Wasserman Schultz has been a fine example of perseverance and a great role model for anyone that has been diagnosed with breast cancer, and I am proud to be a cosponsor of her bill.

I am also eager to hear from the top experts in the field today on our latest legislation, and Mr. Chairman, our colleague, Congresswoman Dr. Donna Christensen, is my partner on my bill, H.R. 2279, the Eliminating Disparities in Breast Cancer Treatment Act, that we will consider today. I would like to thank her for all of her attention to disparate diagnosis and treatment that still plagues health care in America.

It is not secret that quality health care in the United States is not equally accessible to all of our communities. As a Committee, we have worked diligently for the better part of this year to improve health care in America and to make quality care affordable and accessible for all, and we are closer to that than ever before but we still have these underlying issues of disparate diagnosis and treatment that must be addressed directly, and one of the most disturbing involves breast cancer in women of color. Overall breast cancer survival rates in the last two decades have improved with one exception: minority women. Women of color suffer from significantly higher death rates after diagnosis than white women. The American Cancer Society reports that delays in receiving care after breast cancer diagnosis are greater for African-American women than for white women. African-American women with breast cancer are less likely to receive standard therapy than white women. African-American and Hispanic patients are significantly more likely than white patients to be diagnosed at a more advanced stage of breast cancer. And regardless of insurance status, African-American women are almost two times more likely to be diagnosed with an advanced stage of breast cancer than white women and Hispanic women are about one and a half times more likely to be diagnosed with an advanced stage of breast cancer than white women. African-American women are 10 percent more likely not to receive tests to determine if breast cancer has spread to axillary underarm lymph nodes. This screening is essential to preventing the spread of cancer to other parts of the body. Health insurance status, race,

income and educational background are directly linked to irregularity in administering this vital screening. Substantial disparities remain regarding cancer diagnosis and treatment.

So in order to eliminate this unacceptable variance in treatment and quality care, it is necessary that we create real incentives and requirements for medical professionals to provide the best care. All patients should receive the most modern and high-standard treatment for their conditions. So our bill seeks to put an end to the inequities in treatment for breast cancer and will help ensure that every patient has access to the most appropriate care. The legislation will implement breast cancer treatment performance measures, requiring the Secretary of HHS to work with a national quality forum to develop standard best practices for breast cancer treatment. These measures will address patient outcomes, the process for delivering medical care related to breast cancer treatment, patient counseling and engagement in decision-making, overall patient experience, physician care coordination and then the Secretary will develop a 6-year breast cancer treatment quality performance initiative. In years 1 through 3, physicians will be encouraged to follow the new recommendations and report their practices on a voluntary basis. In years 3 through 6 reporting will be required and the Secretary will evaluate the care that is furnished to patients. Low-quality treatment from providers will result in reduced Medicare payments for those physicians. Improvements in treatment will be recognized and payments will be scaled based on the care provided. The Secretary will be required to report to Congress so we can keep track of the progress.

Mr. Chairman, this legislation will help eliminate disparities in the treatment of breast cancer. We must continue to use all of our expertise and modern tools to fight this brutal killer, improve diagnosis and improve treatment. It will save lives, it will save money and it will save heartache.

Thank you very much. I look forward to hearing from the panels.

Mr. PALLONE. Thank you.

The gentleman from Illinois, Mr. Shimkus.

Mr. SHIMKUS. Thank you, Mr. Chairman. I want to welcome my colleagues here. They are all sincere and respected public policy experts, and I appreciate their attendance, and I yield back my time.

Mr. PALLONE. Thank you.

The gentlewoman from Illinois, Ms. Schakowsky.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman. I will put my full statement in the record, but I do want to thank all of my colleagues, Debbie Wasserman Schultz and Rosa DeLauro and Jerry Nadler and Kathy Castor for the wonderful bills that I am proud to be a cosponsor of.

I just do want to tell you that Chicago has one of the largest disparities in death rates as a result of breast cancer. A report released in 2007 showed that breast cancer kills minority women at a rate of 68 percent higher than white women, mostly because of inequities and access to quality and affordable care. And I want to give a shout-out to an organization. We are actually going to have a briefing with them next week. Pin-A-Sister is a Chicago-based organization started by Access Community Health Center. Every Mothers Day the organization coordinates an event in black and

Latino churches. The women in the congregation are invited to place a pin on a sister to empower her to learn more about breast cancer and to show she is not alone in her experience with breast cancer. But they need help.

These bills that you have sponsored and that I feel certain that will pass are really going to help them and all women, those facing breast cancer and potentially those who may face it in the future. Thank you very much. I yield back.

Mr. PALLONE. Thank you.

The gentlewoman from Tennessee, Ms. Blackburn.

Mrs. BLACKBURN. Thank you, Mr. Chairman, and I thank our colleagues for the good work that they have done and the attention that they have brought to this issue and we are delighted that you are here. I will place my full statement in the record.

I do want to highlight some of our volunteers in Tennessee that have done exceptional work on the issue of breast cancer. Our Tennessee Breast Cancer Coalition really has taken the lead in Tennessee. We do know that the work we did last year on the Breast Cancer Environmental Research Center Act was very important. This is something the environmental pressures that come to bear on Tennessee women is something that has gained a lot of attention in our State and has caused a lot of concern, and we have several facilities that are doing a great deal of wonderful research—the UT Cancer Institute, the Vanderbilt Ingram Cancer Center and the Minnie Pearl, Sarah Cannon Center and so I highlight the good work that is being done there.

In Tennessee, we have 3,970 new cases of breast cancer that will be diagnosed this year, and 910 women will probably end up losing their life to this disease. We note the legislation before us will help assist the good ongoing research equally in the manner that the legislation we passed last year did and we look forward to eradicating the disease and certainly making a difference in the lives of men and women that are affected by this, and I thank you for the hearing and yield my time.

Mr. PALLONE. Thank you.

The gentleman from Utah, Mr. Matheson.

Mr. MATHESON. Thanks, Mr. Chairman. I will submit my full written statement for the record, but just very briefly, I would point out that it is appropriate we have four different bills today. This is a complicated issue and there are a lot of aspects in terms of addressing and trying to fight this disease that we should consider as a Committee, and I want to thank the lead sponsors, Representative Castor, Representative Nadler, Representative DeLauro and Representative Wasserman Schultz for championing this issue. Congresswoman DeLauro has been such a great advocate and I was an original cosponsor. I remember we passed this in the House last time and hopefully we get it across the finish line this time.

You know, a lot of people point out different populations that are affected differently, and I would just highlight one interesting demographic in my home State where in Utah the incidence of breast cancer is actually much lower than the national average and yet the mortality rate is about the same, and that is because we have a problem where it is usually diagnosed at later stages. That is why Congresswoman Wasserman Schultz's bill is of particular in-

terest to me that will help in my State. And it just points out that you hear these opening statements from people around the country with different constituencies and whatnot and there are so many ways we need to try to attack this issue.

I commend the Committee for holding this hearing and bringing all these folks together. I look forward to advocating for all these bills. Mr. Chairman, I want to once again thank my colleagues for being here and I will yield back my time.

Mr. PALLONE. Thank you.

The gentlewoman from the Virgin Islands, Ms. Christensen.

OPENING STATEMENT OF HON. DONNA M. CHRISTENSEN, A REPRESENTATIVE IN CONGRESS FROM THE VIRGIN ISLANDS

Mrs. CHRISTENSEN. Thank you, Mr. Chairman, and I thank you and the ranking member for holding this hearing on such an important issue and making, we hope, this Breast Cancer Awareness Month a decisive one in the fight against breast cancer. I would like to welcome my colleagues as well.

With these bills, we not only expand access to mammography and other often lifesaving screening technologies but we protect and ensure the health care coverage for breast cancer patients, educate women earlier about breast cancer and eliminate the breast cancer disparities that have a disastrous impact on far too women of color. I would like to thank Representatives Nadler, DeLauro, Castor, with whom I worked on 2279, and especially Congresswoman Debbie Wasserman Schultz, herself a breast cancer survivor, especially for your bill's emphasis on educating younger women earlier about breast cancer.

It is unacceptable that today one in every eight women will have invasive breast cancer at some point in her life and that breast cancer remains the second leading cause of cancer death for women in this country, but as grim as these statistics are, they are even worse when you consider racial and ethnic disparities in breast cancer incidence and mortality and prevention. For example, while African-Americans have lower breast cancer incidence rates than their white counterparts, they are more likely to die from the disease. Latina, American Indian and Asian-American women are not only disproportionately more than likely than their white counterparts to not have a mammogram in the recent 2 years, but finally, while breast cancer death rates have been on the decline since 1990 overall, we find that that the 5-year breast cancer survival rate for American Indian women is lower than any other population group of women.

So these statistics suggest that while we have made great progress in the fight against breast cancer much to the credit of the witnesses we will hear from today and continuing with the legislation before us. We have a long way to go and I look forward to today's testimonies and discussions and anticipate that this hearing will serve as the impetus needed to take our collective fight against breast cancer and every cancer really to the very next level, and I thank you. I yield back.

Mr. PALLONE. Thank you.

The gentleman from Maryland, Mr. Sarbanes.

Mr. SARBANES. Thank you, Mr. Chairman. I will be very brief.

These are all incredibly important measures, and I just want to salute our colleagues and my colleague, Kathy Castor, for their work on this. I am embarrassed, Debbie, that I am not wearing any pink today, but I am turning pink with embarrassment at that, so that will have to do.

Anyway, congratulations on your work. We look forward to your testimony.

Mr. PALLONE. Thank you.

The gentleman from Georgia, Mr. Barrow. I will mention to members that we have three votes, a 15—I am sorry, four votes. There is a 15 and then three 5s. Mr. Barrow, if you would like to make an opening, go ahead.

Mr. BARROW. Thank you, Mr. Chairman. I would.

It is estimated that one in eight women will develop breast cancer over their time and it is the leading cause of death among women age 45 and older. This disease is far too preventable and too treatable for these numbers to be so high. I know because my mother, who turns 89 years of age today, is a 35-year survivor of breast cancer. Curing breast cancer is a huge challenge and it can only happen with good science, adequate funding, effective treatments and greater awareness and education.

These bills we are addressing here today represent small but important steps along the way. October is National Breast Cancer Awareness Month. This gives us an excuse to come here today and work on this legislation but I look forward to the day when this month will not be a time to raise awareness but a time to celebrate how our collective efforts actually led to the eradication of breast cancer. I want to thank Chairman Pallone and Ranking Member Deal for addressing this important issue in our Subcommittee as well as Representatives Nadler, DeLauro and especially my colleagues, Congresswoman Wasserman Schultz and Congresswoman Castor, for introducing these critical bills that promote breast cancer prevention, research, treatment and quality of care. Thank you, and I yield back.

Mr. PALLONE. Thank you. I think that concludes our opening. Now, we could get a couple of you in. I don't think we can get all three of you. I will dispense with my remarks other than to say the three of you are wonderful, and two of you are cancer survivors. All three of you have been champions of this and other issues so effectively. If anybody can get anything done, it is the three of you, and I start with Congressman Nadler.

STATEMENTS OF THE HONORABLE JERROLD NADLER, MEMBER OF CONGRESS; THE HONORABLE ROSA L. DELAURO, MEMBER OF CONGRESS; AND THE HONORABLE DEBBIE WASSERMAN SCHULTZ, MEMBER OF CONGRESS

STATEMENT OF JERROLD NADLER

Mr. NADLER. Thank you, Chairman Pallone, Ranking Member Deal and the members of the Subcommittee. Thank you for convening this hearing and for inviting me to testify today about H.R. 995, the Mammogram and MRI Availability Act.

I also want to thank the breast cancer advocacy groups for coming to testify about the work they do, the problems we face in the

fight against breast cancer and the ways in which they and their organizations are helping to educate, screen, treat and care for women living with and at risk of developing breast cancer.

We all know people near and dear to us who have battled breast cancer, my wife among them for the last 3 years. We all know the statistics. Breast cancer is the second leading cause of death of women in the United States, the leading cause of death of women age 40 to 49. This year alone, more than 40,000 women in the United States will die from breast cancer. More than 192,000 new cases will be discovered.

We also know that in addition to the need to find a cure, prevention is the difference between life and death. In 2005, the National Institute of Cancer Study confirmed that mammograms contributed to a pronounced drop in the number of breast cancer deaths. Study after study has found that yearly mammograms, annual mammograms done from age 40 on help find tumors at their smallest and most treatable stage. That is why the American Cancer Society and others recommend that women age 40 and older should have yearly mammograms, and that is why I introduced H.R. 995, a bipartisan, commonsense bill to ensure coverage of annual mammograms for this population of women.

While many insurance plans cover diagnostic mammograms, that is, mammograms used to diagnose whether an already known mass or tumor is cancerous, many insurance plans do not cover screening mammograms for the purpose of detecting tumors in the first place. Based on the research and what we know about breast cancer, this is simply unacceptable, and women and their families deserve better. We would save many, many lives if all plans covered annual screening mammograms for women of age 40 and above.

As we have learned, mammograms on their own do not detect every malignant tumor. For women at particularly high risk of breast cancer, women who have a strong family history of breast cancer where a woman's mother, grandmother, sister or daughter was diagnosed with breast cancer or those women with a BRCA1 or 2 genes who have a genetic predisposition to developing the disease, MRIs help detect more tumors at their earliest, most treatable stages that mammograms cannot detect. For this population of women who are particularly susceptible and at high risk of developing breast cancer, the American Cancer Society recommends an annual mammogram and an annual MRI. As with coverage for mammograms, insurance companies do not routinely cover screening MRIs, even for this high-risk population of women.

H.R. 995 would make these important screening exams available to the women who need them most. So, in other words, what this bill would do is to say that any health insurance plan that provides coverage for diagnostic mammograms must provide coverage for screening mammograms for women annually over 40 and for the high-risk population of women over 40 for MRIs annually as well. While women should consult a doctor before undergoing a mammography or MRI, nothing in this bill requires a woman to seek a doctor's referral prior to receiving one of these lifesaving screening exams nor does the bill require women to undergo any tests unless she chooses to do so.

As the Subcommittee well knows, Congress is on course to pass historic health care reform bill this year. That legislation contains important provisions that would eliminate copays and deductibles for recommended prevention services. These recommendations should include screening mammograms. However, neither House of Congress has passed the legislation. Furthermore, even if passed, delays upward of 5 years or more could continue to limit women's access to these exams. Therefore, passage of major health reform won't necessarily prevent these women from continuing to fall through the cracks. Additionally, the prevention measures likely to be included in the final health care reform package do not currently include coverage for MRIs for high-risk women. Thus, the women most at risk, the women with a strong family history of the presence of breast cancer as well as those who are genetically predisposed to the disease will continue to be left without access to these lifesaving exams. Only passage of H.R. 995 either as a stand-alone bill or by inclusion of its provisions in the comprehensive bill that this Committee is helping to shape now will ensure that these women have the coverage they need on which their lives may very well depend.

Mr. Chairman, with the passage of this bill or with its inclusion in the overall bill when that passes, women age 40 and older as well as those women at particularly high risk of developing breast cancer will no longer continue to fall through the cracks. With this legislation, these women will be guaranteed coverage for life-saving screening exams. As we wait to find a cure, ensuring coverage for screening mammograms for all women age 40 or older and where indicated for the high-risk population of women over 40 for MRIs as well could mean tremendous benefits for many, many women and their families in the fight against breast cancer.

Mr. Chairman, I thank you again for giving me an opportunity to discuss this bill, H.R. 995, the Mammogram and MRI Availability Act, and for holding this important hearing on women's health. I look forward to working with you as well as my colleagues on the Subcommittee to pass this legislation in one or the other form. Thank you very much.

[The prepared statement of Mr. Nadler follows.]

TESTIMONY OF U.S. REPRESENTATIVE JERROLD NADLER (D-NY 08)

**Before the Energy and Commerce
Subcommittee on Health**

HR 1740, the Breast Cancer Education and Awareness Requires Learning Young Act, HR 1691, the Breast Cancer Patient Protection Act of 2009, HR 2279, the Eliminating Disparities in Breast Cancer Treatment Act of 2009, H.R. 995, the Mammogram and MRI Availability Act, and HR 2042, the Better Screening Test for Women Act

October 7, 2009

Chairman Pallone, Ranking Member Deal and the Members of the Subcommittee, thank you for convening this hearing and for inviting me to testify before you today about H.R. 995, the Mammogram and MRI Availability Act. I also want to thank the breast cancer advocacy groups for coming to testify about the work they do, the problems we face in the fight against breast cancer, and the ways in which they and their organizations are helping to educate, screen, treat, and care for women living with, and at risk of developing, breast cancer.

We all know the statistics: Breast cancer is the second leading cause of death of women in the United States. It is a leading cause of death of women aged 40-49. This year alone, more than 40,000 women in the U.S. will die from breast cancer, and more than 192,000 new cases will be discovered.

We also know that, in addition to the need to find a cure, prevention is the difference between life and death. A 2005 National Institute of Cancer study affirmed that mammograms contributed to a pronounced drop in the number of breast cancer deaths. Study after study have found that yearly mammograms, done from age 40 on, help find tumors at their smallest and most treatable stage. That's why the American Cancer Society – and others – recommends that women age 40 and older should have

yearly mammograms. And that's why I introduced H.R. 995, a common-sense, bipartisan bill to ensure coverage of yearly mammograms for this population of women.

While many insurance plans cover diagnostic mammograms – that is, mammograms used to diagnose whether a mass or a tumor is cancer – many insurance plans do not cover mammograms for the purpose of screening for tumors. Based on the research and on what we know about breast cancer, this is simply unacceptable, and women and families deserve better.

As we have learned, mammograms, on their own, do not detect every malignant tumor. For women at high risk of breast cancer – that is, those women who have a strong family history of breast cancer, where a woman's mother, grandmother, sister, or daughter was diagnosed with breast cancer, or those women who have a genetic predisposition to developing the disease – MRIs help detect more tumors at their earliest, most treatable stages. For this population of women who are particularly susceptible to developing breast cancer, ACS recommends an annual mammogram and MRI.

As with coverage for mammograms, insurance companies do not routinely cover screening MRIs, even for this high risk population of women. H.R. 995 would make these important screening exams available to the women who need them most.

While women should consult a doctor before undergoing a mammography or MRI, nothing in this bill requires a woman to seek a doctor's referral prior to receiving one of these life-saving screening exams. Nor does the bill require a woman to undergo any test unless she chooses to do so.

As the Subcommittee well knows, Congress is on course to pass a historic health care reform bill this year. That legislation – which has not passed either House of

Congress – contains important prevention provisions that would eliminate co-pays and deductibles for recommended prevention services. These recommendations may or may not include screening mammograms and will depend on the decisions of an outside third party. If screening mammograms are included, delays upward of five years or more could continue to limit women's access to these exams. Therefore, passage of major health care reform won't necessarily prevent these women from continuing to fall through the crack. Only passage of H.R. 995 will achieve that goal.

Additionally, the prevention measures likely to be included in the final health care reform package do not include coverage for MRIs for high risk women. Thus, the women most at risk – the women with strong family histories of the presence of breast cancer, as well as those who are genetically predisposed to the disease – will be left without access to these life-saving exams.

Mr. Chairman, with the passage of my bill, women age 40 and older, as well as those women at high risk of developing breast cancer, will not continue to fall through the cracks. With my legislation, these women will be guaranteed coverage for life-saving screening exams. As we wait to find a cure, ensuring coverage for mammograms and MRIs could mean tremendous benefits for scores of women and their families in the fight against breast cancer.

Mr. Chairman, thank you for giving me an opportunity to discuss my bill, H.R. 995, the *Mammogram and MRI Availability Act*, and for holding this important women's health hearing. I look forward to working with you, as well as my colleagues on the Subcommittee, to pass this legislation. Thank you.

Mr. PALLONE. Thank you.
Congresswoman DeLauro.

STATEMENT OF ROSA L. DELAURO

Ms. DELAURO. Thank you very much, Mr. Chairman, and thank you, Ranking Member Deal, for hosting this effort today. I also want to say thank you to this Subcommittee and to the full Committee on a bipartisan basis that have supported the Breast Cancer Patient Protection Act, and I appreciate that as the women around the country do. Also, my colleagues, Jerry Nadler, Debbie Wasserman Schultz, all of whom have—Kathy Castor, Donna Christensen, try to come to grips with what is a singularly big health issue for women around the country, and I would just say to Debbie that her courage and her tenacity in this effort is well known, and she clearly is a voice for young women. To all of the advocates who are here today, thank you. We can't do this without you. It is an honor to work with you and your efforts again also keep us strong and determined to make sure we pass good legislation.

It was 13 years ago that Dr. Kristin Zarfos, who is a Connecticut breast surgeon, told me that HMOs were forcing her to discharge her patients before they were ready, sometimes just hours after a mastectomy. She testified before this Subcommittee last year that insurers suddenly refused to pay for reasonable hospital stay regardless of any underlying or complex medical problems that patients might have—diabetes, heart disease. This is still happening. Patients continue to be discharged with no consideration for adverse reactions to anesthesia, postoperative pain or even when they are awake enough to understand their discharge instructions. At the Subcommittee hearing last year that was convened, we had a breast cancer patient, Alva Williams. She testified she had a mastectomy on March 6, 2006, was sent home several hours after surgery. The insurance company would not cover an overnight stay. The family didn't receive proper training on how to care for her. She developed an infection in the incisions and recovering from that infection caused Ms. Williams' chemotherapy treatments to be delayed 6 weeks. Arizona—a woman's story on Lifetime TV website: "I had a double bilateral mastectomy in June of this year. I was discharged within 2 hours after surgery. I had severe complications that later resulted in being readmitted to the hospital within the first week post surgery." The stories go on, and my testimony has been submitted. There is a woman in Kansas City whose husband was a physician and she found that it was difficult even with a caregiver who was a physician.

So this is happening across the Nation, which is why in my view we need to pass the Breast Cancer Patient Protection Act. It says that simply, very simply, adequate recovery time in the hospital should not be negotiable. The last thing that any woman should be doing at this time is fighting with their insurance company. The bill does not mandate, it does not mandate a 48-hour hospital stay. If a patient chooses to go home sooner, fine. Nor does it set 48 hours as a maximum amount of time a woman can stay in the hospital. It says that any decision in favor of shorter, longer hospital

stay would be made by a patient and her doctor and not by an insurance company.

I have been in the hospital many months, and let me just tell you, it is not for everyone. It is not where you want to spend your time. But it is important to know that successful outpatient mastectomy programs have been extremely careful to empower their patients through education, monitoring outcomes and working intensely to minimize complications.

Last year, 421 Members of Congress voted to enact this legislation, bipartisan support. We introduced it this year, my colleague, your colleague, Joe Barton. Mr. Dingell has spoken out on it. Lifetime Television has a petition calling for the Breast Cancer Patient Protection Act's passage. Nearly 24 million people have signed on to this petition. We have 236 cosponsors. Senator Snowe, Senator Landrieu, 17 cosponsors in the Senate. We are ready to do this. We need to move forward. We have a number of supportive advocacy groups out there.

I will just conclude by saying to you that let us do this. Let us do this for the women of this Nation. What happened on the Senate side to us last year was the insurance companies. We passed it 421 votes. That tells you something about the need. It tells you something about the support. Let us do it again in the House and let us make sure that our Senate colleagues do the same thing. Thank you so much for letting me speak to you.

[The prepared statement of Ms. DeLauro follows:]

TESTIMONY OF THE HON. ROSA L. DELAURO
HOUSE ENERGY AND COMMERCE COMMITTEE, SUBCOMMITTEE ON HEALTH
BREAST CANCER HEARING
WEDNESDAY, OCTOBER 7, 2009

Good morning and thank you, Chairman Pallone and Ranking Member Deal, for hosting this event today, along with the entire Subcommittee on Health of the Energy and Commerce Committee.

And thanks to our distinguished panelists for being here to testify on the legislation before us today. My colleagues – Congresswoman Wasserman-Schultz, Congresswoman Castor and Congressman Nadler – Dr. Stephen Taplin of the National Cancer Institute, Dr. Otis Brawley of the American Cancer Society, Jenny Luray, President of the Susan G. Komen for the Cure Advocacy Alliance, Fran Visco, President of the National Breast Cancer Coalition, and Dr. Marisa Weiss, founder of Breastcancer.org.

Thanks to all of you for your continued advocacy and hard work on this important issue. It is an honor to come before you to discuss one aspect of breast cancer care in America today.

Over thirteen years ago, Dr. Kristen Zarfos, a Connecticut breast surgeon, told me that HMOs were forcing her to discharge her patients before they were ready – sometimes just hours after mastectomy surgery. As Dr. Zarfos testified before this committee last year, insurers suddenly refused to pay for a reasonable hospital stay regardless of any underlying or complex medical problems patients might have, such as diabetes or heart disease. And we know this is still happening. Patients continue to be discharged with no consideration for adverse reactions to anesthesia, post operative pain, or even whether they are awake enough to understand their discharge instructions.

At an Energy & Commerce subcommittee hearing last year, breast cancer patient Alva Williams testified that she had a mastectomy on March 6, 2006, and was sent home several hours after surgery. Her insurance company would not cover an overnight stay. Ms. Williams' family did not receive proper training on how to care for her, and she developed an infection in the incisions. Recovering from the infection caused Ms. Williams' chemotherapy treatments to be delayed by six weeks.

Another woman from Arizona recently shared her story on the Lifetime TV website: She writes, "I had a double bilateral mastectomy in June of this year. I was discharged with in two hours after surgery. I had severe complications that later resulted in being re admitted to the hospital with in the first week post surgery."

A Kansas woman had this story to tell: "I was diagnosed in May of 2006... I had a modified radical mastectomy with full lymph node removal. I was in the hospital one night... My husband is an Internist and he was shocked that one night was standard of

care for mastectomies. My recovery was very difficult even though my care giver was my husband, a physician!"

All across the nation women continue to suffer the same way these women suffered. And all across this nation, people everywhere are saying: "No More."

That is what the Breast Cancer Patient Protection Act is all about. It says that when it comes to a mastectomy, adequate recovery time in the hospital should not be negotiable. The last thing any woman should be doing at that time is fighting with her insurance company.

This bill *does not* mandate a 48 hour hospital stay if a patient chooses to go home sooner, nor does it set 48 hours as a maximum amount of time a woman can stay in the hospital. It simply ensures that any decision in favor of a shorter or longer hospital stay will be made by the patient and her doctor, and not an insurance company.

And, we do know that being in the hospital is not for everybody. But it is important to note that successful outpatient mastectomy programs have been extremely careful to empower their patients through education, carefully monitor outcomes, and work intensively to minimize complications.

Unfortunately, this is not the standard of care that many women are getting right now. Take, for example, the woman who was sent home only 23 hours after undergoing a bilateral mastectomy in September 2008 -- who noted that "any complications would have been handled by me, myself, and I."

A Lifetime Television petition calling for the Breast Cancer Patient Protection Act's passage has been signed nearly 24 million times. Last year, 421 Members of Congress voted to enact this legislation. The current bill has 236 co-sponsors in the House and 17 cosponsors for Senator Snowe and Landrieu's version in the Senate. In short, there is strong grassroots and bipartisan support for these most basic patient protections.

This legislation also enjoys the support of respected patient organizations including the Susan G. Komen for the Cure Advocacy Alliance, American Cancer Society, Breast Cancer Network of Strength, Breastcancer.org, and many others.

Most of the 192,000 breast cancer patients diagnosed this year will undergo surgery such as lumpectomy or mastectomy. Research has shown that the treatment a woman receives for breast cancer varies by the type of insurance she has and what state she lives in. And twenty states have enacted protections for patients similar to this bill. But the quality and type of health care provided to patients should not depend on what their insurance covers or what state they live in.

Simply put, it is time we put these decisions back into the hands of patients and their doctors, not insurance companies. Of course, insurers would prefer we not set an explicit standard for length of stay after a mastectomy. But for patient after patient, they

already use proprietary standards that may have little to do with clinical necessity to decide treatment. As Wendell Potter testified to the House Oversight and Government Reform subcommittee last month, "These are terms of art and contractual terms that are used like rapiers to limit and deny care."

H.R. 1691 also includes other important protections for patients facing breast cancer, including access to second opinions, coverage of radiation therapy for women choosing a lumpectomy, and access to a third party review process before a rescission can take place. Along those lines, I am proud to support broader health reform legislation that would ban rescissions and institute numerous other insurance market reforms that protect and empower patients.

I urge my colleagues to support the Breast Cancer Patient Protection Act and help put a stop to these practices. We have a tremendous opportunity to meet our obligations as a Congress and nation, to make it clear: we value women's health. Thank you.

Mr. PALLONE. Thank you, and thank you for your passion, really. We only have about a minute left. I was going to suggest we come back, if that is okay. All right. We will reconvene after those votes with Congresswoman Wasserman Schultz. The Committee is in recess.

[Recess.]

Mr. PALLONE. The Subcommittee will reconvene, and we had our Members' panel, and you ended up last, I guess. I apologize for that, Congresswoman Wasserman Schultz. But let me say, since we have a little time, thank you so much. You are like a hero. You really are. Or heroine, I guess, is the word. I mean, I don't know all the details but I remember the speech when you came to the Floor that one day and it was just amazing. All that you do, I don't know how you find the time, but thank you.

STATEMENT OF DEBBIE WASSERMAN SCHULTZ

Ms. WASSERMAN SCHULTZ. Thank you so much, Mr. Chairman. I am happy to bat cleanup today for the Member panel, and Chairman Pallone and Ranking Member Deal when he comes back and the distinguished members of the Subcommittee that are here with us, it really is an honor to be here and to testify in front of the Health Subcommittee of Energy and Commerce, and Mr. Chairman, thank you very much for holding this hearing during Breast Cancer Awareness Month. I think that is a particularly important symbol. It is fitting that we review what is needed in the fight against breast cancer during this special month when, although we pay special attention to breast cancer awareness during the month of October, it is important that we focus on that awareness and help women pay attention to their breast health throughout the year.

Before I go further, I really want to give my deepest gratitude and thanks to the efforts of three of my colleagues, Sue Myrick, Rosa DeLauro and Donna Christensen, who embraced this legislation months ago before I publicly shared my own battle with breast cancer, and it was an honor to testify by the side of my friend and colleague, Rosa DeLauro, and Sue, you are just superhuman. I think there was one day when you got 45 cosponsors for this bill in one small series of votes. It is hard for me to express how much I appreciate your support for me and the fact that I was able to share my story and talk to you about our mutual experience before I shared it with everyone else. Thank you very, very much. You have been there for me every step of the way.

Breast cancer strikes women from all backgrounds, all races, all ages and all ethnicities. It strikes black and white, rich and poor, those with access to quality health care and those without. But many women, too many women do not know their specific risk factors or their family history, and this is especially true with young women who see breast cancer as an older woman's disease. Many young women think breast cancer will never happen before they turn 40 but we know that young women can and do get breast cancer. In fact, each year nearly 24,000 women under 45 are diagnosed with breast cancer in the United States. While incidence rates of breast cancer are much lower in young women than older women, young women's breast cancers are generally more aggressive, they

are diagnosed at a later stage and they result in higher mortality rates. After talking with many health care professionals, advocates in the breast cancer community and the Centers for Disease Control and Prevention, it became clear that there was an urgent need to help build awareness among this often overlooked group. These conversations led to H.R. 1740, the Breast Health Education and Awareness Requires Learning Young Act, or the EARLY Act. This bill will empower young women to learn the facts, know their bodies, speak up for their health and embrace support. The truth is, we all need to be better informed about our own health. We must empower each other to know and reduce our risks.

Recently I learned I had more personal risks than I was aware of. Almost 2 years ago, as most of you know now, only 6 weeks after a clean mammogram, I found a lump in my breast while doing a routine self-exam. My doctor diagnosed me with breast cancer when I was only 41. As a legislator, I have been in the fight against breast cancer for a long time. In Florida, I was the lead sponsor of the drive-through mastectomy law, the focus of Rosa's bill. I never dreamed I would need its protection myself. I thought I knew all of my risk factors. That is why I chose to perform self-exams and saw my doctor regularly. But after I was diagnosed, I learned I had more risk factors than I was aware of. I had no idea, for example, that as an Ashkenazi Jewish woman, I was five times more likely than the general population to have a BRCA1 or BRCA2 gene mutation. I didn't know that that mutation gave me as much as an 85 percent chance of developing breast cancer during my lifetime. Too many young women are unaware of their risk.

The EARLY Act will give all young women the tools and information they need to take more control of their health. It will raise awareness of their personal risks and the importance of paying attention to their breast health. It will encourage young women to be familiar with the look and feel of their breasts. By knowing what feels normal, a young woman has a better chance of knowing when something feels different, and I can tell you that that is how it was for me. Because I did self-exams on a fairly regular basis, I was familiar enough with what my breasts normally felt like so that when I felt that lump, I knew it didn't belong there. The EARLY Act will teach young women and medical professionals about the importance of family history, warning signs of breast cancer and predictive tools such as genetic testing that can help some high-risk women make informed decisions about their health. It will also provide grants to organizations dedicated to supporting young women diagnosed with breast cancer. These grants will help young women tackle the unique challenges that they face like fertility preservation, body image and self-esteem as well as help them manage and understand their risks. And again, when a young woman is diagnosed with breast cancer, I mean, at 28 years old, for example, if they don't even have a boyfriend and they are faced with breast cancer and having a double mastectomy and dealing with chemotherapy and facing their own mortality, on top of that having to think about how to preserve their fertility, that is a unique challenge that young women who are diagnosed with breast cancer face that older women simply do not, and younger women

have to face many more years as survivors which presents in and of itself unique challenges.

So we have 371 cosponsors in the House including nearly all members of this Subcommittee and 34 cosponsors in the Senate. The EARLY Act has garnered broad public support from more than 40 advocacy and health organizations, many of whose representatives are behind me here today, and I just cannot thank these groups enough for their support, for their expertise and their guidance in helping to craft this legislation, but also for their personal support of me because it has just been very moving and special for me.

Some say that we shouldn't be talking to young women about breast cancer at all because it might scare them. Well, I find this quite simply patronizing. Young women and providers can handle the truth. They can and should be empowered with the knowledge that while only 15 percent of breast cancer cases are in women under 45, eight of these women die every here in America. Having no information when you are 35 about breast cancer and finding a lump in your breast, that is what is really scary.

Over the past year I have met with oncologists and other health care professionals that work with breast cancer patients, whether at MD Anderson Cancer Center in Houston, the Dana Farber Cancer Institute at Harvard or the Cancer Center at Memorial Regional Hospital in my district in Florida, the message is clear: too often a diagnosis of breast cancer is delayed or missed in young women. A Harvard study of young women with breast cancer found 26 percent delayed seeking medical attention and 27 percent experienced a delay in diagnosis after seeking medical attention. This means that more than half of young women are not receiving the timely treatment that they need. We must do better. By encouraging young women to know their bodies and their family history and by teaching young women how to effectively talk with their doctors and their doctors with them, we can transform how we approach the fight against breast cancer.

Every young woman that I know has the goal of becoming an old woman. With the passage of the EARLY Act, we can help more young women in America reach their goal and give them powerful tools to take control of their own health for a lifetime. Thank you very much.

[The prepared statement of Ms. Wasserman Schultz follows:]

**Testimony before the House Energy & Commerce Committee
Subcommittee on Health
October 7, 2009
Rep. Debbie Wasserman Schultz**

Thank you, Chairman Pallone, Ranking Member Deal, and distinguished Members of the Subcommittee, for inviting me to testify today. It is an honor to appear before this Committee. It is fitting that you are holding this hearing as we begin Breast Cancer Awareness Month and that we review what is needed in the fight against this terrible disease.

Before I go further, I give my deepest gratitude to the efforts of three of my colleagues: Sue Myrick, Rosa DeLauro, and Donna Christensen, who embraced this legislation months ago, before I publicly shared my own battle with breast cancer. Rosa, it's an honor to testify at your side. Sue, I'm so grateful for all you have done to advance this legislation as the lead Republican co-sponsor. All three of you have been an incredible source of support.

Breast cancer strikes women from all backgrounds, all races, all ages, and all ethnicities. It strikes black and white, rich and poor, those with access to quality health care and those without. But many women -- too many women -- do not know their specific risk factors or their family history. This is especially true with young women who see breast cancer as an older women's disease. Many young women think breast cancer will never happen before they turn 40, but we know that young women can and do get breast cancer.

In fact, each year, nearly 24,000 women under 45 are diagnosed with breast cancer in the United States. While incidence rates of breast cancer are much lower in young women than older women, young women's breast cancers are generally more aggressive, are diagnosed at a later stage, and result in higher mortality rates.

After talking with many health care professionals, advocates in the breast cancer community, and the Centers for Disease Control and Prevention, it became clear that there was an urgent need to help build awareness among this often overlooked group. These conversations led to H.R. 1740 - the Breast Health Education and Awareness Requires Learning Young Act, or "EARLY Act." This bill will empower young women to learn the facts, know their bodies, speak up for their health, and embrace support.

The truth is -- we all need to be better informed about our own health. We must empower each other to know and reduce our risks. Recently, I learned I had more personal risk than I was aware of. Almost two years ago -- only six weeks after a clean mammogram -- I found a lump in my breast while doing a routine self-exam. My doctor diagnosed me with breast cancer. I had just turned 41.

As a legislator, I've been in the fight against breast cancer for a long time. In Florida, I was the lead sponsor of the Drive Thru Mastectomy law, the focus of Rosa's bill. I never dreamed I would need its protection myself. I thought I knew all of my risk factors. That's why I chose to perform self-exams and saw my doctor regularly.

But after I was diagnosed, I learned I had more risk factors than I was aware of. I had no idea that, as an Ashkenazi Jewish woman, I was five times more likely than the general population to have a BRCA 1/BRCA 2 genetic mutation. I did not know the mutation gave me as much as an 85

percent chance of developing breast cancer during my lifetime. Too many young women are unaware of their risk.

The EARLY Act will give ALL young women the tools and information they need to take more control of their health. It will raise awareness of their personal risks and the importance of paying attention to their breast health. It will encourage young women to be familiar with the look and feel of their breasts. By knowing what feels normal, a young woman has a better chance of knowing when something feels different and knowing when to see her doctor.

The EARLY Act will teach young women and medical professionals about the importance of family history, warning signs of breast cancer, and predictive tools such as genetic testing that can help some high-risk women make informed decisions about their health. It will also provide grants to organizations dedicated to supporting young women diagnosed with breast cancer. These grants will help young women tackle the unique challenges, such as fertility preservation, body image and self esteem they face as well as help them manage and understand their risks.

With 369 cosponsors in the House -- including nearly all Members of this subcommittee -- and 34 cosponsors in the Senate, the EARLY Act has also garnered broad public support from more than 40 advocacy and health organizations. I cannot thank these groups enough for their support, their expertise, and their guidance in helping to craft this legislation.

Some say this legislation will detract from other important health care efforts or siphon funding away from the important National Breast and Cervical Cancer Early Detection Program. That's wrong. As a long-time advocate of breast cancer awareness, and as an Appropriator, I have fought for, and will continue to fight for a multi-faceted approach to combating breast cancer.

Others say we shouldn't be talking to young women about breast cancer at all-- because it will scare them. Well, I find this, quite simply, patronizing. Young women and providers can handle the truth. They can and should be empowered with the knowledge that while only 15 percent of breast cancer cases are in women under 45, eight of these women die every day here in America. Having no information when you are 35 and find a lump in your breast, that is what is really scary.

Over the past year I have met with oncologists and other health care professionals that work with breast cancer patients. Whether at the M.D. Anderson Cancer Center in Houston, the Dana-Farber Cancer Institute at Harvard, or the cancer center at Memorial Hospital in my District in Florida -- the message is clear: too often a diagnosis of breast cancer is delayed or missed in young women. A Harvard study of young women with breast cancer found 26 percent delayed seeking medical attention and 27 percent experienced a delay in diagnosis after seeking medical attention. This means more than half of young women are not receiving the timely treatment they need! We must do better!

By encouraging young women to know their bodies and their family history, and by teaching young women how to effectively talk with their doctors, and their doctors with them, we can transform how we approach the fight against breast cancer.

Every young woman I know has the goal of becoming an older woman! With passage of the EARLY Act, we can help more young women in America reach that goal and give them powerful tools to take control of their own health for a lifetime.

Thank you.

Mr. PALLONE. Thank you so much. Really, you know, even now you have given me a lot more insight into what needs to be done and what we need to do, and I just want to stress again, I know that there has been some discussion today about what is in the health care reform bill and how some of these bills relate and some parts of them actually are included, but as I said earlier, this is a legislation hearing and so we do intend to move the bills, and we will look and see what is in the health reform and what isn't and take that all into account.

Ms. WASSERMAN SCHULTZ. Mr. Chairman, I have been a legislator for a long time. Any which way this bill becomes law is fine with me. Thank you very much, and thank you to the Committee staff because they have been an incredible source of support and guidance as we move through the process too. Thank you.

Mr. PALLONE. Take care.

Now, what we are going to do with our second and third panel is that the panelists have agreed, actually on their own initiative, to put the two panels together, so we are just going to have one panel. This way we can save time and have a series of questions that way. So I would ask the second and third panel members to come forward, if you would. Welcome. Let me say that the normal practice is that Administration witnesses have a separate panel, which is why Dr. Taplin from NIH would normally have had the second panel, so I want to thank you for suggesting that you be with the other panel, but I don't want anyone to think that that prejudices what we do in the future. We understand that the Administration is normally not part of another panel.

So let me introduce everyone. Starting on my left is Dr. Stephen Taplin, who is chief of the Applied Cancer Screening Research Branch, Division of Cancer Control and Population Science for the National Cancer Institute, which is part of the National Institutes of Health. Then we have Dr. Otis Webb Brawley, who is chief medical officer for the American Cancer Society; Ms. Jenny Luray, who is president of the Susan G. Komen for the Cure Advocacy Alliance; Debra L. Ness, who is president of the National Partnership for Women and Families; Dr. George W. Sledge, Jr., who is Ballvé Professor of Oncology at Indiana University Medical Center in the Cancer Pavilion; Ms. Fran Visco, who is president of the National Breast Cancer Coalition, and finally, Dr. Marisa C. Weis, who is president and founder of Breastcancer.org. So thank you all for being here, and I think you know we have 5-minute opening statements that become part of the record. I would like you to try to keep your comments to the 5 minutes if you could. You may get questions from the panel that you have to get back to later in writing too, but we would like you to try to answer the questions today.

So we will start with Dr. Taplin from NIH. Thank you.

STATEMENTS OF STEPHEN TAPLIN, M.D., M.P.H., CHIEF OF THE APPLIED CANCER SCREENING RESEARCH BRANCH, DIVISION OF CANCER CONTROL AND POPULATION SCIENCE, NATIONAL CANCER INSTITUTE, NATIONAL INSTITUTES OF HEALTH; OTIS WEBB BRAWLEY, M.D., CHIEF MEDICAL OFFICER, AMERICAN CANCER SOCIETY; JENNIFER LURAY, PRESIDENT, SUSAN G. KOMEN FOR THE CURE ADVOCACY ALLIANCE; DEBRA L. NESS, PRESIDENT, NATIONAL PARTNERSHIP FOR WOMEN AND FAMILIES; GEORGE W. SLEDGE, JR., M.D., BALLVE PROFESSOR OF ONCOLOGY, INDIANA UNIVERSITY MEDICAL CENTER, CANCER PAVILION; FRAN VISCO, J.D., PRESIDENT, NATIONAL BREAST CANCER COALITION; AND MARISA C. WEISS, M.D., PRESIDENT AND FOUNDER, BREASTCANCER.ORG

STATEMENT OF STEPHEN TAPLIN

Dr. TAPLIN. Thank you, Mr. Chairman Pallone, and Committee members. Thank you for the opportunity to speak today. I have also provided a written document that elaborates on my testimony with greater detail. As you have heard, I am Dr. Stephen Taplin, the chief of the Applied Cancer Research Branch at the National Cancer Institute. Before coming to NCI, I spent 20 years as a practicing family physician while also managing an organized breast cancer screening program and conducting screening research at Group Health Cooperative, an integrated health plan in Seattle, Washington.

There is more than 50 years of research in breast cancer screening and treatment that is now having a positive impact on the lives of women. Research shows that the breast cancer incidence increases markedly. Each year among 100,000 women, 1.4 cancers are diagnosed in the age group 20 to 24, but as you can see here in figure 1, the rate rises to a peak of 454 in women ages 75 to 79. The benefit of research for these women is that breast cancer death has fallen across all age groups since 1975. Since 1990, the rate of decline has accelerated and the annual percent reduction in mortality has been a fairly consistent 2 to 3 percent per year over the last 10 years. However, let me be clear that I understand it is not the research that changed the lives, it is the choices women are making and the changes in therapy that physicians that are implementing that have had the impact. The key is those changes are guided by evidence from research.

The mortality reduction we are seeing is due to both improvements in treatment and improvements in screening. An elegant set of modeling studies demonstrated approximately half the reduction in mortality among women ages greater than 40 is due to screening, that in fact screening has become a large part of health in the United States since evidence from randomized trials showed that mortality reductions were possible. However, the integration of screening into care has not been simple because the evidence was sometimes ambiguous. The results from breast cancer screening trials show less benefit for women ages 40 to 49. Furthermore, the benefit appears much later in the lives of these women. Ultimately, however, the results of randomized trials led to national recommendations and increases in breast cancer screening among av-

average-risk women in the United States beginning at age 40. The U.S. Preventative Services Taskforce, as you have heard, suggests considering screening every 1 to 2 years starting at age 40. Screening rates are at about 66 percent within the last 2 years in the United States today.

It is clear that not everyone is at average risk. As our knowledge of the genetic determinates of cancer has grown, there has been increased concern regarding the high-risk populations. The ACS has provided recommendations that women at greater than 25 percent lifetime risk for breast cancer should consider magnetic resonance imaging. This is about 1 to 2 percent of women. These recommendations are based on observational studies showing that technology has a higher sensitivity in dense breast tissue. Unfortunately, it also shows more false positive tests than occur with mammography. We need national work to show that use of MRI in high-risk women actually affects mortality. NCI is sponsoring studies on how to reduce the false-positive testing with MRI but it continues to be a limitation. One approach around the problem is to examine biomarkers and biomarker profiles that may identify the lethal cancers or become a screening test.

Access across most races and ethnicities including whites, women in lower socioeconomic groups are less likely to be screened, in large part because they do not have access to preventive care. People with less than 12 years of education are one of the groups in the United States who have not seen a significant drop in breast cancer mortality. The Centers for Disease Control and Prevention has managed a program to encourage access to screening among low-income populations. That is a step towards addressing access. Access to medical care is critical to screening because it is a process, not a test. The screening process has multiple steps as shown in figure 2, and these steps are managed in clinical trials but not necessarily in usual practice in the United States.

To achieve the full potential of screening in the United States, we must consider how to improve the entire process. We must also consider the effects of the process on all the women, even those who will not get cancer. Some have argued that healthy people should be very skeptical of screening because most people will not have cancer even with a positive test. Improving the screening process means finding better tests and better diagnostic procedures. NCI is supporting research in key areas relevant to optimizing the screening process for breast cancer including risk estimation using biomarkers as a genetic profile, comparative effectiveness studies to evaluate MRI, 3D ultrasound and emerging technologies and the comparison of alternative screening and diagnostic strategies.

In closing, I want to emphasize three points, that fewer women have died of breast cancer because research has led to progress in breast cancer screening and treatment, that the research provides evidence for women and their physicians to choose wisely among options they face but it is their behavior that changes care and improves outcomes, and three, that we have much more research to do to understand the screening process, how to affect behavior, to identify biomarkers of risk, cancer progression and treatment re-

sponse and to use all of this information to begin to personalize screening.

Thank you for the opportunity to testify.

[The prepared statement of Dr. Taplin follows:]



**Testimony
Before the
Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives**

**Breast Cancer Screening Improvement
Means Considering the Entire Process**

Statement of

Stephen Taplin, M.D., M.P.H.

Chief, Applied Cancer Screening Research Branch

Division of Cancer Control and Population Science

National Cancer Institute

National Institutes of Health

U.S. Department of Health and Human Services



For Release on Delivery
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Thank you for the opportunity to speak to you today. I am Dr. Stephen Taplin, the Chief of the Applied Cancer Screening Research Branch at the National Cancer Institute (NCI) within the National Institutes of Health (NIH), an agency of the Department of Health and Human Services (HHS). The National Cancer Institute, dedicated to the understanding, diagnosis, treatment, and prevention of cancer, supports research on all aspects of breast cancer, including numerous research projects to understand and improve breast cancer screening. In my Branch, our research promotes the appropriate use of efficacious cancer screening tests, as well as strategies for informed decision-making regarding cancer screening technologies. Before coming to NCI, I spent 20 years as a practicing family physician while managing an organized breast cancer screening program and conducting screening research at the Group Health Cooperative health plan.

We have nearly 50 years of research in breast cancer screening and treatment that is now having a positive impact on the lives of women. Breast cancer incidence increases markedly as women age. If we count cancers for a year among 100,000 women ages 20-24, 1.4 breast cancers will be diagnosed but if we look instead among the same number of women ages 75-79 the number increases to 454 (Figure 1). While research and infrastructure is required to establish those incidence numbers, a demonstrated reduction in death due to breast cancer (breast cancer mortality) is more convincing evidence of our progress. Across all age groups we have seen breast cancer mortality drop in the United States since 1975. The absolute magnitude of the drop differs by age group such that mortality has dropped since 1975 from 5.3/100,000 to 3.1/100,000 among women ages 20-39, and from 110.6/100,000 to 95.2/100,000 among women ages 70-79. Since 1990

the rate of decline has accelerated and the annual percent reduction in mortality has been a fairly consistent 2-3% per year over the past 10 years across all age groups.(1) This reduction in mortality is due to both improvements in treatment and improvements in screening. It seems clear that most, if not all, of the decrease in breast cancer mortality in women under age 40 is due to improvements in treatment, since women under age 40 are not the typical target for screening efforts in the U.S. An elegant set of modeling studies by Berry and colleagues demonstrated that approximately half the reduction in mortality among women ages over 40 is due to screening.(2)

Screening for cervical, breast, and colon cancers by Papanicolaou tests (Pap smears), mammography, and fecal occult blood tests or endoscopy, respectively, are a major part of health care in the United States. Together they are used by at least 82 million people each year. These tests have been recommended by national expert groups based on national cohort studies (cervix) and randomized trials (breast, colon).(3-6) Randomized trial results in breast cancer screening have been a source of controversy since the mortality reduction among women ages 40-49 is less than among older women and appears later in the course of life after screening.(4;7) Using data from studies supported by NCI and international groups, the United States Preventive Services Task Force (USPSTF), a group supported by HHS's Agency for Healthcare Research & Quality that includes researchers and practitioners responsible for national evidence summaries and recommendations, concluded that the relative risk of breast cancer death is 0.84 (95% CI, 0.77-0.91) for women ages 40 to 74, and they therefore recommend screening begin at age 40.(4)

As a result of these randomized trial results and national recommendations, there has been encouragement of breast cancer screening among average risk women in the United States since the mid 1980s and we saw a rise in use of mammography throughout the 1990s. Recommendations for screening vary. The USPSTF suggests screening every 1-2 years starting at age 40, while the American Cancer Society (ACS) recommends annual mammography from age 40 onward.(4;8) The USPSTF has been reviewing the literature since their last statement in 2002 and an update is anticipated this year.

There are also recommendations from the ACS regarding screening among women at high risk of developing breast cancer. The 1-2% of the population of women at greater than 25% lifetime risk for breast cancer are recommended to screen with magnetic resonance imaging (MRI) based on its higher sensitivity in dense breast tissue.(9) MRI also offers the advantage that it does not use ionizing radiation and therefore avoids the problem that women at high risk may also be more susceptible to the mutagenic potential of mammography.(10) A great deal of work is underway to improve the specificity of MRI since false positive testing continues to be a limitation.(11) There is some concern expressed that MRI screening may identify non-life threatening tumors in the breasts (known as over-diagnosis) that may lead to unnecessary treatments and this is an area of needed research. One approach is to more closely examine biomarkers and biomarker profiles that may identify the lethal cancers or that may someday be the preliminary screening test. (11;12)

In the average-risk population, breast cancer screening occurs primarily by screen-film techniques but digital mammography now accounts for 42% of screenings in NCI's Breast Cancer Surveillance Consortium and that proportion is rising.(13) While there was concern that screening rates were dropping during the middle of this decade, they appear to be stabilizing at about 66%.(14)

Despite the stabilization of screening in the population as a whole there are subpopulations in which screening rates are lower, and those are primarily defined by economic status and access to care. Apparent lower rates of screening among African-Americans, Hispanics, and Asian/Pacific Islanders compared to white non-Hispanics disappear when socioeconomic status is taken into account. Women in lower socioeconomic groups are less likely to be screened, in large part because they do not have access to preventive care. People with less than 12 years education are the one group in the United States in which we have not seen a significant drop in breast cancer mortality.(15)

Access to medical care is critical to screening because screening is a process, not just a test.(16) Even when access exists, the screening process has multiple steps that are managed in clinical trials but not necessarily in usual practice in the United States (Figure 2): identifying the individuals at risk for specific types of cancer, offering screening to those individuals (recruitment), performing the screening test (detection), evaluating abnormalities (diagnosis), and treating the individuals who are diagnosed with pre-malignant conditions or cancer are all steps in the screening process.(16)

To address the challenge of prevention and care for low income and underinsured populations, which, unlike the nation as a whole, have not experienced that reduction in breast cancer mortality rates, HHS's Centers for Disease Control and Prevention (CDC) administers the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). This program provides breast and cervical cancer screening to low income, under- and uninsured women throughout the U.S. through grants to all 50 States, the District of Columbia, 12 American Indian tribes and tribal organizations, and 5 U.S. territories.(41) The NBCCEDP is based on a public health model and encourages these populations to utilize the full screening process by incorporating public education, professional development, and outreach; assuring quality through tracking and surveillance; facilitating screening follow-up, patient navigation, and case management; and referral to treatment for these underserved women. Furthermore, the NBCCEDP is keeping pace with the practices in the field by offering reimbursement for digital mammograms. Ongoing studies indicate that over the past 15 years, the NBCCEDP has saved more than 100,000 life years, creating significant health impacts.(40)

There is evidence of overuse, underuse, and misuse of cancer screening tests in the United States, but documentation of the complete screening process, its adverse consequences, and the potential improvements is limited.(17-19) There is also growing concern about the impact of false positive tests and the treatment of pre-cancerous conditions and cancers that may not affect survival.(20) NCI is currently considering ways to increase our capacity for multi-site, coordinated, transdisciplinary research to evaluate and improve the screening process.

Screening has a large impact on health care and its costs. We used U.S. population census data and published screening rates to estimate that at least 82 million people in the U.S. are screened for breast, colon, and cervical cancers, and 8 million more undergo evaluations of abnormalities to find the 350,000 people who will have one of these cancers. Using these same data and available estimates of the costs of screening tests and follow-up, we estimate that the total costs of screening and follow-up testing each year are at least \$8.8 billion.(21-24)

If we just consider breast cancer, then we estimate at least 22 million women are screened each year. We expect 192,370 new cases of invasive breast cancer by the end of 2009.(25) Over the 10-year period from 1990-2000, the U.S. spent an estimated \$166 billion on breast cancer screening.(23) Analysis of actual practice during that time period suggests there is a need to optimize the screening process because additional quality adjusted life years could have been achieved, as well as \$6 billion in cost savings, with more optimal screening schedules than those demonstrated.(23) NCI is currently considering research to evaluate the screening process in the United States and how it can be systematically improved.

Although we have evidence of the benefit of screening, there is growing concern regarding its consequences for all those who will not get cancer, and some have argued that healthy people should be very skeptical of screening.(2;20;26;27) A small proportion of abnormal screening tests are cancers: 3-19% of abnormal mammograms, 2-29% of abnormal stool occult blood tests, 11% of abnormal virtual colonoscopies, and 0-5% of

Pap smears.(28-32) These numbers change with the prevalence of cancer in the screened population and with the specific test (e.g., digital vs. screen film), but the majority of screened people do not have cancer even with a positive test. Therefore, limiting the adverse impact of screening involves both improving the screening test and evaluating how to improve the additional evaluation of abnormal tests so there are fewer false-positive tests that lead to biopsies and/or unnecessary treatment.

While we have some estimates of specific screening tests' performance we do not have those same estimates for the process as a whole, and furthermore, there is clear evidence that the screening process breaks down in practice.(3-5;33-35) For example, among people in a population where breast and cervical cancer screenings were available without additional charge, breakdowns in recruitment, detection, and follow-up after an abnormality accounted for 50%, 40%, and 10% of the poor outcomes, respectively.(34;35) Addressing these three parts of the screening process, and improving treatment of people with precursor lesions could therefore result in early diagnosis and reduce late-stage cancer rates and cancer mortality.(34-36)

NCI is supporting research across the continuum of steps in the screening process. Key areas relevant to optimizing screening for breast cancer include risk estimation using biologic data acquired before women develop disease; comparative effectiveness studies to evaluate the use of MRI (37), 3D ultrasound (38), and other emerging technologies as screening and diagnostic techniques; comparison of alternative screening and diagnostic strategies; and estimates of false positive screening rates, over-diagnosis, and biologic

markers of cancer progression that can guide treatment and anticipate prognosis. Ongoing research includes work to understand methods of presenting screening to low-income and ethnic minorities, evaluations of imaging technology, how to address the concern that screening is leading to cancer diagnoses that would otherwise not have affected women's lives, and work to personalize screening regimens and treatment by identifying biomarkers of cancer risk and progression.(39) Work supported by NCI through the American College of Radiology Imaging Network and through the American Recovery and Reinvestment Act is testing new technology to improve diagnostic testing, evaluate the effects of treatment, and reduce false positive testing. While we have made great progress in breast cancer screening and treatment we need to do more work to optimize the screening tests, explore the use of biomarkers as screening technology, and improve the screening process as whole.

My major messages are that 1) fewer women have died of breast cancer because research has led to progress in breast cancer screening and treatment, 2) the research provides evidence for women and their physicians to choose wisely among the options they face, but it is their behavior that changes care and improves outcomes, and 3) we have much more research to do to understand the screening process; to identify biomarkers of risk, cancer progression, and treatment response; and to use all of this information to personalize screening.

Thank you for the opportunity to testify.

Figure 1:

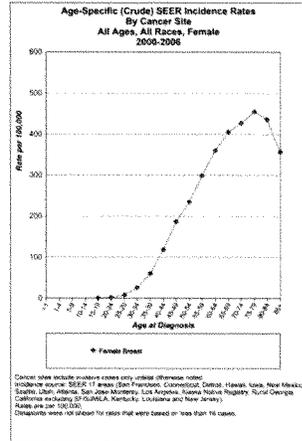
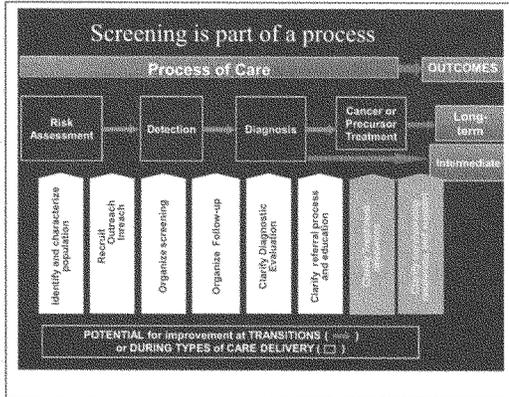


Figure 2:



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http://www.cdc.gov/cancer/nbccedp/pdf/national_report.pdf
<http://www.cdc.gov/cancer/nbccedp/about.htm>

Mr. PALLONE. Thank you, Dr. Taplin.

Dr. Brawley. I see your nametag says "Brawler" but it is Brawley, right? It is Brawley.

Dr. BRAWLEY. It is correct on this.

Mr. PALLONE. Thank you.

STATEMENT OF OTIS WEBB BRAWLEY

Dr. BRAWLEY. Thank you, Mr. Chairman, and good afternoon, distinguished members of the Committee. I am Dr. Otis Brawley, the chief medical officer of the American Cancer Society. I am a medical oncologist by training and a practicing physician, and I am professor of hematology, medical oncology, medicine and epidemiology at Emory University. On behalf of the 11 million cancer patients and survivors in America today, the American Cancer Society thanks you for your continued leadership in the fight against cancer and commitment to enacting comprehensive health care reform this year.

I greatly appreciate the opportunity to testify today on federal initiatives to help fight breast cancer in the United States. Dr. Taplin's comments were quite wise, by the way. Breast cancer is an amazingly devastating disease. It is also a very complicated disease. Too often we do a disservice to women who we want to help by simplifying the concepts of this disease with very simple messages. Sometimes simple messages actually end up doing harm. This year, breast cancer will take the lives of approximately 40,000 women in the United States. This is particularly disheartening because we know that if every woman had access to accurate information about the disease, good science-driven early detection and quality and timely treatment, more of them would survive this disease.

Members of the Committee today quoted a lot of American Cancer Society-generated statistics. One statistic generated by the same ACS epidemiologist that I would like to quote is the fact that with halfhearted approaches to breast cancer from 1991 to 2005, 55,000 to 60,000 women's lives or deaths were averted. We averted 55,000 to 60,000 breast cancer deaths by really in essence halfheartedly approaching this disease and not getting serious about it. At a time when at least a third and indeed in the 1990s perhaps 50 percent of women who should have been getting screened were not getting screened, and even today a substantial number of women who were screened and found with an abnormality get less than good treatment for the disease. Unfortunately, not all women have access to adequate health coverage with the public health programs that have been proven to help save lives. The consequences can be devastating in terms of prognosis.

My testimony today will highlight four priority areas that are essential to improved breast cancer outcomes in the United States. Priority one: You must ensure access to quality health care for all Americans. Our current health care system fails to meet the needs of far too many people. Research has made clear that lack of health insurance can be deadly. Studies have documented that uninsured breast cancer patients are more likely to be diagnosed at a later stage of disease and have lower survival rates than women who are privately insured. That is a polite way of saying the uninsured are

more likely to die. Continued progress against breast cancer requires that we give all cancer patients an equal opportunity to battle this disease by making sure they have access to quality and timely medical care.

Priority two: We need to ensure that we apply what we know about evidence-based prevention and early detection and make these services available to all Americans. Breast cancer is one of the few cancers early through evidence-based screening tests. Absent these screenings, women are at risk of being diagnosed at later stages of the disease when it has spread and become more difficult and more expensive to treat and chances of survival drop precipitously. Now is the time to transform our current sick care system into one that also focuses on prevention and wellness. This requires making evidence-based and early detection services affordable and accessible to all populations. Ironically, not doing so increases our Nation's overall health care costs.

Priority three: Clinical decisions must be patient-centered and made through strict rational and orthodox interpretation of the most current scientific evidence. This is particularly important in the context of a serious illness like breast cancer or any cancer. As practitioners, we need to strive to consistently do a better job of explaining the evidence and the options for screening treatment and care as understandably as possible to help patients make informed decisions together with their health care teams.

Priority four: Finally, we must do a better job of addressing the health disparities that exist in our Nation. Recent studies have shown differences in quality of care provided among certain populations that are of particular concern. For example, Congresswoman Castor actually quoted a study that I published together with colleagues last year that showed that black women were five times more likely to experience huge delays in starting breast cancer treatment compared to white women. We also found that black women were significantly less likely to receive appropriate surgery. Seven and a half percent of black women and 1½ percent of white women with a locally staged potentially curable breast cancer did not get breast surgery, research completed by Halstead in 1903 that was not practiced in the year 2006. It is well documented that insurance status and poverty are principal determinates in cancer disparities. We simply must do a better job in providing access to appropriate early diagnosis and cancer treatment services for all women.

In closing, it is gratifying that since 1990 we have been seeing a rise in the number of women surviving breast cancer each year, and as I said, 55,000 to 60,000 deaths averted. But that success is not enough. All women must have access to accurate information, existing and future early detection methods and quality treatment and care. The number of deaths averted if all women who should have gotten screening and should have gotten accurate diagnosis and should have gotten accurate treatment, the number of deaths averted would have easily doubled over that 55,000 to 60,000.

The Society appreciates the leadership and commitment of the Energy and Commerce Committee in helping eliminate suffering from breast cancer through the work that will be described today and through health care reform. My colleagues at the American

Cancer Society Cancer Action Network, ACS CAN, and I look forward to working with you as we look ahead to help create a world with less cancer.

Thank you again for inviting me here today. I would be happy to answer your questions, sir.

[The prepared statement of Dr. Brawley follows:]



Statement by
 Otis Brawley, MD
 Chief Medical Officer
 American Cancer Society

Before

The Committee on Energy and Commerce
 Health Subcommittee
 United States House of Representatives
 Wednesday, October 7th, 10:00 a.m.
 2123 Rayburn House Office Building

Good morning, Mr. Chairman and distinguished members of the Committee. I am Dr. Otis Brawley, Chief Medical Officer of the American Cancer Society. On behalf of the eleven million cancer patients and survivors in America today, the Society thanks you for your continued leadership in the fight against cancer and commitment to enacting comprehensive health care reform this year. I greatly appreciate the opportunity to testify today on federal initiatives in the United States to help fight breast cancer.

Breast cancer is the most common cancer among women, accounting for nearly one in four cancers diagnosed. This year in the United States, over 192,370 women will be diagnosed with breast cancer and approximately 40,170 women will die from the disease.¹ If every woman in the United States had access to accurate information about the disease, early detection and quality, timely treatment, more women would survive breast cancer. Unfortunately, many women lack access to public health programs and adequate health coverage that provide these life saving services. The consequences are detrimental to their health and can be devastating in terms of their prognosis.

My testimony today will focus on areas that are fundamental for improving breast cancer outcomes in the United States.

Access to Affordable and Adequate Health Insurance

As a practicing oncologist, I see firsthand what lack of adequate health insurance can actually mean. Some of the most disheartening stories are from people who cannot access appropriate health care because of the lack of finances and coverage. Forty-six million people in America are uninsured² and an additional twenty-five million Americans are underinsured³ such that their insurance will not provide affordable cancer screenings and/or adequate coverage if they're diagnosed with cancer.

¹ American Cancer Society. Breast Cancer Facts and Figures 2009-2010.

² DeNavas-Walt, C.B. Proctor, and J. Smith. Income, Poverty, and Health Insurance Coverage in the United States: 2008. U.S. Census Bureau., September 2009.

³ C. Schoen, S. R. Collins, J. L. Kriss, and M. M. Doty, How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007, Health Affairs Web Exclusive, June 10, 2008:w298-w309.

Cancer remains one of the most costly medical conditions in the United States. A 2006 national survey of cancer patients and their families conducted by the Kaiser Family Foundation found that one in five cancer patients with insurance used all or most of their savings when dealing with the financial cost of cancer.⁴ The situation is even worse among the uninsured. The same survey found that nearly half of uninsured cancer patients used all or most of their savings as a result of their cancer.⁴

We also know that lack of health insurance can be deadly. A recent study by the Society found that uninsured breast cancer patients are more likely to be diagnosed at a later stage of diagnosis and have a lower survival rate than women who are privately insured.⁵ The study revealed consistent associations between insurance status and stage at diagnosis across multiple cancer sites. Far too many cancer patients are being diagnosed too late, when treatment is more difficult, more expensive, and less likely to save lives.

No one should have to choose between saving their life and their life savings. But the current health care system puts many Americans in that terrible predicament. That is why the American Cancer Society (The Society) and its nonprofit, nonpartisan advocacy affiliate, the American Cancer Society Cancer Action Network (ACS CAN), have undertaken a broad, joint initiative to promote access to the full continuum of evidence-based, quality health care necessary to optimize health and well-being for all Americans. Looking through the cancer lens, the Society and ACS CAN are advocating for health system reforms that promote prevention and wellness and ensure quality of life throughout disease-directed treatment and continuing into survivorship and through the end of life. We believe that a health system that works well for cancer patients and survivors and those at risk for cancer will also work well for all Americans who may one day be faced with a serious medical condition.

Continued progress in the fight against cancer requires early diagnosis and timely access to medical care that gives all cancer patients an equal opportunity to battle this disease. To help accomplish this – to achieve a world with less cancer and more birthdays for everyone – health care reform must happen now. The cost of waiting to take action, both financially and in lives lost every year, is just too high.

Access to Prevention and Early Detection

Throughout the country, many women are forced to choose between preventive health care and more routine things, such as paying for food, housing, utilities or even the health care of their kids and spouses, especially in hard economic times. ACS CAN conducted a national survey in April 2009 to understand how Americans are dealing with health care costs in the current economic environment, whether they are delaying preventive cancer care, and how prepared they may be to deal with an illness like cancer in the future. One

⁴ *USA Today*, the Kaiser Family Foundation, the Harvard School of Public Health. National survey of households affected by cancer, August 1 – September 14, 2006.

⁵ Halpern MT, Ward EM, Pavluck AL, Schrag NM, Bian J, Chen AY. Association of insurance status and ethnicity with cancer stage at diagnosis for 12 cancer sites: a retrospective analysis. *Lancet Oncol*. 2008;9(3):222-31

in five women surveyed said that they or a family member in their home put off getting a cancer screening test in the past year. Furthermore, nearly one-third of Americans with household incomes less than \$35,000 said they put off potentially lifesaving screenings such as mammograms or colonoscopies.⁶

We are fortunate to have proven programs in place, such as the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), that guarantees access to health care and helps reduce the unequal burden of cancer among low-income and medically underserved women. Through the NBCCEDP, women without health insurance, or with insurance that does not cover these tests, can get breast cancer testing for free or at very little cost. The NBCCEDP attempts to reach as many women in medically underserved communities as possible, including older women and women who are members of racial and ethnic minorities.

Since its establishment in 1991, the program has been implemented in all 50 states, the District of Columbia, four U.S. territories, and 13 American Indian/Alaska Native organizations. It has provided 8 million screening exams to more than 3.3 million medically underserved women. Women who are found to have cancer through the program have access to a Medicaid option that provides cancer treatment.

A new report by the United States Government Accountability Office (GAO) highlights the success of this program, which is the nation's only federal-state cancer screening and treatment program. But the GAO report also reveals that the program is grossly underfunded and thus unable to serve all eligible women. In fact, nationally, the program serves fewer than 15 percent of eligible women aged 40 to 64. The report clearly illustrates the need for comprehensive health care reform so that no woman has to go without critical breast and cervical cancer screenings or treatment because of her income or insurance status.⁷

Other initiatives, like Congressman Jerrold Nadler's Mammogram and MRI Availability Act (H.R. 995), also help increase access to early detection by requiring that insurance companies cover annual screening mammograms and magnetic resonance imaging (MRI) screenings for high-risk women. This bill would ensure that coverage is never a factor in deciding whether to get a screening test for breast cancer.

The Society's guidelines⁸ recommend that certain women with an especially high risk of developing breast cancer should get magnetic resonance imaging (MRI) scans along with their yearly mammogram. The two tests together give doctors a better chance of finding breast cancer early in these women, when it is easier to treat and the chance of survival is greatest.

⁶ The American Cancer Society Cancer Action Network (ACS CAN). The Need for Health Care Reform Through the Eyes of Cancer Patients: A National Poll. <http://acsan.org/pdf/healthcare/reports/healthcare-cancerpoll.pdf>

⁷ United States Government Accountability Office. GAO-09-384: Source of Screening Affects Women's Eligibility for Coverage of Breast and Cervical Cancer Treatment in Some States. May 2009.

⁸ Saslow D, Boetes C, Burke W, Harms S, Leach MO, Lehman CD, Morris E, Pisano E, Schnall M, Sener S, Smith RA, Warner E, Yaffe M, Andrews KS, Russell CA; American Cancer Society Breast Cancer Advisory Group. CA Cancer J Clin. 2007 Mar-Apr;57(2):75-89.

The inability of millions of women to access proven preventive services such as breast MRI and mammograms that can help save lives is a failure of our health care system. Breast cancer is one of the few cancers that can be detected early. Without access to these tools, women are at risk of being diagnosed at later stages of the disease after the cancer has spread, when it becomes harder and more expensive to treat and the chance of survival decreases.

These facts illustrate why all Americans should have access to preventive services as part of health care reform. We must transform our current ‘sick care’ system into one that focuses on prevention and ensures access to the full continuum of quality, affordable care necessary for cancer and other chronic diseases by fully investing in effective programs like the NBCCEDP, and advancing policies that require coverage and remove cost-sharing of evidence-based screening tests that will help reduce barriers to accessing lifesaving screening and treatment.

Bridging the Gap in Program and Services for Young Breast Cancer Patients

An essential part of health care reform is shifting focus to promote health and disease prevention. To achieve this, we need to encourage young adults to take a more active role in their own health and wellness. For example, we should encourage young women to talk to their health care providers about the importance of healthy behaviors that promote wellness, knowing their family cancer history and good breast health practices.

We also need to provide a range of programs to meet the unique needs of young women with breast cancer and their families. Young women with breast cancer identify a variety of health concerns, including: discrimination, a sense of disempowerment, and emotional and psychosocial health issues. At the same time, very little research is currently focused on issues unique to this population of young adults, including their concerns about preserving fertility during and after treatment, genetic predisposition to disease, the impact of hormonal status on the effectiveness of treatment, and late effects of treatment and other long-term survivorship issues.

How young women with breast cancer fare is determined, in part, by their ability to achieve a balance in their lives while minimizing health problems. We must provide health care that integrates health promotion strategies that are based on sound science. In that respect, the Society and ACS CAN support the amended EARLY Act sponsored by Representative Wasserman Schultz. We appreciate all the work that went into developing a bill that is grounded in strong evidence-based science.

Decreasing Disparities and Improving Quality of Care for Breast Cancer Patients

Excessive breast cancer mortality in minority populations, especially Black women, has long been recognized. The statistics are alarming: Black women are less likely than white women to survive 5 years: 78% vs. 90%, respectively.⁹ This difference can be attributed to both later stage at detection and poorer stage-specific survival. Recent

⁹ American Cancer Society. Breast Cancer Facts and Figures 2009-2010.

studies have shown concerning differences in quality of care provided and treatment practices among certain populations. For example, in a study published last year, we found that Black women experienced longer treatment delays, regardless of stage at diagnosis and were 5 times more likely to experience delays in starting treatment greater than 2 months compared to white women. We also found that for local-regional breast cancer, Black women were significantly less likely to receive surgery (7.5% vs. 1.5% of white women).¹⁰

Another study found that use of a less invasive surgical procedure for breast cancer was largely influenced by the patient's age, ethnicity, and insurance status.¹¹ Sentinel lymph node biopsy is a newer, less extensive procedure in which only a single "sentinel" node in the armpit is removed to determine if the cancer has spread. Not removing the lymph nodes under the arm usually minimizes risks and complications after breast cancer surgery, including the risk of painful arm swelling (lymphedema). Therefore, better outcomes are associated with sentinel lymph node biopsy compared with the alternative, axillary lymph node dissection. In this study, colleagues at the American Cancer Society reviewed information about 491,000 patients with breast cancer who underwent surgical treatment including lymph node sampling between 1998 and 2005. They found that fewer Black women and women who were uninsured were likely to receive the less invasive test compared to white women.¹⁰

It is important for physicians to actively involve patients in decisions about their care and educate them about their choices. Decisions about length of stay in the hospital to recover from breast surgery or choosing what type of biopsy to perform should be made by patients and their doctors and should not be dictated by patient income, race, or health insurance status. The Society supports the ability of a physician and patient to discuss and decide together what treatments and care is medically necessary and appropriate for the patient. To that end, the Society opposes any effort on the part of a health plan or health insurance organization that seeks to arbitrarily limit patient access to available treatments deemed medically necessary by a physician.

The goal of expanding coverage, which is the purpose of Congresswomen Rosa L. DeLauro's bill, the Breast Cancer Patient Protection Act (H.R. 1691), is a significant step forward to help remedy some of the existing barriers to accessing quality breast cancer care for all women, and we support the DeLauro bill.

Investing in Cancer Research

Researchers are making remarkable progress in every area of breast cancer prevention, early detection, treatment and care – moving discoveries from laboratories to the bedside. Excellent breast cancer research is being done, including thorough programs like the Breast and Ovarian Cancer Family Registries Project at National Cancer Institute (NCI),

¹⁰ Lund MJ, Brawley OP, Ward KC, Young JL, Gabram SS, Eley JW. Parity and disparity in first course treatment of invasive breast cancer. *Breast Cancer Res Treat.* 2008 Jun;109(3):545-57.

¹¹ Chen AY, Halpern MT, Schrag NM, Stewart A, Leitch M, Ward E. Disparities and trends in sentinel lymph node biopsy among early-stage breast cancer patients (1998-2005). *J Natl Cancer Inst.* 2008 Apr 2;100(7):462-74.

research from the Office of Research on Women's Health, and the technological advances brought about in part through the Human Genome Project that underlie the Genes, Environment and Health Initiative at the National Institutes of Health (NIH).

Despite all the breast cancer research advances we have seen in early detection and treatment, scientists have not yet discovered a way to prevent breast cancer altogether. Moreover, despite what we know about the importance of early detection for breast cancer, only about 60% of women aged 40 and older have had a mammogram in the last year.¹² Research is also required to better apply what we know about breast cancer early detection in all populations so we can save more lives. Increased funding for NIH and NCI targeted toward these problems would enhance and complement current efforts, and would allow the scientific community across the country to identify gaps in our knowledge, design ways to address those gaps and collaborate on the best research needed to respond.

The stimulus law (American Recovery and Reinvestment Act) provided a good down payment on our nation's public health priorities. However, our continued success in reducing gaps in knowledge in breast cancer is directly tied to our sustained commitment to adequate funding. The Society and ACS CAN strongly support President Obama's goal of doubling cancer research funding at the National Institutes of Health and look forward to working with you in support of high-quality and high-impact cancer research that will advance our mutual goal of ending suffering and death from cancer.

Conclusion

Breast cancer deaths have declined about 2 percent each year in the United States since 1990. If we want to eliminate breast cancer suffering, we need to do more. All women must have access to accurate information, existing and future detection methods and quality treatments so that we can reach a day when breast cancer will no longer steal years of life from our mothers, sisters, daughters, wives and friends. We appreciate the leadership and commitment of the Energy and Commerce Committee in helping achieve this through the work that will be described today and through health care reform.

Thank you once again for inviting me to testify today. The Society and ACS CAN look forward to continuing to work with you as we proceed ahead.

¹² American Cancer Society. Cancer Prevention and Early Detection Facts and Figures 2009.

Appendix: How the American Cancer Society Helps Women with Breast Cancer

The American Cancer Society offers several resource programs for breast cancer patients and their families to guide them through every step of the cancer experience so they can focus on getting well. Some of the resources are described below:

American Cancer Society Nationwide Services

- ***National Cancer Information Center (1-800-ACS-2345)***

Trained cancer information specialists are available 24 hours a day, seven days a week, to offer the comfort of live support and to answer questions about cancer, link callers with resources in their communities, and provide information on local events. Spanish-speaking information specialists are available, and callers who speak languages other than English and Spanish can also be assisted.

- ***American Cancer Society Web site (www.cancer.org)***

This user-friendly Web site includes an interactive cancer resource center containing in-depth information on every major cancer type. The site answers questions about breast and cervical cancer, risk factors, strategies for early detection, new diagnostic techniques, and the latest treatment options. Additionally, select content is available in Spanish.

- ***Cancer Survivors NetworkSM (www.cancer.org)***

This virtual community provides connectivity, anonymity, and accessibility for survivors and their caregivers. The Cancer Survivors Network's online services contain survivor and caregiver content, including radio talk show conversations/interviews, personal stories, personal Web pages, discussion forums, an expressions gallery, and survivor-recommended resources.

American Cancer Society Programs

- ***Reach to Recovery[®]***

A one-on-one peer support program, Reach to Recovery trains breast cancer survivors to respond to concerns of people who are going through breast cancer diagnosis or treatment. The success of this program is rooted in the idea that women facing breast cancer benefit from receiving health information and support from someone who has been through what they are experiencing.

- ***"tlc"TM***

A "magalog" (magazine and catalogue in one) that provides medical information and special products for women newly diagnosed with breast cancer, breast cancer survivors, and any woman experiencing treatment-related hair loss. This convenient, nationwide catalog is sent directly to homes upon request. Products in "tlc" include a variety of hats, turbans, kerchiefs, hairpieces, mastectomy bras, and breast forms. Silicone prostheses are also offered.

- ***I Can Cope***[®]

This series of educational classes is for people with cancer and their families and friends. Doctors, nurses, social workers, and other health care professionals provide information about cancer, encouragement, and practical hints through presentations.

American Cancer Society Special Events

- ***Making Strides Against Breast Cancer***[®]

A nationwide series of noncompetitive walking events, Making Strides Against Breast Cancer is designed to raise funds and awareness to fight breast cancer. In 2008, nearly 600,000 walkers across the country raised more than \$60 million to help the American Cancer Society help fight this disease.

- ***Relay For Life***[®]

This unique community event celebrates survivorship and raises money for cancer-fighting programs. Teams of eight to 15 people camp out overnight at a local stadium, park, or fairground and take turns walking around a track or path for 12 to 24 hours. The event usually begins with a survivor lap in which cancer survivors take a victory lap around the track. Later, a candlelight ceremony is held to honor cancer survivors and remember those lost to the disease. Relay for Life events are held in more than 5,000 communities across the country.

Collaborative Programs

- ***Look Good...Feel Better***[®]

This free, national public service program is sponsored by the American Cancer Society, the Cosmetic Toiletry and Fragrance Association Foundation, and the National Cosmetology Association. Look Good...Feel Better is dedicated to teaching female cancer patients beauty techniques to help restore their appearance and self-image during cancer treatments. Services include two-hour group makeover workshops and one-on-one salon consultations. The program also provides educational materials.

Research

- The American Cancer Society's comprehensive research program has four components, all involved with breast cancer research: extramural grants, intramural epidemiology and surveillance, the intramural behavioral research center, and the intramural statistics and evaluation center. Currently, through its extramural research grants program, the American Cancer Society funds 220 extramural research projects relating to breast cancer, totaling nearly \$120

million. These projects include: effectively communicating mammography results to underserved women; how differences in the ability to metabolize alcohol influence breast cancer risk; and how a woman's genetic makeup determines her response to treatment.

- The Society's Department of Epidemiology and Surveillance conducts studies of breast cancer, such as the relationship between obesity and breast cancer, and performs surveillance research to monitor long-term trends and statistics. The Behavioral Research Center, through its long-term study of cancer survivors, is studying the unmet needs of breast cancer survivors. The Statistics and Evaluation Center will analyze data provided from all components and from local American Cancer Society programs to ensure that results are evidence-based.

Advocacy

The American Cancer Society and its nonprofit, nonpartisan advocacy affiliate, the American Cancer Society Cancer Action NetworkSM (ACS CAN), are involved in advocacy efforts at both the federal and state levels that seek to increase access to quality breast cancer screenings, diagnostic services and treatment, and care for all women; increase government funding for breast cancer research; and be a voice for the concerns of breast cancer patients and survivors.

- ACS CAN works with state advocacy and media advocacy staff to ensure they have the most updated information, research, and news on federal cancer issues. ACS CAN organizes an annual National Lobby Day for Society volunteer advocates and staff in Washington, D.C. and schedules meetings for advocates with their Members of Congress or their staff. Additionally, the One Voice Against Cancer Coalition (OVAC) was established in 2000. OVAC is a coalition of nearly 40 cancer-related advocacy groups supporting cancer program funding at the National Cancer Institute, National Center on Minority Health and Health Disparities, National Institute of Health, Centers for Disease Control and Prevention, and Health Resources and Services Administration.
- State government relations and advocacy departments educate and mobilize state advocates to take action on policy issues at the local, state, and federal levels. Volunteers participate in organized one-on-one visits with lawmakers, special advocacy and media events, call-to-action issue alerts, and other modes of communicating to and with lawmakers, like letters to the editor to apply pressure on cancer issues such as state funding for the Breast and Cervical Cancer programs and Medicaid which provides treatment for women served through these programs.

Mr. PALLONE. Thank you, Dr. Brawley.
Ms. Luray.

STATEMENT OF JENNIFER LURAY

Ms. LURAY. Mr. Chairman and members of the Committee, thank you for the opportunity to testify today about the four breast cancer bills before your Committee. My name is Jennifer Luray and I am president of the Susan G. Komen for the Cure Advocacy Alliance and vice president of Government Affairs and Public Policy for Susan G. Komen for the Cure.

This year marks the 25th anniversary of National Breast Cancer Awareness Month. It is an opportunity to reflect on what we have accomplished and to work even harder to fight the war on breast cancer. Before the Nation celebrated breast cancer awareness, we practiced denial. We didn't talk about breast cancer, didn't understand it, did little to find out how to prevent and treat it. This was the world that Susan Komen lived in when she heard those dreaded words at age 33: "You have breast cancer." Her sister, Nancy Brinker, founded Susan G. Komen for the Cure, and a promise made between two sisters to end breast cancer forever has become the promise of millions. Thanks to events like the Race for the Cure, we have invested almost \$1.5 billion in cutting-edge research and community programs and have pledged another \$2 billion over the next decade. The Komen Advocacy Alliance, the sister organization that I am proud to lead, mobilizes a network of 250,000 advocates, men and women, at the State and national level to promote important policy change. Our promise is to leave few scientific opportunities or community needs untouched.

Yet, to make the most of these investments, we need to first empower women to be advocates for their own health, second, to expand access to health care, and third, to improve the quality of care that women receive, and we need the help of Congress to do that. That is why I am so pleased to be here today, because of these bills before the Committee helps us to move closer to these goals.

I will first discuss the Breast Cancer EARLY Act, H.R. 1740. The Komen motto is that information empowers women to be their own best advocates yet too many don't receive information about breast cancer until their doctor recommends their first mammogram at age 40, and that is just too late for information. Each year, 25,000 women in this country under age 45 are diagnosed with breast cancer, and sadly, almost 3,000 under age 45 will die. That is approximately 10 percent of all breast cancer diagnoses this year, certainly not a trivial number. A carefully targeted, evidence-based public health effort will inform young women and importantly their providers that unfortunately breast cancer does occur in young women. It will help women to establish good lifelong breast health habits like regular exercise and to be empowered to seek care when they suspect that something is wrong. It will also prevent fewer young women with breast cancer from being overlooked by the medical system and left undiagnosed until their disease is tragically advanced. We have had an outpouring of support from young women around the country for this bill. We are working with the bill's sponsor to ensure that funding for the EARLY Act won't come

from existing funds for the CDC's breast and cervical cancer program.

Let us now turn to the Breast Cancer Patient Protection Act, H.R. 1691. To be truly empowered, women also need to the ability to impact decisions. That is why the Komen Advocacy Alliance has consistently supported this bill by Representatives DeLauro and Barton. Decisions concerning a women's care after a complicated medical procedure should be made between the woman and her doctor and not dictated by an insurance company.

H.R. 995, the Mammogram and MRI Availability Act, introduced by Representative Nadler, brings us closer to the second goal I mentioned, which is expanding access to health care. At Komen, we believe that all women should have access to recommended screenings including cancer survivors who need follow-up testing and surveillance. Guidelines recommended by the American Cancer Society and the National Comprehensive Cancer Network state that women at high risk should receive annual screening mammograms and an MRI every year. Importantly, women undergoing screening tests should do so in conjunction with their doctor. When we talk about improving access to care, we mean quality care for all women, our third goal. So we commend Congresswoman Castor and Congresswoman Christensen for their attention to the issue of disparities in breast cancer. Low-income women should have access to the same quality care as higher-income women so that they can benefit from the same positive outcomes. Improving the quality of cancer care across income, race and ethnicity has long been a focus of Komen. We recently joined with the American Society of Clinical Oncologists to collect data that can be used for quality improvement. This type of data collection is needed for any performance or quality-based payment system.

In addition to these bills specific to breast cancer, we want to thank Congresswoman Capps for her leadership on two comprehensive cancer bills, one to revamp research and the other to improve care. The Komen Advocacy Alliance also strongly supports the insurance reforms in H.R. 3200 that would prevent patients from being denied coverage due to preexisting conditions, protect patients from high out-of-pocket costs and dramatically improve access to mammograms. Before Congress reconvened this fall, we asked our advocates to share their personal experiences. Nearly 60,000 women and men from around the country contacted their representatives. Their heart-wrenching stories call out the need for health care reform. Breast cancer patients turned down for insurance turn destitute after paying for their care and turn sicker because they couldn't afford screening or treatment.

In conclusion, I want to thank you again for the opportunity to testify before your Committee. As we mark the 25th anniversary of National Breast Cancer Awareness Month, we take a hard look at what we have accomplished and where we need to be. The stigma surrounding breast cancer in our country is largely gone, a fact that makes us the envy of women the world over. In the United States, more women are being screened and living longer as a result, and we have made progress on key scientific fronts. Yet, if we are one day to end the suffering and death from breast cancer, we must continue to make investments across the entire cancer spec-

trum to prevent and better detect and treat the disease, and we must always trust the women to be our partners in this fight. Information empowers women to be their best advocates.

We look forward to working with you and our partners in the cancer community as we continue this important race forward. Thank you, Mr. Chairman.

[The prepared statement of Ms. Luray follows:]



**U.S. House of Representatives
Committee on Energy & Commerce
Subcommittee on Health**

“H.R. 1740, The Breast Cancer Education And Awareness
Requires Learning Young Act Of 2009;
H.R. 1691, The Breast Cancer Patient Protection Act Of 2009;
H.R. 2279, The Eliminating Disparities In Breast Cancer Treatment Act Of 2009;
H.R. 995, The Mammogram and MRI Availability Act of 2009”

Testimony of
Jennifer M. Luray
President

Susan G. Komen for the Cure® Advocacy Alliance

Wednesday, October 7, 2009

Mr. Chairman, Mr. Ranking Member, and Members of the Committee, thank you for the opportunity to testify today about the four breast cancer bills before the committee and provide perspectives from the patient advocate community on other key legislation before your committee. My name is Jennifer Luray, and I am President of the Susan G. Komen for the Cure® Advocacy Alliance and Vice President of Government Affairs and Public Policy for Susan G. Komen for the Cure®. On behalf of the breast cancer patients, survivors, families, friends, researchers, scientists and advocates in the Komen family, thank you for holding this hearing.

Mr. Chairman, this month marks the 25th anniversary of National Breast Cancer Awareness Month. It provides an opportunity for us to reflect on how far we have come over the past two and a half decades and celebrate the great strides we have made in the fight against breast cancer. New discoveries, better screening, community investments and enhanced awareness have helped turned millions of cancer patients across the country into cancer survivors.

Yet while we celebrate our accomplishments, National Breast Cancer Awareness Month is also a reminder of how far we have to go. Almost 200,000 women will be diagnosed with breast cancer this year alone.¹ Sadly, despite all of our advances, we will still lose more than 40,000 of our mothers, sisters, daughters and friends to the disease.² And we still face racial, ethnic, geographic and socio-economic disparities in breast cancer, just as we do in health care across the board. These facts underscore why we must redouble our investment in science and research, and commit ourselves to delivering new discoveries — as well as existing technologies and treatments available today — to patients' bedsides as quickly and as safely as possible. While we invest in searching for the cures for tomorrow, we must not forget about the women and men being diagnosed with breast cancer today. It's about saving lives, and that, Mr. Chairman, is why we are here today.

¹ American Cancer Society, "Breast Cancer Facts & Figures 2009-2010." Available online at http://www.cancer.org/downloads/STT/F861009_final_9-08-09.pdf.

² Ibid.

About Susan G. Komen for the Cure and the Komen Advocacy Alliance

Susan G. Komen for the Cure began with a promise from Ambassador Nancy G. Brinker to her dying sister Suzy that she would do everything in her power to end breast cancer forever. In 1982, that promise became Susan G. Komen for the Cure and launched the global breast cancer movement.

Today, Komen for the Cure is the world's largest grassroots network of breast cancer survivors and activists fighting to save lives, empower people, ensure quality care for all and energize science to find the cures. Thanks to events like the Susan G. Komen Race for the Cure® Series, in our first 27 years, Komen has invested almost \$1.5 billion to fulfill our promise, becoming the largest source of nonprofit funds dedicated to the fight against breast cancer in the world. To continue this progress, Komen will invest another \$2 billion over the next decade into cutting-edge research and community programs.

The Komen Advocacy Alliance, a sister organization to Susan G. Komen for the Cure, is the nonpartisan voice for more than 2.5 million breast cancer survivors and the people who love them. The Alliance's mission is to translate the Komen promise to end breast cancer forever into action at all levels of government to discover and deliver the cures for cancer. With a network of more than 250,000 advocates, the Komen Advocacy Alliance promotes increased funding for cancer research and expanded access to cancer care services for all women.

Komen's goal is to reduce and one day eliminate suffering and death from cancer. To realize this goal, Komen promotes education and awareness to empower women to be advocates for their own health, and we invest in the tools to make it possible. Our investments span the entire continuum of cancer care — from cancer research to early detection to treatment to survivorship. We make significant grants to fund innovative community services, and advocate for improved access to high-quality cancer care and an increased commitment to the fight against breast cancer by the public and private sectors. We believe it is this three-pronged approach — research, community programs, and advocacy — that will make the biggest impact and the most progress toward our promise to end breast cancer forever.

Cancer Research. When Komen advocates for breast cancer research funding, it is as a full partner in the effort to discover and deliver the cures. Neither the federal government nor the private sector can accomplish this goal alone. Over the past three years alone, Komen for the Cure funded \$237 million in research grants to the best minds in cancer science all over the world, to take advantage of new breakthroughs and accelerate treatments for women with aggressive breast cancers that do not respond to current therapies. In fact, a Komen grant has touched every major breast cancer breakthrough in the past 25 years, including the basic discoveries in genetics and biology that have evolved into less invasive, personalized treatments for what was once a "one-treatment-fits-all" approach. In addition, Komen grants helped make possible:

- Discovery of the first breast cancer susceptibility gene (BRCA1), and a test for women to learn about their inherited risk. This has led to very early detection of breast cancer in some women and prevention in others.
- Understanding that breast cancer is not one disease — it is a collection of diseases, each with different characteristics that allow doctors to deliver tailored treatments that are more effective and involve fewer side effects.
- Insight into the role of hormonal factors in breast cancer risk, development and progression, leading to understanding of tamoxifen resistance, tools to identify women who are more likely to develop resistance, and development of new hormonal therapies such as aromatase inhibitors.
- Understanding the role of angiogenesis in providing the blood supply that allows cancer cells to continue to grow and leading to discovery of drugs like Avastin that kill cancer cells by starving them of their blood supply.

- Discovery of signaling pathways 'turned on' by the over-expression of HER2 receptors in some types of very aggressive breast cancers and the role of kinase inhibitors as potential therapeutic agents with fewer adverse effects than Herceptin.

Community Investment. Komen Affiliates operate in more than 120 communities across the country, and this year alone invested nearly \$160 million in their local communities to provide underserved populations with access to breast cancer education, screening and treatment. This includes community grants to more than 1,900 organizations that provide free or low-cost mammograms, as well as physical, emotional and financial support for breast cancer patients and survivors. Many Affiliates also fund treatment assistance programs that help breast cancer patients with day-to-day chores and provide monetary assistance with rent, utilities, and co-pays.

Public Policy and Advocacy. The Komen Advocacy Alliance directly engages policymakers and opinion leaders at the state and federal levels. This year, we opened a new office in Washington, DC and have expanded our presence in the nation's capital. Across the country, our Affiliates work to increase funding for state breast and cervical screening programs, expand access to Medicaid treatment for uninsured women diagnosed with breast and cervical cancer, require insurance companies to cover routine care costs for clinical trials, and require parity in the coverage of oral chemotherapy drugs, compared with intravenous therapy, among other legislative successes.

Breast Cancer Legislation

While we energize science to develop the early detection methods and new treatments that will save lives tomorrow, we must remember that millions of our friends and loved ones do not have access to the detection and treatment methods available today. To fully realize the potential of our investments since the first Breast Cancer Awareness Month 25 years ago, we must:

- **Empower Women** to be advocates for their own health;
- **Expand Access** to breast health services for all women; and
- **Improve the Quality of Care** through care coordination, addressing oncology workforce shortages and provider education.

Each of the pieces of legislation before the committee today will help move us closer to these goals.

The Breast Cancer EARLY Act (H.R. 1740 / S. 994)

The Komen Advocacy Alliance supports H.R. 1740, the Breast Cancer Education and Awareness Requires Learning Young Act of 2009, also known as the EARLY Act. The EARLY Act was originally introduced in the House in March 2009 by Reps. Debbie Wasserman Schultz (D-FL), Sue Myrick (R-NC), Donna Christensen (D-VI) and Rosa DeLauro (D-CT). In May 2009, a similar version was introduced in the U.S. Senate by Senators Amy Klobuchar (D-MN) and Olympia Snowe (R-ME). The EARLY Act will empower young women to take control of their breast health through:

- A carefully targeted public health campaign to teach young women that breast cancer can and does occur in young women, but more importantly to help them establish good lifelong breast health habits;
- An education campaign to increase awareness among health care providers that breast cancer occurs in young women and knowledge of the risk factors for breast cancer in young women; and
- Support services for young women with breast cancer.

The bill's sponsors have worked closely with our staff and scientific advisors, as well as others in the cancer community, to develop and enhance the language of their legislation. The Senate version of the bill reflects this ongoing conversation by increasing the targeted age to under age 45 and under,

emphasizing evidence-based messaging, and adherence to the peer-reviewed guidelines developed by the National Comprehensive Cancer Network (NCCN), an alliance of 21 of the world's leading cancer centers and the respected arbiter of high-quality cancer care.

Breast Cancer in Young Women. While it is relatively rare, young women do get breast cancer. Each year, more than 25,000 women in the U.S. under age 45 are diagnosed with breast cancer, and almost 3,000 women under age 45 will die of the disease.³ Breast cancer is the leading cause of cancer deaths in women under age 40.⁴ Breast cancer in young women tends to be a more aggressive disease and tends to be diagnosed at later stages than for older women. Younger women tend to be diagnosed with higher grade tumors, larger tumor sizes and a higher incidence of lymph node involvement — ultimately leading to lower survival rates.⁵ Here are a few stories of young survivors:

"I was a senior at Boston University when I first found a lump in my left breast in January 2005 and sought help. Without any follow up testing at all, my provider told me my lump was benign because I had no family history and I was too young. In May, a doctor finally took the lump seriously and ordered an ultrasound because it was practically protruding from my chest. On June 3, 2005 we found out that I had breast cancer. The next week, after a series of tests, we found out the cancer had traveled to my liver. Just two weeks after my college graduation, I found out I had Stage 4 breast cancer. The doctors have given me a 16% chance of seeing my 30th birthday.

"Not a day goes by when I don't wish that my provider had taken this lump more seriously. Not a day goes by when I don't wish I could get those five months back and perhaps change my diagnosis. In the past four years I have had three recurrences, four surgeries and dozens of biopsies. I have been in chemotherapy since my diagnosis in 2005. I live my life in three-month increments because every 3 months I get scans to see if my cancer is growing.

Cancer has touched literally every part of my life. That is what it means to be diagnosed late. That is what I wish I could undo by insisting upon a mammogram immediately. I wish I could tell every student in the US my story so no other young girl is diagnosed Stage 4. The EARLY Act does that for me." – Bridget, Boston MA

"At 25 years old, being diagnosed with breast cancer was the last thing on my mind. I knew that there would always be an increased risk for me because my mother had just been diagnosed three years earlier at age 50. So in my mind I said to myself, 'Oh...I have at least another 25 years to start worrying about it.' I couldn't have been more wrong.

"I moved to Texas in January of 2003. In October I saw a new doctor, who felt something in my breast on my first visit. What was most disturbing was the fact that my former doctor back home that I'd had for the past five or more years thought nothing of a lump in my breast and told me that it was fibrocystic tissue.

"Immediately my new doctor ordered a mammogram. I went the very next day and from there I was told they also wanted a sonogram. Everything was moving so quickly. Within a week I was referred to a breast surgeon who performed biopsies. My surgeon called me back within a few days and asked me to come to her office the next morning. She and I were both teary as she gave me my results and recommended a mastectomy and chemotherapy. The teamwork between my primary care physician, my surgeon and oncologist made my journey less taxing. I credit them with saving my life because what had been dismissed before as nothing could have

³ Number of women under age 45 who will be diagnosed with breast cancer in 2009 includes both invasive (18,640) and carcinoma in situ (6,460). American Cancer Society, "Breast Cancer Facts & Figures 2009-2010."

⁴ Ibid.

⁵ Anders, et al, "Young Age at Diagnosis Correlates with Worse Prognosis and Defines a Subset of Breast Cancers with Shared Patterns of Gene Expression", Journal of Clinical Oncology, Vol. 26, No. 20, July 10, 2008, 3324-3330.

claimed my life as it did my friend Kera who was diagnosed during my battle and died in her twenties just a few short years later.” – Crystal, Dallas, TX

Unfortunately, these stories about young women and breast cancer are not unique. They are repeated 25,000 times a year by women under age 45 who are diagnosed with breast cancer in the U.S. Many didn't know what signs to look for. Others, like Bridget and Crystal, have been told by their providers that they are too young to develop breast cancer, or given a false sense of hope by providers who are overlooking the possibility of breast cancer in a young woman. That is why the EARLY Act, with its focus on providing information for young women *and* their providers, is so important.

Education, Awareness and Empowerment. Ultimately, the cures for cancer will come from an increased investment and commitment to research by the government and private sector, and delivering those cures to patients as quickly and safely as possible. But a key component in reducing suffering and death from cancer, both in older and younger women, is a focus on education and awareness. The EARLY Act is intended to help fulfill that need by encouraging young women to know their specific risk factors, be more aware of changes in their bodies, know when to talk to their medical provider, know what questions to ask, and know what support is available for younger women with breast cancer. By sharing these messages in a carefully targeted, age-appropriate way that is soundly based on the science, we can empower women and provide them with the tools to be advocates for their own health.

Messages directed toward a young population to raise awareness and knowledge about breast health must be done in a careful, responsible manner. That is why the EARLY Act puts the evidence-based education campaign in the hands of experts. The EARLY Act directs the Centers for Disease Control and Prevention to base its outreach to young women on the recommendations of an advisory committee of breast cancer experts, and specifically calls for the messaging to be based on the NCCN guidelines. Thus, as the science evolves — and new evidence-based methods are developed — so, too, will the messaging.

We may not have all the answers, but we have learned much about specific risk factors and early warning signs of breast cancer, and we should share what we know. We are learning, for example, that breast cancer tends to be more aggressive in younger women, and that aggressive types of breast cancer are more common in certain subpopulations like certain African American women. And we know that certain women have increased risk, including women with a strong history of breast cancer at an early age; a family history of breast and ovarian cancers; a family history of male breast cancer; or Ashkenazi Jewish heritage and also have some family history of breast or ovarian cancer.

Since the EARLY Act was introduced, we have seen an outpouring of support from our grassroots network and the young women we serve. They appreciate the attention to this important group of patients that all too often is overlooked by the health care system and the advocacy community. Further, the Komen Advocacy Alliance partnered with the Young Survival Coalition, Living Beyond Breast Cancer and the Breast Cancer Network of Strength to issue a joint statement in support of the EARLY Act. The joint statement is available online at www.KomenAdvocacy.org/EarlyAct. I respectfully request that the report be entered into the record.

While the Komen Advocacy Alliance firmly supports the EARLY Act, we also want to ensure that the funding for this initiative does not detract from existing programs, in particular the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), which serves uninsured and under-insured women. We know that Congresswoman Wasserman Schultz supports the NBCCEDP and appreciate her commitment to ensure that funding for this important program will not be reduced.

Breast Cancer Patient Protection Act of 2009 (H.R. 1691)

The Komen Advocacy Alliance has consistently supported the “Breast Cancer Patient Protection Act of 2009” introduced by Reps. Rosa DeLauro (D-CT) and Joe Barton (R-TX). The Act would amend the Employee Retirement Income Security Act of 1974 to require coverage for a minimum hospital stay

for mastectomies, lumpectomies, and lymph node dissections for the treatment of breast cancer and coverage for secondary consultations.

Decisions concerning a patient's care, including the length of a hospital stay subsequent to mastectomy, lumpectomy or lymph node dissection for the treatment of breast cancer, should be made jointly by the patient and her doctor — not by her insurance company. We are committed to ensuring all Americans have access to affordable, high-quality health care, and we encourage patients to talk with their doctors about all treatment decisions, including the length of any hospital stay.

Mammogram and MRI Availability Act of 2009 (H.R.995)

The "Mammogram and MRI Availability Act," introduced by Rep. Jerrold Nadler (D-NY), requires group health plans that provide coverage for diagnostic mammography for women age 40 years and older to also provide no-less-favorable coverage for annual screening mammography for women age 40 and older. It also requires group health plans and individual health plans to cover annual screening mammography and annual MRIs for any "high risk" woman. A screening mammogram is performed on a woman with no signs or symptoms of breast cancer, while a diagnostic mammogram is performed to evaluate a breast problem.

The bill is consistent with guidelines recommended by Komen for the Cure, American Cancer Society and NCCN that women at high risk receive annual mammograms and an MRI every year and that women at moderately increased risk should talk with their health care providers about the benefits and limitations of MRIs.

About 80 to 90 percent of breast cancers in women without symptoms in the U.S. will be detected by mammography.⁶ Yet, only 51.2 percent of women 40 and older in the U.S. reported having a mammogram in the last year.⁷ Recent studies suggest that many women in the U.S. are getting their first mammogram later than recommended, not having mammograms at recommended intervals or not receiving appropriate and timely follow-up of positive screening results.⁸ This may lead to more advanced tumor size and stage at diagnosis.

The Komen Advocacy Alliance believes all women should have access to recommended screenings. We have promoted this by seeking increased funding for programs that provide screening for underserved women like the NBCCEDP, advocating for patient protections in the House and Senate health care bills that will increase access to early detection services and addressing other gaps that infringe on access to quality care. Further, the Komen Advocacy Alliance believes that women should have access to the appropriate diagnostic tests, including cancer survivors who need follow-up testing and surveillance.

"I found a lump on the day of my daughter's first birthday – April 2007 – and immediately went to my OBGyn. I was just 36 years old. I have no family history and eventually was tested for the BRCA gene, which I don't carry. It came out of nowhere. I had two biopsies which showed the cancer was pretty much all over my left breast.

"Navigating the health care system was overwhelming. Anyone in cancer treatment should never have to deal with front line customer service representatives at health insurance companies. I repeatedly worked my insurance company over until I was assigned a dedicated person in claims who ended up being a saving grace. As a cancer patient, you have so many doctors and bills you have to coordinate you just have to be able to work with someone internally who is well educated about the claims process.

⁶ American Cancer Society, "Breast Cancer Facts & Figures 2009-2010."

⁷ American Cancer Society, "Cancer Prevention and Early Detection Facts and Figures 2009." Available online at http://www.cancer.org/downloads/STT/CPED_2009.pdf.

⁸ Ibid.

"This year my husband changed jobs and we began with a new insurance company. My first horror story with them was that they flat out denied – even on appeal – a breast screening MRI that my oncologist wanted me to have. When I called and spoke with front line customer service reps, they could not even tell me why the test was denied or what to do to get it approved. It was a rough week. Ironically, that day the front page of The Washington Post featured a story about how health insurance companies were cutting costs and it was the patients that would suffer as a result. To make a long story short, I finally found the right person at my insurance company and was able to get the MRI." – Anna, McLean, VA

Eliminating Disparities in Breast Cancer Treatment Act of 2009 (H.R.2279)

The "Eliminating Disparities in Breast Cancer Treatment Act" by Rep. Kathy Castor (D-FL) amends the Social Security Act to establish a breast cancer treatment quality system in coordination with the National Quality Forum that would develop quality measures for breast cancer treatment by health care providers, with a focus on improving outcomes for underserved women. It also would institute a pay-for-performance payment system within Medicare by 2012 that would reward providers for performance against the new quality measures.

We commend Congresswoman Castor for her attention to the important issue of disparities in breast cancer. We know that there are disparities in access to breast cancer care and breast cancer survival rates: African American women have a 37 percent higher rate of mortality from breast cancer than white women, despite having an overall lower level of incidence of breast cancer.⁹ Improving the quality of cancer care and ensuring access to high-quality care has been a focus at Komen for some time.

An example of Komen's commitment to reducing disparities by improving quality measures is our partnership with the Metropolitan Chicago Breast Cancer Task Force, which was formed in response to the growing disparity in breast cancer mortality rates between African-Americans and whites in Chicago. The mortality rate for African Americans in Chicago is 68 percent higher than for whites.¹⁰ The Task Force developed action plans that would address three probable causes of the disparity: 1) inadequate access to mammography; 2) poor quality of mammography; and 3) inadequate access to and poor quality of treatment. In June 2008, Komen invested \$1 million toward the creation and ongoing work of the Chicago Breast Cancer Quality Consortium, which will coordinate the collection and sharing of breast cancer quality data; provide rapid cycle improvement support to institutions whose quality of care falls short of the Consortium guidelines; and help coordinate timely breast cancer care for women in need. The Consortium will reduce disparities in breast cancer mortality by instituting breast cancer screening and treatment quality metrics and systems for follow-up care. The important work being done in Chicago illustrates the essential role of quality care in reducing disparities in outcomes for underserved women and parallels the intent of H.R. 2279.

Further, Komen recently joined with the American Society of Clinical Oncologists on a "Quality of Care Initiative" that will address quality issues including cancer workforce issues, access to care, disparities, clinical trials and survivorship, with a focus on breast cancer.¹¹ The initiative will enhance coordination of patient care between oncologists and other practitioners to improve efficiency and patient care. It will also collect data in a breast cancer registry that can be used for practice-based quality improvement. Currently there is no registry that specifically targets outpatient medical oncology care, where about 85 percent of cancer care is delivered. This type of data collection is a fundamental requirement for any performance- or quality-based payment system.

⁹ American Cancer Society, "Cancer Facts & Figures for African Americans 2009-2010." Available online at http://www.cancer.org/downloads/STT/cffaa_2009-2010.pdf.

¹⁰ Hirschman J, Whitman S, Ansell D. The Black:White disparity in breast cancer mortality. The example of Chicago. *Cancer Causes Control* 2007; 18:323-333.

¹¹ More information about the Quality of Care Initiative" is available online at <http://www.ascocancerfoundation.org/TACF/Our+Donors+and+Supporters/Susan+G.+Komen+for+the+Cure-ASCO+Cancer+Foundation+Collaborative+Commitment>.

Other Issues before the Energy & Commerce Committee

America's Affordable Health Choices Act (H.R. 3200)

The Komen Advocacy Alliance believes all cancer patients deserve access to affordable, high-quality health care. Unfortunately, in today's health care system, not every patient is able to get the care they need. Congress must *consider cancer* as they debate proposals to reform the nation's health care system. Our primary focus is on reforms that will directly affect cancer patients and survivors. As such, the Komen Advocacy Alliance supports insurance reforms in H.R. 3200 that would increase access to affordable health insurance for all, prevent insurance companies from denying coverage due to pre-existing conditions such as cancer, protect patients from high out-of-pocket costs, and increase access to early detection services.

During the August Congressional recess, we asked our network of more than 250,000 advocates to vote on their priorities for health reform and to share their personal experiences with the health care system. Nearly 60,000 Komen advocates have shared these priorities with Congress. Below is an analysis of how H.R. 3200 would address some of the concerns and challenges faced by cancer patients and survivors as they navigate the current health care system.

Access to Affordable Health Insurance. 46 million Americans lack health insurance, and that number is climbing.¹² Many are a pink slip or major medical diagnosis away from losing their health insurance. For example, a cancer patient in treatment who needs to reduce hours or leave a job may lose his/her insurance. Lack of adequate health insurance means lower screening rates, more advanced cancer at diagnosis and lower chances of survival. Patients with private insurance are more likely to be diagnosed at earlier stages, and are more likely to survive at all stages of diagnosis than the uninsured. Cancer patients who are uninsured — and those who were Medicaid-insured at time of diagnosis — are 60 percent more likely to die in 5 years than those with private insurance.¹³

H.R. 3200 will help provide affordable access to insurance through a variety of mechanisms. It would prohibit insurers from excluding patients or charging higher premiums for pre-existing conditions, restrict insurers from charging higher premiums or dropping coverage based on health status, create Health Insurance Exchanges through which individuals and small employers can purchase coverage, and provide credits to help individuals and families up to 400 percent of the federal poverty purchase health insurance. It would also expand Medicaid to 133 percent of the poverty level. These provisions will make health insurance easier to purchase and more affordable. Guaranteed access to affordable health insurance will make cancer care more accessible for all.

"I am a six-year anal cancer survivor. My outstanding medical bills are well over \$100,000. I have no insurance and have applied for every program that I know of for assistance. According to every program, I do not qualify for any assistance. I can't even get disability, so I am dependant on my husband's minimal fixed income. The cancer treatment I got saved my life but left my quality of life less than tolerable...We are stuck in a hole from which there is no escape." — Marcia, Johnson City, TN

Exclusion of Coverage for Preexisting Conditions. Cancer survivors face tremendous hurdles when they try to buy health insurance, because their cancer is defined by insurance companies as a pre-existing condition. Cancer patients or survivors may experience "job lock," in which they cannot leave their current job for fear of losing their health insurance. Even cancer survivors who have been in remission for years with a good long-term prognosis have trouble finding coverage in the individual market because of medical underwriting and the existence of their pre-existing condition.

¹² U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2008," September 2009. Available online: <http://www.census.gov/prod/2009pubs/p60-236.pdf>.

¹³ Elizabeth Ward, et al., "Association of Insurance with Cancer Care Utilization and Outcomes," *CA: A Cancer Journal for Clinicians*, Vol. 58, No. 1, January/February 2008, p.9-31.

H.R. 3200 prohibits health insurers from excluding patients or charging higher premiums for pre-existing conditions. As a temporary measure, until the pre-existing conditions provisions are effective, it also provides for a reduction in the pre-existing condition "look-back" period. Elimination of pre-existing condition exclusions is essential for cancer patients and survivors - people who have battled cancer should not have to battle health insurance companies to find affordable health insurance.

"I am a breast cancer survivor...twice. I have been dealing with it for three long years. We pay \$1,900 per month for insurance on a COBRA plan because no one else will take me on a policy. This is so unfair to add to what a family already deals with when dealt a cancer diagnosis! It affects every family member, emotionally, physically, and financially. The cancer patient takes on all of that burden on top of their own fears and guilt. We are fighting for our lives and need all the strength we can muster up. You lose your hair, your breasts, your eyebrows and your eyelashes. Give us some sense of hope that on top of it we are not bankrupting our families in the process."
— Karen, Irvine, CA

"My husband's job was down-sized primarily because of our high cost of medical care due to my breast cancer. The jobs of everyone who had high medical expenses were down-sized. Once the COBRA insurance expired, I was unable to get insurance due to PREVIOUS MEDICAL CONDITIONS. I was finally able to get insurance through the state insurance but [it] was extremely expensive. I had to work two jobs just to pay for the coverage—a lot of stress for someone recovering from radiation & chemo. NO ONE should have to face this!!!" — Stella, Collinsville, IL

Protection from High Out-of-Pocket Costs. Cancer patients with health insurance are not always protected from high out-of-pocket costs, requiring them to deplete their savings or incur thousands of dollars in medical debt. Many health insurance policies have annual and lifetime caps on benefits or other limitations and exclusions. Patients may be exposed to large out-of-pocket expenditures because cancer treatments can be very expensive — some therapies run hundreds of thousands of dollars a year and may require extensive and long-term monitoring and follow up.

The financial impact on patients and their families can be disastrous. A recent study by Harvard University found that half of all bankruptcy filings were partly the result of medical expenses, and 68 percent of those who filed for bankruptcy had health insurance.¹⁴ Further, a national survey commissioned by the American Cancer Society Cancer Action Network shows one in five cancer patients has significantly or completely depleted their savings because of medical costs — one in seven has incurred thousands of dollars in medical debt.¹⁵

Under H.R. 3200, patients will have protections from exorbitant out-of-pocket costs, deductibles and co-pays, with limits of \$5,000 per individual and \$10,000 per family. The bill also prohibits insurance companies from establishing annual or lifetime benefit limits. These measures will help ensure that a cancer diagnosis does not lead to financial ruin.

"I am 60 years old, retired and paying for my own insurance. I have a maximum out-of-pocket of \$14,000 per year. I chose a high deductible because I couldn't afford anything else. This year I was diagnosed with bilateral breast cancer and already owe \$18,000. It is ironic how 'maximum out-of-pocket' does not include co-pays. My treatment plan will extend into next year so I will again incur at least \$15,000. I have no prescription coverage and need to take a cancer drug for five years which cost \$400/month. That is another \$4,800 every year. This is devastating to me."

¹⁴ Himmelstein, et al., "Illness and Injury as Contributors to Bankruptcy," Health Affairs Web Exclusive, w563, February 2, 2005.

¹⁵ Lake Research Partners and American Viewport conducted the survey, which was sponsored by the American Cancer Society Cancer Action Network, May 1 through 11, 2009, among a national sample of 1,057 adults age 18 and older, in households with cancer or a history of cancer. Available online: <http://www.acscan.org/pdf/healthcare/reports/poll-05202009.pdf>.

I worked hard all of my life and lived a healthy and active lifestyle. Now with one diagnosis, my life is turned upside down. — Mary, Asheville NC

Early Detection & Prevention Services. Early detection is the key to survival. For example, when breast cancer is detected early, the 5-year relative survival rate is 98 percent, but declines to 84 percent for regional disease and 23 percent when cancer has metastasized or spread to other parts of the body.¹⁶ Women who are uninsured or underinsured are more likely to skip potentially life-saving cancer screenings. In fact, a recent study by the Government Accountability Office reveals that the NBCCEDP only screens about 15 percent of eligible women, while about 26 percent of eligible women are screened by other providers, such as free clinics and mobile vans, some of which are funded by Komen Affiliates. Unfortunately, these resources are limited and often not available in rural or other underserved areas. Shockingly, 60 percent of eligible women do not receive recommended breast cancer screening from any provider¹⁷ – a disturbing revelation that is much higher than previously understood and underscores the need for access to affordable insurance. And for women who do have insurance, even a small co-payment can significantly reduce mammography rates.¹⁸

A renewed focus on prevention and early detection will save lives. H.R. 3200 will improve prevention by covering preventive services in Medicare and Medicaid, eliminating cost-sharing for preventive services, and increasing Medicare payments for certain preventive services. Women who cannot get a mammogram today because they lack insurance or cannot afford co-pays will now have improved access to these services.

"I lost my grandmother to cancer in 1994. She went without insurance for several years before her Medicare kicked in. As a direct result, her cancer went undetected and untreated. When doctors at University Hospital in St. Louis made the diagnosis, we were told that even with radical radiation and chemotherapy that her chances of survival were slim. The doctors said that if she had been seen sooner, that the outcome could be quite different. She passed away 15 months later. Even after 14 years, her passing still affects my life. She was my guardian while growing up and later became my mentor. I still miss her. Because she did not have access to affordable health care, my life was robbed of her joy too soon. NO FAMILY SHOULD HAVE TO GO THROUGH THIS!" — Tina, Santa Fe, TX

H.R. 3200, the America's Affordable Health Choices Act, addresses many important priorities. However, there are two additional issues that should be included in the House health reform bill: extending access to patient navigation services to help guide patients through the complex health care system, and ensuring access to clinical trials.

Patient Navigation. Navigating the complex health care system can be an insurmountable task for patients facing a complicated or chronic disease, especially if they are underserved, have a lower level of medical literacy, or do not speak or read English well. Patient navigators are trained to serve as personal guides and help people overcome obstacles to receiving timely cancer treatment and care. Patient navigation is a proven concept that is cost-effective, promotes prevention, saves lives, and addresses health disparities. This provision is in the bill reported out of the Senate Health Education Labor and Pensions. We respectfully request that the Committee reauthorize and fully fund the Patient Navigator Outreach and Chronic Disease Prevention Act of 2005 (PL 109-18) for five years, FY2011 through FY2015. Current authorization expires at the end of FY2010.

¹⁶ American Cancer Society, "Breast Cancer Facts & Figures, 2009-2010."

¹⁷ Government Accountability Office, "MEDICAID: Source of Screening Affects Women's Eligibility for Coverage of Breast and Cervical Cancer Treatment in Some States," May 2009. Available online at <http://www.gao.gov/new.items/d093384.pdf>.

¹⁸ Amal N. Trivedi, et al., "Effect of Cost Sharing on Screening Mammography in Medicare Health Plans," *The New England Journal of Medicine*, Vol. 358, January 24, 2008, pp. 375-383. (Available online: <http://content.nejm.org/cgi/content/full/358/4/375>). The study examined 174 Medicare managed-care plans from 2001 through 2004, which included 550,082 individual-level observations for 366,475 women between the ages of 65 and 69 years.

"Due to cultural and language barriers, not to mention the complexity of our health care system, many are having a terrible time navigating the road between their doctors, oncologists and providers. It's not right that some of us have access to the most cutting edge treatments, while others are shut out and left mired in a web of confusion. We must ensure all women have access to patient navigators, and are aware of and have access to clinical trials." — Maria, El Paso, TX

Access to Clinical Trials. Each year, thousands of people gain access to the highest-quality cancer care and receive new treatments before they are widely available by participating in a clinical trial. Millions more benefit from the findings. Yet, while more than 1.4 million Americans are diagnosed with cancer each year, fewer than 5 percent will participate in an approved clinical trial.¹⁹ Some health insurance companies do not cover routine medical care expenses for patients enrolled in approved clinical trials, or refuse to cover complications that sometimes occur during the course of an approved clinical trial. Failure to cover these items may mean otherwise-eligible people are turned away, or are exposed to high out-of-pocket costs when they encounter complications.

The Cancer Clinical Trials Act of 2009 (H.R. 716/S.488) would require group health plans and health insurance providers to cover routine patient care costs for individuals enrolled in clinical trials. The Act would remove a large barrier to patient participation and provide access to many more people. The Komen Advocacy Alliance supports the Access to Cancer Clinical Trials Act of 2009 and respectfully requests that access to clinical trials be included in H.R. 3200.

"A clinical trial saved my life. I had stage 2B cancer and went on a trial to receive Herceptin. I am convinced that the drug saved my life. It should not be so rare that people take part in these trials. We need to educate the public on the benefits of clinical trials, and make it easier for them to have access to trials. I am LIVING proof that it not only will help us find a cure sooner, it can save lives." — Sharon, Roanoke, VA

These are the stories of real people with cancer who faced real problems with the health care system as it is today. We urge you, as Members of the Energy & Commerce Committee, to ensure that the final bill includes all of these provisions to protect patients and improve care.

21st Century ALERT Act (S. 717)

Finally, Komen would like to remind the Committee that while the bills discussed today are enormously important, the cancer research and care enterprise must be addressed. We are facing a crisis in our investment in prevention and early detection of cancers; in our dedication to innovative cancer research; and in patient access to the highest quality cancer care and treatment. During our Komen Community Challenge tour, a nationwide year-long campaign designed to bring communities and policymakers together to close the gaps in access to care, we heard firsthand from patients, family members, and lawmakers just how severe this cancer crisis is.

The impact of cancer on the lives of ordinary citizens is extraordinary, but often unimaginable to those who have not lived through it. We applaud the late Senator Edward Kennedy and Senators Kay Bailey Hutchison and Dianne Feinstein for their introduction of the 21st Century Cancer ALERT Act (S. 717) last spring. This bill enjoys the support of many members of the cancer community and is critical to addressing the cancer crises. Among other things, the bill would make significant investments in early detection of cancer, facilitate translational and clinical cancer research and improve patient access to high quality cancer care. We know that Rep. Lois Capps and other members have been working on a companion bill to be introduced in the House, and we look forward to working with Congresswoman Capps and the committee on this important legislation.

With the mapping of the human genome and the availability of new medical technologies, there is much potential for new, personalized medicines that are targeted to individual patients and individual

¹⁹ American Cancer Society.

tumors with a reduced risk of side effects. We need more research on early detection and promoting the discovery and development of biomarkers so breast cancers — and all cancers for that matter — can be detected at the earliest possible stage, when cancer is most treatable.

We must remember that many cancers still do not have effective early detection methods. Ovarian cancer is a particularly devastating example: There is no screening diagnostic, thus a diagnosis is most often made after the cancer has spread. When ovarian cancer is detected locally, the survival rate is 93 percent; however, only 1 in 5 cases are detected at this stage, dropping the overall five-year survival rate to only 46 percent.²⁰ Mortality rates are even more disturbing for lung and pancreatic cancers. This has to change.

While health reform should continue to be the Committee's first priority, upon its completion, we urge you to turn your full attention to the Cancer ALERT Act. Despite a few highly-successful cancer therapies, the fundamental goal of the "War on Cancer" launched in the 1970s—to diminish death and suffering—remains largely unrealized. Indeed, cancer now exceeds heart disease as the leading cause of death among people under 85 years old.²¹ The Cancer ALERT Act could change this for the better, and we look forward to working with you on this important legislation.

Comprehensive Cancer Care Improvement Act (H.R. 1844)

The Komen Advocacy Alliance also supports the "Comprehensive Cancer Care Improvement Act" (H.R. 1844), introduced by Reps. Lois Capps and Charles Boustany, as we have in previous Congresses. The Act would provide coverage for comprehensive cancer care planning services within Medicare and will make strides toward a cancer care system that coordinates all levels of care. Cancer patients should have a coordinated plan for treatment and follow-up from the time they are diagnosed through the years of their survivorship. A written cancer plan and the opportunity to review it in person with their doctor will better enable cancer patients to understand the process ahead, monitor their own health, and participate in decisions about their care. Further, a written plan will help coordinate care among a patient's many doctors and providers, reduce medical errors, and ultimately improve patient care.

"I was living in New Orleans when I was diagnosed with breast cancer in 2005. My treatment included six months of chemotherapy to shrink my tumor before having surgery to remove it. After that, my doctors found there was still more cancer in my body, which meant they had to operate again. My second surgery was on Friday August 26, 2005. Three days later, Hurricane Katrina washed away everything in New Orleans — including the results of my last surgery and my doctor's instructions for my follow-up treatment.

"You may not think there was anything fortunate in that story, but let me tell you how lucky I was. Somehow, even as the water rose and people came to rescue us in canoes, I knew I should grab the record I had of my treatment and surgeries. I tell people that I spent seven days with no underwear, but I had my pathology report!

"Like thousands of other Katrina survivors, my family and I lived in the Cajundome in Lafayette, Louisiana for three months. It was there that medical personnel interviewed me and got me to a medical team that would figure out my care from that point forward. Surviving a natural disaster that wiped away my records is an extreme situation. Unfortunately, it is not very different from the confusion that other cancer survivors experience in everyday life.

"When you have cancer, you suddenly have several doctors caring for you through different stages of treatment. One doctor performs your surgery. Another gives radiation. And then there's

²⁰ American Cancer Society "Cancer Facts & Figures 2009." Available online at <http://www.cancer.org/downloads/STT/500809web.pdf>

²¹ Ahmedin Jemal, et al., "Cancer Statistics, 2009," CA: A Cancer Journal for Clinicians," Vol. 59, No.4, July/August 2009. Available online at <http://caonline.amcancersoc.org/cgi/content/full/59/4/225>.

chemotherapy, which is usually prescribed by an oncologist and given to you by a nurse. Others draw blood and perform scans. If you're lucky, you also have a social worker helping you through all this while you try to carry on with your family and keep your job. If you have other health issues – such as diabetes, high blood pressure, kidney disease or lung failure – all those doctors need to understand your cancer and the effects of its treatment.

"But guess what? The system does not have a way to coordinate all that. Cancer survivors usually have to figure out a lot of new and scary issues on their own. They have to do it while they are feeling sick, stressed out and scared. And they have to do it quickly.

"Patients need to talk to their doctors about their cancer care plans before they start their treatments, and doctors should give their patients a paper copy of that plan. It is hard to hear anything after, 'You have cancer.' And then you have a lot of things to learn and a lot of decisions to make – a lot of things to talk over with your family. A written plan would have helped me, and I know it would help many other survivors.

"And when survivors like me finish their therapies, they should be given something on paper that describes all of their treatments, the possible side effects, what they should do to monitor their health and who will be following up on their care. There's so much to remember- no one can possibly keep it all in their head." Patricia, New Orleans, LA

Conclusion

Thank you, again, for the opportunity to testify before this committee. As we observe the 25th anniversary of National Breast Cancer Awareness Month, we should take the time to reflect on the last two and a half decades — the accomplishments, the triumphs, the losses. We should take the time to think about the daunting challenges that lie ahead of us over the next 25 years. If we are to help alleviate and one day hopefully end suffering and death from cancer, we will have to commit ourselves to an increased investment across the cancer continuum, in research, early detection and treatment — and make a commitment to enhancing community resources and promoting education and awareness. We look forward to working with you, the other organizations represented on this panel, and our partners in the cancer community to reignite our efforts in the fight against cancer. Thank you.

Mr. PALLONE. Thank you.
Ms. Ness.

STATEMENT OF DEBRA L. NESS

Ms. NESS. Good afternoon, Chairman Pallone, members of the Subcommittee. Thank you for this opportunity to testify.

The National Partnership for Women and Families is a nonprofit, nonpartisan organization with more than three and a half decades of experience working on issues important to women and families. Over the years we have brought together a wide range of consumer voices to push for health reform that would expand affordable coverage, help us get costs under control, improve quality and reduce disparities. We are very pleased to support the efforts of this Subcommittee to enact comprehensive health reform this year. This is truly a historic moment. For the first time in decades, Congress is poised to enact comprehensive reform that would vastly improve the lives and well-being of America's women and families.

We are pleased to endorse H.R. 3200 for many reasons. It provides meaningful financial assistance to help low- and moderate-income families purchase insurance. It ensures adequate coverage and scope of benefits. It creates a health insurance exchange with strong patient protections. It prevents insurers from denying or dropping people from coverage because of their health status or raising rates based on gender. Very importantly, it charts a pathway for real delivery system reform. This pathway is key to ensuring that the reforms we enact today are meaningful and sustainable for the long haul. I believe H.R. 3200 lays the groundwork for a system that over time will deliver better care to patients and enable us to get more value for our health care dollars. It does this by shoring up primary care and encouraging better coordination through new payment models and it creates the necessary foundation for those models through things like comparative effectiveness research, workforce development, better data collection and quality measures and improvements.

It is the development and use of quality measures that I want to particularly focus on today, not just for breast cancer care but for our system as whole. The use of measures to generate performance information about provider performance is critical to getting us to a system that at some point delivers on the promise of the right care to the right patients at the right time for the right reasons. Without measurements, we can't know if the new models we are putting in place are actually resulting in better patient care. We can't assess whether we are really eliminating disparities. Without measurement, we can't tell if we are using our health care dollars effectively. We can't transition to a system that is based on value rather than volume. Without good measures and good measurement and the quality improvement that they enable, we simply cannot achieve the high-quality, effective and equitable care that patients need and deserve.

Congresswoman Castor, you have clearly recognized the importance of measurement in your bill, H.R. 2279, and we applaud your commitment and leadership on women's health issues. We share your goals of rewarding value over volume, of incentivizing quality, of improving the patient's experience of care and eliminating dis-

parities, and we particularly appreciate the provisions of your bill that move us toward quality measurement and public reporting at the individual provider level and that help us begin to align our payment system so that we have incentives that encourage better quality and practice that lives up to the best standards of care. These elements are essential to building a more effective delivery system and they should be integral not just to care for breast cancer but to the broader reforms that we all seek. We stand ready to work with you and your colleagues to implement a pathway for these reforms but we also urge that we do this in a way that benefits all patients no matter what their condition or diagnosis and in ways that are going to generate accountability for all providers across all settings. It is this vision that led the national partnership to work with the Stand For Quality Coalition, which is a broad group of about 200 health care stakeholders that include consumers, purchasers and providers to issue a set of recommendations that are now largely embodied in H.R. 3200. These recommendations call for a national comprehensive strategy that includes setting priorities for quality improvement and measurement, developing good measures and then endorsing and maintaining those measures as national standards, collecting and analyzing measurement data and then using that data for quality improvement, for public reporting and for payment. This broad coalition of stakeholders also called for a multi-stakeholder consultative process to provide input and make recommendations so that the implementation of this strategy would engage in reflective perspectives of all of us who have a stake in health care.

So in closing, I want to say how pleased we are that H.R. 3200 has incorporated these recommendations and I thank the members of this Subcommittee for their leadership in recognizing that a comprehensive quality strategy is the critical foundation for health reform that is meaningful, equitable and sustainable over the long term. Thank you.

[The prepared statement of Ms. Ness follows:]



Statement of Debra L. Ness
President, National Partnership for Women & Families
House Committee on Energy & Commerce
Subcommittee on Health
Hearing on H.R. 1740, 1691, 2279, and 995
October 7, 2009

Chairman Pallone, Ranking Member Deal, and members of the Subcommittee on Health, thank you for the opportunity to participate in this hearing regarding the prevention and treatment of breast cancer.

The National Partnership for Women & Families is a non-profit, non-partisan advocacy organization with over three and a half decades of experience promoting access to quality health care, fairness in the workplace, and policies that help women and men meet the dual demands of work and family. Over the past 15 years, the National Partnership has brought together a wide range of consumer and patient groups to push for meaningful reforms of our health care system -- focusing on improving quality, getting costs under control and expanding affordable coverage. We are pleased to support the efforts of this Subcommittee and others in Congress to enact comprehensive health care reform this year.

Health care reform is essential to the well-being of women and families, and the long-term economic vitality of our nation. For women, health care reform must include:

- *Affordable and adequate coverage.* The high cost of health care is a huge problem for women, who are more likely to need and use services but often have less ability to pay.
- *Meaningful choices.* Today, far too many women face no or limited choice of insurance coverage.
- *Strong market protections.* Insurance companies can turn women away because of their health status, raise rates simply because of their gender, drop coverage if they get sick, and delay or deny essential care.
- *Quality health care.* Today's health care system is largely blind to quality, outcomes, or the appropriateness of the care delivered and received. Women and people of color tend to receive lower quality health care. (And as Ms. Castor has so eloquently pointed out, this is particularly true with breast cancer treatment, in which it has been found that African-American women are more likely to receive substandard care after a breast cancer diagnosis than White women. Further, substantial disparities exist regarding diagnosis and treatment for all cancers). In addition, women who serve as caregivers, either of young children or aging parents, face a system incapable of providing adequate coordination, continuity or quality care.

This is a historic moment – a moment of great opportunity. For the first time in decades, Congress is poised to enact comprehensive reform that would vastly improve the lives and well-being of America’s women and families. We thank this Subcommittee for its leadership and commitment to reform, and are pleased to endorse H.R. 3200, “America’s Affordable Health Choices Act of 2009”, because it:

- Provides meaningful financial assistance to help low- and middle-income families purchase coverage.
- Ensures that insurance policies provide adequate coverage and a broad scope of benefits, consistent with medical evidence.
- Creates a health insurance exchange with strong patient protections, fostering a transparent marketplace where insurers compete for enrollees based on the quality and cost of their benefit packages.
- Sets a federal floor of insurance market protections so that no insurer can deny or drop people from coverage because of their health status or pre-existing conditions, or raise rates based on gender or health status. We also strongly support the provisions that would ban lifetime and annual caps on coverage, which can put a devastating financial burden on people with serious illness or chronic conditions.
- Charts a pathway for real delivery system reform. While it may not get the headlines, one of the most important things H.R. 3200 does is establish new and better incentives for a health care system in which patients receive the right care, at the right time, and for the right reason, and we make better use of and get more value for our health care dollars.

H.R. 3200 helps to shore up primary care for patients, encourages better care coordination through new payment models such as bundling, accountable care organizations, and medical homes, and supports these new payment models with comparative effectiveness research, workforce development, better data collection and quality measurement and improvement.

It is the development and use of quality measures that I am here today to discuss, for breast cancer care and for our system as a whole. The assessment of provider performance and the use of measures to generate better accountability are critical to the delivery system reforms outlined in H.R. 3200. Without the right measures and measurement, we can’t know if we are delivering better quality or more patient-centered care; we can’t tell if we are using our health care dollars effectively, and we can’t transition to value- as opposed to volume- based payment. Without good measurement, we can’t assess and eliminate disparities, and we can’t tell whether new payment models like ACOs, medical homes, or bundled payment are resulting in better care for patients or leading to adverse results like under-use or cherry picking. Without good measurement, we simply cannot achieve the quality, effective care that all patients need and deserve.

Congresswoman Castor has clearly recognized the importance of measurement in her bill, H.R. 2279, the “Eliminating Disparities in Breast Cancer Treatment Act of 2009.” Ms. Castor, I applaud you for your commitment and leadership on women’s health issues. We share your goals of moving our delivery system to reward value over volume, incentivize quality and accountability, improve patient experience of care, and eliminate disparities in access and treatment.

We particularly appreciate the provisions of H.R. 2279 that move us towards quality measurement and public reporting at the individual provider level, and the implementation of a value-based

purchasing program. We believe that these elements – measurement, reporting, quality improvement, and the right payment incentives – are critical to the broader delivery system reforms contemplated in the health reform debate. Therefore, we stand ready to work with you and your colleagues to develop and implement a pathway for these reforms. But we urge that we do so in a way that benefits *all* patients, no matter what their condition or diagnosis, and in a way that generates accountability for quality and patient care among all providers and in all care settings.

It is this vision that led the National Partnership to work with a broad group of health care stakeholders – including the American Medical Association, America’s Health Insurance Plans (AHIP), the American Hospital Association, major employers, AARP, the AFL-CIO and many consumer groups, who all share the belief that good performance measurement is the necessary platform for the payment and delivery system changes that will get us to better quality and lower costs. This group, which now includes more than 200 endorsing organizations and has come to be called “Stand for Quality”, issued a set of recommendations earlier this year that call for:

- **A national, comprehensive strategy that includes:**
 - Setting priorities for measurement,
 - Developing measures (especially in critical areas like outcomes, functional status, disparities, and care coordination),
 - Endorsing and maintaining measures as national standards, so that everyone uses the same measures, reducing the burden on providers and helping consumers and purchasers make apples-to-apples comparisons.
 - Collecting and analyzing measurement data – both public and private - across providers and settings, and
 - Using measurement data for quality improvement, public reporting, and payment.
- **Use of a multi-stakeholder consultative process to inform and make recommendations to the Secretary on all the above functions.** We should build on the current infrastructure of public-private partnerships that has evolved over the last decade because, for the first time, it has enabled consumer and purchaser voices to play a major role, alongside the provider community, in shaping and driving the measurement agenda. Further, it fosters the necessary “buy-in” from all the stakeholders, which is essential to make measurement, quality improvement, and cost reduction work over the long-term.
- **To the extent possible, use of nationally endorsed measures recommended through the multi-stakeholder process.** And where this is not possible, and non-endorsed measures are used, the Secretary should use a transparent rationale and when appropriate submit the measures for consensus-based national endorsement.

We are pleased that H.R. 3200 has incorporated the Stand for Quality recommendations and applaud the members of this subcommittee for their leadership in recognizing that a comprehensive strategy for quality measurement and improvement is the critical foundation for the delivery system reforms that will make health insurance reform sustainable over the long term.

Mr. Chairman, and members of this subcommittee, I thank you for the opportunity to testify here today, and I look forward to working with you to ensure passage of a health care reform bill that will improve access to quality, affordable and equitable care for all Americans.

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Mr. PALLONE. Thank you.
Dr. Sledge.

STATEMENT OF GEORGE W. SLEDGE, JR.

Dr. SLEDGE. Mr. Chairman Pallone, members of the Subcommittee, thank you for the opportunity to submit testimony today. My name is Dr. George Sledge. I am a medical oncologist from Indianapolis who specializes in the treatment of breast cancer. I also serve as professor of medicine at Indiana University's Simon Cancer Center, and I am president-elect of the American Society of Clinical Oncology. ASCO's mission is to ensure that the highest quality, evidence-based care is delivered to all people with cancer during all stages of their disease. We are especially pleased to speak at today's hearing as it focuses on the cornerstones of ASCO's mission: cancer prevention, quality, access to care and education.

Many of us have been touched by breast cancer either personally or through family members' or friends' experiences. ASCO supports the underlying goals of all four bills being discussed today and we urge this Committee to ensure the resulting legislation is grounded in sound scientific evidence. In today's testimony, I will focus on three areas that span the continuum of cancer care: patient access to appropriate screening, patient education and public awareness, and quality measurement in cancer care.

The first is patient access to appropriate screening. Studies have shown the value of cancer screening, particularly mammography in women over the age of 40. ASCO supports provisions that prohibit health plans from establishing policies or barriers to medically appropriate testing. While MRI is a highly sensitive test, we should not overlook the potential risk of overdiagnosis that lead to additional diagnostic tests including biopsy. Tests and procedures cause anxiety and can lead to harms so we should be very clear about the associated costs, risks and benefits. The greatest utility for MRI appears to be for women who are at high risk for breast cancer such as individuals who have a strong family history. For women at high risk, detection of abnormalities is less likely to result in false positive findings. However, all women undergoing screening MRI should be informed about the odds of false positive findings and the potential adverse consequences of those findings.

The second issue I will discuss is patient education and public awareness. With respect to educating young women on the causes and risks of breast cancer, such an endeavor must be evidence based. An informed patient has a critical advantage in cancer care treatment and the American Society of Clinical Oncology has directed considerable resources and expertise to informing patients through our cancer.net website.

Finally, I would like to address quality measurement and reporting, which is at the very core of ASCO's mission. More than 500 oncology practices throughout the country participate in ASCO's Quality Oncology Practice Initiative, or QOPI, a system for practicing oncologists to submit clinical data where practice-specific comparative data reports are generated. QOPI allows oncologists to systematically assess the quality of care they provide and engage in data-driven practice improvement activities. The majority of the

80 quality measurements in QOPI are applicable to breast cancer patients and 14 are specific to breast cancer treatment. QOPI together with the breast cancer registry pilot made possible by generous support from the Susan G. Komen For the Cure will provide tremendous insight into how breast cancer patients receive care, where improvements are needed and strategies for breast cancer care. A project that tests well-designed quality measures in breast cancer would move the field forward. However, such a project must remain flexible, especially with respect to public reporting of quality information. Studies of quality performance suggest that the most important element is the very active measuring and sharing outcomes with physicians. Value-based purchasing that reduces payment for low-quality providers rather than rewarding high-quality providers may have the unintended consequence of further stressing systems that are already struggling. The development and testing of quality measures would benefit from ASCO's long history of work in this area. Some measures developed by ASCO have already been endorsed by the National Quality Forum but the number of NQF-endorsed measures for cancer is quite limited. Significant work will be required to expand this portfolio so that it includes the full range of measures required in H.R. 2279. ASCO would be delighted to provide its expertise in this area.

In closing, ASCO appreciates the tremendous thought and attention the Subcommittee and sponsors of the four bills have devoted to the care of women with breast cancer. We look forward to working with you and our partners throughout the cancer community to achieve the important goals set out in these bills. Thank you very much.

[The prepared statement of Dr. Sledge follows:]



**STATEMENT OF GEORGE W. SLEDGE, JR., M.D.
ON BEHALF OF
THE AMERICAN SOCIETY OF CLINICAL ONCOLOGY**

Thank you for the opportunity to submit testimony today before the Subcommittee on Health of the Committee on Energy and Commerce. My name is George Sledge, M.D., and I am a medical oncologist treating cancer patients in Indianapolis, Indiana where I serve as a Professor of Medicine at Indiana University's Simon Cancer Center. I have focused much of my professional career on the prevention, diagnosis and treatment of breast cancer, and I serve as the current President-Elect of the American Society of Clinical Oncology (ASCO).

ASCO is the leading specialty society in the United States and throughout the world for physicians who treat people with cancer and who conduct research that leads to improved patient outcomes. ASCO is committed to ensuring that high quality, evidence-based practices for the prevention, diagnosis and treatment of cancer are available to all Americans in every community throughout the United States.

ASCO works both to promote a strong national research enterprise (which is critical to the development of improved therapies) and to realize the promise of these discoveries through delivery of high-quality, evidence-based care. Today's hearing focuses on issues that are the cornerstones of ASCO's mission: cancer prevention, quality, access to care, and education.

ASCO supports the underlying goals of all four bills. Our Society has dedicated significant resources to pursuing many of their aims in the fight against cancer. We urge this subcommittee, as it deliberates, to ensure the resulting legislation is grounded in sound scientific evidence. Obtaining such evidence requires a robust national research enterprise able to conduct the rigorous research that will inform and improve cancer treatment, screening and prevention. To this end, ASCO has long advocated for predictable and consistent funding for the National Institutes of Health and the National Cancer Institute, and we will continue to pursue this overarching need with Congress in the weeks and months ahead.

In today's testimony, I will focus on three areas that span the continuum of cancer care and that underpin the bills that are the subject of today's hearing: patient access to

appropriate screening, patient education and public awareness, and quality measurement in cancer care.

Patient Access to Appropriate Screening

Screening tests that are based on solid scientific evidence can be useful in early diagnosis of cancer. Studies have shown the value of cancer screening tests in many settings, but there is still much to be learned. Although MRI, especially in expert hands, is a highly sensitive test, we should not overlook the potential risks of over-diagnosis that leads to utilization of additional diagnostic techniques, including biopsy. Tests and procedures cause anxiety—and can lead to harms—so we should be clear about their costs, risks and benefits.

The greatest utility for MRI appears to be present in women who are at heightened risk for breast cancer, including those who have a strong family history of breast cancer, those with BRCA1 and BRCA2 genetic mutations, or who are HER2 positive. In these situations, detection of abnormalities is less likely to result in the number of false-positive findings that would result from the use of these tests in women who are not in high risk categories. However, women undergoing screening MRI need to be informed about the odds of false-positive findings and the potential adverse consequences of those findings.

ASCO supports provisions that prohibit health plans from establishing policies or rules creating unnecessary barriers to medically appropriate testing. We strongly encourage providers to base their clinical decisions on high quality evidence and the same holds true for payers setting policies and procedures for covered services.

Patient Education and Public Awareness

ASCO is fully supportive of efforts to build an informed public and to educate health care consumers. With respect to educating young women on the causes and risks of breast cancer, we believe such an endeavor must be carefully constructed. Young women should have access to information that will help them determine whether they might be in a high-risk category for breast cancer. However, care should be taken to reduce the very real possibility of alarming individuals who are not at increased risk, which could inadvertently lead to unnecessary biopsies, tests and radiation exposure for such individuals.

ASCO has invested heavily in patient information programs, including an award-winning website, Cancer.Net. We have literally “put our money where our mouth is” by directing considerable resources and expertise to informing patients about issues related to the

continuum of cancer care, including prevention, screening, diagnosis, treatment and survivorship. As oncologists, we know that an informed patient has a critical advantage in cancer care treatment. We applaud efforts to make high quality information more available to women considering options and making decisions regarding screening, prevention and treatment.

Patient and public education programs, particularly in the case of cancer, face challenges in delivering constructive messages that educate without causing undue alarm or anxiety. ASCO supports a robust evaluation component that can help to determine the extent to which education programs are successful in reaching target audiences and the extent to which refinement is necessary to achieve relevance in targeted populations. Although we are focused on breast cancer today, ASCO is concerned about overall cancer awareness, and we encourage the subcommittee to consider this effort as part of a broader strategy to educate the public more generally about cancer prevention and risk.

ASCO urges support of public education programs that leverage the latest information and insights from behavioral science to target selected audiences in the most effective ways. Messages should be narrowly tailored to resonate with culturally and ethnically diverse groups, underserved populations, and women who have genetic or other factors placing them at high risk.

Quality Measurement and Reporting

ASCO has a deep and abiding concern for the quality of cancer care. In response to a study published by the Institute of Medicine more than a decade ago, ASCO began a series of initiatives to evaluate the care of patients with breast and colon cancer in the United States. These efforts have given rise to a strong culture of self-examination, quality measurement and continuous improvement throughout ASCO's membership. More than 500 practices across the United States now participate in our Quality Oncology Practice Initiative, QOPI.

QOPI provides a system for practicing oncologists to submit clinical data, using a secure electronic interface, to a central database where practice-specific and comparative data reports are generated.

QOPI reports allow oncologists to systematically assess the quality of care they provide and engage in data-driven practice improvement activities. The majority of the 80 quality measures assessed through QOPI are applicable to breast cancer patients, and 14 are specific to breast cancer treatment.

QOPI, together with a breast cancer registry pilot made possible by generous support from Susan G. Komen for the Cure, will provide tremendous insight into how breast

cancer patients receive their care, where improvements are needed, and strategies for addressing issues in care coordination, doctor/patient communication and clinical quality in breast cancer care.

With this demonstrated commitment, ASCO supports use of performance measures to assess and improve quality, including enhancing our ability to understand and address disparities in cancer care. Implementation of a 6-year project that uses well-designed and implemented quality measures in breast cancer would move the field well forward. Cancer care is extraordinarily complex. It relies on the collaboration of multiple medical specialties across the health care system. Although value based purchasing and public reporting are appealing concepts, designing an effective system requires extreme caution and the recognition that an intricate web of providers is involved in the care of each patient.

Performance measures need to be carefully developed, especially measures that assess care across settings. Development and testing of quality measures requires significant time, resources and expertise. ASCO has both a long history of work in this area and the infrastructure in place for ongoing development and testing. Some measures developed by ASCO have been endorsed by the National Quality Forum, but the number of NQF-endorsed measures for cancer remains limited. Significant work will be required to expand this portfolio to include the full range of measures required by H.R. 2279. ASCO has the expertise, commitment and track record, both through QOPI and in working with professional societies, patient advocacy groups, and other stakeholders, to develop a useful set of performance measures for breast cancer.

To ensure that doctors devote their time and resources where most needed—to their patients—quality measurement and reporting systems must maximize useful data and minimize burden. Systems currently in place to collect data on cancer were designed to meet a variety of goals. ASCO's quality registries are actively collecting clinical data, analyzing and reporting quality measures, and are well positioned to report the disparities-focused quality data specified in this bill. Focusing on enhancing and linking existing systems, and expanding to electronic health records-based reporting, will be the best use of resources.

Implementation of provider reporting requirements for breast cancer will require careful review and evaluation as well as appropriate funding to support these activities. It will be crucial to maintain flexibility regarding the content and strategy for public reporting of quality information, allowing time to ensure the system is functioning correctly and providing appropriate, reliable and meaningful information.

Reductions in payment for low quality providers (rather than rewarding high quality providers) may have the unintended consequence of further stressing systems that already

are struggling. Evidence to date has not demonstrated a clear benefit for the punitive use of performance measures. Studies of quality performance suggest that the most important elements are the act of measuring and sharing outcomes with physicians coupled with an iterative process for continuous quality improvement. Rewarding desirable efforts and providing support tools through high functioning systems are likely to have much more dramatic impacts on quality than punishing outliers.

ASCO is a strong advocate for quality reporting and practice improvement. To achieve buy-in from providers, people with cancer, and the public, it is crucial for the information provided in any quality measurement and reporting program to be trustworthy and meaningful.

In closing, ASCO appreciates the tremendous thought and attention the subcommittee and sponsors of the four bills have devoted to the care of women with breast cancer. Many of the issues addressed today are relevant to all types of cancer. Developing the best evidence to guide clinical decisions, supporting the research that develops such evidence, assuring cancer care is delivered based on consideration of the resulting guidelines, and educating patients about prevention and treatment, are at the core of ASCO's mission. We look forward to working with Members of Congress, the Administration, colleagues who are represented here today, and partners throughout the cancer community to achieve these goals. On behalf of ASCO and its members, I thank you for the opportunity to be part of today's discussion.

Mr. PALLONE. Thank you, Dr. Sledge.
Ms. Visco.

STATEMENT OF FRAN VISCO

Ms. VISCO. Thank you. Thank you, Chairman Pallone, members of the Subcommittee. I appreciate very much the opportunity to testify today on behalf of the National Breast Cancer Coalition.

I am a 22-year breast cancer survivor. I was diagnosed when I was 39 years old. My son, David, was 14 months old. I was a partner in a law firm in Philadelphia and I was fortunate that I became involved with a group of women who launched the National Breast Cancer Coalition and I soon left my law practice to devote my life to our mission to eradicate breast cancer.

We are a coalition of organizations from across the country. Our board of directors is a board of 25 of these organizations representing the diversity that is breast cancer from the Women of Color Support Group, to Nueva Vida, to the Alamo Breast Cancer Coalition, to the California Alliance of Breast Cancer Organizations. Our national grassroots network consists of representatives of many different organizations. We set priorities. We educate our members to understand the language and the concepts of science. We know that women are quite capable of understanding these issues, of accepting the truth no matter how difficult that may be, and of speaking up for themselves. We critically analyze information. We critically analyze public policies before we set our priorities and before we take positions, and we have but one agenda and that is to eradicate breast cancer.

I know the Committee today is focusing on a number of bills specific to breast cancer and we have submitted analyzes of some of those bills to members, and I will submit them for the record. But what I want to focus my remarks on today is our number one priority, and that is the bill that we believe will have the largest impact for all women at risk of and all women who have received a diagnosis of breast cancer and that is guaranteed access to quality health care for all. We followed our process of research of critical analysis. We spent several years educating our grass roots, looking at various health care systems, reading the literature, researching the system, and we developed our framework which was submitted with our written testimony to support guaranteed access for all, educated patient participation at all levels of the system, shared responsibility and benefits based on evidence. We strongly support comparative effectiveness research because we believe that it is necessary to help ensure quality and affordable health care for all. We need a high level of evidence for doctors and patients to choose which care is appropriate, for whom and under what circumstances. In addition, our framework calls for a significant number, and that is 25 percent of educated patient and consumer member on all committees, commissions and boards involved in health care including those established to review and assess the best evidence-based treatment options.

We commend the Committee for its work on H.R. 3200, which achieves many of the benchmarks set forth in our framework, and we are pleased to endorse that bill and we look forward to working with you to ensure that all individuals have access to the com-

prehensive quality care they deserve, quality care they need. Everyone should have access and it must be affordable, not just for the federal budget but to people. It must be affordable to individuals. We very much appreciate your interest and support of our shared goal to save lives and to end breast cancer. You have the power to make a real difference for all of us, and we know how complicated these issues are, how difficult your task is. We know how complex breast cancer is and how careful we all have to be to make certain that what we are doing is the right thing in terms of women's lives.

There are too many unfortunate examples of policy messaging and beliefs that have taken hold when there was in fact no real evidence behind it, and these actions resulted in harm to women. My written testimony describes them from bone marrow transplants to breast self-exams and hormone replacement therapy to the misuse of statistics by opponents to health care reform that are looking inappropriately at survival statistics that are outdated from different countries. All of that has been submitted with my written testimony.

I know firsthand the horror of breast cancer and I see that horror over and over again for too many women of all ages, all races, all walks of life. That is why we are so firmly committed to the evidence-based approaches, to our passionate commitment to eradicating breast cancer.

I want to take a moment to talk about Carolina Hinestrosa, a strong, passionate, unbelievable activist. She was the executive vice president of the National Breast Cancer Coalition. She founded Nueva Vida, a national support group for Hispanic women with breast cancer. She was diagnosed 15 years ago at the age of 35 and then again 6 years ago. She died in June of a soft-tissue sarcoma, a result of her treatment for breast cancer, not breast cancer, her treatment for breast cancer, just one more story of how complex this disease is, how complicated the issues are. I dedicate my testimony and my work to her memory, and I thank you again.

[The prepared statement of Ms. Visco follows:]



**Testimony of
Fran Visco, J.D.
President
National Breast Cancer Coalition**

**Submitted to the
House Energy and Commerce Committee
Health Subcommittee**

October 7, 2009

Thank you, Chairman Pallone and members of the House Energy and Commerce Health Subcommittee, for the opportunity to testify at this hearing on breast cancer. I am honored to have this opportunity to appear before you. The National Breast Cancer Coalition commends your attention to breast cancer and your efforts to enact comprehensive health care reform – which is our highest legislative priority. While this hearing is examining a number of breast cancer specific bills today, I would like to focus my comments on the need for comprehensive health care reform.

I am Fran Visco, a 22-year breast cancer survivor, a wife and mother, lawyer, and President of the National Breast Cancer Coalition (NBCC). I was diagnosed at age 39 when my son David was 14 months old. As you may know, NBCC is made up of hundreds of organizations from across the country. Our Board of Directors consists of 25 of these organizations and represents the diversity that is breast cancer. These groups come together under our umbrella to focus on systems change in policy, health care and research. NBCC's mission is to eradicate breast cancer. NBCC's main goals are to increase federal funding for breast cancer research and collaborate with the scientific community to implement new models of research; improve access to high quality health care and breast cancer clinical trials for all women; and expand the influence of breast cancer advocates wherever breast cancer decisions are made.

Background

Our work is driven by the hundreds of groups that form our coalition, many of which are made up of women who have had breast cancer. We are a coalition of organizations: we are African American Women in Touch. We are Women of Color Support Group. We are the Alamo Breast Cancer Foundation, Linda Creed, SHARE Network, Nueva Vida and many, many more. We are all of these incredibly diverse groups who have come together to make the decisions on behalf of NBCC, to set the agenda, to be the National Breast Cancer Coalition.

We know that each woman's experience with this devastating disease is unique. And in 1991 when NBCC was formed, we knew that there was a need to focus on public policy, research, and the health care system outside the context of any individual's disease or health care status, and within the realm of the public good.

In order to maintain and fulfill that focus, NBCC does its homework. We thoroughly research issues before we adopt positions and to determine if they warrant attention by our committed grassroots network, who give so much to our cause. We believe in evidence, and that women and men – all of us -- deserve the truth about breast cancer and policies that are rooted in fact, research and science. We take that belief very seriously. Each year our grassroots leadership sets policy priorities to help achieve our mission to end breast cancer. We follow a comprehensive process of critical analysis of the issues, research and education of our members on the background, controversies, and pros and cons of each issue we may address. After much discussion and debate, we determine those policies NBCC will support.

We followed this process to determine that *Guaranteed Access to Quality Health Care for All* would be our number one priority. It has been the primary focus of our organization for several years now because we recognize we will not achieve our mission to end breast cancer until all women have access to the care they need. We believe that access to quality and affordable health care and access to medical treatment that is founded in scientific evidence are two of the best tools available to achieve our mission.

NBCC's Commitment to 'Guaranteed Access to Quality Care for All'

Since its inception in 1991, NBCC has known that the only way to achieve our mission to end breast cancer is to ensure guaranteed access to comprehensive, quality health care for all. After several years of research and analysis, in 2007, NBCC articulated its vision for accomplishing this goal when our grassroots board of Directors approved a *Framework for a Health Care System Guaranteeing Access to Quality Care for All* which builds on principles it adopted in 2003.

Throughout the process of developing the *Framework*, NBCC applied its longstanding commitment to advancing evidence-based medicine and training consumers to strive towards systems change. NBCC believes strongly in guaranteed access for all, educated patient participation at all levels of health system decision making, shared responsibility and benefits that are based on medical evidence and cost effectiveness so that patients can be assured of consistent, high quality healthcare. I am submitting a copy of the *NBCC Framework* for the record.

NBCC applauds the Chairman's commitment to passing a comprehensive healthcare reform bill. Specifically, NBCC's *Framework* calls for a healthcare system in which coverage is guaranteed to all individuals, and does not discriminate or deny coverage for any reason, including pre-existing conditions.

Our *Framework* also strongly supports comparative effectiveness research because we believe that it is necessary to help ensure quality, affordable healthcare for all. We need a high level of evidence for doctors and patients to choose which care is appropriate, for whom, and under what circumstances as well as who should pay for it. This is critical to patient-centered care. There are two necessary components to this evidence: the first is high quality clinical research of new interventions and the second, and equally necessary component, is comparative effectiveness

research of interventions in the real life settings all doctors and patients face. This research provides an opportunity to find these answers, in settings that reflect the situations of the average person, adding value beyond what we obtain from the highly controlled setting of traditional clinical trials.

In addition, NBCC's *Framework* calls for a significant number (25%) of educated patient/consumer members on all committees, commissions and boards involved in health care including those established to review and assess the best evidence-based treatment options, their cost effectiveness, and the appropriate level of benefits.

We commend the Committee for its work on HR 3200, America's Affordable Health Choices Act of 2009, which achieves many the benchmarks set forth in our *Framework*. NBCC was pleased to endorse H.R. 3200 and looks forward to working with you to ensure that all individuals have access to the comprehensive quality health care they deserve.

NBCC's Work to Challenge the Status Quo Using an Evidence-Based Approach

We very much appreciate your interest and support of our shared goal to save lives and end breast cancer. You have the power to make a real difference for all of us. We know how complicated these issues are, how difficult your task is. We know how complex breast cancer is and how careful we all have to be to make sure that what we are doing is the right thing in terms of women's health. There are too many unfortunate examples of policy, messaging and beliefs that have taken hold when there was in fact no real evidence behind them, and these actions resulted in harm to women.

We are all familiar with the story of *Autologous Bone Marrow Transplants (ABMT)* in treating breast cancer. The community believed more chemotherapy would be better and that transplants worked in some cancers so why not breast cancer? While clinical trials were launched, too many women received the treatment outside of the trials, the trials did not accrue and it took many more years than it should have to get the real answer. Women died from the treatment itself. NBCC said from the beginning that we needed the trials to get the answers. When we finally had the evidence, it was clear that ABMT was not better than conventional chemotherapy. And yet laws were passed in various states mandating insurance coverage of this treatment, an example of misplaced advocacy when evidence did not exist. And harm resulted.

We also know the story of *hormone replacement therapy (HRT)* becoming a widely used intervention for women based on the belief, without evidence, that it would help cardiac health among other benefits. Yet when the clinical trials were completed, we found out that HRT increased a woman's risk of breast cancer and other harms. Many many women took HRT when we had no evidence of its effectiveness and many women were harmed.

Breast self examination (BSE) falls into this category also. BSE became gospel, yet there was no evidence at all that it saved lives or found breast cancer at an earlier stage. When we did have the evidence that, not only did it not save lives or find cancer earlier, it resulted in the harm of

unnecessary biopsies and increased anxiety, the public would not believe it because the marketing of this approach had been so successful. Again, the perils of acting with no evidence when women's health is at stake.

NBCC has taken the position many times that we cannot afford to waste our limited resources and risk women's lives on medical treatments and on public health interventions that have not been shown effective, particularly when there is evidence that the intervention may be causing harm. These resources would be better spent on funding more research studies to identify interventions that really do work, such as better ways to detect, treat, and prevent breast cancer. These resources would also be better spent on interventions that have already been shown to reduce breast cancer mortality, such as access to appropriate treatment for all.

Breast Cancer Survival Rates

Let us be very careful not to make the same mistakes again. This holds true for the breast cancer bills currently pending before this committee and also holds true for health care reform. Currently, opponents of meaningful health care reform have begun to use incomplete, outdated and misleading statistics about breast cancer to support their arguments in opposition to these efforts. NBCC wants to set the record straight for the members of this Committee and for anyone else who may have come across this misleading information.

Opponents are using five year survival statistics from 1990-94 for breast cancer in England to support the claim that health care reform that includes a nationalized health care system would result in more breast cancer deaths in the United States. This is simply not true. Indeed, arguments for reform can be supported by breast cancer survival statistics from different countries: the same *Lancet* article that reported the rates for England, reported that the United States had a rate of 84%, Sweden, 82%, Canada, 83%, Australia 81%, Japan 82% and Cuba 84%. Different countries, different systems, similar survival rates. And none of it is relevant to the current debate.

Some people use "survival rates" to show progress in breast cancer, but this is not appropriate. A "survival rate" is the proportion of people diagnosed with a disease at a point in time, and who are alive at some fixed time in the future, for example in 5 years or 10 years. "Mortality rates" which compare the death rates in two groups at a specific point in time, should be used instead. Our analysis shows that the U.S. breast cancer mortality rate is indeed lower than it is in England. However, the breast cancer mortality rate in the England is falling at a faster rate than here in the U.S. What do these statistics tell us about how we should deliver health care in our country? Not very much. Mortality rates depend on many factors that often have little to do with the health care delivery system, such as the general health of the population and lifestyle choices such as smoking. Linking health care reform to breast cancer mortality is complex. We simply do not know how to quantify the connection. We do know that all women with and at risk of breast cancer deserve access to quality health care. The attached analysis explains the complexity of the statistics and the reality of the connection between a health care system and breast cancer deaths.

There are three million women living with breast cancer in this country today. This year, more than 40,000 will die of the disease and more than 240,000 will be diagnosed. We still do not know how to prevent breast cancer, how to diagnose it truly early or how to cure it. It is an incredibly complex disease and we must be very careful that the actions we take are the right ones that will move us forward and will not result in harm to the women they are intended to help.

Conclusion

We believe we have made progress in breast cancer. Yet time and again we are reminded that we have made much too little.

NBCC lost a passionate, strong and brilliant advocate in June of this year to soft tissue sarcoma, a side effect of past breast cancer treatment. She died not from breast cancer, but from her treatment for breast cancer. Carolina Hineirosa served as Executive Vice President at NBCC and was the co-founder Nueva Vida, a support network for Latinas with breast and cervical cancer. Nueva Vida formed in 1996, two years after Carolina was diagnosed with breast cancer at the age of 35. Carolina was born in Bogota, Colombia and came to the United States in 1985 as a Fulbright Scholar to pursue a master's degree in economic development. She worked as a business economist in Colombia and New Zealand before returning to Washington, DC in 1993. Carolina had incredible courage and compassion. She dedicated herself to pushing the research community to think about their work differently and to focus on saving lives. Her contributions to NBCC and to the breast cancer community were significant and will continue to live on as will her spirit through all of us who continue in this fight.

The individuals who comprise the myriad of organizations that make up NBCC have selflessly given of their time and of themselves and have made great sacrifices to work toward this cause. They do not continue this important work because they think it will benefit them. In fact, some of our advocates with metastatic breast who continue to fight and keep coming to Washington do so knowing full well they will never see the breakthroughs and progress in research and access to care. It is a sense of obligation and purpose on the part of these women to contribute toward something greater than themselves and the commitment and desire to help bring about a day when our daughters and granddaughters and great-granddaughters will not have to confront this disease.

Linda Croucher is NBCC Volunteer Lead Field Coordinator for Ohio and a member of the board of the Breast Cancer Alliance of Greater Cincinnati. These are her words:

“There are so many women, not only in Ohio, but all across the United States that depend on research as a hope for a cure for breast cancer. Unfortunately, with the extent of my disease, it is doubtful that I will ever be cured. Having said that, I do hope for a cure for my two girls, Sarah and Molly. I am the fourth generation in my family to be diagnosed with breast cancer. I cannot bear to think about my daughters suffering the same fate.”

We owe all of these women, their families and friends, the strongest, most meaningful and exact policies to achieve our mission to end breast cancer. For now, let's focus our efforts in breast cancer on making certain all women and their families, everyone in this country, has access to the quality care they need.

Mr. Chairman, I thank you so very much for this opportunity to testify before this Committee and for the Committee's commitment to our mission.



**Health Care Reform and Breast Cancer
An Analysis**

October 2009

Introduction

There have been several attempts to argue that reforming the United States health care system will result in increased breast cancer deaths. This is simply incorrect. Opponents of reform use statistics reported in the *Lancet*¹ on five year survival from England, a country with a nationalized health care system, to support their claim. Survival statistics do not predict mortality rates and neither statistic is a direct measure of the success of a health care system. The statistics used are outdated and other countries with different health care systems, including nationalized systems, have survival and mortality rates similar to those of the United States². The factors underlying mortality rates are complex and vary from country to country and even state to state.

What are survival rates and what do they tell us about breast cancer?

Some people use "survival rates" to show progress in breast cancer, but this is not appropriate. A "survival rate" is the proportion of people diagnosed with a disease at a point in time, and who are alive at some fixed time in the future, for example 5 years or 10 years. "Mortality rates" which compare the death rates in two groups at a specific point in time, should be used instead.

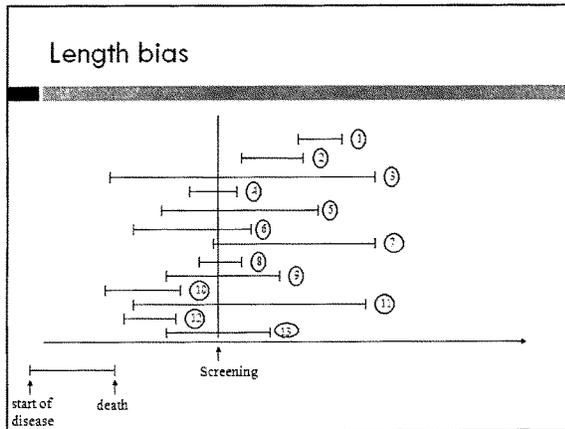
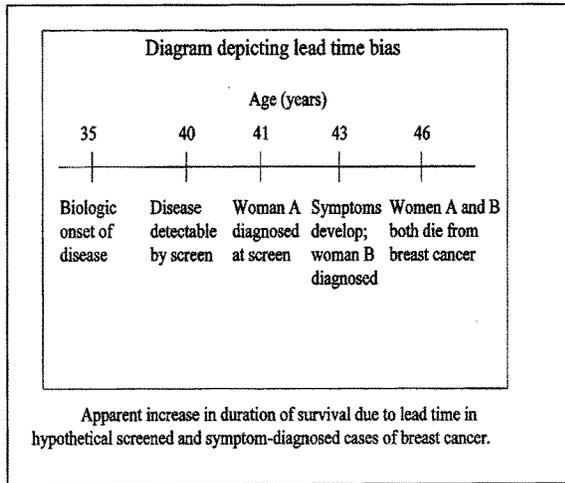
Survival rates cannot be meaningfully compared across nations.

Screening programs often underlie differences in survival rates, along with other confounders. The idea behind screening is that, by finding breast cancer before there are symptoms, the cancer will be easier to treat, so early detection will save lives. Unfortunately, it's not that simple.

Screening often detects cancer earlier than it would have been detected because of symptoms. This means that screened people know they have the disease longer than unscreened people, but *this doesn't mean that screened people live longer*, if one counts from the time the disease actually began. This is a well known statistical bias ("lead time bias"), but unfortunately survival rates are still used by those who are unaware of the bias. The graphs on the next page clearly show the problems:

¹ The claim that the survival rate for breast cancer in England is much lower than that in the U.S. because England has a nationalized health care system is based on an article that looked at five-year survival rates of women diagnosed with breast cancer between 1990-1994. (Coleman MP, Quaresma M, Berrino F, et al. Cancer survival in five continents: a worldwide population-based study (CONCORD). *Lancet Oncology*, 2008;9:730-56). Survival in England has improved for most cancers since then. According to more recent registry figures, the five-year survival rate for breast cancer is now 82% in England. (National Statistics Online, Cancer Survival, accessed Sep 17, 2009 at <http://www.statistics.gov.uk/CCI/nugget.asp?ID=861>)

² Another issue with these data is that the rates from England are determined from a cancer registry that includes everyone. The U.S. rates are estimates, based on cancer registry data, which only include about 42% of the population. Thus the U.S. rates may only reflect the reality among those who can access the health care system.



Source: National Breast Cancer Coalition, Project LEAD® curriculum 2009

The notion that “more screening is better” ignores the very real harms of over-diagnoses and over-treatment. More aggressive screening results in discovering more women with tumors that never would have caused symptoms or death due to breast cancer. These women, nonetheless, often undergo extremely invasive and painful treatment. If we screened every women of every age every six months,



we would certainly find more cancer.³ **But we would not save more lives from breast cancer and we may cause other life threatening conditions that never would have occurred. It would be a terrible waste of resources and cause much more harm than good, because survival rates do not predict the mortality rate.**

Even if we do compare breast cancer survival rates between countries, as the Lancet Oncology journal article did in 2008, the claim that countries with nationalized health systems have lower survival rates does not hold true. The Lancet Oncology article reported that the U.S. had a survival rate of 84%, Sweden 82%, Canada 83%, Australia 81%, Japan 82%, and Cuba 84%. Survival statistics are not evidence of a direct relationship between the type of health care system and breast cancer survival rates.

But what about comparing breast cancer mortality rates? Surely if we have lower breast cancer mortality rates than another country, then that proves that our health care system is better? Sounds reasonable, but it is a false assumption.

What are mortality rates?

Mortality rate, also called the death rate, is the number of people who died of a particular illness compared to the number of people who were alive at the beginning of a specific time period. Comparing breast cancer mortality rates across time can be very useful because, as long as the death rate from other diseases is not adversely affected, our goal is to have fewer people die of breast cancer.

Comparing mortality rates among countries is comparing the proverbial apples to oranges.

The U.S. breast cancer mortality rate (23 per 100,000 women in 2006) is indeed lower than it is in England (27 per 100,000 in 2007). However, the breast cancer mortality rate in the UK is falling at a faster rate than here in the U.S.

And note this: the WHO Global InfoBase for 2005 reports that the projected mortality rate in Sweden was 19 per 100,000, in Canada 21 per 100,000, in Australia 18 per 100,000, in Japan 9 per 100,000, and in Cuba 16 per 100,000. Should we therefore adopt the health care systems of these countries?

What do these statistics tell us about how we should deliver health care in our country? Not very much. Mortality rates depend on many factors that often have little to do with the health care delivery system, such as the general health of the population and lifestyle choices such as smoking. Linking health care reform to breast cancer mortality is complex. We simply do not know how to quantify the connection. **We do know that all women with and at risk of breast cancer deserve access to quality health care.**

³ The United States breast cancer screening program is more aggressive than that of England. In this country women are told to have mammograms every year, while in England it is every other year, and in this country women in their 40s are told they need a mammogram while in England mammograms are not routinely offered until age 50.



Conclusion

We cannot allow misinformation to interfere with our resolve to do what is right. NBCC is deeply disturbed that women's fears about breast cancer are being exploited to thwart health care reform efforts that, if done right, will provide access to quality health care for every woman with and at risk of breast cancer.



**NBCC's Framework for a Health Care System
Guaranteeing Access to Quality Health Care for All
April 2008**

The National Breast Cancer Coalition (NBCC) has advocated for guaranteed access to quality health care for all since its inception in 1991. In 2003 NBCC adopted its *Principles for Achieving Guaranteed Access to Quality Health Care for All*. NBCC analyzed various approaches to achieving its goal in order to develop public policy that moves beyond incremental changes to the existing health care system toward true comprehensive reform. NBCC's extensive research and analysis gave rise to its *Framework for a Health Care System Guaranteeing Access to Quality Health Care for All*. This *Framework* is intended primarily to address the issue of health care coverage. NBCC continues to work on approaches to quality and access beyond coverage.

NBCC presented the *Framework* at its Annual Advocacy Training Conference in April 2008 and NBCC advocates presented it to their Members of Congress during Lobby Day on April 29th. NBCC looks forward to working with Members of Congress and other stakeholders to advance the goals articulated in the *Framework*.

Key Points of NBCC's Framework

- The *Framework* is premised on the fundamental belief that health care is a right and that all people present in the United States should have access to quality health care regardless of their immigration, residency status, or ability to pay.
- The *Framework* is an outline for legislation that will support a system of evidence-based health care coverage for everyone.
- The *Framework* provides that the basic benefits covered are comprehensive and evidence-based.
- The system resulting from the *Framework* will include mechanisms to:
 - Support development of new evidence through clinical research
 - Continually refine benefits through comparative effectiveness and cost effectiveness analyses
 - Reduce over and under use of care
 - Include educated consumers in all decision making
- The system will be financed in part through cost savings and shared responsibility:
 - Everyone – individuals, employers, and government – share responsibility to support the system.
 - Individuals will be required to financially contribute to the system based on their ability to pay.
 - All employers will be required to contribute to the system. The *Framework* would phase out employer-sponsored health insurance. Subsidies or a sliding scale should be implemented to ensure that small businesses are not disproportionately affected by these payments.



**NBCC's Framework for a Health Care System
Guaranteeing Access to Quality Health Care for All**

The National Breast Cancer Coalition's number one public policy priority is guaranteed access to quality health care for all. This document outlines a *Framework* developed by NBCC's Board of Directors that is based on the organization's Principles for Guaranteed Access to Quality Health Care for All adopted in 2003. This *Framework* addresses a legislative approach to coverage issues. NBCC recognizes that access to quality health care goes beyond coverage.

A health care system that is built on this *Framework* will:

- provide a basic benefits package that is comprehensive and based on sound scientific evidence;
- maintain continuity of coverage;
- be efficient and cost-effective;
- be fully-funded through shared financial responsibility;
- be sustainable and affordable.

The health care system must be accountable to the users and the public. A system must be established to:

- evaluate and support development of medical evidence for health interventions upon which coverage will be based;
- support ongoing and continuous comparison of interventions to ensure access to appropriate and cost-effective health care;
- modify and expand current benefits as appropriate based on evidence.

I. Benefits Package

1) All eligible individuals will be provided with coverage for a benefits package equivalent to the most comprehensive plan available to Members of Congress through the Federal Employees Health Benefit Plan.

2) The benefits package guarantees coverage for care that is based on the best available scientific evidence and is cost effective (as determined by the Federal board described below). Care that does not meet these criteria will not be covered, unless it is being provided as part of a quality clinical trial or otherwise appropriately contributing to the further development of the evidence base.

II. Eligibility

1) Coverage is guaranteed to all eligible individuals.

a) An eligible individual is one who is present in the United States. (Note: the extent of coverage will vary based upon reason for presence and duration of stay).

2) All eligible individuals will be automatically enrolled and covered at the point of attaining eligibility.

III. Determination of, Modifications to and Expansion of Benefits:

- 1) A Federal-level board shall have the authority to implement a system of coverage determination based on evidence. The board shall be appointed and include members representing the lay public (at least 25%). The members shall have staggered terms longer than 4 years.
 - a) Cost-effectiveness shall be a factor considered by the Board in making benefit coverage decisions.
- 2) A separate and independent body, including at least 25% membership from the lay public, shall be appointed to develop a system for assessing comparative effectiveness of interventions, the results of which must be utilized by the board determining coverage benefits.
- 3) The comprehensive benefits package and any modifications thereto shall be limited to those interventions that the boards deem to be: efficacious, safe, cost-effective, based on sound evidence; or either as part of a quality clinical trial or otherwise appropriately contributing to the evidence base.
- 4) Elective Benefits
 - a) Commercially available private health plans may provide coverage of benefits not included in the benefit package.

IV. Efficiency

- 1) The government shall implement strategies to significantly reduce the current administrative costs of the health care system and all such savings shall go toward providing coverage.
- 2) The government shall also develop and implement strategies to simplify the current system, reduce duplication, inaccuracies, and inefficient record keeping and provide for system-wide, interoperable electronic record keeping.

V. Information and Education

- 1) Accurate, timely, and readily accessible information about health care coverage, access and the scientific evidence base shall be available to everyone. All health care providers must offer clear information to consumers on the benefits and harms of all options, and the quality of the evidence for each option.
- 2) A national panel shall be established to work with the public to review evidence and help design effective methods for communicating health care information to consumers, providers and plans.

VI. Financing

- 1) All individuals are required to financially contribute to the system according to their ability to pay.
- 2) All employers are also required to financially contribute to the system. Under this *Framework* employer-sponsored health insurance will be phased out, however, all employers are required to financially contribute to the system.

- 3) The federal government shall establish a method for determining the financial contributions for individuals and employers.
- 4) No individual can be denied coverage because of inability to pay.
- 5) In addition to individual and employer contributions, the system will be financed by the public and private savings from efficiencies (referred to in the section on efficiency) as well as other government funding sources.

Mr. PALLONE. Thank you, Ms. Visco.
Dr. Weiss.

STATEMENT OF MARISA C. WEISS

Dr. WEISS. Thank you, Chairman Pallone, Subcommittee members and other panelists. It is a true privilege for me to be here today to talk about breast health and breast cancer issues that have been my core professional focus and driving mission for over 20 years, but more importantly, these issues directly affect about half the United States population and the rest of us who care for them.

My name is Dr. Marisa Weiss. I am a breast oncologist and founder and president of the nonprofit Breastcancer.org. We are the world's most utilized online resource for breast health and breast cancer information, reaching 8 million people annually. As a doctor, I have had the honor taking care of thousands of women with breast cancer and have seen up close its devastating effects, and our laws govern how I can best care for the unique needs of each individual that comes to me.

Everyone here knows how much is at stake. The breasts are the favorite place for cancer to occur in women, often in their prime of their lives and when these women are most indispensable to so many. The bills before the Committee today represent critical ongoing efforts to improve diagnosis and patient care. I would like to start with the EARLY Act. I believe this legislation will do much to advance public health efforts and combat the threat of breast cancer, and I commend Congresswoman Wasserman Schultz for her leadership. There are concerns that outreach to young women will produce more harm than good by creating the fear of breast cancer, but what we have found is that fear already widely exists. Information about breast cancer is pervasive. Young women like the rest of us are bombarded by breast cancer messaging aimed at adult women. To better understand the impact, Breastcancer.org conducted a research project with 3,000 girls ages 8 to 18 across the country. Consistently, nearly 30 percent of girls feared that they may have had breast cancer. It was triggered by breast pain, a diagnosis in someone close to them, or mistaking the changes of normal breast development for signs of breast cancer. Over 70 percent of girls have someone close to them who has been diagnosed, a mother, grandmother, best friend's mom, teacher or neighbor, and when breast cancer diagnosis strikes this close to home, their fears were magnified. Many young women think breast cancer messages in the media targeted to mature women directly apply to them as well, but they simply don't have the resources to understand the meaning and relevance of these critical issues nor do they have the dialog skills or opportunities to discuss their fears or clarify breast cancer misinformation. Only 47 percent of the girls had talked to a parent, 40 percent to a doctor.

To resolve unrealistic fears, young women in this era need accurate information and reassurance that age-appropriate and scientifically grounded education can arm them with the facts of what is normal and what is not, empower them to take charge of their breast health. It is these girls during the ages of 8 to 18 and into their 20s that are using what they eat, what they drink, what they

breathe in, medicines they take, personal products that they use to build their breast tissue, laying down the foundation of their future breast health. It is at this early point also that young women are establishing their lifelong behavioral patterns.

Concerns have been raised about the value of education outreach to low-risk populations in the absence of modifiable risk factors, and we know how complex a disease breast cancer is with multiple causes, but most of these risks for breast cancer don't begin at age 45. Rather, they accumulate over a lifetime beginning at conception. There are periods when breast cells are hypersensitive to internal and external environmental insults: the first trimester of pregnancy, the 4 to 10 main years of breast organogenesis between adolescence and the 20s, as well as the stretch of time leading up to a woman's first full-time pregnancy when breast cells are highly active and immature. So the behaviors of women under age 45 impact not only their own breast health but the future breast health of their daughters through pregnancy and modeled behaviors. Some risks are modifiable and some are not but even the tiny risks can combine and really add up, particularly during these sensitive times. An example of a modifiable risk factor is the obesity epidemic across the United States associated with an increase in risk of breast cancer in adult women. Extra fat makes extra hormones that could stimulate extra breast cell growth. In addition, fat stores hormonally active pollutants that are lipophilic such as bisphenol A, atrazine, dioxins, nonylphenols, which could potentially stimulate unhealthy breast cell growth. And moreover, obesity in childhood predicts for obesity in adults and obese mothers are more likely to raise obese daughters. And contrary to the claim that proven breast cancer risks can't be modified, our obesity epidemic is doing just that, by accelerating the age of menarche. Early education and behavioral modification that increases athletic activity and health weight management early enough could postpone the onset of puberty, and lessons learned from the EARLY Act programs will benefit current and future generations since it is the women under the age of 45 who are in their prime childbearing and parenting years.

Another example is the opportunity to provide breast cancer risk reduction strategies to high-risk women. In the EARLY Act, the 5 to 10 percent of breast cancers due to an inherited breast cancer genetic abnormality, over 13,000 per year, would more likely be identified, giving these women a greater chance to reduce the risk of breast cancer by as much as 90 percent with prophylactic mastectomies or 50 percent with anti-estrogen therapies.

It is important that we impart this knowledge along with what we, the scientific and medical community, know are not risk factors for breast cancer. Fear certainly breeds myths, and in our survey many young women believe that only their mother's family history is important and that breast cancer skips generations. They also were fearful that they could have caught breast cancer from their mothers during pregnancy and breastfeeding. Education can change attitudes, knowledge and behaviors. We do a disservice to this and future generations by neglecting to provide this information and facilitate this dialog.

I am also here today in full support of the Breast Cancer Patient Protection Act, the Mammogram and MRI Availability Act, and Eliminating Disparities in Breast Cancer Treatment. I am prepared to answer any questions about the medical content.

And in conclusion, I thank the chairman, the Subcommittee and the panel for giving me the opportunity to speak to you today. Thank you.

[The prepared statement of Dr. Weiss follows:]



BREASTCANCER.ORG

House Committee on Energy and Commerce Health Subcommittee Testimony

Marisa Weiss, M.D., *Breast Oncologist and President and Founder of Breastcancer.org*

Thank you Chairman Pallone, sub-committee members, and other panelists.

It's a privilege and honor to be here to talk about breast health and breast cancer—issues that have been my core professional focus and driving mission and passion for over 20 years, but more importantly, issues that directly affect about half of the United States population and arguably impact all of us.

My name is Dr. Marisa Weiss. I am a breast oncologist at Lankenau Hospital in the Philadelphia area and founder and president of the nonprofit Breastcancer.org, the world's most utilized online resource for breast health and breast cancer, reaching eight million individuals annually. I am also founder and past president of the nonprofit organization Living Beyond Breast Cancer and author of several books on these subjects. I've had the honor of taking care of thousands of women with breast cancer and have been witness to the profound and devastating effects of this disease. I remain committed to improving the diagnosis and care for every woman and am also dedicated to research and education to improve the long-term breast health of women and girls.

Everyone here knows how much is at stake. The breasts are the favorite places for cancer to occur in women, often in the prime of their lives and when women are indispensable to so many other lives. There are 153 million women and girls in the U.S. today, and one in eight is projected to get breast cancer in the course of her lifetime.



The bills before the committee today represent critical ongoing efforts to improve diagnosis and patient care by promoting education among consumers and health care professionals and holding providers accountable for the quality of their care. The bills are all vitally important, touch on complex health issues, and deserve our full and serious consideration.

EARLY ACT

I would like to start with H.R. 1740, the EARLY Act—a bill that aligns with the results of Breastcancer.org’s recent research in the area of breast health education and breast cancer risk reduction. The EARLY Act seeks to use education and breast health awareness of young women to promote healthy behaviors to modify or reduce established risk factors. I believe this legislation will do much to advance public health efforts and combat the threat of breast cancer and I commend Congresswoman Wasserman Schultz for her leadership.

Concern: Creating Unnecessary Fears

Opponents of the EARLY Act have expressed concerns that outreach to young women will cause more harm than good by creating fear of breast cancer. But that fear already widely exists. Information about breast cancer is pervasive. Young women—like the rest of us—are surrounded by breast cancer messaging aimed at adult women.

To better understand the impact, Breastcancer.org conducted a research project with girls ages eight through 18 across the U.S. and their mothers. Over 3,000 girls have been surveyed. Nearly 30% of girls have already feared that they might have breast cancer—fears triggered by breast pain, diagnosis in someone close to them, or mistaking the changes of normal breast development for signs of breast cancer. Our data also indicate that over 70% of girls have someone close to them who has been diagnosed with breast cancer, such as a mother, grandmother, best friend’s mom, teacher, or neighbor. And when a breast cancer diagnosis hit close to home, fears were greatly magnified. Girls also experienced significant fear by overestimating their mother’s risk of breast cancer.



Many young women respond with fear to breast cancer messages in the media. Although targeted to mature women, younger women think these messages directly apply to them as well. They simply don't have the resources to understand the meaning and relevance of these critical issues, nor do they have the dialogue skills or opportunities to discuss their fears or seek clarification of breast health myths and misinformation. Overall, only 47% of girls have talked to a parent and 40% have talked with a doctor on this subject. African American girls were less likely to get their information from an adult and more likely to get it from a sister or friend.

To resolve unrealistic fears, young women living in the breast cancer-awareness era need accurate information and reassurance that is age-appropriate and scientifically grounded. Education can arm them with the facts, inform them of what's normal and what's not, and empower them to take charge of their breast health future as they build their breast tissue using what they eat and drink, medicines they take, personal products they use, and by how they use their bodies. At this early point in life, young women are establishing their life-long behavioral patterns.

Concern: Unsubstantiated Value and Content of Educational Programs

Opponents of the EARLY Act have also expressed concerns about the value of educational outreach to low-risk populations in the absence of modifiable risk factors. I respectfully disagree.

Breast cancer is a complex disease with multiple causes, some proven and others suspect. Most risks for breast cancer don't begin at age 45. Rather, they accumulate over a lifetime, beginning at conception. There are periods when breast cells are hypersensitive to internal and external environmental insults and agents: the first trimester of pregnancy during initial organogenesis, the four to 10 main years of breast organogenesis between adolescence and the twenties, as well as the stretch of time leading up to a woman's first full-term pregnancy, when breast cells are highly active and immature. So, the behaviors of women under age 45 impact not only their own breast health, but the future breast health of their daughters through pregnancy and modeled behaviors.



As others have pointed out, not all risk factors are created equal. Some risks—like being a woman, growing older, having a strong family history, and/or a specific breast cancer gene abnormality—carry more significance than others, such as obesity, physical inactivity, alcohol consumption, smoking, and an unhealthy diet. Some risk factors are modifiable, some are not. But even tiny risks can combine and really add up. Concentrated exposures, combined exposures, regular exposures over time—particularly during sensitive periods—can accumulate and collectively increase risk.

For example, besides being a woman, growing older is the biggest risk factor for breast cancer. And while you can't control *that* you are aging, you can control *how* you age: how your inside environment interacts with the outside environment. **We cannot undo past behaviors, but we can limit the damage by promoting a breast healthy lifestyle and behaviors starting as early as possible.**

Another example of a modifiable risk factor: the rising obesity epidemic across the U.S. in children, adolescents, and adults. This epidemic is associated with unhealthy factors that may increase the risk of breast cancer in adults. Extra fat makes extra hormones that can bring on earlier puberty and over-stimulate breast cell growth. In addition, fat stores hormonally active pollutants such as bisphenol A, atrazine, dioxins, and nonylphenols, which might further stimulate unhealthy breast cell growth and activity. Obesity is also associated with reduced physical activity. Moreover, obesity in childhood predicts for obesity in adults and obese mothers are more likely to raise obese daughters.

Contrary to the claim that proven breast cancer risk factors can't be modified, our obesity epidemic is doing just that by accelerating the age of menarche. In the other direction, early education and behavior modification that increases athletic activity and healthy weight management can postpone the onset of puberty. Lessons learned from EARLY Act programs will benefit current and future generations, since women under the age of 45 are in the prime of their childbearing and parenting years.



Opponents cite the HPV vaccine to help prevent the leading cause of cervical cancer as an ideal and preferred approach to prevention. Relative to what we know about the dominant cause of cervical cancer, this is true; my own daughter was one of the first to be vaccinated. But the reality is that this vaccine is given to millions, yet the annual incidence of cervical cancer in this country is 11,270. There is at least the same opportunity to provide breast cancer reduction strategies in high risk women. With the consumer and healthcare education programs in the Early Act, the 5-10% of breast cancers due to an inherited breast cancer genetic abnormality—over 13,000 per year for women of all ages—would more likely be identified, giving these women a greater chance to reduce their risk of breast cancer by as much as 90% with prophylactic mastectomies or 50% with anti-estrogen therapy. They may even pursue embryo selection to essentially eliminate the risk of transmitting the gene to their offspring.

It's imperative that we impart this knowledge, along with what we, the scientific and medical community, know are NOT risk factors for breast cancer. Fear breeds myths. In our survey, more than 20% of the girls surveyed believe that breast cancer is caused by infection, tanning, drug use, stress, and breast injury or bruising. Many girls also believe that only their mother's family history is important and that breast cancer skips generations. These myths were even more widely held by African American girls. And where mothers affected by breast cancer were close in age to their daughters, the daughters were fearful that they could have caught breast cancer from their mothers during pregnancy and breast feeding.

Education can change attitudes, knowledge, and behaviors. We simply must invest in education—from explaining normal breast development and function and imparting facts about breast cancer and breast cancer risk, to providing evidenced-based behaviors and lifestyles that promote breast health. We do a disservice to this and future generations by neglecting to provide this information and facilitate this dialogue. And what a perfect opportunity to reach younger women while they are students in high school and college. Our ability to reliably reach this population vanishes quickly once they are beyond their years of institutional education. Responsible live and print media outreach is also a critical approach. Both fall within the EARLY Act.



Education is Needed to Avoid Over-Reliance on Any Single Early Detection Tool

I've seen how crucial early detection is to not only "survivorship," but to the quality of life. For many patients, early detection could mean not having to lose a breast with mastectomy or not having to experience aggressive chemotherapy.

But as far as we've come, we still have a long way to go. There is no one or combination of perfect tests that can find all cancers early. Each breast cancer detection tool in the limited arsenal for early detection in the general population is both powerful and flawed: mammography, clinical and self breast examinations. This is particularly true in young women whose background dense breast tissue can easily distract or obscure early breast cancer detection. Yet for most women under 40, the use of breast self exams for breast self awareness and clinical exams are the only detection resources they have. A study from Harvard presented at the April 2009 American Society of Breast Surgeons' annual meeting found that 71% of women diagnosed with breast cancer at 40 or younger discovered their cancers through breast self-exam.

Education can help clarify the strengths, weaknesses and complementary properties of each detection method. The ability of "breast awareness" to detect breast cancer early is severely limited by the frequent absence of signs or symptoms. By the time cancers make their presence known through "breast awareness," they are usually later in stage and the opportunity for early detection has passed. The value of mammography in young women with dense breasts is limited by the thick curtain of breast tissue that may block a mammographer's ability to find the relatively infrequent number of breast cancers observed in young women. Prescribed to women age 40 and above and to women 10 years younger than their earliest affected family member, mammography might have to pull in other tests for backup. MRI is a powerful example. With sensitivity as its greatest strength—it's the best at finding invasive breast cancers in their earliest form—and the most guilty of ringing too many false alarms. Comparing and correlating findings of all detection methods require a significant investment of attention and time but will yield the best overall interpretation.



The EARLY Act addresses these complex issues by promoting education—not only to consumers, but among health care professionals who may dismiss early breast cancer signs and symptoms under the premise that breast cancer is rare in women under age 45.

But 24,000 annual cases of breast cancer in women under age 45 does not make it rare. It is just relatively uncommon compared to the much higher incidence in women over 45 (since a woman's risk increases with age). Compared with other cancers, that incidence is not considered rare. When we factor in that breast cancer survival rates are lower for women under 45, we must be realistic about how vitally important the tenets of the EARLY Act are.

Unique Concerns of Young Women with Breast cancer

Special issues that uniquely affect young women with breast cancer will also be included in the EARLY Act. Beyond issues of quality of life and ability to fully function like fertility and cognition, there are issues that affect risk of recurrence and survival, such as, knowing how to get the full benefit of Tamoxifen without major interference from commonly used medicines that might be taken at the same time, like anti-depressants, Benadryl, and Lamisil.

There are many issues to address with regard to the EARLY Act and I look forward to your questions.

Breast Cancer Patient Protection Act of 2009

I've been a long-time champion for Congresswoman DeLauro's bill— H.R. 1691, the Breast Cancer Patient Protection Act of 2009. Mandatory "drive-through mastectomies" are an unconscionable practice that can endanger a woman's recovery and lead to avoidable complications.

A mastectomy and lymph node dissections are serious, invasive surgeries with profound physical and emotional impact. While many women are ready to go home after 24 hours, some need more time. They may experience unexpected complications or have no support at home,



and therefore they may require a longer stay to manage bleeding, pain, drains, and the risk of infection. When patients are turned out of the hospital because insurance refuses to cover necessary post-operative care, their physical and emotional health is further endangered by this unnecessary practice.

There is no "one size fits all" solution. The decision about the length of needed in-hospital recovery time following breast surgery must be made within the sacred relationship between a woman and her doctor, not reduced to a business decision that overrides a doctor's best judgment and the patient's best interest.

Breast cancer is a serious condition that requires serious—and sensitive—attention to the physical and emotional needs of each patient. As someone who has treated thousands of women, I know that the care of these women at this most vulnerable and high-risk time must be individualized. To suggest otherwise demeans the challenge these women face in their fight against breast cancer. I urge this committee to support this bill. It will not only improve patient lives, but potentially save them from preventable serious complications.

Mammogram and MRI Availability Act of 2009

I am also highly supportive of Congressman Nadler's H.R. 995, the Mammogram and MRI Availability Act of 2009, which further requires providers to cover annual screening mammography for women 40 and older and diagnostic mammography, annual screening mammography, and annual magnetic resonance imaging for high risk women. Again, my support stems from the demonstrated survival and quality of life benefits of early detection—particularly for young, high-risk women for whom more sensitive tests may be necessary to find the most life-threatening types of cancer that can hide from standard imaging procedures.

**Eliminating Disparities in Breast Cancer Treatment Act**

H.R. 2279, the Eliminating Disparities in Breast Cancer Treatment Act, sponsored by Congresswoman Castor, addresses a critical gap in the quality of medical care for all Americans. I've witnessed this on a daily basis in my clinical practice in the Philadelphia area. Sadly, African American women continue to have worse outcomes than Caucasian women: they tend to utilize mammography less, get diagnosed with more aggressive types and stages of cancer, and their treatment outcomes and survival are also significantly worse. These disparities are absolutely unacceptable and have persisted for far too long. I commend Congresswoman Castor for her efforts to improve a situation that will not otherwise resolve itself.

In conclusion, I would like to thank the Chairman, the Subcommittee, and the panel for giving me the time to speak with you today. I applaud the efforts of the sponsors and supporters of these bills and am grateful for the platform to openly discuss these vitally important issues affecting so many precious Americans lives.

Mr. PALLONE. Thank you, Dr. Weiss.

Now we will have questions from the members, and I will start myself, and I wanted to ask Dr. Taplin some questions initially.

In fiscal year 2007, the National Cancer Institute invested nearly \$600 million in breast cancer research. I understand the Institute devoted roughly the same amount of resources towards research on this topic in 2008. Can you describe, Dr. Taplin, the activities that NIH is supporting, understand how women can actually prevent breast cancer in the first place and how is NIH investing in research into improved breast cancer screening as well as into treatment of breast cancer once it has been diagnosed, in less than 2 minutes? Whatever you can do.

Dr. TAPLIN. There are many studies related to breast cancer at NCI. As you have already noted, we had \$572.6 million and 2,146 studies at NCI in fiscal year 2008. Those are concentrated in several areas but the ones relevant to your question are prevention, early detection and treatment. We spent approximately \$27 million on prevention, \$54 million on early detection and \$169 million on treatment studies, so all of those are relevant to your question. I think probably the most interesting piece, and there are several, and many places we can go among the 2,146 studies we did. The most important, I think, is the Breast Cancer and Environmental Research Act, which came from you folks and resulted in a center, a set of centers to look at basic—the relationship between environment and biology of young women's breast development, and so there are biologic studies in women, there is epidemiology study in young women and there is also a group of people looking, academicians and educators, looking at how you communicate these issues to women and to young women especially so that we can begin to adapt those message to the population that we are targeting. Those are some of the areas we are working on.

Mr. PALLONE. All right. Thank you.

Dr. BRAWLEY, I wanted to ask you, the U.S. Preventative Taskforce recommends that women over 40 have annual or biannual mammograms. Your organization recommends annual mammograms for women over 40 and clinical breast examinations for women in their 20s or 30s. So unless a woman under 40 has an identified risk factor, there is no recommendation that she get a mammogram. Obviously, you know, this relates to Congresswoman Wasserman Schultz's legislation. Would you elaborate on the challenges for women under 40 and what can we do for these women to detect their cancers as early as feasible?

Dr. BRAWLEY. Yes, sir. Thank you for the question. Part of the answer to your question is mammography is a terrible test for women who have younger breasts and denser breasts. It is a terrible test for two reasons. Number one, it is very difficult for the radiologist to actually make an interpretation of that X-ray because of the breast density, and number two, radiation does cause some cancers and causes cancers in young breasts that are more active in terms of biology. So if you actually were to give radiation to the breasts of, say, 10,000 women who are under the age of 20 and do it on an annual rate, there are some people here—I am not one of them—but they can calculate how many breast cancers we will ultimately manufacture. Now, in randomized clinical trials of women

who are older, in their 40s, 50s and 60s, we have evidence that mammography clearly saves lives in screening, so what we like to do is, if a woman has a mass and she is in her 20s or 30s, if she finds the mass or if someone finds it on clinical exam, a clinician, be it a nurse practitioner or a physician, then perhaps doing a mammogram is appropriate in that one particular individual. If you have someone who is at very high risk, perhaps the mammogram is appropriate or perhaps an MRI is, but to do mammography, mass mammography in the United States in younger women, it would be literally public health malpractice because we would actually manufacturing some breast cancers.

Mr. PALLONE. Okay. I was going to ask a third question but I don't have that much time left, so I will move to other members. The gentleman from Georgia, Mr. Gingrey.

Mr. GINGREY. Mr. Chairman, thank you, and I will ask all of the panelists, and I thank you for being here, the same question, and I will start with Dr. Taplin. Some have said that this bill will spread fear of breast cancer among women who shouldn't be concerned at such a young stage of their life. As physician, I believe that arming patients with medical information is a good practice as long as the message is, of course, well crafted and well delivered. Do you have any concerns that keeping this demographic well informed will cause more harm than good?

Dr. TAPLIN. That is an excellent question. I think the problem is that we don't have the evidence to give you the answer. The problem is that there is some evidence out there that there is a U-shaped curve, that there is a perfect amount of fear. A little bit of fear may be helpful. A little bit too much fear may be harmful, and we don't really know where the balance is between those things and we don't know enough about messaging from my standpoint to know what the answer is to the question you are posing, so that is part of why we are sponsoring the study that I have already mentioned.

Mr. GINGREY. Dr. Brawley.

Dr. BRAWLEY. Dr. Gingrey, part of the American Cancer Society's early concern about this bill was that it wasn't clear who was going to create the messages that were going to be conveyed to the population. Now that it is very clear that a committee of scientists appointed by the director of the CDC will be those that craft the messages that should be conveyed, we feel very comfortable with educating the population because we have some assurances that the messages will be created by experts. So yes, I am agreeing with you and I think that the messages that would be conveyed through the EARLY Act would be message that would be scientifically valid. Now, you are correct that the messaging to individuals, be they youth or be they people in their 50s, is sort of like a T1 line. The more health messages that you put forth, you diminish all the other health messages. Currently, the EARLY Act, as I see it, allows for messages about diet, messages about exercise and nutrition, and it actually may be more than a breast health act, much more a health act because it is going to—if the messages are received appropriately, it is going to prevent diabetes and heart disease which actually, by the way, kill more people in their 30s and 40s, females in their 30s and 40s, than breast cancer.

Mr. GINGREY. Ms. Luray.

Ms. LURAY. Congressman, we agree with Dr. Brawley. We are pleased how the bill has evolved over time. One study of young survivors found that 40 percent didn't believe that young women could even get breast cancer, so part of what we are looking for is a very targeted campaign that lets women know that while it is a very small risk, it is possible so that if they feel that lump, they don't ignore it, or if they go into their doctor's office and they say I feel like I have a lump and the doctor says oh, it is just dense breast tissue, don't worry about it, they can't pursue their concern, and again, based on factual information pulled together by the appropriate sources.

Mr. GINGREY. Ms. Ness.

Ms. NESS. I will just reinforce what my colleagues here have said. I think we can't underscore enough the importance of basing what we do on evidence, and we need the research to tell us what makes us both in terms of medical practice but also in terms of how we educate and increase awareness.

Mr. GINGREY. And Dr. Sledge.

Dr. SLEDGE. Well, I think we all agree that knowledge is power, but it is only powerful to the degree to which it is accurate and we can act on it, and I think careful evidence-based data is actionable. The problem in younger women, to be honest, is that a lot of what we don't know exceeds what we do in terms of prevention for young women in terms of early diagnosis, in terms of the health habits for these women. So I think physicians and all of us need to be very careful about pretending more than we currently know.

Mr. GINGREY. Ms. Visco.

Ms. VISCO. Well, I couldn't have said it better than Dr. Sledge did. I think it is very important that message that we give out are based on evidence, that are factually correct and that there is something you can actually do about that information, but I want to make clear that the evidence of harms that some people are concerned about and we are concerned about certainly with giving messages about breast cancer to millions and millions of healthy women, the vast, vast majority of whom will never get breast cancer, is also the distinct and clear possibility that has been shown in clinical trials of unnecessary biopsies, that young women are going to feel things in their breasts, they are going to have biopsies. Those biopsies can result in infections and in further harm. So it is not just the issue of anxiety. That is why it is so incredibly complex.

Mr. GINGREY. Dr. Weiss, before you respond, and as a breast cancer surgeon and having treated many, many patients, how young do you think we really should give this information to young women? At what age do you start doing that?

Dr. WEISS. Well, this information becomes—it is important to deliver it when it is most relevant, and we find that girls are going through puberty earlier and earlier these days and their breasts are very much on their minds. I think the power of education is not just delivering education along the way but correcting this massive misinformation that is out there. Our surveys have shown that over 20 percent of girls think that antiperspirant use, getting bumped in the breast, infection, drug use, drinking coffee, wearing

a bra, an underwire bra, increase the risk of breast cancer, and without the correct information that is well established today. So I do think that when you replace myths with facts that you do free these girls of some of the anxiety they have about growing up and going from a big girl to a young woman and a young woman to a mature woman, and I think that that is going to make them more engaged in proactive healthy behaviors through their life, and while they are in high school and college, they are in educational institutions, they are within a system where knowledge delivery is——

Mr. GINGREY. So educating them as teenagers but not necessarily preteens?

Dr. WEISS. Well, we have found that a lot of misinformation, fears and questions present themselves upon adolescence, and whether or not you want to go back that early is a question that has to be studied, but those questions certainly exist, and they are inadequately addressed right now in current health classes within middle schools and high schools.

Mr. GINGREY. Mr. Chairman, thank you very much, and thank all the panelists. I appreciate your response.

Mr. PALLONE. Thank you.

Ms. Castor.

Ms. CASTOR. Thank you, Mr. Chairman, and thank you all. Your testimony was very insightful, everyone.

Ms. LURAY, I would like to thank you and the Susan G. Komen for the Cure Advocacy Alliance for extending your support to my Eliminating Disparities in Breast Cancer Act since it was first introduced last Congress, and I would like to return the thanks and commend you all for everything that you have done to raise awareness about disparities in access, access to screening, access to quality care and treatment. The work you have done both with the American Society of Clinical Oncologists and the Metropolitan Chicago Breast Cancer Taskforce to reduce disparities is very commendable. Could you discuss what you believe we can do further to educate women about the types of treatment that they should look to receive after diagnosis so that women are not in the dark and are empowered to take control of their health and diagnosis? And please explain how moving forwards towards rewarding providers for quality care and ensuring that providers are not rewarded for inadequate care will help to reduce disparities in treatment.

Ms. LURAY. Thank you, Congresswoman, and we appreciate your leadership as well. I would like to take a minute just to talk briefly about our partnership with the Metropolitan Chicago Breast Cancer Taskforce because I think it is partnerships like this that will give us the data that then can be modeled by other community-based programs to promote the type of quality breast cancer care you are talking about across common and racial ethnic lines. In Chicago, the breast cancer mortality rate for African-Americans is even worse than in the rest of the country. African-American women in Chicago have a 68 percent higher mortality rate than white women do, and the taskforce that we are involved in and are supporting developed an action plan for three main causes of the disparity, and it is almost like a tragic Rube Goldberg image be-

cause first of all, they have to get access to mammography, and that is either physical, where it is, how do you get there, and economic, can they afford it. But then they have to make sure that is of high quality, and we as providers and advocates need to make sure that that mammography is of high quality. And then they have inadequate access to treatment, and then you have to ask the same questions about their treatment, is the treatment that they are getting at the same level of evidence and the same level of quality that higher-income women are getting. So again, there are so many barriers that need to be addressed in terms of ensuring that this disparity in care does not continue in communities. But we are very hopeful that what we are doing in Chicago and what we are funding in communities across the country can help to promote a very high-quality breast cancer treatment program.

Ms. CASTOR. Have you targeted other communities besides Chicago?

Ms. LURAY. Yes, we have, and I would be happy to share that information with your staff.

Ms. CASTOR. Terrific.

The American Cancer Society found in 2007 that certain additional screenings after diagnosis and initial treatment are not equally administered among patients, particularly tests to ensure that cancer has not spread to nearby lymph nodes. Maybe Dr. Brawley, can you share with us, have you found that additional screenings after treatment that are considered essential are not always accessible? I think you testified to that account.

Dr. BRAWLEY. Yes, ma'am.

Ms. CASTOR. To what do you think that we can attribute the fact that some providers simply are not universally screening patients for potential spread of their cancer to other areas of the body?

Dr. BRAWLEY. I think the likelihood—I don't have a study that I can quote for you but I can tell you as someone who has practiced medicine, the likelihood is that there can be a couple different reasons, and what we are talking about there is follow-up exams after treatment to see if the disease has come back. Sometimes the physicians simply forget, which is unfortunate on the part of the physicians. Sometimes the patients are advised to get the test or it is prescribed and they don't go and get the test. Sometimes, and this is the more common problem, there is an affordability problem, copays and other things that people are just unable to come up with, even if insured, and I am actually much more concerned very frequently about the insured individual who doesn't have very good insurance than even the uninsured individual because quite a few people today—I just saw a figure, more than 60 percent of personal bankruptcies are due to health care costs. Quite a few individuals with breast cancer who need to get a chest X-ray or even just a simple liver function test that might cost \$80 simply can't afford the continued copays over time so they don't get those therapies.

Ms. CASTOR. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you.

The gentlewoman from Ohio, Ms. Sutton.

Ms. SUTTON. Thank you, Mr. Chairman. Before I begin, I could ask unanimous consent to enter into the record testimony from Lifetime Networks.

Mr. PALLONE. Without objection, so ordered.

Ms. SUTTON. Thank you. And before I turn to the panel, Mr. Chairman, if I could, I would also just like to recognize Kathy and Lee Giller, who are here from Akron, Ohio, my district, and they are town for the 3-day Susan G. Komen Walk, and Kathy was the number one fundraiser from Cleveland this year, and we are proud to have her here with us.

As for the panel, thank you very, very much for your testimony, and it is hard to sit here without thinking about the people that we have known in our lives who have suffered from breast cancer, some who have been lost, some who are fighting the fight now, and of course, wondering about those who may encounter this battle in the future. Several of you in your remarks and in your testimony, you stress the need for the access to quality, affordable health care. Ms. Visco, you talk about quality, affordable health care for all. I appreciate that, and I concur. Dr. Brawley, you also talked a lot about the need to get health care for women. And Dr. Weiss, one of the things that you said that was striking to me and I think it is important is, you talked about the unique needs of patients because not always does one size fit all on this issue. And as I sit here, one of the people who comes to mind was a woman who I knew 10 years ago when I was working on these issues in the State legislature, and her name was Linda. She had breast cancer. Her mother had had breast cancer, her aunt. It was very pervasive in her family. Her doctor wanted to treat her aggressively because of the family history, a doctor attached to an institution that is of high renown when it comes to treatment, and the insurance company said no, we are not going to pay for coverage of that treatment. Her treatment was delayed because she had to raise money for the treatment. She ultimately succumbed to cancer. I went to her funeral and I listened to her young daughter get up and give a report about an essay that she wrote in school about how her mom was her hero because not only did she fight against breast cancer, she fought against the insurance company to try and make things better for other people in the future.

So my question, I guess, is, that was a decade ago, is it better now? Are the treatments that the doctor is asking for, are they covered? Dr. Brawley, would you like to respond?

Dr. BRAWLEY. Yes, and I get in trouble for just saying the flat-out truth. There have been instances where the insurance companies have been wrong and there have been instances where the patients have been wrong and there have been instances where physicians have been wrong. Ms. Visco talked about bone marrow transplant for breast cancer. Very quickly, the thumbnail history of that, in the early 1990s many people thought high-dose chemotherapy with bone marrow transplant would be beneficial for women at high risk for relapse of breast cancer. Many hospitals started these bone marrow transplant programs as a way of making money. Ten State legislatures passed laws saying that insurance companies had to pay for them. Many women sued their insurance companies because they didn't want to pay for it. There was no scientific evidence to support it. Ultimately, this delayed the NCI studies that ultimately showed that bone marrow transplant in breast cancer was more harmful than helpful. This is when people stop being sci-

entific and start practicing—you know, earlier I said in my statement that one of the problems with this disease is, it is a complex disease and we all want to make it very simple and we all want to have very simple messages. That is a darn good example of how the simple message, more chemotherapy must be better, actually killed women. It wasn't that it was just a waste of money. It actually killed women.

Ms. SUTTON. I appreciate your answer, and I think that again goes back to the point of, it isn't simple. It is all very multi-faceted and there are unique considerations in every story right, so it is very difficult to—

Dr. BRAWLEY. But Congresswoman Sutton, the answer to your question is what you described does happen where people want to get the right therapy and someone in an insurance company or others somehow decides that they should not get the right therapy. That does happen.

Ms. SUTTON. It is one thing to make a determination based on health needs and it is another thing to make a determination based on money.

Ms. LURAY. And Congresswoman, if I may add, there is the issue of access to experimental treatment and how that access is granted and whether or not it is based on scientific evidence but there is also access to ongoing treatment that many of our patients experience. There was a young woman here, Anna van Lear, who had to fight her insurer after being diagnosed with breast cancer, had to fight to get her MRI because of her age, and that occurs again and again, so the experimental treatments are one issue but it is the ongoing need for surveillance care, side effects, et cetera and having to battle the insurer every day, and of course the economic loss that they experience too because of the high out-of-pocket expenses.

Ms. SUTTON. Thank you.

Dr. Weiss.

Dr. WEISS. The cost of negotiating with the insurance companies throughout each clinical day has lengthened my day by 2 hours and it has slowed down the urgent feeling a patient—you know, her ability to get what she needs when she needs it, and we have doubled our office staff just to get enough people on the phones to get the authorizations for tests or for treatment or see a new doctor or to get a second opinion and maybe even a third opinion in a complex case. So in terms of the cost of health care, I don't think that these barriers are saving us money, I think that we need these laws today to give the physicians the ability to deliver the optimal care in terms of early detection, treatment and surveillance of women beyond their initial treatment.

Ms. SUTTON. Thank you.

Mr. PALLONE. Thank you.

The gentleman from Iowa, Mr. Braley.

Mr. BRALEY. Thank you, Mr. Chairman.

Dr. Brawley, I want to follow up with your observation because you might find it interesting to note that I used the exact example that you were describing in an earlier markup we were having on health care in this same conference room, and one of the things we can't ignore is sometimes the political implications of important public policy decisions we are making that involve academic re-

search, scientific research, medical research and most importantly people. Because the story I used was from a book by Shannon Brownley. It was given to me by a family practice doctor, "Over-treatment" and this exact scenario that you were describing is mentioned at length in that book, and this very conference room was filled with women who were getting high-dose chemotherapy with bone marrow transplants and the person who developed that treatment methodology was sitting in these witness chairs and turned with his back to members of Congress and had all those women stand up and then said to the members sitting in this hearing room, "Fifty percent of these women will be dead if you don't approve funding for this treatment." So we are really talking about a high-stakes poker game here, and I think what all of us want to get to is a health care delivery system that is based upon evidence-based decision making that makes sense for the greatest portion of the population.

I had the opportunity before I came to Congress to represent a retired swimming coach who was diagnosed with prostate cancer, and the treatment of choice that he decided upon was not covered by Blue Cross/Blue Shield through an employer-sponsored health care plan, and after a lot of research and investigation, we determined that Blue Cross/Blue Shield was also the administrator for Medicare in the State of Iowa and covered that form of treatment as non-experimental. So when we are talking about making health care available to women who have been diagnosed with breast cancer, we all need to know the best evidence available and we also need to eliminate these bizarre distinctions between coverage options so that no woman who has been diagnosed with breast cancer is faced with the difficult decision of deciding how she is going to pay for treatment under one program that she could get if she was old enough to be covered under Medicare or something else.

And so one of the things I would like to ask the panel about is why this particular class of women, younger women who do not fit traditional theories of who is most likely to be diagnosed with breast cancer, why are they more vulnerable than other segments of the population, if they are, and what types of attitudes do they bring to their treatment that make them more challenging as a group, if they are, than other groups of women?

Dr. BRAWLEY. If I could start first, sir, and thank you. I truly do believe that adequate health care reform includes reforming how we consume health care. We have to all learn to be more scientific and appreciate the science and the evidence. One aspect of the EARLY bill which I think is important is, it actually puts aside some money to address the very questions that you just addressed: what is different about younger women, how can we help younger women who have this disease. That is actually some of the most important parts of the EARLY bill. The ACS had some difficulty with the bill early on because some of the messages that were in it were not messages that we thought we could support. We wanted evidence-based good messages. Now we have scientists and survivors in a committee coming up with what the evidence-based messages should be, but one thing this bill always had was research to look at the quality of life needs of women with breast

cancer, women who have been diagnosed who are in their 20s, 30s and 40s. That has always been a very good part of this bill.

Mr. BRALEY. Yes?

Ms. VISCO. I would say that we don't know very much about breast cancer in any age group. There are some data that younger women are more likely to be diagnosed with triple negative breast cancer, a specific type of breast cancer, for which we have treatments for estrogen receptor-positive breast cancer that work well. We have treatments for HER2 overexpressing breast cancer that works well. For triple negative, we don't yet have targeted therapies that work well. So more research into looking at that type of breast cancer, although there are a number of new possibilities in clinical trials now.

There is also the issue of fertility. I was 39 when I was diagnosed. I had chemotherapy. I did go into premature menopause. I didn't have the opportunity to have more children. There are side effects with treatment no matter how old you are. That is a side effect of treatment for younger women. It is something we need to do more research on. But we just don't have the information. We just don't know enough about breast cancer and certainly not enough about breast cancer in younger women.

Dr. SLEDGE. I can only add a little, but these women are vulnerable in many ways. One is, as Fran has just mentioned, they are biologically vulnerable. They tend to have much more aggressive cancers than do older women, cancers that grow rapidly, cancers that are more likely to spread to other parts of the body at an earlier point in time, cancers that are less targetable in terms of hormonal therapy or HER2-targeted therapy, so they are biologically vulnerable. They are economically vulnerable. These are women who by and large are less likely to have insurance just because they are at an earlier point in their life and they are not as far along up the chain that would allow them to have a good health care ability to cushion any blows. Economically, they can't cushion the blows because they don't have any money in the bank. Socially, they are vulnerable because they perhaps just started their family or just got married. They have to worry about these fertility issues that a woman who is 20 or 30 years older would not have to worry about. So across the board, Congressman, they are far more vulnerable than our older patients.

Mr. BRALEY. Are the criteria that the AJCC staging manual is using for breast cancer adequate to try to delineate any of these specific concerns that you have mentioned here today or are they using broad groupings of women that don't allow us to have the ability to drill down and define criteria that would be more age-appropriate for different segments of the population?

Dr. BRAWLEY. Sir, I can only give my opinion as a physician who treats breast cancer patients. I think the AJCC which does the staging manual has done a good job although it actually being re-evaluated right now as we speak. I think one of the great problems we have in breast cancer is, our definition of what cancer is actually comes from some German pathologist in the 1840s, and we have not actually brought the definition into a molecular or genetic age. We are still using the same science, looking at it under a microscope with a glass to say this is cancer that we used 160 years

ago, and one of the challenges to us in science is to find a genetic way to look at a tissue and say that this particular tissue in this woman's breast is going to behave in this particular way over the next 20, 30, 40 years and that is how we ought to treat it. This particular tissue is going to be very aggressive so we need to treat it aggressively. This other woman's breast cancer is going to be less aggressive so we will treat it or maybe even watch it and be less aggressive. We have not gotten there but that is where hopefully the science is going to take us. That is hopefully where the sequencing of the human genome is going to take us, and maybe 20 years from now we will be talking about those tests.

Mr. BRALEY. Thank you.

Dr. WEISS. I would just also add that in the care of any woman who has been diagnosed with breast cancer who is also a mother, one of her biggest concerns is, what does my diagnosis mean for the women in my family, and that question comes up all the time and so that is an area of research that I know we are all involved in that deserves much better answers because if you don't deal with that profound fear and concern for her, you haven't really taken care of the whole woman or her whole family.

Mr. BRALEY. Thank you very much.

Mr. PALLONE. Thank you all. I know it has been a long day. We had a delay and had votes and all that, but I thank you for bearing with us, and this was very enlightening in terms of the whole issue. As I said earlier, this was a legislation hearing so we are going to have to sift through all this and figure out what is in the health care reform and what isn't, but we do intend to try to move the bills that were considered today. And let me just mention that members can still submit written questions to you. They are supposed to submit them within 10 days and then the clerk notifies you, so we may ask you to respond in writing to some additional questions. But thanks again, and without objection, this meeting of the Subcommittee is adjourned.

[Whereupon, at 4:00 p.m., the Subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

October 7, 2009

STATEMENT OF THE HONORABLE JOE BARTON
RANKING MEMBER COMMITTEE ON ENERGY AND
COMMERCE

SUB-COMMITTEE HEARING:
"BREAST CANCER"

Mr. Chairman, thank you for recognizing me for an opening statement on this important issue. Breast cancer is the most common cancer among women in the United States, Fortunately death rates have declined since 1990 because of the success of early detection programs and advances in treatment.

I am pleased we are discussing the significance of breast cancer awareness during October as it is National Breast Cancer Awareness Month. There have been many initiatives taking place across America to recognize the women battling breast cancer and the programs to educate women on how to detect cancer in the earliest stages. This past weekend, the Dallas Cowboys players and coaches wore pink to recognize the Susan G. Komen for the Cure Advocacy Alliance and the need to continue research and educational efforts through public and private partnerships. I think the only thing I would have changed about that game on Sunday would have been the

final score, but I am happy to see that even the NFL is involved with educating the public about a cancer that affects nearly every household in America.

However, I do have an overall concern about why these bills were not discussed during debate on H.R. 3200, which creates numerous new programs in the public health realm. HR 3200 creates a “Public Health Investment Fund” which would be used to fund all public health and workforce activities. The fund is authorized at \$88.7 billion. Let me repeat, that is \$88.7 billion and all funds are outside of any pay-go requirements. This money is also in addition to any other monies already being spent on similar activities. HR 3200 also authorizes \$35.3 billion from the Public Health Investment Fund to be used for prevention and wellness activities. This includes grants to states and local public health departments for providing community wellness services.

The bills that we are going to discuss today deal with breast cancer from a public health standpoint. They involve new funding for education and outreach campaigns, new funding for research, quality and performance measures for breast cancer treatment, and hospital length of stay requirements for breast cancer patients. I am supportive of these efforts; however, we could have had this discussion during our health care reform

debate. I would like to understand whether many of these activities be covered under the Public Health Investment Fund? What will the essential benefits package look like if these bills are passed? In addition, I would like to know how much funds we are already spending on breast cancer outreach and research? These are just some of the questions that come to mind as we learn more about these bills.

Breast cancer is a very important issue to address. I hope as we continue to discuss the direction of America's health care system we have the opportunity to take a closer look at the programs that tax payer dollars are being spent upon. I want to thank our witnesses today and the Breast Cancer community for their commitment and endless dedication to finding a cure, educating the public, and research activities. Also, thank you Representatives DeLauro, Lowey, Nadler, and Wasserman-Schultz for joining us as witnesses before the Energy and Commerce Committee today. Mr. Chairman, I yield back the balance of my time.

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ENERGY AND
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Vice-Chairman, Oversight
and Investigations Subcommittee

POPULIST CAUCUS
Chairman

**Congress of the United States
House of Representatives
Washington, DC 20515**

October 7, 2009

Congressman Bruce Braley
Opening Statement

House Energy & Commerce Subcommittee on Health
Hearing on H.R. 995, the Mammogram and MRI Availability Act of 2009, H.R.
1691, the Breast Cancer Patient Protection Act of 2009, H.R. 1740, the Breast
Cancer Education and Awareness Requires Learning Young Act of 2009, and H.R.
2279, the Eliminating Disparities in Breast Cancer Treatment Act of 2009

Thank you Chairman Pallone, and thank you for holding
this hearing. Since October is National Breast Cancer
Awareness month, I think it is fitting that this committee is
devoting its time to address the causes, prevention and
treatment of breast cancer by considering these four bills.

Breast Cancer accounts for more than a third of the
cancer diagnoses of women in the United States, and is the
7th leading cause of death among women of all ages. In
Iowa alone in 2009, it is estimated that 2,150 women could
be diagnosed with Breast Cancer and that 420 could die

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from this disease. In the midst of work on broad Healthcare reform and during National Breast Cancer Awareness Month, the House should pause to consider addressing access to care, education, and treatment for breast cancer.

I support the goals of these four bills. Improving access to care by ensuring the coverage of breast cancer screening and treatments by insurance will ensure that women can receive the care they deserve to treat the cancer and beat this disease. Education at an early age on the risks and diagnoses of breast cancer can make early detection possible and improve the chances of survival by beginning treatment in the early stages of cancer. Comparative effectiveness studies on treatments in relation to breast cancer can improve the quality of care these patients receive and further improve their chances of survival.

This Congress, through the appropriations process, we have demonstrated our commitment to battling breast cancer by supporting funding for the important cancer research

projects at the National Cancer Institute of the NIH, and through the Centers for Disease Control and Prevention efforts to research the causes of breast cancer and provide screening services to underserved women. I have also worked to secure funding for a mobile mammography unit within my district to improve access to screening services, and am proud to say that women in northeastern Iowa are now receiving free mammograms as a result of this effort. The bills before us today take the next steps in ensuring better access to care and further education to prevent breast cancer from going undetected and untreated.

Thank you, Mr. Chairman, for taking up this important issue, and thank you to the witnesses for coming in today.

Rep. Joseph R. Pitts
Opening Statement
Energy and Commerce Committee Subcommittee on Health

Hearing on Breast Cancer

October 7, 2009

- Mr. Chairman, I would like to thank you for convening this hearing on such an important issue.
- In my home state of Pennsylvania, breast cancer is the leading cancer among women.
- It is the second leading cause of overall female cancer *death* in Pennsylvania.
- In 2006, there were 9,739 cases of invasive breast cancer in my state, and breast cancer claimed 2, 294 lives.
- On average, last year in Pennsylvania, 25 cases of breast cancer were diagnosed daily, and approximately 5 women lost their battle with breast cancer every day.
- Sustained awareness and education campaigns have taught women the risk factors that increase their chances of getting breast cancer; given women important tools to lower their risk of breast cancer; and emphasized the necessity of screening and early diagnosis.
- NIH, CDC, and even DOD have been working hard for years to develop prevention strategies, treatments, and, ultimately, a cure for breast cancer.
- We've made great strides in those areas, and I hope our witness from NIH can bring us up to date on NCI's latest research.
- For all of our progress, though, we need to do more, and I look forward to learning about the four bills before us today, as well as hearing the thoughts and testimony of our witnesses.
- Thank you, and I yield back my time.

October 7, 2009

MEREDITH WAGNER | EVP



Dear Members of the Subcommittee on Health:

In 1996, 13 years ago, Lifetime first heard about the practice of "drive-through" mastectomies, when women are forced out of the hospital hours after major breast cancer surgery, even if they and their doctors do not think they are ready to go home.

That was the year that Representative Rosa DeLauro (D-CT) first introduced the bipartisan Breast Cancer Patient Protection Act, to allow a woman and her doctor to decide whether she should recuperate for at least 48 hours in the hospital or whether she has enough support to get quality care at home. It never did and still does not mandate a hospital stay, if both the woman and her doctor feel it unnecessary.

Having a mastectomy is not simple surgery. It is painful. General anesthesia is used. Drainage tubes are put in place that need to be emptied of fluid and kept very clean. It is also traumatic for women to lose a breast, a noticeable piece of themselves that carries both the important function of feeding babies and unfortunately, too much societal weight of being considered a measurement of attractiveness. Some women have family and close friends who can help them deal with these physical and emotional challenges. Others do not.

One size does not fit all. One length of stay does not work for everyone. That is why there needs to be flexibility to fit with women's needs and doctors' recommendations. This flexibility would help create a basic standard of care that all patients deserve. This is a bill about providing the option for up to a 48-hour stay in the hospital. Again, there are no mandates of hospital stay length in this bill, just the added ability to take control of one's health according to doctor recommendations, if one chooses.

It may be unusual for a television network to be involved in any legislative effort, but as the #1 channel for women, Lifetime has a long history of advocating for its viewers.

As soon as the network began talking to viewers about the issue of "drive-through" mastectomies, we heard from thousands of women and their families that they were indeed facing the problem and wanted Congress to take action to address it.

Lifetime went on the air with PSAs and launched an online petition to urge Congress to pass the bipartisan Breast Cancer Patient Protection Act. In the first year, the petition had 17,000 signatures. Today, the petition on myLifetime.com has been signed nearly 25 million times. Based on unscientific research, this may be the largest petition in support of a bill.

Routinely, Lifetime and members of Congress from both sides of the aisle, including Representative DeLauro and Senators Snowe (R-ME) and Landrieu (D-LA), have come together to present these signatures and stories to all lawmakers.

Nearly five years ago, Lifetime stood on Capitol Hill with a single mother from Maryland named Shelly Slick, who had signed the petition after she had been forced out of the hospital too soon and got an infection that delayed her chemo treatment. No one can know if the delay made a difference, but sadly, Shelly died, leaving a young son behind.

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Two years ago, Alva Williams, who signed the petition from her home in North Carolina, came to the Capitol steps and recounted how, after her breast surgery, she was forced to drive three hours to get home following her outpatient surgery and then have her 80-year-old brother change her drainage tubes once she was home. She too developed an infection that delayed treatment, but fortunately is doing well today.

Grammy-nominated singer/songwriter Jewel and "Desperate Housewives" star Marcia Cross have also come to Washington and joined the chorus to bring even more attention to the cause.

In addition to signing the petition, many women and men have shared their stories about "drive-through" mastectomies. And those stories underscore our concern that 13 years after the bill was first introduced, drive-through mastectomies are still occurring every day in this country.

Abi, a woman from Arizona wrote just last month, "I had a double bilateral mastectomy in June of this year. I was discharged with in two hours after surgery. I had severe complications that later resulted in being re admitted to the hospital within the first week post surgery. "

Ann wrote, "I had a bilateral mastectomy in April 2003 and was sent home on pain meds and with drain tubes still in place. A few days later I had a severe infection in the left side drain incision and was back in the hospital."

Bethany shared, "I had a mastectomy in July 2004. I stayed one night and had to leave the next morning. My drains became a problem; one stopped working and became infected."

Betty said, "I'm one of those who suffered from the 'kick 'em out, even with tubes' rules. I developed a staph infection that became deadly -- I believe it would not have gotten so bad if I'd stayed another night."

Last Congress, the Breast Cancer Patient Protection Act overwhelmingly passed the House of Representatives. This Congress it is again being championed by more than half of the Congress, with 237 cosponsors from both sides of the aisle. The Senate bill, introduced by Senator Olympia Snowe (R-ME) and Mary Landrieu (D-LA) has 17 cosponsors. Prestigious organizations including the American Cancer Society, breastcancer.org, Breast Cancer Network of Strength (formerly Y-Me National Breast Cancer Organization), Families USA, the Oncology Nursing Society, Sisters Network Inc. and Susan G. Komen Foundation also support the legislation.

Lifetime's viewers, lawmakers from both parties and prominent nonprofit organizations believe this bill is an important first step to increasing research into the causes and treatments of breast cancer and to improving access to quality health care for all Americans. This is a standard of care all women deserve.

For Shelly, Alva, Lynn and the millions of women and families who have shared their horrific stories of "drive-through" mastectomies on myLifetime.com, it is 13 years too late. But for the nearly 200,000 women who will face breast cancer this year, it is about time.

On behalf of the millions of women and men who have signed the petition on myLifetime.com, we thank Representative Pallone and the entire Subcommittee on Health within for the House Energy and Commerce Committee for your initiative in giving the Breast Cancer Patient Protection Act a hearing. We hope that you will move quickly in order to allow this life-saving bill to come to a vote on the House floor.

Sincerely,



Meredith Wagner

Executive Vice President

Lifetime Networks



