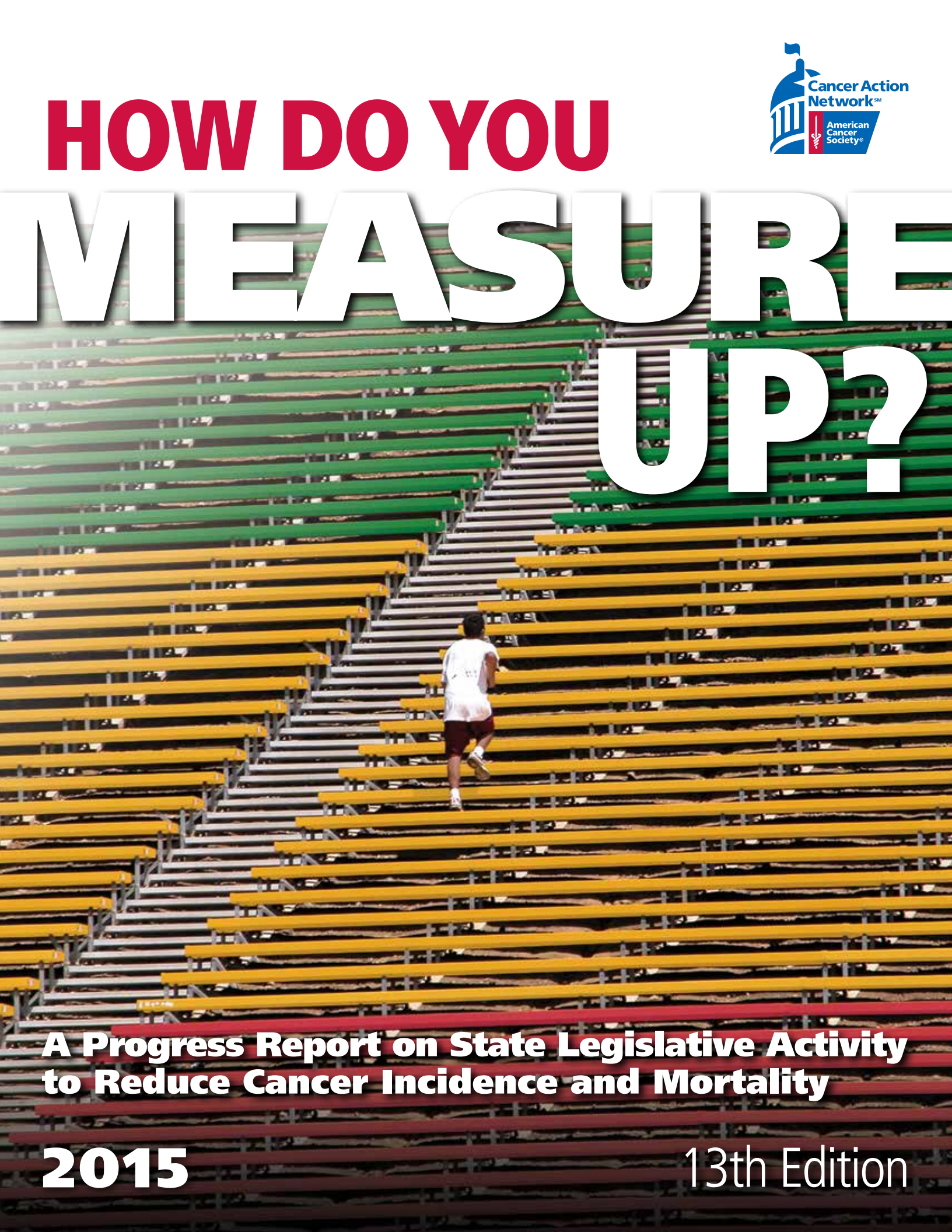
HOW DO YOU MEASURE UP?



A Progress Report on State Legislative Activity to Reduce Cancer Incidence and Mortality

2015 13th Edition

MISSION STATEMENT

American Cancer Society Cancer Action Network (ACS CAN)

ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. ACS CAN works to encourage elected officials and candidates to make cancer a top national priority. ACS CAN gives ordinary people extraordinary power to fight cancer with the training and tools they need to make their voices heard. For more information, visit acscan.org.

Our 13th Edition

The 13th edition of ***How Do You Measure Up?*** illustrates where states stand on issues that play a critical role in reducing cancer incidence and death. The goal of every state should be to achieve "green" in each policy area delineated in the report. By implementing the solutions set forth in this report, state legislators have a unique opportunity to take a stand and fight back against cancer. In many cases, it costs the state little or nothing to do the right thing. In most cases, these solutions will save the state millions and perhaps billions of dollars through health care cost reductions and increased worker productivity. If you want to learn more about ACS CAN's programs and/or inquire about a topic not covered in this report, please contact the ACS CAN State and Local Campaigns Team at (202) 661-5700 or call our toll-free number, 1-888-NOW-I-CAN, 24 hours a day, seven days a week, and we can put you in contact with ACS CAN staff in your state. You can also visit us online at acscan.org.

TABLE OF CONTENTS

How Do You Measure Up?

More CAN, Less Cancer

On September 1, 2012, American Cancer Society divisions across the country integrated their advocacy programs with ACS CAN. By aligning all federal, state and local advocacy efforts within a single, integrated nationwide structure, our advocacy work has become more efficient and effective, and we will sooner achieve our shared mission to save lives from cancer. Like the Society, ACS CAN continues to follow the science and supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. ACS CAN also remains strictly nonpartisan. The only side ACS CAN is on is the side of cancer patients.

HOW DO YOU MEASURE UP?

Over the past several decades, we've taken the fight against cancer to new levels. Today, there are 14.5 million cancer survivors alive in the United States because of the efforts of researchers, doctors, volunteers and lawmakers. In fact, nearly 500 more lives are being saved from this disease each day than just over a decade ago. During that time, we've discovered that cancer can't be beat solely in a doctor's office or a research lab. We've learned that by passing policies at the federal, state and local levels to better prevent, screen and treat cancer, we can save countless lives. But did you know that by enacting these policies, lawmakers can also add jobs and generate significant long-term cost savings in their communities? Fighting cancer through effective public policy is truly a win-win scenario.

In 2015 alone, more than 1.6 million people in the United States will be diagnosed with cancer – that's more than 4,500 people every single day. Sadly, an estimated 580,000 people will die from the disease this year.[1] The cost of cancer is too high. It impacts the quality of life of our loved ones and often takes them from us far too soon, but it also carries with it a significant financial burden to both individuals and our nation as a whole. This year, cancer will cost our economy an estimated $216 billion in medical costs and lost productivity.[2]

Fortunately, we know what needs to be done to curb the human and financial toll of cancer. Investments in cancer research have resulted in an astounding number of scientific breakthroughs, including new treatments that better target cancer cells, targeted therapies that aim at specific genes linked to certain cancers and improved screenings that help detect cancer early and, in some cases, prevent it altogether. We've also learned from research that if everyone were to quit tobacco, exercise regularly, eat a healthful diet and get recommended cancer screenings, nearly half of all cancer deaths could be prevented. But this knowledge means little if people still lack access to new screenings and more effective treatments or tobacco cessation services and healthy food.

By passing proven public health policies to prevent tobacco use and help those addicted quit, increase access to affordable health coverage for people with cancer and their families and promote patient access to palliative care that improves their quality of life during and after treatment, we will save lives and reduce health care costs.

Tackling Tobacco Use

Tobacco is the number one preventable cause of death nationwide. Tobacco products claim the lives of more than 480,000 people in the United States annually.[3] In fact, nearly 171,000 of the estimated 589,430 cancer deaths nationwide this year will be caused by tobacco.[4] But did you also know, this year alone, tobacco use will cost the nation $289 billion in health care costs and productivity losses?[5]

In the past decade, ACS CAN has worked to pass strong tobacco control policies, including comprehensive smoke-free laws, regular and significant

tobacco tax increases and well-funded tobacco prevention and cessation programs that prevent youths from becoming addicted and help tobacco users to quit. In that time, national adult and youth smoking rates have hit historic lows. But the tobacco industry hasn't given up on addicting new, lifelong customers, and, therefore, our efforts to reduce tobacco use must remain strong.

Unfortunately, progress in passing strong tobacco control policies has slowed in recent years. Since August 2014, Nevada is the only state to significantly increase its tobacco taxes. Not one state has implemented a comprehensive, statewide smoke-free law covering all workplaces, including bars and restaurants, since 2012. States are currently spending less than 2 percent of the revenue from tobacco taxes and Master Settlement Agreement payments on proven programs to reduce tobacco use.[6]

With one-third of all cancer deaths caused by tobacco use, we can't afford to become complacent. It's time state lawmakers turn up the heat on tobacco companies and recommit to policies that will not only save lives from diseases caused by tobacco, but also save millions in taxpayer dollars currently spent on tobacco-related health care costs and lost productivity.

Preventing Cancer

For the majority of Americans who do not use tobacco, weight control, healthy dietary choices and physical activity are the best ways to prevent cancer. State lawmakers have the opportunity to make the healthy choice an easier choice while helping youths form healthy habits. By strengthening physical education requirements in schools to ensure students are getting enough exercise and are learning the importance of being active, as well as by implementing critical nutrition standards for school meals, lawmakers can reduce the cancer burden in their state and our nation.

Many states are also working to prevent cancer by protecting young people from cancer-causing indoor tanning devices. Skin cancer is now the most commonly diagnosed cancer in the United States, and melanoma, the most deadly form, is on the rise. By prohibiting the use of tanning devices to minors under the age of 18, lawmakers can prevent serious and potentially deadly diseases later in life for youths and cut down on costs associated with treating those diseases.

Improving Access to Health Coverage

Access to health care is one of the most significant factors that determine one's chances of surviving cancer. Research shows uninsured individuals are more likely than those with health coverage to be diagnosed with cancer at a late stage, when it is more costly to treat and more difficult to survive.[7]

Thanks to major provisions of the Affordable Care Act, the rate of uninsured individuals has been reduced significantly in recent years – one study estimated that 20 million previously uninsured Americans have gained insurance coverage as of May 1, 2014.[8] This is because of provisions in the act that ACS CAN worked to include, such as the guarantee of coverage regardless of one's health status, the prohibition on charging sick patients more than healthy ones and rescinding coverage when a policyholder falls ill, the creation of state-based marketplaces where consumers can compare and purchase health plans and the ability of states to increase access to health coverage through their Medicaid programs.

Unfortunately, too many people living in America still lack access to affordable health care – including eight million people living in states that have refused to accept available federal funds to increase access to health coverage through Medicaid. Did you know that states that do not increase access to health coverage through their Medicaid programs, as a whole, will lose a net $31.6 billion in federal funds as a result of this decision?[9]

ACS CAN is not only working to increase access to health care to more individuals throughout the country, but also to ensure that those who remain uninsured have access to potentially lifesaving screenings such as mammograms and colonoscopies. Our volunteer advocates are also working with lawmakers to ensure health insurance plans make it easier for cancer patients to understand whether their prescription drugs are covered, patients have access to oral chemotherapy drugs through their current coverage, as well as pain medication as appropriate, and more patients have access to palliative care services to improve their quality of life while fighting cancer and other serious disease.

While states continue to navigate tough economies and shrinking budgets, it is more important than ever to invest in efforts to combat cancer. Not only will effective policies to prevent, detect and treat cancer save countless lives, but they will significantly reduce the financial strain that this disease puts on states and the nation as a whole. This report, in its 13th year, is a blueprint for state legislators on how to reduce the cancer burden in the country by tackling the problem at the city, county and state level. Framed entirely on evidence-based policy approaches, ***How Do You Measure Up?*** provides an outline of what states can do to reduce the cancer burden and delivers a snapshot of how states are progressing on critical public health measures.

How does your state measure up?

TACKLING TOBACCO USE

The burden of tobacco use is staggering. The 50th anniversary Surgeon General's report, *The Health Consequences of Smoking – 50 Years of Progress*[1], released January 2014, reported that more than 20 million premature deaths over the past half century can be attributed to cigarette use. Tobacco use costs our nation $289 billion in health care and productivity losses each year.

We have made progress in the last few decades. Currently, 15.7 percent of youths and 17.8 percent of adults smoke cigarettes – historic lows for both populations.[2] The low cigarette smoking rate among youths is proof that implementing a comprehensive tobacco control strategy that includes mass media efforts about the hazards of smoking and proven public health policies that raise tobacco taxes, establish smoke-free places as the social norm and fund tobacco prevention programs is working. Additionally, increased access to cessation coverage in Medicaid and private insurance plans, as well as hard-hitting media campaigns like the Centers for Disease Control and Prevention's national Tips from Former Smokers Campaign, have supported adults in quitting permanently.[3] However, the decline in cigarette smoking rates is only half of the story. Some youths and price-sensitive adults are turning to other tobacco products that either are less expensive because the product is not taxed at the same rate as cigarettes, or are not currently regulated by the Food and Drug Administration (FDA). Unlike cigarettes, use of smokeless tobacco products among youths and the use of cigars among African American youths has not declined in recent years,[4] and the use of e-cigarettes among middle and high school-aged students has doubled.[5]

ACS CAN calls on the FDA to quickly finalize its proposal to regulate all other tobacco products – including e-cigarettes – and urges federal and state lawmakers to combat the industry's tactics by subjecting these products to tobacco control policies that increase the price, limit the use and help people quit. As of the time of publication, FDA had not taken this action.

According to the Surgeon General, 5.6 million youths are expected to die prematurely from tobacco-related disease if we do not take further action.

If we're going to achieve a tobacco-free generation, lawmakers must continue to utilize the evidence-based solutions they have at their fingertips to reduce use of all tobacco products among youths.

We know what works to reduce the number of youths who start using tobacco, to help more adults quit and to reduce exposure to secondhand smoke. ACS CAN supports a comprehensive approach to tackling tobacco use through policies that:

1. Increase the price of all tobacco products through regular and significant tobacco tax increases;
2. Implement comprehensive smoke- and tobacco-free policies; and
3. Fully fund and sustain evidence-based, statewide tobacco use prevention and cessation programs and increase comprehensive insurance coverage for cessation.

Like a three-legged stool, each component works in conjunction with the others, and all three are necessary to overcome this country's tobacco epidemic. ACS CAN works in partnership with state and local policymakers across the country to ensure tobacco use is addressed comprehensively in each community.

TOBACCO EXCISE TAXES

The Challenge

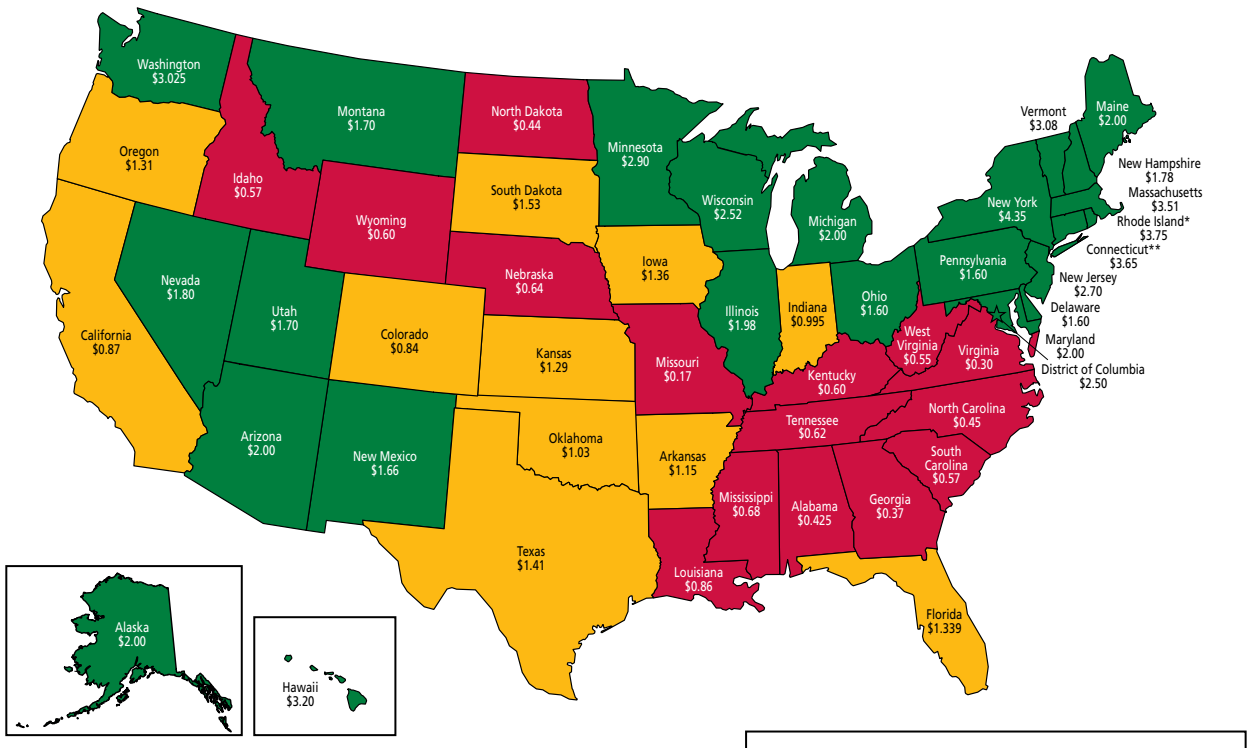
By increasing taxes on cigarettes, regular cigars, little cigars, smokeless tobacco and all other tobacco products (OTP), states can save lives, reduce health care costs and generate much-needed revenue. Evidence clearly shows that raising tobacco prices through regular and significant tobacco tax increases encourages tobacco users to quit or reduce their usage and helps prevent youths from ever starting to use tobacco. In fact, for every 10 percent increase in the retail price of a pack of cigarettes, youth smoking rates drop by 6.5 percent and overall cigarette consumption declines by 4 percent.[1,2]

ACS CAN advocates for increased excise taxes on cigarettes and OTP, and urges legislators to reject any proposals to roll back tobacco taxes. As of July 1, 2015, the average state cigarette excise tax is $1.59 per pack, but state cigarette excise tax rates vary widely, from a high of $4.35 per pack in New York to a low of 17 cents per pack in Missouri. In the past 15 years, all but three states – California, Missouri[2] and North Dakota – have raised their cigarette taxes in more than 100 separate instances.[3] However, progress in increasing cigarette and OTP tax rates has stalled in recent years.

The Solution

Many state lawmakers have recognized the public health and economic benefits of tobacco tax increases, as evidenced by the fact that 15 states, the District of Columbia, Puerto Rico and Guam have cigarette taxes of $2 or more per pack. ACS CAN challenges

State Cigarette Excise Tax Rates



How Do You Measure Up?

*Rhode Island's tax rate is scheduled to increase 25 cents to $3.75 on 8/1/15.
** Connecticut's tax will be $3.65 as of 10/1/15.
Only taxes in effect as of 7/1/15 are included in the national average.
As of July 1, 2015

For every 10 percent increase in the retail price of a pack of cigarettes, youth smoking rates drop by 6.5 percent and overall cigarette consumption declines by 4 percent.

states to raise cigarette and OTP taxes regularly and significantly, as research shows this is the best way to curb tobacco use. States should also tax OTP at a rate equivalent to the state's tax on cigarettes. Additionally, dedicating tobacco tax revenues to tobacco prevention and cessation programs, along with other programs that will help prevent cancer and benefit cancer patients, can be even more effective in reducing suffering and death from tobacco-related diseases.

Measuring the Public Health and Economic Benefits of State Tax Increases

ACS CAN, in partnership with the Campaign for Tobacco-Free Kids, has developed a model to estimate the public health and economic benefits of meaningful increases in state cigarette excise taxes. The model can predict the amount of new annual revenue from increases in the state's cigarette tax, as well as the following public health and economic benefits:

- Reduction in adult smokers
- Reduction in future smokers
- Adult smoker and future smoker deaths prevented
- Smoking-affected births prevented
- Lung cancer health care cost savings
- Heart attack and stroke health care cost savings
- Smoking-affected pregnancy and birth-related health care cost savings
- Medicaid program savings for the state
- Long-term health care cost savings

State-specific projections are available upon request.

Achieving Tax Parity

As states increase their taxes on cigarettes and smoking rates decline, increasing the tax on all OTP to achieve tax parity becomes particularly important. In many states, cigarettes are taxed at a much higher rate than OTP, making the lower-priced tobacco alternatives – such as cigars, snus and newer products such as dissolvable orbs – more appealing to youths. When OTP are taxed at a much lower rate than cigarettes, smokers may switch to another lower-priced tobacco product, instead of quitting or cutting back on tobacco use. Youths are particularly price sensitive, and are most likely to be impacted by this price differential. Further compounding the issue, some OTP, such as orbs, look like candy and use flavorings to appeal to youths.

The primary difference between a cigarette and a cigar is that a cigarette is usually wrapped in paper, or a substance other than tobacco, and a cigar is usually wrapped in tobacco leaf, or another substance containing tobacco. Cigars contain many of the same cancer-causing substances as cigarettes and OTP. Little cigars – which are referred to as little

Success Story

This year, Nevada passed a historic $1.00 per pack increase – more than doubling its current tax! The measure took effect on July 1 and raised the state cigarette tax of 80 cents per pack to a new total of $1.80 per pack. Nevada ACS CAN staff and volunteers staged a major campaign that involved meetings with lawmakers, writing letters to the editor for local papers and placing print ads and radio spots in Nevada's major media markets. ACS CAN's annual "Nevada Day at the Capitol" proved to be a key point in the legislative session, with volunteers traveling in from all corners of the state to urge their lawmakers to support this lifesaving measure. The state lobby day was the day the Nevada ACS CAN team started gaining traction for the idea of a $1.00 increase with lawmakers, and by the end of the session, both chambers of the Nevada legislature cast supermajority votes in favor of the cigarette tax. As is the case with any policy, there remains work to be done. Nevada missed an opportunity to raise tobacco taxes on non-cigarette tobacco products, and the state also has large unmet needs in terms of cancer and tobacco-related prevention programs and services.

Weight Shouldn't Matter: The Importance of Tax Parity for Cigars

To protect the public's health and promote tax parity, it is important for all cigars – regardless of their size – to be taxed at a rate equivalent to cigarettes with no cap on the tax.

The primary difference between a cigarette and a cigar is paper. A cigarette is usually wrapped in paper while a cigar is usually wrapped in tobacco leaf or another substance containing tobacco. Cigars contain many of the same cancer-causing substances as cigarettes.

Nearly one in four (23%) male high school seniors smokes cigars.

Little cigars – which are referred to as little because of their weight – are often almost indistinguishable from cigarettes and are taxed at a lower rate in many states than cigarettes. This results in lower costs, making them more affordable for young smokers.

Some cigars also contain candy and fruit flavoring that is prohibited in cigarettes.

In many states, "large" cigars are taxed at a lower rate than "small" cigars, prompting manufacturers to manipulate their product's weight to evade higher tax rates.

because of their weight – are often almost indistinguishable from cigarettes. They often have a size, shape, filter and flavor similar to cigarettes and are often sold in cigarette-like packs. Despite this, in many states, little cigars are taxed at a lower rate than cigarettes and they cost less as a result, making them more affordable for youth smokers. Some cigars, especially little cigars, also contain candy and fruit flavoring that is prohibited in cigarettes. Not surprisingly, cigar use has increased significantly in recent years among certain groups of youths, including black high school students.[5] Nearly one in four (23 percent) male high school seniors smoke cigars.[6]

Similarly, in many states, "large" cigars are taxed at a lower rate than little cigars, prompting manufacturers to manipulate their product's weight to evade higher tax rates. For example, after the federal tax rate on little cigars was increased, annual sales of large cigars more than doubled, both because consumers switched to cigars that were taxed at a lower rate and because of product manipulation by manufacturers that allowed some cigars to qualify for the lower tax rate.[7] This type of product manipulation is a strategy the tobacco industry has used for decades to attract and addict new, especially young, customers and must be kept in mind when considering tobacco legislation.

Did You Know?

- Significant increases in a state's cigarette and OTP taxes reduce tobacco use and tobacco-caused diseases, which in turn reduce health care costs.
- Among certain groups of youths, cigar use is even more common than cigarette use, in part because of the lower taxes on cigars in many states.

SMOKE-FREE LAWS

The Challenge

According to the U.S. Surgeon General,[1,2] there is no safe level of exposure to secondhand smoke. It contains approximately 70 known or probable carcinogens[3] and more than 7,000 substances, including formaldehyde, arsenic, cyanide and carbon monoxide.[4] Each year in the United States, secondhand smoke causes approximately 42,000 deaths[5,6] among nonsmokers, including up to 7,300 lung cancer deaths, and can also cause or exacerbate a wide range of other adverse health issues, including cardiovascular disease, stroke, respiratory infections and asthma.

As of July 1, 2015, 24 states, Puerto Rico, the U.S. Virgin Islands, Washington, D.C., and 763 municipalities across the country have laws in effect that require 100 percent smoke-free workplaces, including restaurants and bars.[7] Combined, these laws protect 49 percent of the U.S. population.[8]

According to a 2011 CDC report, all states could have comprehensive smoke-free policies by 2020 if current progress continues. Reaching that goal will require faster progress in parts of the country where there are no comprehensive smoke-free laws.[9] As of January 1, 2015, 12 states, American Samoa, and the Northern Mariana Islands have statewide smoke-free laws covering one or two of the following: non-hospitality workplaces, restaurants and bars. Fourteen states still do not have a statewide smoke-free law covering any of these three types of venues. In addition, 20 states, Puerto Rico and the U.S. Virgin Islands have laws in effect requiring all state-regulated gaming facilities to be 100 percent smoke-free.[10]

Unfortunately, progress in passing comprehensive statewide smoke-free laws has stalled in recent years. No state has implemented a comprehensive statewide smoke-free law covering all workplaces, restaurants or bars since 2012. As a result, certain segments of the population, such as hospitality and gaming facility workers in states or communities without comprehensive laws, continue to be denied their right to breathe smoke-free air.[11]

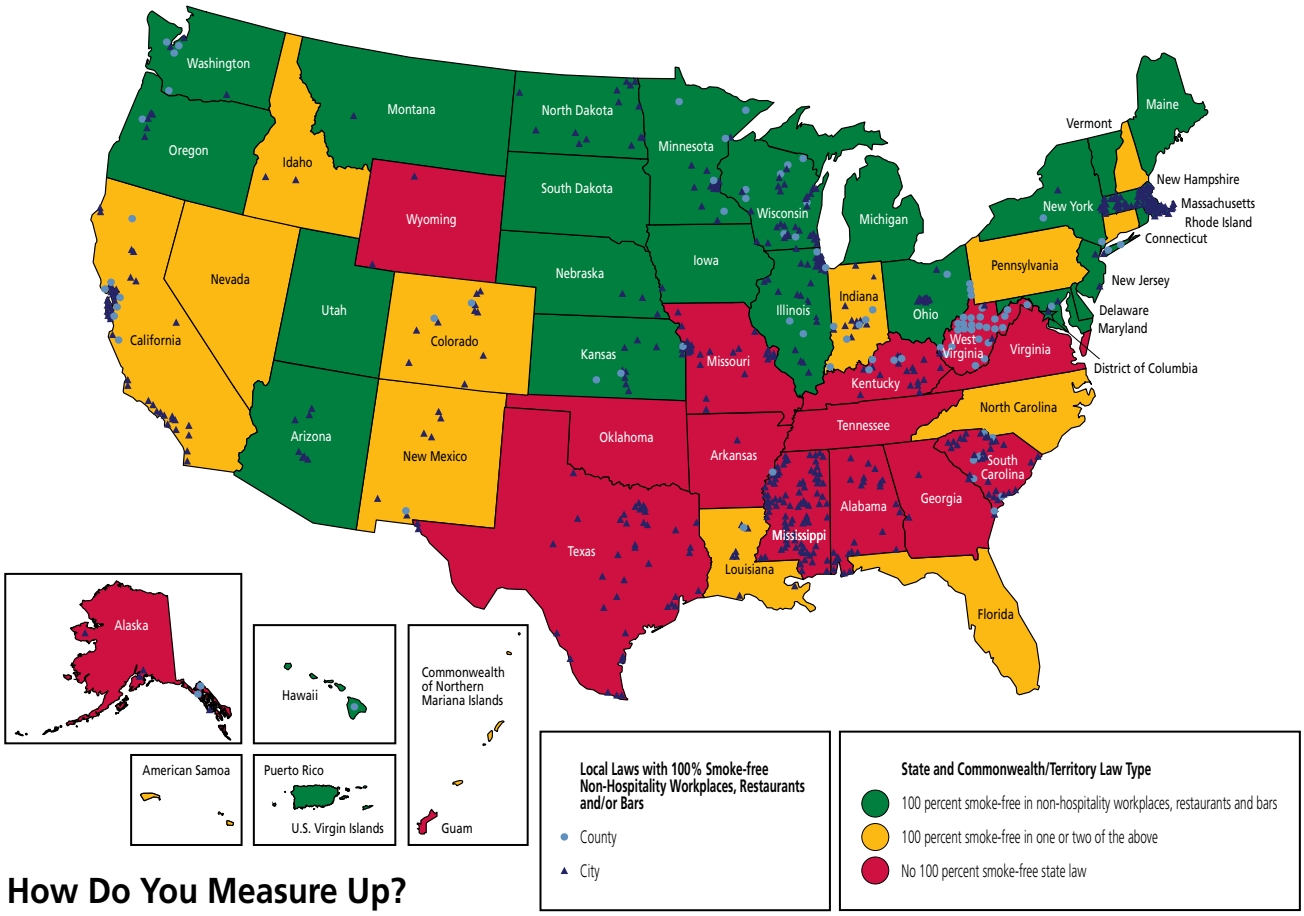
The Solution

The best way to reduce exposure to secondhand smoke is to make all public places 100 percent smoke-free. Smoke-free laws reduce exposure to secondhand smoke, encourage and increase quitting and cutting back among current smokers and reduce health care, cleaning and lost productivity costs.[12,13,14] Smoke-free laws also reduce the incidence of cancer, heart disease and other conditions caused by smoking and exposure to tobacco smoke.[15]

The Institute of Medicine and the President's Cancer Panel recommend that comprehensive smoke-free laws cover all workplaces, including restaurants, bars, hospitals, health care facilities, gaming facilities and correctional facilities.[16,17] Implementing comprehensive smoke-free laws has been proven to have immediate health benefits.

Across the country, elected officials at the state and local levels are recognizing the health and economic benefits of comprehensive smoke-free laws. However, despite the evidence of the positive impact of the laws on people's health, legislators in several states are considering repealing or weakening existing smoke-free laws by adding exemptions for places such as cigar bars, hookah bars and gaming facilities. ACS CAN staff and volunteers are fighting for the health

Smoke-Free Legislation at the State, County and City Level



How Do You Measure Up?

Note: American Indian and Alaska Native sovereign tribal laws are not reflected on this map.
Source: American Nonsmokers' Rights Foundation U.S. Tobacco Control Laws Database(c)
In effect as of July 1, 2015

of all workers and have successfully defended strong laws in states in which comprehensive smoke-free laws have been challenged.

ACS CAN urges state and local officials to pass or maintain comprehensive smoke-free laws in all workplaces, including restaurants, bars and gaming facilities, in order to protect the health of all employees and patrons. Policymakers are also encouraged to overturn and prevent preemption legislation that restricts a lower level of government from enacting stronger smoke-free laws than laws that exist at a higher level of government. Preemption laws will not only slow and prevent future progress to protect all workers from the cancer-causing toxins in secondhand smoke, but also may lead to weakening of existing smoke-free policies. ACS CAN believes everyone has the right to breathe smoke-free air and no one should have to choose between their health and a paycheck.

The best way to reduce exposure to secondhand smoke is to make all public places 100 percent smoke-free.

Success Story

On January 22, 2015, The New Orleans City Council unanimously voted to pass a citywide smoke-free ordinance covering all workplaces and public spaces including bars and casinos. This historic vote and subsequent implementation of the law on April 22, 2015, is a significant victory in the fight against cancer and ensures that no worker in New Orleans will have to choose between their health and their job, and residents and tourists will be protected from the cancer-causing toxins found in secondhand smoke. ACS CAN staff and volunteers together with coalition partners and New Orleans residents who've been touched by cancer are celebrating this decision, and public health advocates nationwide are calling on elected officials in other municipalities and states with casinos and gaming facilities to follow New Orleans' lead and protect everyone's right to breathe smoke-free air.

Missed Opportunities

ACS CAN continued strong support of the 2015 Smoke Free-Kentucky Act, which would protect the rights of employees and patrons to breathe clean, smoke-free indoor air. Recognizing the consistent statewide public support for a comprehensive smoke-free law, for the first time the Kentucky House of Representatives passed an amended version of a smoke-free law that while not comprehensive, sent an important signal to the Senate regarding everyone's right to breathe smoke-free air. Unfortunately, despite strong support from the Chair of the Senate Health and Welfare committee and others, the Kentucky Senate Leadership missed an opportunity to save lives and reduce financial costs associated with secondhand smoke. Disappointingly, the Senate Leadership failed to allow a free, open and fair debate on the merits of the smoke-free law and assigned the bill to a Veteran's Affairs committee where no further action was taken.

E-cigarettes

Electronic cigarettes, or e-cigarettes, are battery-operated devices that allow users to inhale an aerosol produced from cartridges filled with nicotine, flavors and other chemicals. E-cigarette companies often market them as healthier, more convenient and more socially acceptable alternatives to traditional combustible cigarettes. Regardless of how they are marketed or used, e-cigarettes are often made to resemble traditional cigarettes, making it difficult for business owners to distinguish between the two and making enforcement of smoke-free laws difficult. The use of e-cigarettes in public places has the potential to undo decades of progress in changing social norms around tobacco use. In addition, the aerosol produced by e-cigarettes could be harmful to the user and bystanders. As a result, states should prohibit the use of e-cigarettes in all venues where cigarette smoking is prohibited – including workplaces, restaurants, bars and gaming facilities.

ACS CAN staff and volunteers together with coalition partners worked with the city council of Tempe, Arizona to prohibit the use of e-cigarettes in all workplaces and public places where smoking is already prohibited. On July 31, 2014, with a vote of five to one, Tempe became the first city in Arizona and among the first cities in the nation to pass such a law. To date, three states and more than 350 municipalities have implemented laws that prohibit the use of e-cigarettes in otherwise smoke-free venues.

Top Priority for 2016

ACS CAN advocates and partner organizations are working with legislators and moving ever closer to protecting all Alaskans with a comprehensive smoke-free workplace law. The "Take It Outside Act" was introduced in 2015 by Senator Peter Micciche (R-Soldotna) and is well positioned to pass in 2016. Backing for the measure keeps growing, with now more than 875 businesses and organizations across the state signed on in support.

Did You Know?

Since the first Surgeon General's report on smoking and health was released more than 50 years ago, at least 2.5 million nonsmokers in the U.S. have died from a disease caused by exposure to secondhand smoke.[18]

Smoke-free laws are good for business. In fact, no independent study has shown that smoke-free laws negatively affect the restaurant or bar industry.[19]

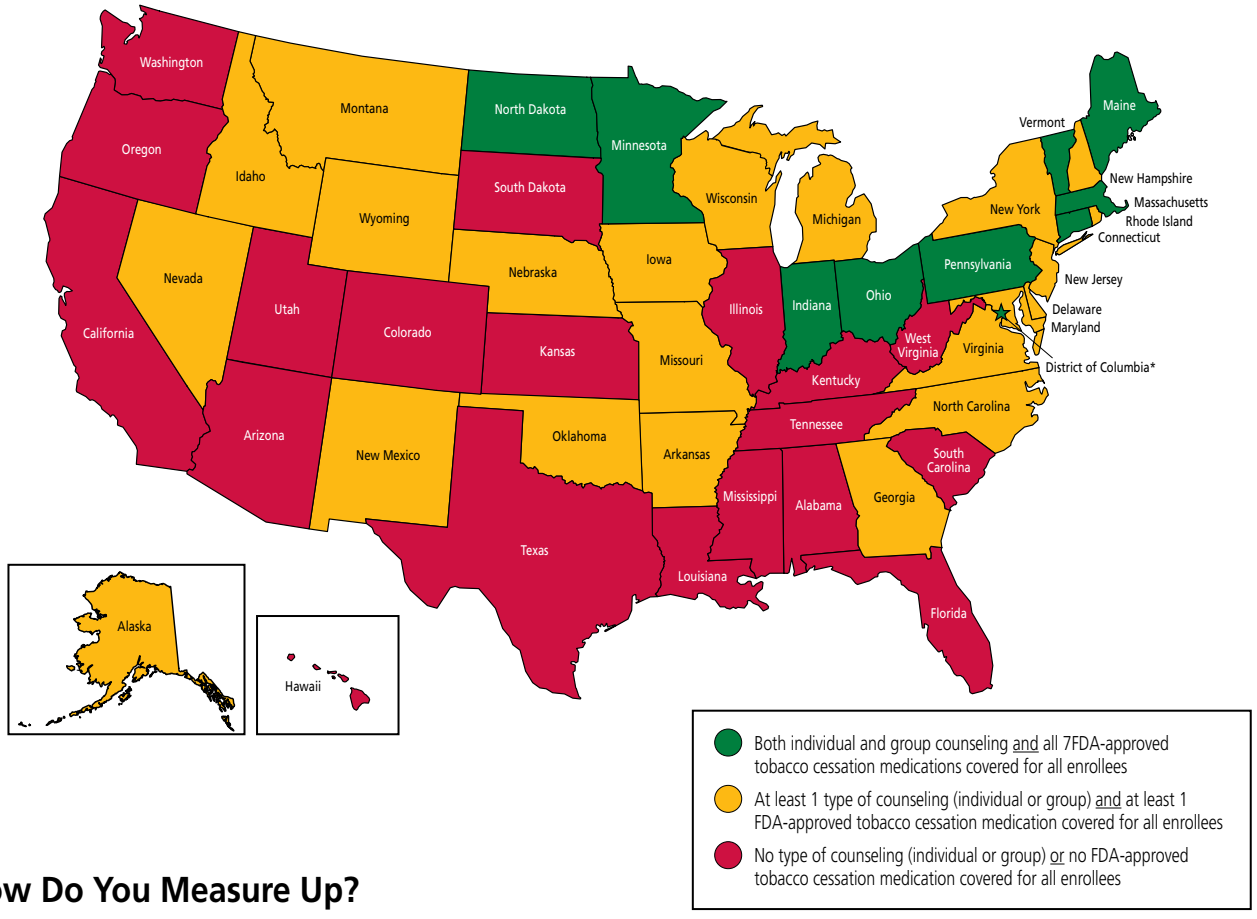
TOBACCO CESSATION SERVICES

The Challenge

Public health experts have long supported proven strategies to prevent children and adults from using tobacco and to help current tobacco users quit. Almost 70 percent of current smokers say they want to quit, and about half have made a quit attempt in the past year. However, only 6 percent were successful.[1] All tobacco users need access to a range of treatments to find the most effective cessation tools for them. States with comprehensive tobacco prevention and cessation programs that include cessation services for a wide scope of their population experience faster declines in cigarette sales, smoking prevalence and lung cancer incidence and mortality rates than states that do not invest in these programs. Research shows that the most effective tobacco cessation treatments combine cessation counseling and cessation medications approved for that purpose by FDA.

Medicaid beneficiaries have a smoking rate that is more than 50 percent higher than that of the general population – 30.1 percent of adult Medicaid beneficiaries ages 18-64 smoke,

Medicaid Coverage of Tobacco Cessation Treatments



How Do You Measure Up?

Source unless otherwise noted : American Lung Association. State Tobacco Cessation Coverage Database. Available at http://www.lungusa2.org/cessation2/. Accessed May 19, 2015.
* Source for Washington, DC: Response from D.C. Department of Health Care Finance to Memorandum with Questions Regarding Tobacco Cessation Benefits.
ACS CAN advocates for access to telephone counseling for cessation through state quitlines. However, coverage for quitlines is not included in this map.
Coverage in only some plans or only for pregnant women does not count as coverage for all enrollees.

Comprehensive Tobacco Cessation Coverage

Only nine states – Connecticut, Indiana, Massachusetts, Maine, Minnesota, North Dakota, Ohio, Pennsylvania and Vermont – provide comprehensive tobacco cessation coverage under Medicaid that includes individual and group counseling and all seven FDA-approved tobacco cessation medications.

compared with 18.1 percent of adults of all ages.[2] However, only nine states – Connecticut, Indiana, Massachusetts, Maine, Minnesota, North Dakota, Ohio, Pennsylvania and Vermont – provide comprehensive tobacco cessation coverage under Medicaid that includes individual and group counseling and all seven FDA-approved tobacco cessation medications. While Medicaid programs in all 50 states and Washington, D.C., provide access to some tobacco cessation coverage, many barriers exist. Common barriers include duration limits (35 states for at least some populations or plans), annual limits (32 states), prior authorization requirements (34 states) and copayments (28 states).[3]

The Affordable Care Act (ACA) requires Medicaid programs to offer cessation services to all pregnant women at no cost. In states that have increased access to health coverage through Medicaid, cessation services must be offered to all individuals enrolled in Medicaid expansion at no cost. Additionally, the ACA requires non-grandfathered private health plans to cover patients being screened for tobacco use and offer tobacco users cessation support without cost-sharing. Federal guidance for non-grandfathered private health plans specifies that plans must cover, without cost-sharing, at least four sessions of telephone, individual and/or group-based counseling and provide access to a 90-day supply of all FDA-approved medications per quit attempt, for at least two quit attempts per year.[4] However, as of February 2015, only one state (West Virginia) had all FDA-approved cessation medications on the formularies for all of their marketplace plans. At that time, in 21 states, at least half of insurers include all seven tobacco cessation medications on their formularies.[5]

Under the ACA, states have an incentive to improve access to cessation services with an "A" rating by the U.S. Preventive Services Task Force (USPSTF), in the form of a 1 percent increase in the amount of funds the federal government provides to support the program. Additionally, states that accept federal funds to broaden access to health care coverage to individuals earning up to 138 percent of the federal poverty level are required to provide all A-rated tobacco cessation services to the newly eligible adults.

The USPSTF's A-rated *Counseling and Interventions to Prevent Tobacco Use and Tobacco-Caused Disease in Adults* recommendations include counseling for all adults about tobacco use

Missed Opportunity: New Jersey

Tobacco companies spend an estimated $1.86 million a year advertising their deadly products in New Jersey. The state received $720 million last year in revenue on its tobacco tax. The smoking-related health care costs covered by Medicaid in New Jersey is $1.17 billion. The Centers for Disease Control recommends New Jersey spend $103.3 million a year on tobacco prevention and cessation, yet since 2012, there has been no state funding for the state's tobacco prevention and cession program. This is a missed opportunity for the health of citizens in New Jersey. Almost 12,000 people die each year from tobacco related diseases and 143,000 kids under 18 who are alive today will ultimately die from tobacco use. ACS CAN staff and volunteers will continue to educate and advocate for fulling funding for tobacco control in New Jersey.

combined with therapy and medications for all tobacco users. FDA-approved pharmacotherapy includes nicotine replacement therapy, sustained-release bupropion and varenicline.

The Solution

Requiring all non-grandfathered health insurance plans, plans for state employees and state Medicaid programs to cover a comprehensive cessation benefit that includes a range of treatment options will curb tobacco-related death and disease in states, and ultimately save money.

Covering tobacco cessation services for all population groups through insurance plans is critical to reduce tobacco use and save lives, especially for low-income populations that need it most. ACS CAN continues to work to ensure that the full range of cessation services is covered at all levels of benefits and in all plans. State and local governments should also take advantage of the CDC's community-based grants, which support efforts to reduce chronic diseases, such as heart disease, cancer, stroke and diabetes.

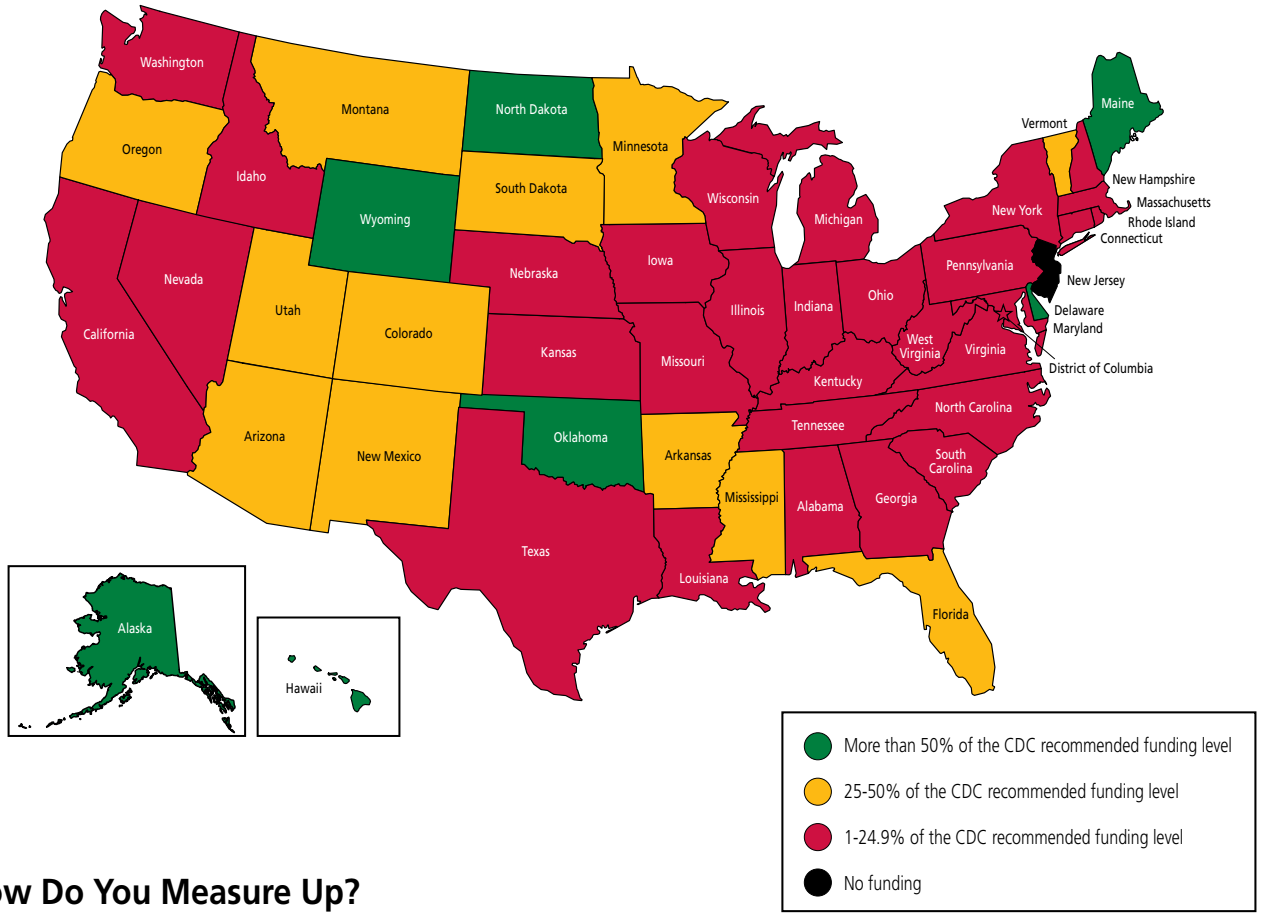
TOBACCO CONTROL PROGRAM FUNDING

The Challenge

The 2014 U.S. Surgeon General's report on tobacco concluded that comprehensive statewide and community tobacco control programs "... prevent initiation of tobacco use and reduce the prevalence of tobacco use among youth and adults." The report called for fully funding these programs at levels recommended by CDC as part of a comprehensive strategy to accelerate progress in eliminating death and disease caused by tobacco.[1] The level of funding and the emphasis states place on proven prevention and cessation programs over time directly influence the health and economic gains from their tobacco control interventions. Comprehensive, adequately funded tobacco control programs reduce tobacco use by preventing youths from starting to use tobacco and helping adults quit, thus, reducing tobacco-related health care costs.

Unfortunately, states currently spend only a small percentage of the revenues from tobacco taxes and Master Settlement Agreement (MSA) payments – billions of dollars in yearly installments the tobacco companies agreed to pay states and territories as compensation for costs associated with tobacco-related diseases – on tobacco control programs. In fiscal year 2015, states budgeted a total of $490.4 million for tobacco prevention and cessation programs, similar to last year's $481.2 million and more than 30 percent less than the $717.2 million dedicated to tobacco control funding seven years ago.[2] Although states are estimated to collect $25.6 billion in tobacco revenue this year, they will devote less than 2 percent of it to support prevention and cessation efforts.[3]

Fiscal Year 2015 State Funding for Tobacco Control



How Do You Measure Up?

Sources: Robert Wood Johnson Foundation, Campaign for Tobacco-Free Kids, American Cancer Society Cancer Action Network, American Heart Association, American Lung Association, and Americans for Nonsmokers' Rights. *Broken Promises to Our Children: A State-by-State Look at the 1998 State Tobacco Settlement 16 Years Later*. December 2014. Available at http://www.tobaccofreekids.org/content/what_we_do/state_local_issues/settlement/FY2015/2014_12_11_brokenpromises_report.pdf. Centers for Disease Control and Prevention (CDC). *Best Practices for Comprehensive Tobacco Control Programs — 2014*. Atlanta: U.S. Department of Health and Human Services, CDC, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014. Current annual funding includes state funds for FY2014 and does not include federal funds directed to states.

Additionally, the $490.4 million in budgeted funds represents only 14.8 percent of the CDC-recommended level of funding for statewide tobacco control programs. When federal and state funding are taken into consideration together, two states currently fund their programs at the CDC-recommended level (Alaska and North Dakota).[4,5] Only five additional states fund their programs at more than half the CDC-recommended level (Delaware, Hawaii, Maine, Oklahoma and Wyoming).[6] It would take only 13 percent of annual state tobacco tax and settlement revenue to fund all states' programs at CDC-recommended levels.[7] The current low funding threatens the viability of state tobacco control programs that promote the health of residents, reduce tobacco use and provide services to help people quit.

Comprehensive, adequately funded tobacco control programs reduce tobacco use and tobacco-related disease, resulting in reduced tobacco-related health care costs.

The Solution

The CDC released an updated version of its evidence-based guide for state investment in tobacco control, *Best Practices for Comprehensive Tobacco Control Programs*, in 2014.[8] As outlined in the guide, these programs should consist of the following five components to be most effective:

1. **State and community interventions**, which include supporting and implementing programs and policies to influence societal organizations, systems and networks that encourage and support individuals to make behavior choices consistent with tobacco-free norms

2. **State health communication interventions**, which deliver strategic, culturally appropriate and high-impact messages about the health impact of tobacco use

State Tobacco Prevention Spending

State	State Tobacco Prevention Funding Allocations (FY15)*	CDC Recommended Spending	Tobacco Prevention Spending % of CDC Recommended
North Dakota	$9.5 million	$9.8 million	97.1%
Alaska	$9.7 million	$10.2 million	95.6%
Delaware	$8.7 million	$13.0 million	66.7%
Oklahoma	$23.6 million	$42.3 million	55.7%
Hawaii	$7.5 million	$13.7 million	55.0%
Wyoming	$4.6 million	$8.5 million	54.1%
Maine	$8.2 million	$15.9 million	51.4%
Arkansas	$17.5 million	$36.7 million	47.6%
Vermont	$3.9 million	$8.4 million	46.4%
Colorado	$23.1 million	$52.9 million	43.7%
Minnesota	$22.3 million	$52.9 million	42.2%
South Dakota	$4.5 million	$11.7 million	38.5%
Utah	$7.4 million	$19.3 million	38.2%
Montana	$5.4 million	$14.6 million	37.0%
Florida	$66.6 million	$194.2 million	34.3%
Mississippi	$10.9 million	$36.5 million	29.9%
Arizona	$18.6 million	$64.4 million	28.9%
New Mexico	$5.9 million	$22.8 million	26.0%
Oregon	$9.9 million	$39.3 million	25.2%
New York	$39.3 million	$203.0 million	19.4%
District of Columbia	$2.0 million	$10.7 million	18.7%
West Virginia	$4.9 million	$27.4 million	17.8%
Maryland	$8.5 million	$48.0 million	17.7%
Iowa	$5.2 million	$30.1 million	17.4%
Idaho	$2.7 million	$15.6 million	17.1%
California	$58.9 million	$347.9 million	16.9%
Louisiana	$6.8 million	$59.6 million	11.4%
Nebraska	$2.4 million	$20.8 million	11.4%
Connecticut	$3.5 million	$32.0 million	11.0%
Pennsylvania**	$13.8 million	$140.0 million	9.9%
South Carolina	$5.0 million	$51.0 million	9.8%
Virginia	$8.5 million	$91.6 million	9.3%
Wisconsin	$5.3 million	$57.5 million	9.2%
Illinois	$11.1 million	$136.7 million	8.1%
Indiana	$5.8 million	$73.5 million	7.8%
Tennessee	$5.0 million	$75.6 million	6.6%
Massachusetts	$3.9 million	$66.9 million	5.8%
Ohio	$7.7 million	$132.0 million	5.8%
Kentucky	$2.5 million	$56.4 million	4.4%
Texas	$10.7 million	$264.1 million	4.1%
Kansas	$946,761	$27.9 million	3.4%
Nevada	$1.0 million	$30.0 million	3.3%
Rhode Island	$388,027	$12.8 million	3.0%
Washington	$1.9 million	$63.6 million	2.9%
Georgia	$1.8 million	$106.0 million	1.7%
Michigan	$1.5 million	$110.6 million	1.4%
North Carolina	$1.2 million	$99.3 million	1.2%
New Hampshire	$125,000	$16.5 million	0.8%
Alabama	$362,000	$55.9 million	0.6%
Missouri	$70,788	$72.9 million	0.1%
New Jersey	$0.0 million	$103.3 million	0.0%

Source for Tobacco Prevention Funding, unless otherwise noted: Robert Wood Johnson Foundation, Campaign for Tobacco-Free Kids, American Cancer Society Cancer Action Network, American Heart Association, American Lung Association, and Americans for Nonsmokers' Rights. Broken Promises to Our Children: A State-by-State Look at the 1998 State Tobacco Settlement 16 Years Later. December 2014. Available at http://www.tobaccofreekids.org/content/what_we_do/state_local_issues/settlement/FY2015/2014_12_11_brokenpromises_report.pdf.
Source for Funding Recommendations: Centers for Disease Control and Prevention (CDC). *Best Practices for Comprehensive Tobacco Control Programs - 2014.* Atlanta, GA: U.S. Department of Health and Human Services, CDC, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.
* Only state government allocations are included in this chart.
**PA funding allocation estimated but not confirmed

3. **Cessation interventions**, which ensure that all patients are screened for tobacco use, receive brief interventions to help them quit and if needed, more intensive counseling services and FDA-approved cessation medications, as well as telephone-based cessation (quit line) counseling for all tobacco users who wish to access the service

4. **Surveillance and evaluation** to monitor the achievement of overall tobacco prevention and cessation program goals and to assess the implementation and outcomes of the program and demonstrate accountability

5. **Implementation of effective tobacco prevention and control programs** requires substantial funding. An adequate number of skilled staff enable programs to plan their strategic efforts, provide strong leadership and foster collaboration between the state and local tobacco control communities.

Funding statewide tobacco control programs as outlined in the CDC's *Best Practices for Comprehensive Tobacco Control Programs* guide and at the CDC-recommended levels will result in millions of fewer tobacco users and hundreds of thousands of lives saved from premature tobacco-related deaths.

Funding statewide tobacco control programs as outlined in the CDC's best practices guide and at CDC-recommended levels will result in millions of fewer tobacco users and hundreds of thousands of lives saved from premature tobacco-related deaths. ACS CAN challenges states to combat tobacco-related illness and death by sufficiently funding comprehensive tobacco control programs at CDC-recommended levels or above; implementing strategies to continue that funding over time; and applying the specific components delineated in the CDC's best practices guide. When considering tax increases on cigarettes and other tobacco products, states should always dedicate a portion of the funds to state tobacco control programs. Legislators are urged to resist sacrificing tobacco prevention and cessation programs in tough economic times as short-term budgetary fixes and to instead consider the long-term health and economic burden that such cuts will ultimately put on the state and its population.

Did You Know?

- States could fully fund evidence-based tobacco control programs for a fraction of the amount they earn in tobacco taxes and MSA funds.

- For every $1 that states spend to reduce tobacco use, tobacco companies spend $18 to market their products.

HEALTHY EATING AND ACTIVE LIVING

Setting Priorities

ACS CAN's nutrition, physical activity and obesity policy priorities include:

- Establishing strong nutrition standards for all foods and beverages sold or served in schools
- Increasing the quality and quantity of physical education in K-12 schools, supplemented by additional school-based physical activity
- Increasing funding for research and interventions focused on improving nutrition, increasing physical activity and reducing obesity
- Reducing the marketing of unhealthy foods and beverages, particularly to youths

ACS CAN recommends that legislators focus their efforts on changing policies in these key areas, which research shows could have a significant impact on making healthy choices easier, particularly for youths.

The Challenge

For the majority of Americans who do not use tobacco, the greatest behavioral risk factors for cancer are weight, diet and physical activity levels. In fact, one-quarter to one-third of all cancers are tied to poor nutrition, physical inactivity or excess weight.[1] Being overweight or obese increases a person's risk for many cancers, including colon, endometrium, esophagus, gall bladder, kidney, pancreas, rectum and possibly postmenopausal breast cancer.[2] There is also highly suggestive evidence of a link between being overweight or obese and cancers of the cervix, liver and ovary, for multiple myeloma, Hodgkin disease and aggressive prostate cancer.[3] In addition to increasing the risk for cancer and other chronic diseases, overweight and obesity place a huge financial burden on the health care system in the United States. Obesity alone costs the nation $147 billion in direct medical costs each year, approximately half of which is paid for by Medicaid and Medicare.[4]

Overweight and obesity have become an epidemic in this country, with more than double the rate for adults and triple the rate for youths from just 30 years ago. Today, approximately two in three adults and one in three youths are overweight or obese.[5,6] The increases in childhood overweight and obesity are particularly troubling because children who are overweight and obese are much more likely to be so as adults. Overweight and obesity rates vary widely by geography and by racial and ethnic group, with many Southeastern states and African Americans and Hispanics having disproportionately high rates.[7]

The rapid increase in overweight and obesity during the past few decades is largely attributable to environmental and social changes that create barriers to healthy eating and active living. Most schools no longer provide daily physical education and other opportunities for students to be physically active. Many communities also lack pedestrian-friendly infrastructure, such as sidewalks and parks, which can facilitate daily physical activity among children and adults. Large portions of inexpensive, high-calorie foods and beverages with little to no nutritional value are abundant and widely marketed. Together, environmental and social factors have significantly contributed to the overweight and obesity epidemic in our country. Increasing opportunities for physical activity and healthy eating and promoting good choices are critical for cancer prevention.

The Solution

The American Cancer Society's *Guidelines on Nutrition and Physical Activity for Cancer Prevention* recommend that individuals achieve and maintain a healthy weight; adopt a physically active lifestyle; consume a healthy diet with an emphasis on plant-based foods, like whole grains, legumes, fruits and vegetables; and limit consumption of alcoholic beverages.[8] The guidelines also recommend that public, private and community organizations work collaboratively at all levels of government to implement policy and environmental changes that increase access to affordable, healthy foods in communities, schools and at work; decrease access to and the marketing of foods with low nutritional value, particularly to youths; and provide safe, enjoyable and accessible places for physical activity at school, work and in local communities.[9] Both the individual and community recommendations in the guidelines are consistent with the 2010 *Dietary Guidelines for Americans* and other evidence-based recommendations from CDC,[10] the Institute of Medicine[11] and other experts.

Approaches in Legislation for Improving Student Physical Fitness in Schools through Physical Education and Physical Activity

Mandatory physical education

- Using a planned, sequential K-12 physical education curriculum that adheres to national and state standards to implement physical education
- Adequate equipment, facilities, student-teacher ratios
- No waivers, substitutions, exemptions
- Taught by licensed, certified physical education teachers
- Annual professional development for physical education teachers that is specific to their field and integrates the public health model
- Include modifications or adaptions that allow physical education courses to meet the needs of disabled students rather than providing them with waivers
- Fitness and cognitive assessment in physical education that is reported to parents for individual student progress and to the community and relevant state agencies in an aggregate manner
- Require 150 minutes of physical education per week in elementary school and 225 minutes per week of physical education in middle school and high school

School-based Physical Activity Should Include:

- Daily use of classroom physical activity breaks
- An implemented school wellness policy that establishes requirements for physical activity and physical education
- An active transportation policy to and from school
- Daily elementary school recess for at least 20 minutes
- A shared use policy that makes physical activity facilities available to the community during out of school time
- Intramural/club/sports activities provided by the school/district

Assessment/Accountability

- Fitness and cognitive assessment in physical education that is reported to parents for individual student progress and to the community and relevant state agencies in an aggregate manner
- School-based comprehensive self-assessment of physical education programs and physical activity offerings using existing tools such as the Physical Education Curriculum Analysis Tool; the results of the assessment should be integrated into the school district or school's long-term strategic planning and/or school improvement plan, and school wellness policy

Overall, these recommendations focus on making healthy choices easier – meaning healthy foods should be more convenient and affordable and physical activity should be more easily incorporated into a person's daily routine.

The Problem with Preemption

While some states and localities have advanced policies aimed at promoting healthier foods and beverages, other states have passed laws that would prevent localities within their state from doing so. For example, a law in Mississippi – the state with the highest obesity rate – prevents localities from taking action on policy relating to calorie labeling in restaurants; zoning to increase access to healthy foods and decrease access to fast-food restaurants and other unhealthy food vendors in underserved areas; and setting nutrition standards for restaurant meals that include toy giveaways. It is important for localities across the country to have the opportunity to put their own innovative initiatives in place that have the potential to improve nutrition, increase physical activity and decrease obesity in order to increase the health of residents. Just as is the case with tobacco control, local control is essential for good public health.

Multi-faceted policy approaches across a population can significantly enhance nutrition and physical activity and reduce obesity rates by removing barriers, changing social norms and increasing awareness. ACS CAN stands ready to work with state and local policymakers to plan, implement and evaluate these strategies and move the nation toward a healthier future – one with less cancer.

School Nutrition and Wellness

There are significant opportunities for states to pass and implement policies to improve food and physical activity environments. As a result of the Healthy, Hunger-Free Kids Act of 2010, the federal government set updated, national nutrition standards for school meals and updated national nutrition requirements for snacks and beverages, which took effect in fall 2014. While the federal requirements set a minimum baseline, it is not preemptive. States and localities are responsible for fully implementing the nutrition standards and have the opportunity to fill in gaps, including strengthening the federal standards, extending them beyond the end of the official school day, closing loopholes and setting nutrition standards for school-sponsored fundraisers. Local communities also have an opportunity to set stronger school nutrition and wellness requirements by reviewing and updating their local wellness policies, which is also required by federal law. Local wellness policies must:

- Include goals for food marketing, nutrition education and promotion, physical activity, nutrition standards for foods sold in schools and other school-based wellness activities
- Be developed with input from a broad group of stakeholders
- Be widely disseminated throughout the community

Physical Education

State legislators can also help to increase physical activity by setting strong requirements for physical education in schools. The U.S. Department of Health and Human Services (HHS) report *Physical Activity Guidelines for Americans*, recommends children and adolescents engage in at least one-hour of physical activity daily,[12] and the Institute of Medicine recommends children have opportunities to engage in an hour of physical activity at school each day, half of which should be during the regular school day.[13,14]

Quality physical education is the best way for youths to get a significant portion of their recommended physical activity, improve their physical fitness and obtain the knowledge and skills they need to be physically active throughout their lifetimes.[15] Physical education may even increase students' academic achievement. Physical education should be part of a comprehensive school physical activity program, which also provides opportunities for and encourages students to be active before, during and after school through recess, classroom physical activity breaks, walk-to-school programs, joint- or shared-use agreements that allow community use of school facilities and vice versa, and after-school physical activity programs, such as competitive, intramural and club sports and activities. However, these other opportunities for physical activity before, during and after school should supplement – rather than supplant – physical education.

Along with the American Heart Association and the American Diabetes Association, ACS CAN advocates for public policies that improve student fitness and increase physical activity through a comprehensive school-based physical education and physical activity program. This comprehensive approach is anchored by quality K-12 physical education that is mandatory for all students and based on a planned, sequential curriculum consistent with national and state standards for a minimum of 150 minutes per week in elementary schools and 225 minutes per week in middle and high schools.

School districts should also provide opportunities for students to be active in other ways, including daily recess policies in elementary schools, classroom physical activity breaks, active transportation policies to and from school, intramural, club, and sports offerings, local school wellness policies that set physical education and physical activity requirements, and shared use policies that makes school facilities available to the community outside of school time.

Additionally, school districts should be held accountable for fully implementing physical education and physical activity programs and policies. They should be assessing the quality of the program using existing tools and assessing student fitness and cognitive achievement, with aggregate results being reported to parents, the community and relevant state agencies.

Did You Know?

- One-quarter to one-third of all cancer diagnoses and up to one-third of cancer deaths are due to poor diet, physical inactivity and overweight and obesity.
- Children and teens who are overweight and obese are likely to remain so as adults, increasing their lifelong risk for harmful and costly diseases, including several forms of cancer.

Why healthy eating and active living?

ACS CAN is changing its focus from reducing overweight and obesity to improving healthy eating and active living. Changing policies and environments to make it easier for people to consume a healthy diet and lead a more physically active lifestyle are what science shows will ultimately support Americans in achieving and maintaining a healthy weight and reducing their long-term risk of cancer, cardiovascular disease, diabetes and a host of other chronic diseases.

INDOOR TANNING

Success Story

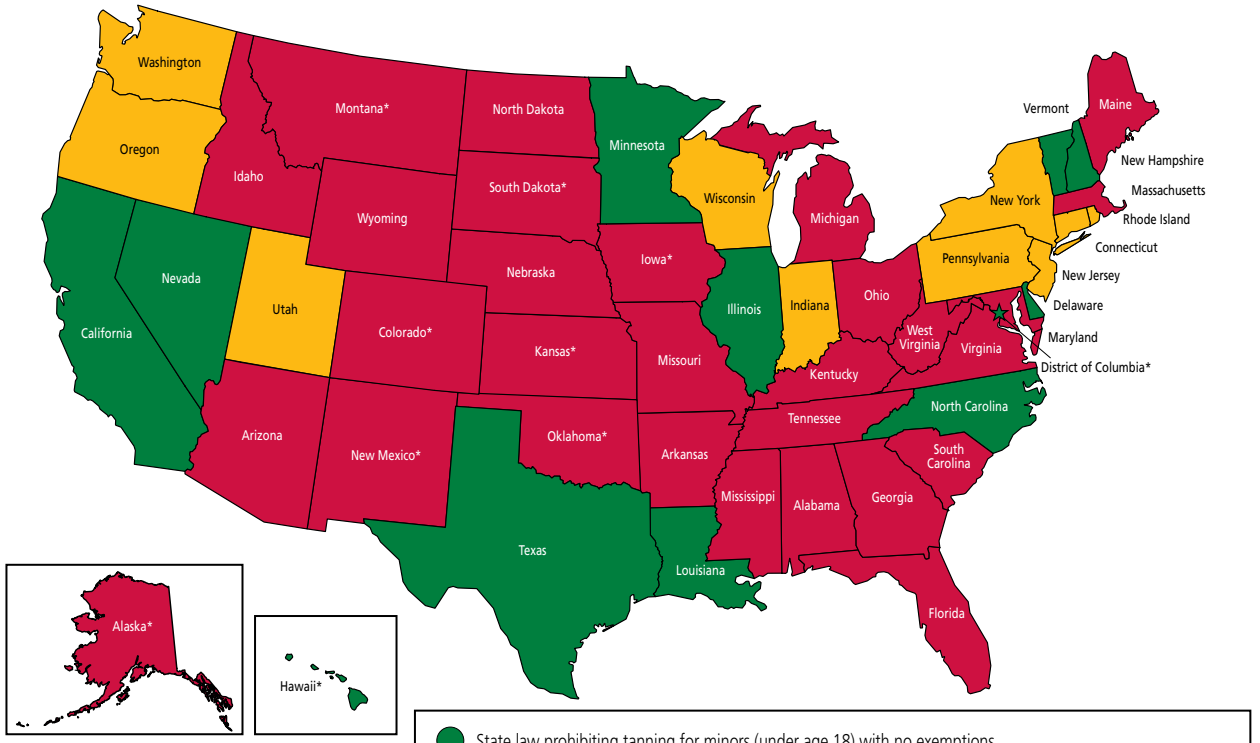
In April, the New Hampshire Senate passed a comprehensive law protecting all minors from the dangers of indoor tanning devices. The Senate overturned its health committee's down vote after hearing from ACS CAN volunteers, survivors and health professionals, ensuring Granite Staters under the age of 18 will be protected from an increased risk of skin cancer.

The Challenge

Skin cancer is the most commonly diagnosed cancer in the United States, and rates have been rising for the past 30 years.[1] In 2015, an estimated 73,870 cases of melanoma will be newly diagnosed, in addition to millions of basal and squamous cell skin cancers. In total, more than 13,300 men and women are expected to die of skin cancer this year, and 9,940 of those deaths will be from melanoma.[2]

Exposure to UV radiation, through sunlight and indoor tanning devices, is one of the most avoidable risk factors for skin cancer. In fact, the effects of UV radiation are so harmful that they have drawn local, state, national and international attention resulting in additional restrictions being placed on their use, especially among youths under age 18. The World Health Organization's International Agency for Research on Cancer (IARC) categorizes tanning devices into its highest cancer risk category – "carcinogenic to humans."[3] Additionally, the FDA recently

State Tanning Device Restrictions



State law prohibiting tanning for minors (under age 18) with no exemptions.

State law prohibits tanning for those under 17 (NY, NJ, CT, PA), or under 16 (WI, IN). State law requires parental accompaniment for every visit for those under 18 (UT), allows for physician prescription under 18 (OR, WA), or prohibits tanning for under age 18 unless a signed parental permission slip is obtained for every two visits (RI).

No state law regarding tanning (indicated with an *), state law prohibits those 14 or 15 or under, law allows for signed parental permission, or law requires parental accompaniment for every visit under 16 or younger.

Sources: Health Policy Tracking Service & Individual state bill tracking services

How Do You Measure Up?

In July 2014, the U.S. Surgeon General released the first-ever Call to Action to Prevent Skin Cancer. The report outlines a plan to reduce the toll of skin cancer and save lives. Through a series of achievable goals and strategies focused on public policy and education, the plan supports more Americans in making healthy choices about protecting their skin. A goal of the report is to reduce harms from indoor tanning through strategies such as:

- Supporting organizational policies that discourage indoor tanning by adolescents and young adults
- Enforcing existing indoor tanning laws and consider adopting additional restrictions

increased its classification of tanning devices, resulting in new restrictions for manufactures and requiring a black-box warning on every machine which advises against use for minors.

Despite the dangers, misconceptions about the risks and benefits of indoor tanning exist. Users mistakenly believe a "base tan" has a protective effect against burns; UV light is the only way to get Vitamin D; and the risk of getting cancer from using tanning devices is low. These misconceptions are due, in part, to misleading advertising and health claims put forth by the tanning industry.[4,5]

Youths are especially susceptible to the harmful effects of UV radiation. This is a serious cause for concern as teens are tanning at increasingly high rates. In the past year, one in five high school girls have used a tanning device, with numbers increasing to one in four high school girls by their senior year.[6] Among teens who tanned, 58 percent reported getting a burn from a tanning device within the past year.[7] This is especially worrisome since studies have shown using an indoor tanning device before the age of 35 increases the risk of melanoma by 59 percent, squamous cell carcinoma by 67 percent and basal cell carcinoma by 29 percent.[8,9]

The Solution

Laws that prohibit the use of indoor tanning devices for everyone under the age of 18 can go a long way toward reducing skin cancer incidence and mortality rates across the country. Parental consent laws are not sufficient in effectively deterring minors from using tanning devices, but age restrictions have been shown to be effective.[10]

To protect youths from the harmful effects of UV radiation, legislation is needed to restrict youth access, without exceptions, in every state. In addition, states need to ensure oversight mechanisms are in place to guarantee youths are not gaining access to these harmful devices.

Missed Opportunity

For the third year in a row Maryland lawmakers missed an opportunity to pass legislation protecting minors from the increased risk of developing skin cancer. Instead, a bill that would have strengthened an existing weak law died in the Senate Finance Committee. We are proud of the work our ACS CAN staff, volunteers and skin cancer prevention coalition partners did to educate lawmakers on why parental consent and accompaniment is insufficient in protecting minors from the increased risk of skin cancer incurred by UV radiation. We hope Maryland lawmakers will use the 2016 legislative session to put in place a law prohibiting minors from using indoor tanning devices, without exemptions.

Did you know?

- Youths are 80 percent more likely to use a tanning device if they believe their parents allow it.[11]
- Restricting access to tanning devices is consistent with other policies that protect youths from harmful substances like tobacco and alcohol.

ACCESS TO CARE

Access to health care is a significant determinant in whether or not an individual diagnosed with cancer will survive. Individuals without health insurance are more likely that those with coverage to be diagnosed with cancer at a late stage, when the disease is harder to treat and more difficult to survive.[1] ACS CAN believes all Americans should have access to affordable, quality health insurance. In 2015, ACS CAN focused on improving access to care in the following areas: health plan transparency for consumers; prescription drug transparency and affordability; oral chemo fairness; provider network adequacy; increasing access to Medicaid; and the preservation of the Medicaid breast and cervical cancer treatment programs.

ACCESS TO CARE: PRESCRIPTION DRUG TRANSPARENCY AND COST-SHARING

The Challenge

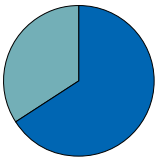
In 2011, direct medical spending for cancer in the United States was $88.7 billion.[2] While private or public insurance provides coverage for many cancer patients, these patients often face high out-of-pocket costs due to their plans' cost-sharing requirements or coverage limitations. Unfortunately, due to a lack of transparent drug coverage information, patients often buy plans without knowing whether their drug is covered or affordable.

In March 2014, ACS CAN conducted a study of cancer drug coverage in the new health insurance marketplaces and found significant gaps and inconsistencies in prescription drug formulary information available from health insurance companies.[3] We also found that patients undergoing chemotherapy administered by a physician would find it nearly impossible to determine if their drug is covered by the available health plans.

Marketplace Drug Formularies and Disparities between Copayments and Coinsurance

Complicated formularies and costs associated with specialty drug tiers make it difficult for cancer patients to determine if their chemotherapy drugs are covered prior to choosing a plan, or what out-of-pocket costs might be.

November 2013 Study
Federal and State Marketplace Plans



Approximately two-thirds of plans had 4-tier formularies

2015 Marketplace Study
Cancer Drugs Placed on High Tiers

For one drug class, all drugs were placed on a specialty tier in 60% of plans analyzed

For another class, all drugs were placed on a specialty tier in 47% of plans analyzed

34% of plans analyzed charge patients 30% or more for all drugs falling into these two classes.

Plans Analyzed Applying Coinsurance – Drugs on the Highest Tier

Patients pay *on average* 26% of the drug's total cost

Plans Analyzed Applying Copayments – Drugs on the Highest Tier

Patients pay *upwards* of a $75 copayment

A November 2013 study of plans sold in both the federal and state marketplaces found that approximately two-thirds of plans had a four-tier formulary.[4] The same study found that, on average, patient costs for drugs placed on a the highest tier were $75 for plans that applied copayments and 26 percent of the drug's total cost for plans that applied coinsurance. A subsequent study of 2015 marketplace plans examined the formulary placement of several classes of cancer drugs.[5] For one drug class, all drugs in that class were placed on a specialty tier in 60 percent of plans analyzed. For another class, all drugs in that class were placed on a specialty tier in 47 percent of plans analyzed. The study also found that 34 percent of plans analyzed are charging patients 30 percent or more for all drugs falling into these two classes.

For all individuals, but particularly for cancer patients who have already been diagnosed and know which medications they need, it is critically important to have access to clear, complete and comparable information on prescription drug coverage and cost-sharing when choosing a health plan. Of equal importance is ensuring that when someone receives a cancer diagnosis, they have coverage for the drugs they need at a cost they can afford.

Navigating the Insurance Marketplace: Being a Cancer Patient Changes Purchasing Priorities

Insurance Coverage Priorities for the Average Insurance Shopper

When a shopper for insurance is basically healthy, priorities may focus on low premium costs and rare emergencies.

- What premium can I afford?
- Is my primary care provider in network?
- Are my current meds covered?
- Could I afford cost of Urgent Care/ER Visit?

Insurance Priorities Change when Diagnosed with Cancer

A cancer patient with a low-cost premium may find many unexpected obstacles to treatment.

- Low premium meant high cost sharing.
- Didn't know the closest oncology provider is 45 minutes away.
- I have to pay a 30% coinsurance for my chemotherapy treatment.
- Can't pay my $3,000 deductible for surgery.

Navigating the Insurance Marketplace: A Cancer Diagnosis Brings Shortfalls in Coverage into Focus

Insurance Coverage Information Can Frustrate and Confuse Cancer Patients

- Need to be sure I can afford my premium AND deductible.
- Are all of my oncologists in-network?
- Are my drugs on the formulary and can I afford them?
- What is my cost sharing for CT scans, PET scans, MRI's?

Insurance Coverage May Leave Cancer Patients with Unknown or Unanticipated Costs

- I paid a higher premium to avoid up-front deductible for chemo.
- I could only access a provider list AFTER I bought the plan. My oncologist is covered as a "tier 2" provider, increasing my costs.
- Couldn't find my IV drug on the formulary and my oral drug had a 20% coinsurance, which turned out to be $2,000 per month!
- 30% coinsurancefor my CT scans, who knows what my bill will be?

Success Story

During the 2015 session, Hawaii and Texas successfully passed legislation that will help cancer patients better understand if their drugs are covered and how much they will cost. Hawaii House Bill 261 and Texas House Bill 1624 will require insurers to provide greater transparency around the drugs covered under each of their plans, as well as the dollar amount a patient would have to pay. Currently, many cancer medications are subject to a coinsurance, where a patient pays a percentage of the total cost of the drug. However, patients do not know what that total cost is so they cannot determine the dollar amount they would have to pay to get the drug. These laws will require insurance carriers to disclose an estimated dollar amount a patient would pay for drugs subject to a coinsurance. Additionally, both laws will require insurance carriers to list all drugs covered under each plan including drugs that are administered intravenously (IV) by a doctor or nurse. Unlike oral medications dispensed at a pharmacy, covered IV drugs are rarely included in plan information leaving consumers to wonder if they are covered and how much they will cost. Now cancer patients who take IV medications will be able to buy a plan knowing whether their drug is covered and if it is affordable. The Texas law will be effective for all plans sold on or after January 1, 2016 and the Hawaii law will be effective for all plans sold on or after January 1, 2017.

The Solution

ACS CAN recommends that the U.S. Department of Health and Human Services (HHS), state legislatures and departments of insurance adopt the following recommendations to improve prescription drug formulary transparency and reduce patient cost-sharing:

Drug Formulary Transparency Legislation/Regulations

- Require health plans to post standardized and complete prescription drug formularies on their websites, including a list of physician-administered drugs covered under the medical benefit, to make it easier for consumers to know which drugs are covered
- Require health plans to disclose the actual dollar amount a patient would have to pay for drugs subject to coinsurance (rather than listing a percentage of the cost of the drug)
- Prohibit plans from increasing patient drug cost-sharing during the plan year
- Provide robust oversight of prescription drug benefits to ensure health plan formularies are not discriminatory in how they provide coverage and cost sharing for drugs that treat serious and chronic conditions like cancer

Cancer Drug Affordability Legislation/Regulations

- Require patient costs for oral chemotherapy medications to be fair and equitable relative to the cost of intravenous chemotherapy medication covered under the plan
- Cap patient copayments or coinsurance for specialty-tier medications
- Define the exceptions process a patient can use to gain coverage for a medically necessary drug not covered under the plan at the same cost as a drug that is covered
- Allow patient cost-sharing for drugs provided under an exceptions process to count toward the patient's annual out-of-pocket maximum

Did You Know?

- Without increased transparency requirements for health insurance plans, cancer patients may have to buy a plan without knowing how much their potentially lifesaving drugs will cost each month.
- In some cases, a cancer patient shopping for a health plan has to actually sign up for a plan before they can get information about whether their intravenous chemotherapy drug is covered.

Did You Know?

A recent study found cancer patients with monthly cost-sharing of $500 or more were four times more likely to abandon the prescribed chemotherapy drug than cancer patients with cost-sharing of $100 or less per month.[8]

ACCESS TO CARE: ORAL CHEMOTHERAPY FAIRNESS

The Challenge

Scientific advancements have increased the availability and effectiveness of oral medications for cancer treatment. Approximately one-quarter of all oncology drugs in the development pipeline are oral medications,[6] and many oral chemotherapy drugs have already been approved by the FDA. However, health plans often require higher cost-sharing for oral chemotherapy drugs than for drugs administered intravenously (IV) by a physician. This disparity can affect patient and physician decision-making about treatment options and may lead patients to forgo the best treatment for their situation. In addition, research suggests high cost-sharing for oral chemotherapy medications may lead patients to abandon treatment.[7]

Oral chemotherapy can offer advantages to patients and caregivers, such as:

- Less frequent visits to a doctor's office or cancer treatment center
- Less need to schedule long appointments for infusions
- Less worry about finding transportation to and from appointments

This flexibility is particularly important for people living in rural areas who would have to travel long distances to the nearest treatment facility, as well as for employed patients and family members who are trying to reduce hours away from work during treatment.

The Solution

To date, 39 states and Washington, D.C., have passed oral chemotherapy fairness legislation to help equalize patient out-of-pocket costs for oral chemotherapies and IV chemotherapies. These laws generally require state-regulated health insurance companies and group health plans to apply cost-sharing to orally administered anticancer drugs "on a basis no less favorable than" IV-administered ones. Over time, states have added additional protections for cancer patients, such as prohibiting insurance companies from increasing IV chemotherapy cost-sharing to comply with the law.

Cancer patients' access to anticancer oral drugs has improved as a result of these states' legislative efforts and successes. ACS CAN applauds these state efforts and encourages all states to pursue similar legislation.

Health plans often require higher cost-sharing for oral chemotherapy drugs than for drugs administered intravenously (IV) by a physician.

Success Story

Wyoming was the first state to pass Oral Chemotherapy Fairness (OCF) legislation in 2015, thanks to planning that began in 2014 and a strategic coalition led by ACS CAN that included patient groups and professional medical organizations. Senator Jim Anderson, primary sponsor and cancer survivor, guided the bill expertly through the full Senate and the Senate committee process without a single dissenting vote being cast. House sponsor, Representative Dan Kirkbride, was able to get the bill across the finish line in the House without a single amendment being introduced, making Wyoming the first state in almost three years to pass an unamended OCF bill.

Also instrumental in the campaign's success were hundreds of phone calls, targeted emails and a social media campaign featuring videos of a Wyoming patient and doctor that helped humanize the issue for legislators and the public.

Wyoming started a trend in 2015 with Mississippi, North Dakota, South Dakota and West Virginia also passing OCF legislation.

ACCESS TO CARE: NETWORK ADEQUACY

The Challenge

Under the ACA, insurance companies can no longer deny coverage or charge more to patients with pre-existing conditions, and all insurance offered to individuals must cover a broad set of essential health benefits. In order to keep premiums lower, some insurance companies offer products that limit the range of doctors and specialists available—a practice that results in what are known as "narrow networks."[9]

Cancer patients often require highly specialized care to treat their specific form of cancer. When a patient visits a specialist who is not included in their plan's coverage network, their insurance company may pay for little or none of the cost of that care. In addition, patient costs for out-of-network providers do not count toward the patient's annual out-of-pocket maximum. ACS CAN is concerned cancer patients enrolled in plans with narrow networks may face significant financial barriers to receiving appropriate care. In addition, ACS CAN is concerned that cancer patients in active treatment who are shopping for insurance coverage may not be able to accurately identify plans that cover their preferred providers and facilities at in-network rates.

Research by ACS CAN found that it would be very difficult for cancer patients in active treatment to accurately identify marketplace plans that cover their oncologist with the information provided by health plans and the marketplaces.[10] In addition, among the plans reviewed, 43 percent offered no out-of-network coverage.

The National Association of Insurance Commissioners (NAIC) is in the process of updating its Network Adequacy Model Act. Several states, including California, Connecticut, Hawaii, Washington and the District of Columbia, have passed laws and regulations to define provider network standards for plans sold in the marketplaces, and at least 21 states have enacted laws or regulations to set provider network standards that impact a broader range of plans sold in that state.[11] Starting in 2016, the U.S. Department of Health & Human Services (HHS) will require plans sold in the federal marketplace to submit detailed provider network information. Despite federal and state actions that have already taken place to ensure adequate access to health care providers, many challenges still remain for patients.

Did You Know?

- In 2015, the NAIC is expected to release an updated Model Act to define provider network adequacy standards that can be used by the states.
- The NAIC model law will create a blueprint for states to ensure cancer patients have access to the specialty care they need without burdensome travel distances or unreasonable delays in getting an appointment.

The Solution

The ACA and its implementing regulations require qualified health plans sold in federal or state marketplaces to make a provider directory available to enrollees and prospective enrollees that includes information on whether in-network physicians are accepting new patients. However, many of these directories are difficult to navigate, are out of date or do not include all of the required information. In addition, these regulations often do not apply to plans sold outside of the marketplace. We therefore urge states and HHS to:

- Apply the same network adequacy standards to all plans in the individual and small group markets, regardless of marketplace participation
- Require standardized provider directories with requirements to update directories as soon as a provider is no longer in-network or no longer accepting new patients
- Require provider information be made available to consumers before they purchase a plan so shoppers can compare provider networks and chose the plan that best suits their health care needs

Considering the risks that narrow networks pose to cancer patients, it is important that states and HHS closely monitor the impact these plans are having on individuals diagnosed with serious diseases by:

- Collecting data on out-of-network requests and payments, patient complaints and coverage denials
- Requiring an exceptions process to allow enrollees to access out-of-network services at in-network cost-sharing rates if no in-network providers are available within a reasonable distance or timeframe
- Requiring that insurers count all patient costs for out-of-network providers toward the patient's annual out-of-pocket maximum, if approval of coverage is granted by the plan

Success Story

Passed in 2014, New York's "Emergency Medical Services and Surprise Bills" law went into effect on April 1, 2015. The law creates a model patient protection against having to pay medical bills incurred when a patient receives care from an out-of-network provider without their knowledge or consent. The law requires New York health plans to meet a new set of provider network adequacy standards and requires hospitals and providers to give patients more information about the procedures for which they will be charged. Finally, the law provides two important protections for consumers: patients who receive emergency services will only pay the cost sharing required for in-network providers under their health plan; for non-emergency services patients will only pay the in-network cost sharing if they are not informed about receiving care from an out-of-network provider prior to the procedure.

ACCESS TO CARE: INCREASE ACCESS TO HEALTH COVERAGE THROUGH MEDICAID

The Challenge

Medicaid is the health care program for lower-income Americans. It is jointly financed and administered by the federal government and the states. States have a great deal of flexibility in how they design and administer their Medicaid programs, which leads to significant variation in eligibility, benefits and coverage from one state to the next.

Historically, health care coverage through Medicaid was only available to certain eligible populations, such as pregnant women, the elderly, children, people with disabilities and some parents. As of January 1, 2014, states have the option to increase access to health care through Medicaid to all non-elderly adults who earn up to 138 percent of the federal poverty level (FPL) (about $16,242 for a single adult in 2015). The federal government will pay 100 percent of the states' costs to cover the newly eligible population through the end of 2016, and will pay no less than 90 percent of the cost after that.

As of June 2015, 29 states and the District of Columbia had chosen to accept federal funds to cover more uninsured people through Medicaid, resulting in an estimated 7 million individuals gaining access to health care coverage. However, more than 8 million low-income adults and families below the FPL will continue to lack access to affordable health care coverage solely because their states have not increased access to Medicaid. Nearly 5 million of these individuals fall into the "coverage gap" – they do not qualify for Medicaid, they earn too little to receive federal tax credits for private insurance and they cannot afford health coverage in the private market. By refusing to increase access to their Medicaid programs, governors and lawmakers in these states are denying affordable health care coverage to their residents and are asking hospitals and providers to continue providing billions of dollars of uncompensated care.[12] At the same time that federal payments to help cover the cost of uncompensated care are being cut, these states are walking away from millions of dollars already set aside by the federal government to help cover these individuals, thus turning down an opportunity to return millions of their own taxpayer dollars to their state. States that do not increase access to health coverage through their Medicaid programs will lose a total of $31.6 billion in federal funds as a result of their decision.[13]

Improved Access to Health Care Coverage Through Medicaid

Historically, Medicaid has covered people with disabilities, children, the elderly, pregnant women and some parents/adults.

As of January 1, 2014, states have the option to broaden access to health care coverage to more than 16 million Americans who earn up to 138% of the federal poverty level (FPL)*

*For 2015, 138% of the FPL is equal to $16,242 for an individual and $27,724 for a family of three.
Sources: http://aspe.hhs.gov/poverty/14poverty.cfm and GAO -12-821 MEDICAID EXPANSION: States' Implementation of the Patient Protection and Affordable Care Act

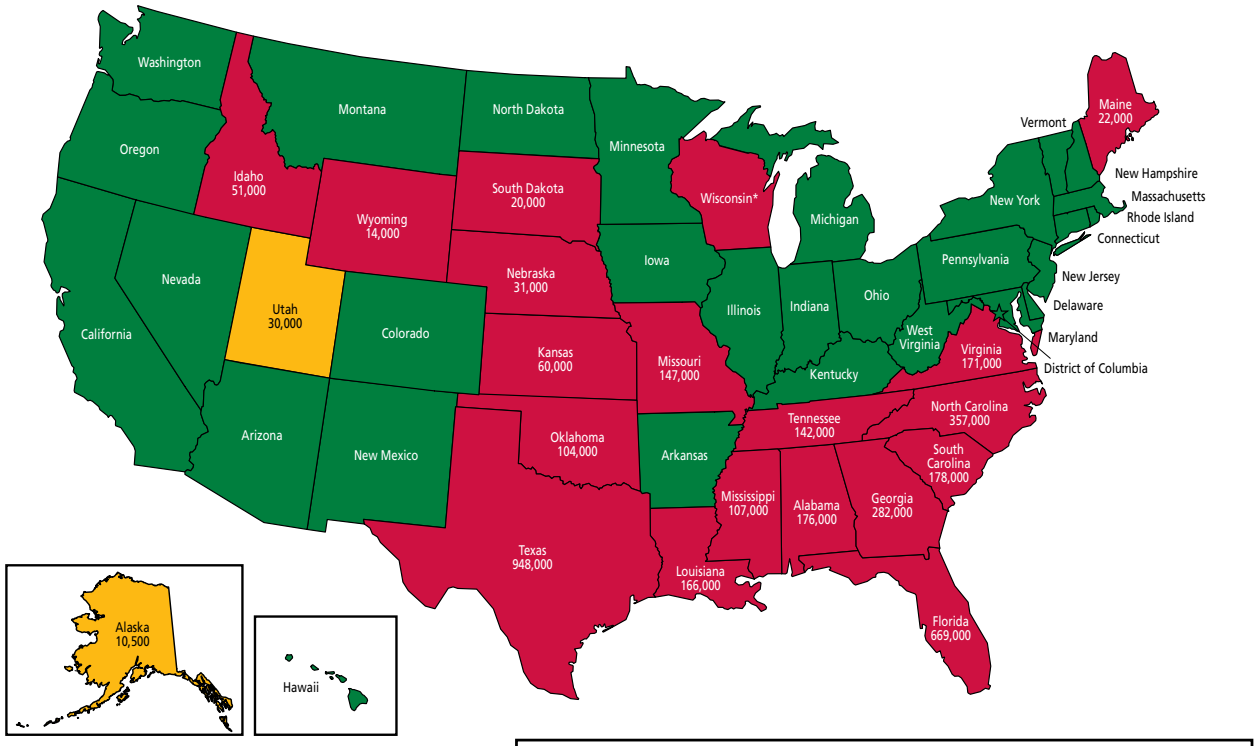
Safety net programs and charity care for individuals and families in the coverage gap are woefully underfunded or nonexistent in many states and seldom provide appropriate preventive and cancer screening services. In addition, safety net and charity programs are rarely able to provide affordable or adequate care to treat a complex and often expensive disease such as cancer.

The Solution

Providing low-income adults and families access to affordable, comprehensive health care coverage is critical in the fight against cancer. Governors and lawmakers have the opportunity to provide millions of Americans access to health care coverage to help detect cancers early, when treatment is more effective and less costly, and to save lives by preventing some cancers from occurring in the first place. ACS CAN encourages states to protect and improve access to health care coverage through Medicaid by:

- Increasing eligibility to cover all patients up to 138 percent of the FPL
- Imposing reasonable cost-sharing, consistent with that allowed under the ACA, and limiting financial barriers, such as high premiums, cost-sharing, wellness programs and employment referral programs, so they do not create barriers to care
- Adequately covering benefits and services critical to cancer patients, such as non-emergent transportation; low-income

State Decisions on Increasing Access to Health Care Through Medicaid Up to 138% FPL



State has broadened Medicaid eligibility, covering individuals under 138% FPL

Legislature still in session or executive pursuing 1115 waiver / alternative expansion proposal – federal approval pending, final decision is unknown

Governor/legislature opposed to improving access to health care coverage through Medicaid, includes estimated number of individuals under 100% Federal Poverty Level (FPL) in coverage gap

How Do You Measure Up?

Source: ACS CAN and Kaiser Family Foundation: A Closer Look at the Impact of State Decisions Not to Expand Medicaid on Coverage for Uninsured Adults
*State provides low income residents access to health care coverage, not consistent with the provisions of the federal health care law/ACA
Updated April 2015

cancer patients often do not have a car or other means of transportation to treatment, and failure to provide this benefit could lead patients to skip treatment, increasing their risk of dying from cancer

- Providing patients managing complex, chronic conditions, such as cancer, the option to enroll in coverage designed for the medically frail, providing greater flexibility in benefits, delivery system, care management and cost-sharing

ACS CAN believes increasing access to health coverage through Medicaid to all low-income adults will ensure that they have access to routine cancer prevention, early detection screenings and treatment services, which may allow them to live longer, healthier lives.

Missed Opportunity

In January 2015, Governor Bill Haslam convened the Tennessee General Assembly for a one-week special session to examine and deliberate Insure Tennessee — a two-year pilot program to provide health care coverage to low-income Tennesseans who currently lack access to affordable health care coverage options. ACS CAN worked with a diverse coalition of hospital, business, provider and patient-focused organizations to engage policymakers and activate grassroots and grasstops volunteers and supporters of Insure Tennessee. Thousands of emails and phone calls were placed, hundreds of concerned state residents made their voices heard at rallies and meetings on the Hill, and the media covered the stories of those affected by a lack of access to coverage. Despite these efforts, it was not enough to convince state legislative leaders to consider the merits of a plan to expand access to health coverage for more than 400,000 low-income, working Tennesseans caught in the Medicaid coverage gap. The special session produced minimal substantive debate, as committees failed to move legislation forward to enable the governor to develop his recommended plan. While we fell short of our goal, ACS CAN and our coalition partners continue to advocate for Tennessee to take action to broaden access to care, which includes encouraging the governor to work with leaders in the legislature to make Insure Tennessee a reality.

ACCESS TO CARE: MEDICAID BREAST AND CERVICAL CANCER TREATMENT PROGRAMS

The Challenge

On October 24, 2000, the federal Breast and Cervical Cancer Prevention and Treatment Act was signed into law, giving states the option to provide Medicaid coverage to eligible women who were diagnosed with breast or cervical cancer through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). (See page 38 for more information on the companion screening program.) All 50 states and Washington, D.C., have adopted the program, allowing thousands of women to receive access to comprehensive Medicaid coverage through the end of their treatment.

As of July 2015, two states — Arkansas and New Hampshire — had revoked this potentially lifesaving access to treatment for women diagnosed with breast or cervical cancer through the NBCCEDP. Other states have considered proposals to eliminate the program. This is due to the misunderstood

Success Story

The Montana Legislature passed and the Governor signed into law the Health and Economic Livelihood Partnership (HELP) Act (Senate Bill 405), a compromise Medicaid expansion bill that will extend health care coverage to 70,000 low-income Montanans.

Over the past three years, ACS CAN has worked with a diverse coalition, including the Montana Human Rights Network, Montana Budget and Policy Center, Montana Primary Care Association, Montana Organizing Project, Planned Parenthood Advocates of Montana, Western Native Voice, SEIU 775, MHA (an Association of Montana Health Care Providers) and AARP Montana to encourage the legislature to cover low-income Montanans as provided by the federal health care law. Our collective campaign efforts lead to over 10,000 Montanans making calls and emails into their lawmakers asking them to support Medicaid expansion.

ACS CAN's legislative ambassadors, volunteer leadership and ACS CAN Board Member Bill Underriner were integral to our success on this issue. As a result of these collective efforts, lives will be saved and quality of life will be improved for thousands of residents in Big Sky country.

1115 Waivers: States Pursuing Medicaid Program Flexibility

Over the past two years, a number of states have filed 1115 Research and Demonstration Project waivers requesting permission from the Centers for Medicare and Medicaid Services (CMS) to allow them to take an alternative approach to covering individuals in the newly eligible Medicaid population. ACS CAN has been actively involved in state efforts to take alternative approaches to increasing access to coverage through Medicaid by filing public comments at both the state and federal levels regarding the 1115 Medicaid expansion waivers.

ACS CAN's comments have emphasized the unique health care needs of people with cancer – those newly diagnosed, those in active treatment and survivors. Our primary focus has been on ensuring that these alternative approaches provide adequate access and coverage to more low-income residents and do not have the effect of creating barriers to care for low-income cancer patients. ACS CAN continues to closely monitor all proposals that seek to take an alternative approach to providing coverage for the newly eligible population, and strongly advocates for policies that adequately provide coverage for individuals who will receive a cancer diagnosis, are currently undergoing treatment or are cancer survivors.

To date, the following states have received approval for 1115 Medicaid expansion waivers:

- Arkansas (approved September 2013)
- Iowa (approved December 2013)
- Michigan (approved December 2013)
- Pennsylvania (approved August 2014)
- Indiana (approved January 2015)

Waiver proposed:

- New Hampshire

assumption that all women will have access to health care coverage, especially in states that have chosen to increase Medicaid coverage to everyone up to 138 percent of the FPL, including childless adults. However, even in the 29 states and Washington, D.C., that have accepted federal funds to increase access to Medicaid coverage, millions of women remain uninsured and are eligible for the program in 2015. These women:[14]

- Reside in a state that did not increase access to coverage through Medicaid
- Have language or literacy challenges
- Qualify for an exemption from the individual mandate
- Experience coverage disruptions
- Lack knowledge or understanding of ACA coverage options

In fact, the Congressional Budget Office estimates that 30 million people in this country will be uninsured in 2016 – including 23 million uninsured people who will be exempt from the individual mandate[15] – leaving many women in need of the breast and cervical cancer treatment program. Without the program, these uninsured women may be unable to access appropriate, timely treatment.

The Solution

ACS CAN strongly opposes proposals to eliminate potentially lifesaving breast and cervical cancer treatment programs in Medicaid. Any attempts to eliminate the programs are premature. ACS CAN strongly encourages states to monitor and evaluate the demand and continued need for their treatment programs prior to considering any proposals to eliminate eligibility for state breast and cervical cancer treatment programs.

Following are some of ACS CAN's biggest concerns with 1115 waivers:

- ACS CAN has expressed specific concerns with proposals that seek to impose various types of cost-sharing for enrollees, including premiums, copayments and the use of health savings accounts (HSAs), as these approaches could cause cancer patients and those in active treatment to reach their plan's annual out-of-pocket limit faster than they otherwise would.
- ACS CAN opposes state efforts to seek a waiver from providing non-emergency medical transportation to newly eligible populations.
- ACS CAN opposes proposals that would penalize patients for failing to make premium payments or HSA contributions by dropping them from coverage and preventing them from re-enrolling during what's known as a "lock-out" period. During lock-out periods, cancer patients are denied access to health insurance, making it difficult or impossible to continue cancer treatment.

ACCESS TO COLORECTAL CANCER SCREENING

The Challenge

Colorectal cancer is the third most common cancer in both men and women in the United States. More than 130,000 people are expected to be newly diagnosed with colorectal cancer and nearly 50,300 people are expected to die from the disease in 2015.[1] Many of these cases could have been prevented if people received recommended cancer screenings. Colorectal cancer is unique because it usually develops slowly as a noncancerous growth, or polyp. Through screening the polyp can be identified and removed, thereby preventing cancer altogether.

Screenings are only effective if people receive them in a timely manner and in an appropriate medical setting. After several years of increases, colorectal cancer screening rates have stabilized in recent years – 59 percent of people aged 50 and older get screened, but one in three adults ages 50 to 75 are still not getting screened as recommended.[2] Individuals less likely to get screened are those who are younger than 65, are racial/ethnic minorities, have lower education levels, lack health insurance and are recent immigrants.

In 2014, ACS CAN and the American Cancer Society joined with more than 100 organizations across the country in embracing a shared goal to increase colorectal cancer screening rates to 80 percent nationwide by 2018. While many states are above the national average, with Massachusetts and New Hampshire leading the way, not one has reached an 80 percent screening rate. On the other hand, some states, specifically Alaska, Montana and Wyoming, have screening rates well below the national average and have a long way to go to reach 80 percent.[3]

To help increase screening rates, ACS CAN encourages lawmakers to make colorectal cancer screening a priority and to work across all sectors to increase the rates. Specifically, state policymakers can:

- Improve current screening programs by allocating additional funding for state screening and treatment programs
- Establish statewide screening programs where ones do not exist
- Partner with hospitals, community health centers and other organizations to increase knowledge of and improve access to screenings
- Broaden access to health care coverage and health insurance programs, such as Medicaid
- Take action to reduce cost and access barriers to screening services
- Increase outreach to all populations, especially those with historically low screening rates

Did you know?

Incidence rates for colorectal cancer have been decreasing for two decades, in part because of increased colorectal cancer screening rates.[4]

While many states are above the national average, with Massachusetts and New Hampshire leading the way, not one has reached an 80 percent screening rate.

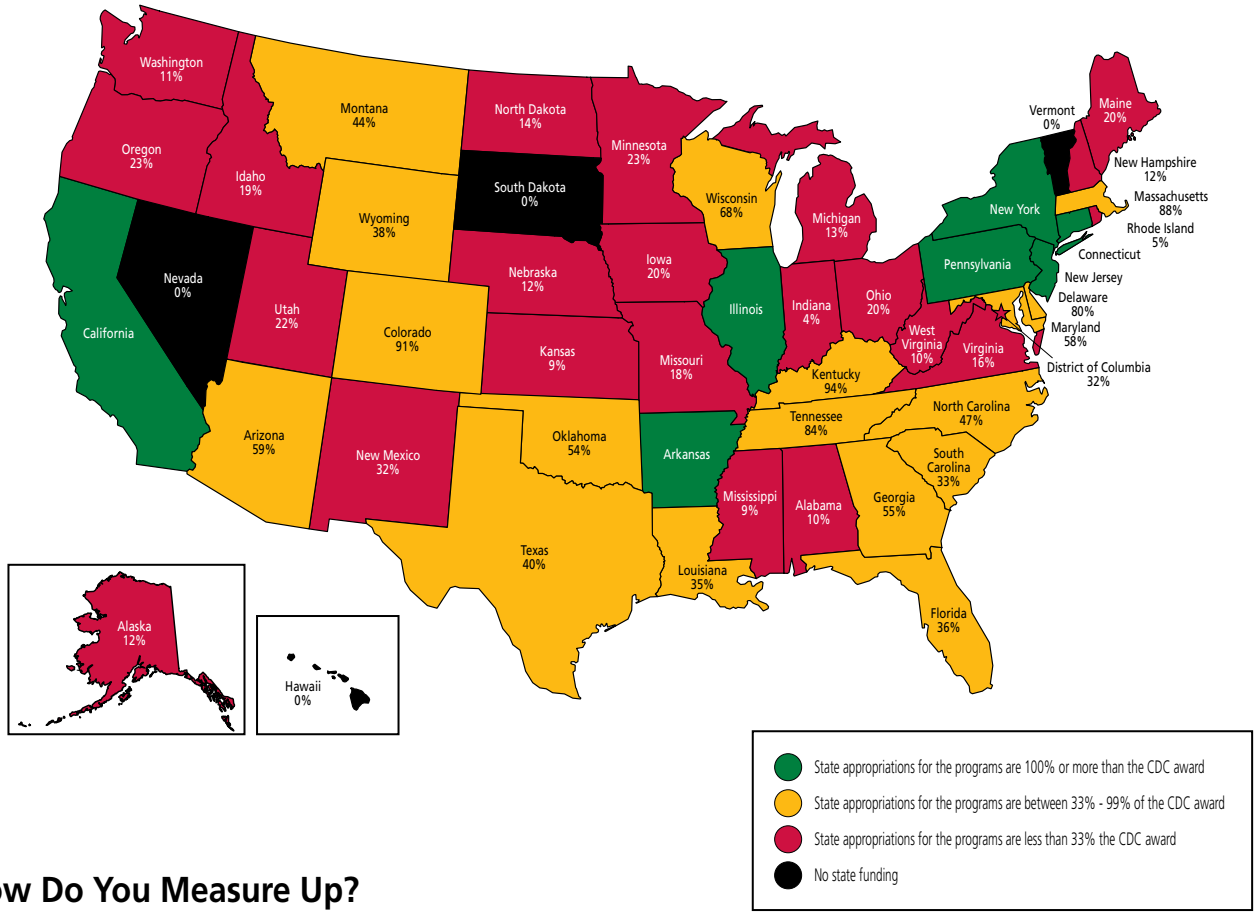
FUNDING FOR BREAST AND CERVICAL

The Challenge

Evidence-based screenings are the most important tools for detecting breast and cervical cancer early and improving survival rates. More than 230,000 people living in the United States are expected to be diagnosed with breast cancer in 2015.[1] If detected early, the five-year survival rate is 99 percent. But, when it is diagnosed at a late stage, the survival rate drops to only 25 percent.[2] Unfortunately, more than 40,000 individuals are expected to die from this disease in 2015 alone.[3]

Cervical cancer can be prevented altogether by removing precancerous lesions found during screenings. However, when the cancer is diagnosed at a late stage, the survival rate drops to only 16 percent. An estimated 13,000 women in the United States will be diagnosed with cervical cancer and more than 4,000 will die from the disease in 2015.[4]

State Appropriations for Breast and Cervical Cancer Screening Programs - Fiscal Year 2014-2015



How Do You Measure Up?

Source: 2014-2015 data from the Centers for Disease Control and Prevention and unpublished data collected from ACS CAN and ACS Divisions, including input from NBCCEDP directors.
Updated June 2015

Despite the effectiveness of screening in detecting cancer early and improving survival, screening rates are still not as high as they need to be, especially among low-income, uninsured and minority women. In fact, only 51 percent of women have received a mammogram in the past year and 80 percent have had a Pap test in the past three years. These rates are significantly lower for the uninsured, at 22 percent and 61 percent respectively.[5]

In 1990, Congress established the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) to address the problem of low screening rates and access issues among uninsured and underinsured, low-income women. The program serves our country's most vulnerable women in all 50 states, Washington, D.C., five U.S. territories and 11 American Indian/Alaskan Native tribes or tribal organizations. Since the program began, it has served more than 4.6 million women, provided more than 11.6 million screenings and diagnosed more than 64,000 breast cancers, 3,500 cervical cancers and 167,000 premalignant cervical lesions.[6] These great achievements are the result of efforts to make screening services available to those in need and community interventions including public education and outreach, patient navigation, care coordination and quality assurance that help to increase awareness and knowledge of screening and encourage women to use these services.

Unfortunately, limited federal and state funding has forced the program to turn away women in need and reduce many of the outreach and educational services provided through the program.

Impact of the Affordable Care Act on NBCCEDP

With the introduction of the Affordable Care Act, many women will be able to receive breast and cervical cancer screenings through newly acquired insurance. With this in mind, the NBCCEDP is able to work synergistically with communities in need to put a heavier emphasis on education and outreach about the importance of screening as well as monitoring screening rates, and organizing screening systems.

The NBCCEDP is a lifeline for many women in need of screening services. In states that have chosen not to increase access to their state Medicaid programs, millions of women still rely on this potentially lifesaving program for cancer screening services. Of particular concern are the following four states that have not only refused to increase access to health care through Medicaid, but also have reduced or eliminated funding for their state breast and cervical cancer screening programs: Kansas, Mississippi, South Dakota and Texas.

Success Story

In FY 2014, the Michigan Legislature eliminated state funds for the Cancer Prevention Program. The elimination of this funding directly impacted Michigan's Breast and Cervical Cancer Control Program (BCCCP), Colon Cancer Early Detection Program and Comprehensive Cancer Control Program.

In response, ACS CAN Michigan kicked off a campaign to restore funding for the cancer control and prevention programs, with specific emphasis on the BCCCP in the FY 2015 budget. Through the pink bra "Don't Leave Women Exposed" campaign, ACS CAN's grassroots and media advocacy efforts resulted in the collection of more than 3,600 petition signatures; the mailing of 1,000 postcards; 50 letters to the editor submitted throughout the state; 25 in-district meetings; and thousands of action alerts sent to the Governor and members of the legislature, urging them to restore funding for the BCCCP.

As a result of these efforts, the legislature passed a budget that restored half a million dollars for the Michigan Cancer Prevention Programs in fiscal year 2015. Our collective efforts resulted in this program being the only health and wellness program that had funding restored in the FY 2015 budget. In these challenging fiscal times, it is very difficult, or next to impossible, to successfully advocate for restoration of program funding, especially in programs that have had funding eliminated in a fiscal year. This was a hard fought, well deserved win for our Michigan team and our advocacy will continue, emphasizing the continued need for state investment in cancer control, prevention and early detection services for underserved Michiganders.

The Solution

One of the most important factors for ensuring that women have access to breast and cervical cancer screenings is adequate funding of state cancer screening programs. The Affordable Care Act (ACA) has improved women's access to potentially lifesaving cancer screenings and diagnostic and treatment services, but there continues to be a critical need for the NBCCEDP. Many women with or without insurance will continue to face barriers to care and will rely on the NBCCEDP to help them get needed breast and cervical cancer screenings. These women include those with geographic isolation, limited health literacy or ability to self-advocate, lack of provider recommendation, inconvenient times to access services and language barriers.

Under the ACA, states have the opportunity to increase access to health care coverage through state Medicaid programs for Americans earning less than 138 percent of the federal poverty level. However, not all states have chosen to take advantage of this opportunity, leaving millions of low-income Americans without any affordable, comprehensive health care coverage options. In the states that have not increased access to Medicaid, the NBCCEDP will remain a lifeline for low-income and uninsured women. Adequate funding is necessary to continue providing benefits and services to women who have historically accessed the program for cancer screenings, but the program will also provide educational outreach and potentially lifesaving screening services to women who continue to lack an affordable health care coverage option and remain uninsured.

PALLIATIVE CARE

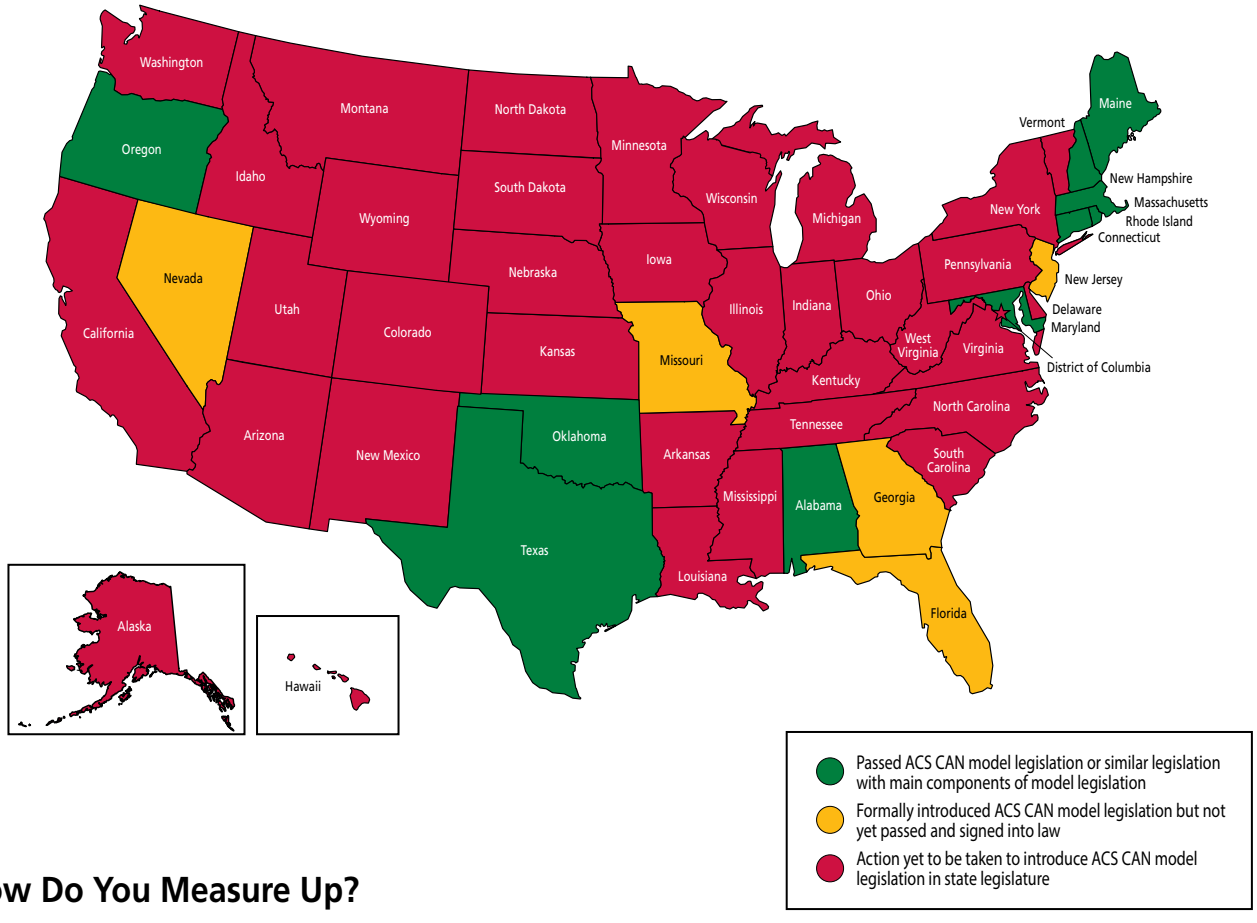
The Challenge

Advances in cancer research continue to provide new and more effective treatments for cancer, but therapies do not meet all the needs of cancer patients. Focusing exclusively on treating a patient's disease can result in a failure to address the full spectrum of issues that arise as part of a cancer diagnosis and treatment. These issues include emotional distress and physical symptoms such as pain, fatigue and nausea. Fatigue, for example, is one of the leading reasons for cancer patients to skip follow-up medical appointments, and patients suffering from side effects find it much harder to return to the workforce or engage in family activities.

The Solution

Palliative care is specialized medical care that can provide the best possible quality of life for a patient and his or her family by offering relief from the symptoms, pain and stress of a serious illness. Palliative care is essential to achieving the goal of comprehensive, cost-effective care that improves patient satisfaction and health outcomes. Contrary to some misconceptions, palliative care is not end-of-life care – it is appropriate at any age and any stage of disease and can be provided along with curative treatment as an extra layer of support for patients.

Palliative Care Across the United States



Source: ACS CAN
As of June 1, 2015

How Do You Measure Up?

Palliative care provides a coordinated, team-based approach among medical professionals to help meet a patient's needs during and after treatment. It helps patients complete treatments, including rehabilitation to address impairments, and improves quality of life for patients, survivors and caregivers. Studies show cancer patients receiving palliative care during chemotherapy are more likely to complete their cycle of treatment, stay in clinical trials and report a higher quality of life than similar patients who do not receive palliative care. According to a 2010 study conducted at Massachusetts General Hospital and published in the New England Journal of Medicine, patients with metastatic lung cancer who received palliative care showed improved quality of life and less depression and lived nearly three months longer than patients who received care that only focused on treating the cancer.[1]

Palliative care is clearly in the best interest of patients, but hurdles remain to the widespread adoption of palliative care. It is often assumed that adding services leads to increased cost. However, a large body of research has demonstrated that when palliative care is used to proactively address many of the side effects of serious illness, patients are more satisfied and overall patient care costs actually go down. In a study of hospitals in Texas, the provision of palliative care within the first 10 days of admission resulted in an average $2,696 savings per patient discharged and an average $9,689 in savings per patient who died in the hospital. Another study looking at Medicaid patients in New York state hospitals found an average savings of $6,900 per patient when palliative care was provided. Specifically, the savings were $4,098 for each patient discharged and $7,563 per patient who died in the hospital. The New York study concluded that if the assumed 2-6 percent of Medicaid patients in need of palliative care received it, the New York Medicaid program could save between $84 million and $252 million per year.[2,3]

Given the benefits of this type of specialized medical care, it's no surprise it has become one of the fastest growing trends in health care over the past 10 years. In fact, the prevalence of palliative care in U.S. hospitals with 50 or more beds has increased 164 percent over the past 12 years.[4] Demand for this type of care is expected to continue increasing as the public becomes more aware of its benefits. Recent public opinion research found that once people are informed about palliative care, 92 percent report they would be highly likely to consider it for themselves or their family members if they had a serious illness.[5] However, millions of adults and children currently facing a serious illness do not have access to palliative care services to help ease their suffering.

People facing serious illness want the types of services palliative care provides – and they expect today's hospitals, cancer centers and other care settings to deliver. The pillars of palliative care involve:

- **Time** to devote to intensive family meetings and patient/family counseling
- **Expertise** in managing complex physical and emotional symptoms such as pain, shortness of breath, depression and nausea
- **Communication and support** for resolving family/patient/physician questions concerning goals of care
- **Coordination** of care transitions across health care settings

The public recognizes the benefits of this added layer of support from a palliative care team focused on patient quality of life. To benefit from palliative care, patients and families must be able to access these services in their local hospital or other care settings. In addition, health professionals in training must learn from direct experience at the bedside with high-quality

Success Story

After nearly passing the ACS CAN model Quality of Life/ Palliative Care legislation during the 2014 legislative session, Alabama succeeded in the 2015 session with unanimous votes in the Senate (28-0 on April 2nd) and the House (99-0 on May 19th) before being signed by Governor Robert Bentley on May 19th.

Senate champion J.T. Waggoner, Chair of Rules Committee, and House champion, April Weaver, Chair of Health Committee, worked with ACS CAN staff and volunteers to successfully pass the model legislation that establishes a multi-disciplinary advisory council made up of palliative care and health care experts from within Alabama. The legislation also designates the Alabama State Health Department as the central disseminator of up-to-date information regarding palliative care for the public, patients, care givers and medical professionals in the state.

Similar legislation was also passed and signed into law in 2015 in Maine, Oklahoma and Texas.

Did you know?

Studies conducted in variety of states including New York and Texas have found that providing palliative care alongside disease-focused treatment in hospitals can reduce costs from approximately $1,700 per patient to nearly $10,000 per patient.[2,3,6]

palliative care teams. ACS CAN supports policy initiatives to improve patient access to palliative care through the following mechanisms:

1. **Educate the public about palliative care.** In partnership with state departments of health and community stakeholders, provide palliative care information online and through other channels to help consumers and clinicians understand palliative care and the benefits of integrating it with disease-directed treatment for all seriously ill adults and children.

2. **Improve access to palliative care services.** Encourage policies requiring routine screening of patients for palliative care needs and facilitating access to palliative care services in all health care settings serving seriously ill adults and children (e.g., hospitals, cancer centers, nursing homes, assisted living facilities, home care agencies).

3. **Boost palliative care clinical skills.** Foster training in palliative care for all practicing health professionals and students of medicine, nursing and other professions. This would be done by aligning educational requirements and professional practices with current evidence demonstrating the importance of integrating palliative care alongside disease-directed treatment.

4. **Preserve access to pain therapies for people in pain.** Implement balanced policies that promote the delivery of integrated pain care for all people facing pain, including preserving access to prescription medications and other therapies, as well as improving workforce training in pain assessment, management, responsible prescribing and use of prescription monitoring programs.

ACS CAN has created model palliative care legislation that focuses on public education and access to palliative care and urges lawmakers to adopt this, or similar legislation, in their state.

CANCER PAIN CONTROL: ADVANCING BALANCED STATE POLICY

The Challenge

Pain remains one of the most feared and burdensome symptoms for cancer patients and survivors, but nearly all cancer pain can be relieved. Cancer-related pain can interfere with the ability of patients to adhere to recommended treatments and can devastate their quality of life – affecting work, appetite, sleep and time with family and friends.

The prevalence of pain and its inadequate treatment has remained consistently high despite the recognition that pain relief is an integral part of comprehensive palliative care for patients. Research shows that pain is still a problem for nearly 60 percent of patients with advanced disease or those undergoing active treatment, along with 30 percent of patients who have completed treatment.[1] Still more troubling, significant disparities in access to quality pain treatment exist in medically underserved and socioeconomically disadvantaged populations.

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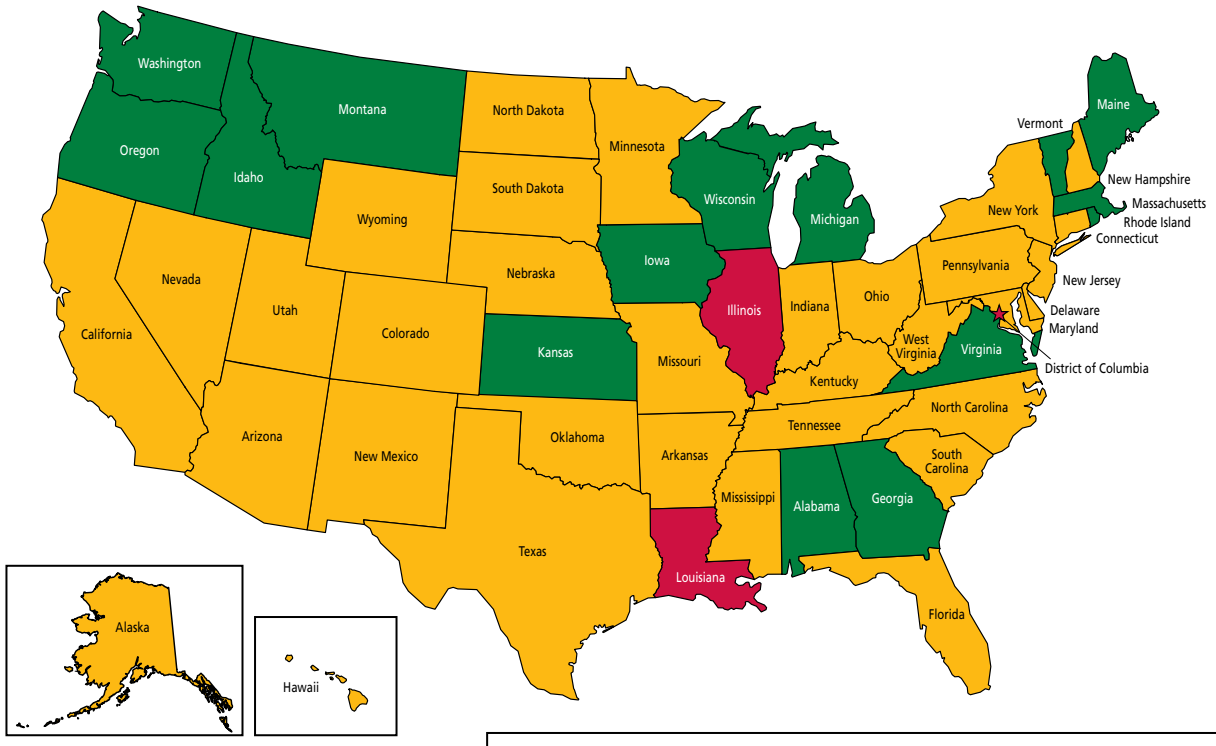
Current Pain Policy in the States



How Do You Measure Up?

Source: Pain Policy Studies Group (PPSG) at the University of Wisconsin. For more information on this report card, please visit: http://www.painpolicy.wisc.edu/sites/www.painpolicy.wisc.edu/files/prc2013.pdf
As of July 1, 2015

Integrative pain care that includes medications and non-drug therapies can keep a patient's pain under control. While not the only tool, opioid medications are recognized as a mainstay of treatment for moderate to severe cancer pain and can be a beneficial treatment for managing serious, persistent pain in carefully selected patients. These medications provide much-needed pain relief to patients, but their properties also make them subject to misuse and abuse. In recent years, there has been major emphasis on policies aimed at curtailing misuse of opioids at both the federal and state levels. Combating illegal use of prescription drugs is necessary, but it is also important to ensure these well-intentioned efforts do not simultaneously prevent patients suffering from pain from accessing appropriate relief using legal medications. States face challenges to creating and promoting balanced public policies that will make medications available to patients who need them, while also keeping those medications away from those who intend to misuse them.

The Solution

State policies can play a significant role in ensuring patient access to pain relief while controlling abuse of pain medication. ACS CAN encourages states to carefully balance these considerations in prescription drug monitoring programs, public education efforts and policies governing the prescribing of opioid pain medicines. Many recently enacted state policies have focused solely on preventing illicit drug abuse – they risk jeopardizing legitimate patient access to pain relief. ACS CAN recommends that states:

- **Establish evaluation mechanisms for pain policies.** Review mechanisms will vary from state to state and could include task forces, commissions, advisory councils or summit meetings. Regardless of the mechanism, each state should systematically review its pain policies for balance between providing patients access to pain medications and efforts to reduce abuse.

- **Make a commitment to implementing pain policies.** Studies have shown that health care providers often are not fully aware of the policies that govern pain management, which ultimately affects their ability to abide by these policies. Thus, every state should commit to disseminating information about pain policies to clinicians and the public.

While good policies are necessary, written policies by themselves can be ineffective when practitioners are unaware of them or are confused by conflicting messages.

Many recently enacted state policies have focused solely on preventing illicit drug abuse – they risk jeopardizing legitimate patient access to pain relief.

Did you know?

In the U.S., pain results in somewhere between $560 billion and $635 billion in combined direct medical costs and lost productivity.[1]

STATE APPROPRIATIONS FOR CANCER

The past two decades have seen significant improvements in the way we diagnose and treat cancer. Through scientific discovery, we have also learned how to more effectively reduce our cancer risk or prevent it altogether. But our work is far from over, and sustained investment in cancer research and prevention is critical to ensuring the next breakthroughs reach those who need them.

The federal government is by far the largest funder of cancer research and the American Cancer Society is the largest non-profit entity providing funding for cancer research. However, state governments also play an important role investing in lifesaving research. Many states have committed funding to support cancer prevention and early detection programs, and scientific research on cutting-edge treatments. Below are examples of states that have provided significant investments in cancer research funding. ACS CAN urges state legislatures to consider investing in lifesaving cancer research.

Texas

Created by the Texas legislature and authorized by Texas voters in 2007, the Cancer Prevention and Research Institute of Texas (CPRIT) began in 2009 to award grants to Texas-based organizations and institutions for cancer-related research and product development. In addition, 10 percent of CPRIT's funding is used for the delivery of cancer prevention programs and services. CPRIT is charged to:

- Create and expedite innovation in the area of cancer research and enhance the potential for a medical or scientific breakthrough in the prevention of and treatment for cancer;
- Attract, create or expand research capabilities of public or private institutions of higher education and other public or private entities that will promote a substantial increase in cancer research and in the creation of high-quality new jobs in this state; and
- Develop and implement the Texas Cancer Plan – a statewide call to action for cancer research, prevention and control. The intent of the Plan is to provide a coordinated, prioritized and actionable framework that will help guide efforts to fight the human and economic burden of cancer in Texas.

CPRIT's current funding is $300 million for FY 2015.

Florida

In 1999, the legislature created the Florida Biomedical Research Program, now known as the James and Esther King Biomedical Research Program, to award peer-reviewed competitive grants to researchers studying tobacco-related diseases. In 2006, the Bankhead-Coley Cancer Research Program was established, employing the same methodology to fund the best science in all cancers. Between 2006 and 2010, the programs were funded with a scheduled sunset date of January 1, 2011, subject to legislative review in 2010. The legislature reauthorized the programs during the 2010 session and dedicated $20 million annually for each program from tobacco surcharge revenues. In 2011, faced with a budget deficit, the legislature recognized the importance of maintaining the James and Esther King Program and the Bankhead-Coley Program, but they were funded at reduced levels of $7.2 million and $10 million, respectively. In 2012, Bankhead-Coley Funding was reduced to $5 million.

Fortunately, lawmakers made investment in this critical program a priority in FY 2014-2015, allotting each program $10 million ($20 million total). The programs are anticipated to have this level funding for the upcoming fiscal year. Florida has not yet finalized its FY 2015-16 state budget.

California

The California Breast Cancer Research Program (CBCRP) is the largest state-funded breast cancer research effort in the nation, administered by the Research Grants Program Office within the University of California's Office of the President. CBCRP is funded through a tobacco tax, voluntary tax contributions on personal California income tax forms and individual donations. CBCRP funds California investigators to solve questions about basic breast cancer biology, causes and prevention of breast cancer, innovative treatments and ways to protect a patients' quality of life following a breast cancer diagnosis. The program involves advocates and scientists in every aspect of CBCRP decision-making, including program planning and grant application review. Since 1994, more than $240 million in research funds has been awarded to institutions across California.

FY 2015 funding for this important research program is $11,314,285.

California also has a robust Tobacco-Related Disease Research Program (TRDRP) that is funded through the tobacco tax (Proposition 99) and individual contributions. The program supports critical new priorities that represent gaps in funding by other agencies or areas where other agencies are reluctant or unable to provide support. Since TRDRP's inception, more than 1,200 research grants on tobacco-related studies have been funded. TRDRP revenue is used to make grants for California scientists and community researchers to find better ways to prevent and reduce tobacco use and its related diseases; 300 grants totaling $78,660,473 have been awarded in the cancer field.

The FY 2015 funding level for TRDRP is $10,553,000.

Maine

Maine voters passed a ballot measure in 2014 to provide funding for state research capabilities. The legislation to refer the question to the ballot, which had strong bipartisan support, passed the legislature during the 2014 session and was signed into law by the governor. The measure was designed to issue $10 million in bonds, matched by $11 million in private funding to build a research center for genetic solutions to cancer and diseases of aging including cancer.

Did You Know?

- Nearly 4,000 jobs have been created by Florida's biomedical research programs, with an estimated 2,376 from the King Program and approximately 1,600 from the Bankhead-Coley Program.[1]
- Ongoing state investments in cancer research will stimulate a state's economy while also saving precious lives. Not only do these dollars create jobs, but they allow grantees to leverage additional dollars from outside the state.

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