Cancer Action Network℠
American Cancer Society®

10th Edition

HOW DO YOU **MEASURE UP**?

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

AUGUST 2012

Mission Statement

American Cancer Society Cancer Action Network (ACS CAN)

The American Cancer Society Cancer Action Network (ACS CAN) is the nation's leading voice advocating for public policies that are helping to defeat cancer. As the advocacy affiliate of the American Cancer Society, ACS CAN works to encourage elected officials and candidates to make cancer a top national priority. ACS CAN utilizes its expert capacity in lobbying, policy, grassroots and communications to amplify the voices of patients in support of laws and policies that save lives from cancer. For more information, visit www.acscan.org.

Our Tenth Edition

This tenth edition of *How Do You Measure Up?* illustrates how 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 in health care costs 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) 585-3206 or call our toll-free number, 1-888-NOW-I-CAN, 24-hours a day, seven days a week. You can also visit us online at www.acscan.org.

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How Do You Measure Up?

More CAN, Less Cancer

On September 1, 2012, American Cancer Society Divisions across the country will integrate their advocacy programs with ACS CAN. By aligning all federal, state and local advocacy efforts within a single, integrated nationwide structure, our advocacy work will 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 support 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.

We have made great strides in the fight against cancer. Today there are 350 more lives saved from the disease per day than in 1991 and 13.7 million survivors living in the United States. Despite that progress, 1,500 people still die every day from cancer in this country.

We know what needs to be done to save more lives from cancer. If everyone were to stop smoking, get screened for cancer according to guidelines, have access to adequate health care and eat a healthy diet and exercise regularly, we could prevent nearly half of all cancer deaths each year. That translates into approximately 285,000 lives that could be saved annually.[1]

Research has shown that those goals can be achieved through stronger tobacco control laws, improved access to cancer treatment and screening and increased education about the importance of proper nutrition and physical fitness.

For the tenth year, ACS CAN has published a blueprint for state legislators on how to save more lives from cancer. 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 provides a snapshot of how states are progressing on critical public health measures.

Every day, legislators at the state and local levels are making decisions that impact cancer patients and their families. Health insurance coverage, access to cancer drugs, investments in research and the development of new treatments, tobacco control policies and funding for prevention and screening programs are all issues that could be decided by state and local lawmakers. Changes in laws for the better can impact millions of people, exponentially expanding and enhancing the efforts of ACS CAN and the Society to eliminate cancer as a major health problem.

The challenges are clear. States are struggling with difficult budget choices and heightened levels of partisanship. ACS CAN believes that fighting cancer is not only non-partisan, but it should be a priority – and we stand ready to work with advocates and lawmakers in the states to pass and protect laws and policies that benefit those with cancer or at risk of getting cancer.

As advocates, we have the responsibility to educate the public on how to prevent and treat cancer effectively, but we cannot do it unless state and local policymakers take action. That is why ACS CAN urges lawmakers to work with us to fight back against cancer and save lives.

A Decade in the States

Since the first issue of *How Do You Measure Up?* was published, states have made tremendous progress toward implementing laws and policies that help fight cancer. In that time, 45 states increased their tobacco taxes more than 100 times and 21 states implemented comprehensive smoke-free laws covering bars, restaurants and workplaces. Since being established in 1991, the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) has served more than 4 million low-income and uninsured women and provided more than 10 million screening exams. During the past five years, 20 states and D.C. have passed oral chemotherapy parity legislation, improving patient access to anticancer oral drugs. And in the two years since the passage of the Affordable Care Act (ACA), 15 states have established exchanges, or marketplaces, where consumers can easily compare quality health plans and choose the one that is best for them and their families.

These milestones are examples of how state legislators are saving lives and saving money by implementing common-sense policies that help make a dent in the fight against cancer. Each year, as new lawmakers take office, ACS CAN continues education efforts on how specific legislative initiatives can benefit the public health and the economic wellbeing of the states.

Over the last decade, advocates have also been working tirelessly to protect laws and programs that help fight cancer. Tight budget environments have caused some lawmakers to make short-sighted cuts that reduce access to state Medicaid programs or to cancer screening or tobacco control programs. These decisions ultimately cost states more in terms of lives lost, reduced productivity and increased health spending on treating diseases that could have been caught at an earlier stage or prevented all together.

In recent years, advocates have also been pitted against the largesse of the tobacco industry when it comes to protecting or passing strong tobacco control policies. In many situations, ACS CAN and the Society have had to protect smoke-free laws or tobacco taxes already in place from being weakened or repealed completely.

What's at Stake

Nearly 50 million people in America are uninsured. Another 25 million or more are underinsured – they have insurance, but their coverage is inadequate. Insured or not, millions of people don't have access to cancer prevention, early detection and evidence-based treatment and care options that give them a fighting chance against this disease.

State lawmakers play a critical role in guaranteeing access to care through state-funded screening programs, Medicaid coverage for low-income populations and the development of health benefit exchanges as outlined in the ACA.

One third of all cancer deaths are directly related to tobacco use. ACS CAN supports a comprehensive approach to tackling tobacco use through polices that raise the price of tobacco products through tobacco tax increases, implement comprehensive smoke-free laws and fully fund and sustain evidence-based, statewide tobacco prevention and cessation programs.

Comprehensive smoke-free laws, which include all restaurants, bars and workplaces, reduce exposure to secondhand smoke, encourage people to quit or cut down on smoking and prevent youth from starting to smoke. As of July 1, 2012, 23 states, the District of Columbia, Puerto Rico, the U. S. Virgin Islands and 520 municipalities across the country require 100 percent smoke-free workplaces, restaurants and bars. According to an April 2011 report by the Centers for Disease Control and Prevention (CDC), if current progress to enact smoke-free laws, all states could have comprehensive smoke-free policies by 2020.

Increasing cigarette excise taxes has been proven to reduce the number of current and potential smokers. Research shows that every 10 percent increase in the price of tobacco reduces youth smoking rates by 6.5 percent and overall cigarette consumption by 4 percent. Cigarette taxes are also a powerful economic tool, directly producing sustained increases in state revenues and resulting in large savings in health care costs.

The current average state tobacco tax is $1.49, with 20 states still having taxes at less than $1.00 per pack. New York has the highest cigarette tax at $4.35 per pack and Missouri has the lowest cigarette tax at 17 cents per pack. No state comes close to matching the health and economic costs attributed to smoking, which are estimated at $10.47 per pack.

Many states are also working on policies and programs to reduce cancer risk related to poor nutrition, lack of physical activity and obesity. For the majority of Americans who do not use tobacco, weight control, dietary choices and physical activity are the best ways to prevent cancer. ACS CAN encourages state legislators to make a commitment to creating healthy environments for all Americans.

ACS CAN continues to work on all of these issues because too many women in the United States still miss their annual mammogram due to lack of insurance; families continue to be forced to declare bankruptcy due to a cancer diagnosis; nearly 4,000 children still pick up their first cigarette every day; and cancer patients continue to die simply because they do not have access to lifesaving treatments.

The data in this report show that there is still much public policy work to be done to achieve our mission of eliminating suffering and death from cancer. Nearly 1.6 million people in the United States will be diagnosed with cancer in 2012 and more than 570,000 people will die from the disease this year alone.[2] ACS CAN is dedicated to ensuring that lawmakers enact state health reforms that help prevent cancer and save lives.

How does your state measure up?

Tackling Tobacco Use

The burden of tobacco use across the states, which results in more than 443,000 deaths and $193 billion in health care and productivity losses each year, is well known. However, troubling trends continue despite the understanding of the extent of the problem and clear evidence for what policies work to reverse it. We now have even better information on just how tobacco use effects one particular vulnerable population – youth and young adults – and the dramatic consequences of youth tobacco use on the health of our entire population.

According to information presented in the 2012 Surgeon General's report, Preventing Tobacco Use Among Youth and Young Adults, 99 percent of tobacco users start before they are 26 years old.[1] Unfortunately, declines in youth smoking have stalled in recent years. Use of smokeless products and cigars is actually increasing among several groups of youth – white males and black females, for example.[2] Also troubling, use of more than one tobacco product at a time is rising among high school students.[3]

Beginning regular tobacco use at a young age has serious health risks. The chronic diseases most associated with smoking, including lung cancer and respiratory and heart diseases, can begin to develop immediately upon starting to use tobacco and the health risks are greater for people who start early in life. The Surgeon General's report highlighted that tobacco use is just as potentially addictive for youth as for older age groups and that quitting can be just as difficult for youth.

Youth face unique pressures from peers, and when combined with the tobacco companies' efforts to promote tobacco use to them despite laws restricting such activities, kids are even more vulnerable to picking up the habit. This growing evidence around youth and tobacco underlines the critical need for states to invest heavily in prevention efforts to stop youth from ever starting to use tobacco. These properly funded prevention efforts will also provide resources for youth, young adults and older adults who want to quit.

ACS CAN supports a comprehensive approach to tackling tobacco use through policies that:

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

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.

10-Year Retrospective:

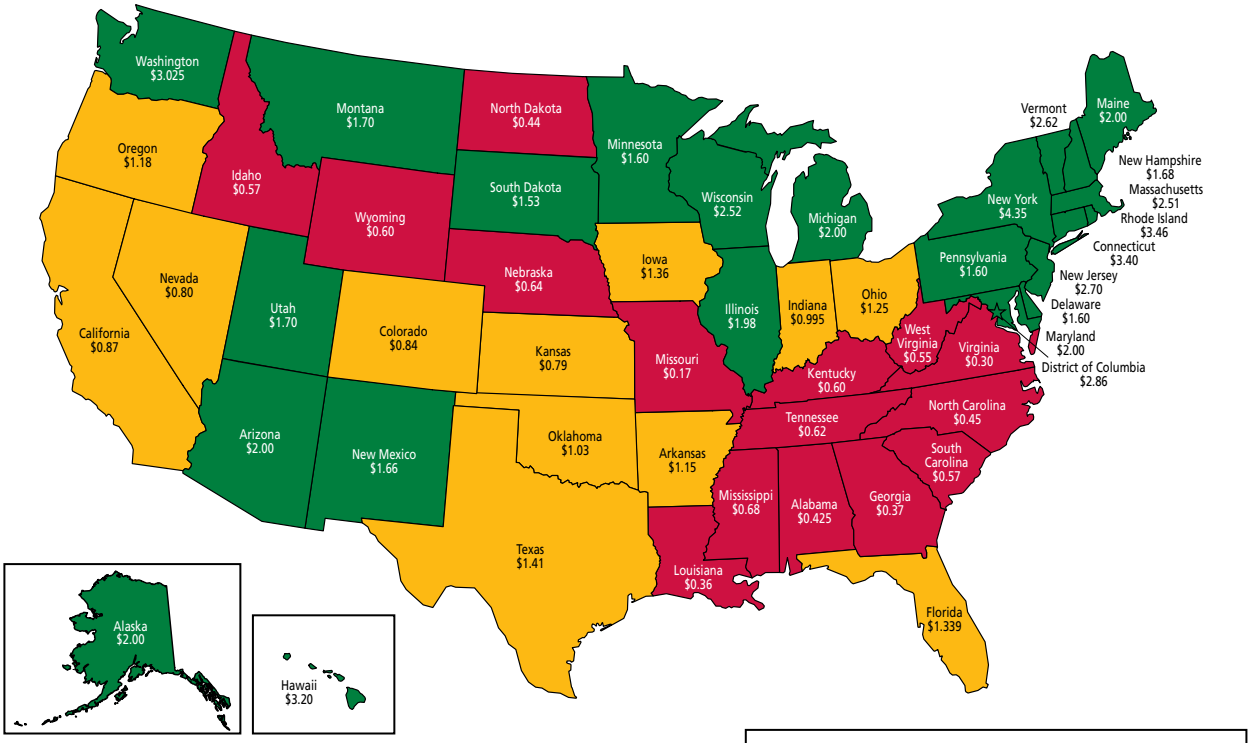
In 2003, the national average for the tobacco tax was $0.61. Today, it has more than doubled to $1.49.

The Challenge

By increasing taxes on cigarettes, cigars, little cigars, smokeless tobacco and all other tobacco products (OTPs), states can save lives, reduce health care costs and generate much-needed revenue. Evidence clearly shows that raising tobacco prices through regular and significant tax rate increases encourages tobacco users to quit or cut down and prevents kids from ever starting to smoke.

In many states, cigarettes are taxed at a much higher rate than all OTPs, making the lower-priced tobacco alternatives more appealing to youth. Due in part to the price differential, OTP usage rates among youth have increased in recent years. For example, smokeless tobacco use increased by 15 percent among youth ages 12-17 between 2002 and 2010.[1] Further compounding the issue, some OTPs, such as "orbs," look like candy and use flavorings to appeal to kids. Low taxes on these products in conjunction with tobacco companies' marketing practices make OTPs attractive to this population.

State Cigarette Excise Tax Rates



How Do You Measure Up?

As of 7/7/12

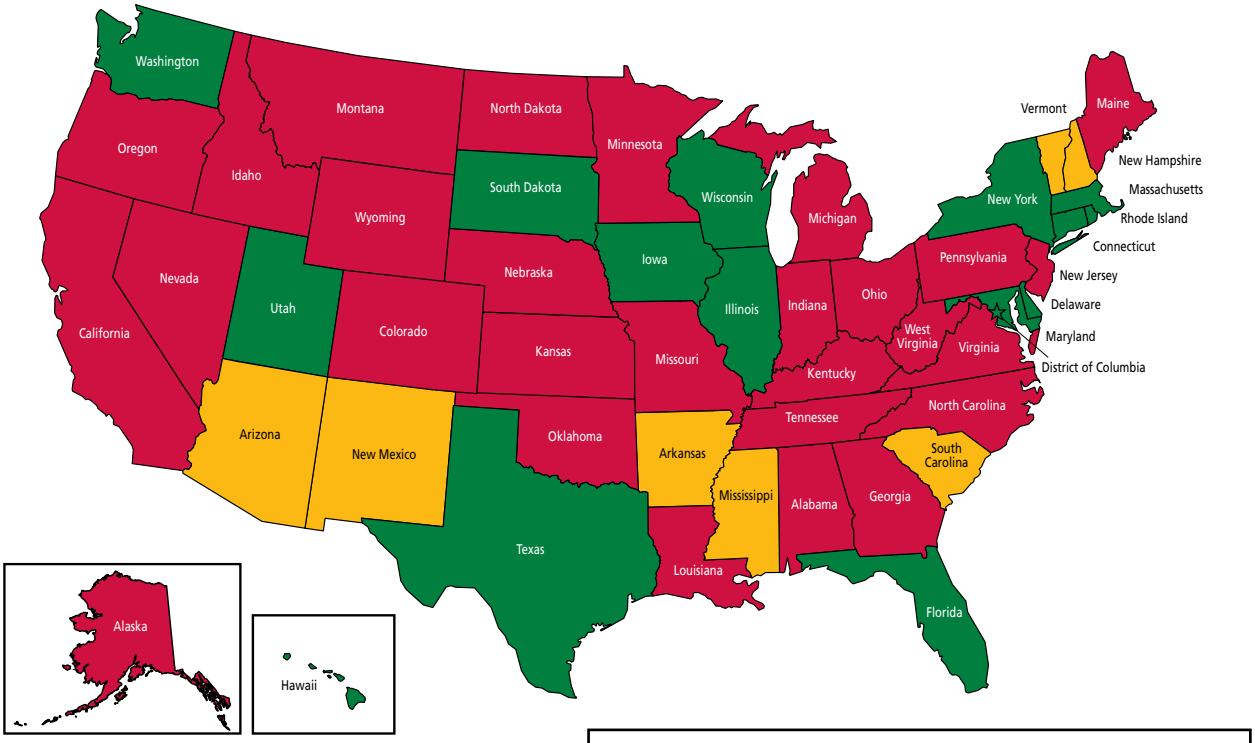
Taxing OTPs at a rate comparable to cigarettes would help curb usage.

ACS CAN continues to advocate for increased excise taxes on cigarettes and OTPs and urge legislators to reject any proposals to roll back tobacco taxes. Currently, the average state cigarette excise tax is $1.49 per pack. In the past 10 years, only three states – California, Missouri and North Dakota – have not raised their cigarette tax. In June 2012, California voters considered a $1.00 increase in their state's cigarette excise tax and an equivalent increase in the tax on OTPs. The tobacco industry spent $50 million to defeat the initiative, far more than public health advocates spent to support it. The proposed tax increase lost by less than 1 percent of the more than 5 million votes cast. Voters in Missouri will consider an increase of 73 cents per pack in their state's cigarette tax and a significant but not quite equivalent increase in their state's OTP tax on November 6. Missouri currently has the lowest cigarette tax in the nation, at 17 cents per pack, and, if passed by the voters, this increase would bring the state's tax rate up to 90 cents per pack and generate an estimated $278 million in new revenues the first year.

Since the last publication of this report in August 2011, the District of Columbia changed the way it taxes cigarettes in order to facilitate tax collection and lessen the burden on retailers. The District replaced its sales tax on cigarettes with an additional 36 cent-per-pack excise tax. While their excise tax appears to have increased, the total amount of the taxes per pack has not changed significantly. Illinois successfully increased its cigarette tax by $1.00 per pack, which will result in 53,400 adults

State Cigarette Tax and Price Increases

Since July 1, 2006



- At least $1.00 tax increase over 6 years and a 30% price increase per pack
- Tax increase over 6 years between $.50 and $.99 and a 30% price increase per pack
- No tax increase over 6 years or total tax increase less than $.50

How Do You Measure Up?

As of 7/7/12

quitting who currently smoke and 72,700 kids in Illinois who will not become addicted adult smokers. Vermont and Maryland also made progress in equalizing their OTP taxes in 2012.

The Facts

- Nationally, health costs and reduced productivity costs attributed to smoking are $10.47 per pack of cigarettes.[2]
- State cigarette excise tax rates vary widely, ranging from a high of $4.35 in New York to a low of $0.17 in Missouri. New York City has the highest combined city and state cigarette tax in the country, with a total tax of $5.85 per pack.
- 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.[3, 4]

The Solution

Many state lawmakers have recognized the public health and economic benefits of tobacco tax increases, as evidenced by the fact that 14 states, the District of Columbia, Puerto Rico and Guam now have cigarette taxes of $2 or more per pack. Raising tobacco taxes minimizes the health consequences of smoking, reduces health care expenditures and is a significant, stable and predictable source of revenue in challenging fiscal times.

ACS CAN challenges states to raise taxes on both cigarettes and OTPs regularly by a significant percentage of the retail price. Research shows the best way to curb tobacco use is through regular, significant increases in the price of cigarettes.

ACS CAN has recently rolled out a new way to measure a state's progress in preventing cancer by reducing tobacco use. In addition to rating the states on a green, yellow and red scale based on the state's tobacco tax rate, the new rating will also take into account the timeframe in which the state most recently raised its cigarette tax, with the benchmark being within six years or three legislative cycles, as well as the size of the tax increase and the percentage increase in the overall price per pack within that time period. ACS CAN believes that states should aim for tax increases that are at least $1.00 per pack and result in at least a 30 percent increase in the retail price of a pack of cigarettes. States should also raise taxes on OTPs to an equivalent percentage of the manufacturer's price as the tax on cigarettes. ACS CAN also encourages states to earmark tobacco tax revenues for tobacco prevention and cessation programs, along with other programs that will benefit cancer patients.

Missed Opportunity

On June 5, 2012, despite a huge volunteer effort and significant campaign funding from the American Cancer Society and ACS CAN, California voters were deceived by the tobacco industry into defeating Proposition 29 by less than a 1 percent margin. By increasing the state cigarette tax by $1 per pack, Prop. 29 would have saved more than 104,000 lives, stopped more than 228,000 kids from smoking and invested more than $500 million annually into cancer research in California. But the tobacco industry waged a $50 million misinformation campaign to deceive voters and obscure the measure's public health benefits. ACS CAN joined the Society's California Division, other public health leaders and thousands of people across the state who care about cancer in an effort that lost by less than a percentage point. But we learned valuable information from the California campaign about the tobacco industry's tactics and we will put that information to use as we continue to battle Big Tobacco over the lives of millions of Americans.

Quantifying the Public Health and Economic Benefits of State Tax Increases

In partnership with the Campaign for Tobacco-Free Kids, ACS CAN has developed a model to estimate the public health and economic benefits of meaningful increases in state cigarette taxes. The model is able to predict the amount of new annual revenue that could be raised with increases in the state's cigarette and OTP taxes, as well as the following public health and economic benefits resulting from increases in the state's cigarette tax rate:

- Reduction in adult smokers
- Reduction in future smokers
- Total 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

10-Year Retrospective:

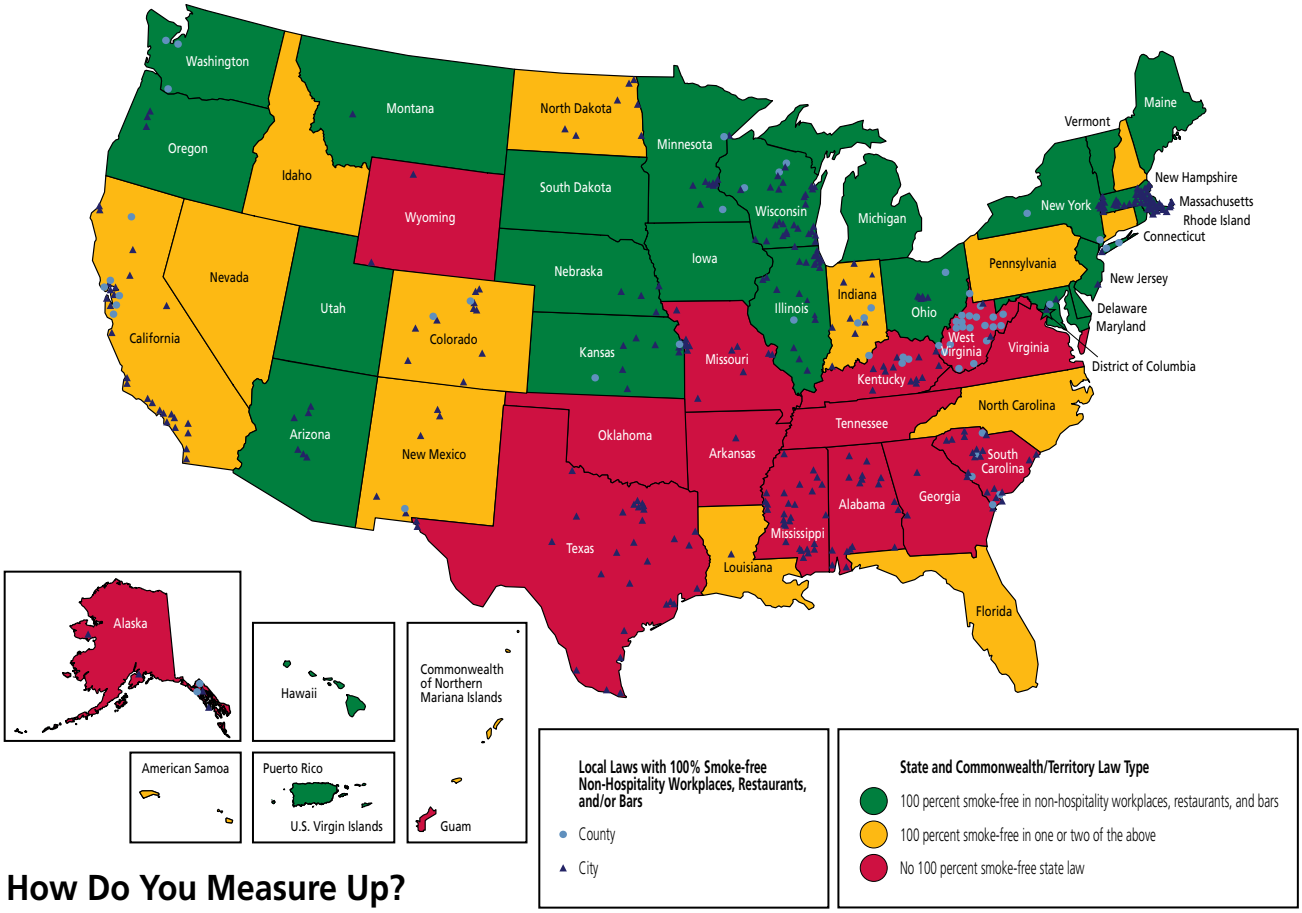
In 2003, two states had comprehensive smoke-free laws in effect that applied to all workplaces, bars and restaurants. Today, 23 states plus the District of Columbia, Puerto Rico and the U.S. Virgin Islands are considered "green" with a comprehensive smoke-free law in place.

The Challenge

The 2010 Surgeon General's report, How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking – Attributable Disease and the 2006 Surgeon General's report, The Health Consequences of Involuntary Exposure to Tobacco Smoke, confirm there is no safe level of exposure to secondhand smoke.[1, 2] Each year in the United States, secondhand smoke causes approximately 50,000 deaths from heart disease and cancer among nonsmokers. Secondhand smoke also can cause or exacerbate a wide range of other adverse health issues, including respiratory infections and asthma. Secondhand smoke is a serious health hazard, containing more than 60 known or probable carcinogens and more than 4,000 substances, including formaldehyde, arsenic, cyanide, and carbon monoxide.

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

In effect as of July 1, 2012



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), 07/01/12

As of April 1, 2012, 23 states (along with Puerto Rico, the U.S. Virgin Islands and Washington, DC) and 520 municipalities have laws in effect that require 100 percent smoke-free workplaces, restaurants and bars. [3] Combined, this represents 48.2 percent of the U.S. population. According to a 2011 report by the U.S. Centers for Disease Control and Prevention, if current progress continues, all states could have comprehensive smoke-free policies by 2020. However, this will require accelerated progress in parts of the country where there are no comprehensive smoke-free laws.[4] Currently, 13 states have a statewide, smoke-free law covering 100 percent workplaces, and/or restaurants, and/or bars, and 14 states still have no 100 percent, statewide smoke-free laws covering any of these three types of venues.

Despite major legislative advances during the past decade, certain segments of the population, such as hospitality and casino workers, continue to be denied their right to breathe smoke-free air. Low-income individuals are especially vulnerable. While the levels of serum cotinine, which is a measure of secondhand smoke exposure, decreased for all populations from 1988-1994 to 1999-2004, the decline was smaller among low-income individuals.[5] Approximately 88 million nonsmokers ages 3 or older in the United States remain exposed to secondhand smoke.[6]

The Facts

- Smoke-free laws reduce exposure to cancer-causing pollutants and reduce the incidence of disease.[7]
- Smoke-free laws encourage smokers to quit, increase the number of successful quit attempts and reduce the total number of cigarettes smoked.[8, 9]
- Smoke-free laws reduce health care spending and improve employee productivity.[10]

The Solution

The best way to reduce exposure to secondhand smoke is to make public places, including all workplaces, restaurants and bars, 100 percent smoke-free. The Institute of Medicine and the President's Cancer Panel recommend that comprehensive smoke-free laws cover all workplaces, including restaurants, bars, hospitals and health care facilities, gaming facilities and correctional facilities.[11, 12] Implementing comprehensive smoke-free policies will have immediate health benefits for all individuals, especially those most at risk, such as those with cancer, heart disease and asthma, as well as casino, restaurant and bar workers.

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 about the positive impact of smoke-free 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 casinos. ACS CAN advocates are fighting for the health of all workers and have successfully maintained strong laws in a majority of the 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, 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 laws that restrict a lower level of government from enacting stronger smoke-free laws than exist at a higher government level in a state. Everyone has the right to breathe smoke-free air.

The Red to Green Campaign

ACS CAN continues to work on its nationwide Red to Green initiative, which was first launched in late 2009 to help build a smoke-free nation. The initiative is named to reflect the colors of the ACS CAN smoke-free ratings map – with red indicating states with no law requiring 100 percent smoke-free workplaces, restaurants or bars and green indicating states protected by 100 percent smoke-free laws in all three categories. Red to Green is a coordinated effort led by ACS CAN across the "red" states to enact smoke-free laws strategically, beginning at the local level and eventually statewide. The campaign builds on ACS CAN's fight to enact comprehensive smoke-free laws in every state and community.

Since the beginning of the Red to Green campaign, four states, three of which were initially "red," have gone completely "green," or smoke-free. Kansas, Michigan and Wisconsin moved their states from red to green and South Dakota turned from yellow to green. In addition, 137 municipalities have implemented "green" smoke-free workplace, restaurant and bar laws.[13]

Despite these recent successes, the fight continues as opponents are relentlessly working to repeal or weaken strong smoke-free laws. ACS CAN advocates, together with coalition partners, must continue to work hard to stave off attempts to rollback existing laws, further demonstrating the importance of a sustained campaign initiative.

In June 2011, as part of its Red to Green campaign, ACS CAN released a first-of-its-kind report highlighting the public health and economic benefits of implementing a 100 percent smoke-free law in each state that lacks a comprehensive law. The data show that comprehensive smoke-free laws would decrease the number of adult smokers by tens of thousands in many states. If every state without a comprehensive smoke-free law enacted one:

- Nearly 400,000 fewer young people would become smokers.
- There would be approximately 624,000 fewer smoking-related deaths among smokers.
- There would be 70,000 fewer smoking-related deaths among nonsmokers.
- It would save states hundreds of millions of dollars in reduced health care costs.

Across the 27 states without a comprehensive law in place, if each state enacted one the combined savings would total:

- $316.11 million in lung cancer treatment savings.
- $875.57 million in heart attack and stroke savings.
- $128.26 million in smoking-related pregnancy treatment savings.
- Almost $43 million in state-funded Medicaid program costs.

For states that already have a comprehensive law, the report highlights the law's successes and the need to protect strong laws against rollbacks and exemptions.

Tough battles lie ahead in the fight to enact the next wave of statewide smoke-free laws and protect current laws, but with the Red to Green initiative providing advocates with the knowledge and resources needed to win, a smoke-free nation is within reach.

Missed Opportunity

Indiana missed becoming "green" this year when, despite overwhelming public support, the Indiana General Assembly passed a version of a smoke-free workplace law that exempts bars, taverns and gaming facilities – leaving too many Hoosier workers unprotected from the deadly effects of secondhand smoke. The legislation, which went into effect on July 1, moved Indiana from a "red" state to a "yellow" state, but still leaves Indiana with the weakest smoke-free law in the Midwest and one of the worst such laws in the nation. ACS CAN staff and volunteers will continue to advocate for local smoke-free laws in Indiana and challenge the next Indiana General Assembly to step up and pass a statewide law that will protect all Hoosiers from secondhand smoke.

The Problem with Exemptions for "E-Cigarettes"

Electronic cigarettes, or "e-cigarettes," are battery-operated devices that allow the user to inhale a vapor produced from cartridges filled with nicotine, flavor and other chemicals. While e-cigarette companies often market them as healthier, more convenient and more socially acceptable alternatives to traditional cigarettes, there is no scientific evidence that e-cigarettes are safe or that they can help smokers quit. E-cigarettes also may be available in flavors appealing to youth. Regardless of how they are marketed, e-cigarettes are often made to resemble traditional cigarettes, making enforcement of smoke-free laws difficult. As a result, comprehensive smoke-free laws should prohibit use of e-cigarettes in all venues where cigarette smoking is prohibited – including workplaces, restaurants and bars.

Emerging Tobacco Products

The Challenge

Cigarettes are the most well-known and commonly used tobacco products. However, smokeless tobacco, cigars and a number of new tobacco products have been gaining popularity in recent years. While smokeless tobacco and cigar use is not new, the recent successes in enacting smoke-free laws, cigarette tax increases and other policies focused on curbing smoking has led the tobacco industry to adjust its development and marketing approaches to focus on these products. Within the past few years, the tobacco industry has also made large investments in the development and marketing of new tobacco products – including snus, sticks, orbs, dissolvables, waterpipes (also known as hookah) and e-cigarettes – all of which may keep existing tobacco users from quitting, promote the use of multiple tobacco products or encourage youth to start using tobacco. Although the tobacco industry touts some of the new tobacco products as "reduced harm" or "reduced or modified risk" – and indeed, not all tobacco products are equally harmful – there is no such thing as a safe tobacco product. Smokeless tobacco products have been shown to cause oral, esophageal and pancreatic cancers, precancerous mouth lesions, dental problems such as gum recessions, bone loss around the teeth and teeth staining and can lead to nicotine addiction.[1]

The Facts

- While cigarette smoking among youth ages 12-17 declined more than 50 percent between 2002 and 2010, the use of smokeless tobacco products among youth increased 15 percent during that same time period.[2]
- According to the 2012 Surgeon General's report, Preventing Tobacco Use Among Youth and Young Adults, concurrent use of multiple types of tobacco products is common among teen smokers. Among high school students who use tobacco, nearly one-third of females and more than one-half of males report using more than one type of tobacco product in 30 days.[3]
- Spending on advertising and promotions by smokeless tobacco companies increased from $354.1 million in 2006 to $537.9 million in 2008. While cigarette marketing still far outweighs smokeless tobacco marketing, advertising and promotions of smokeless tobacco increased more than 50 percent in a two-year period, an unprecedented rate of growth.[4]
- The specific health harms of many new tobacco products are unknown because the products have not yet been adequately studied. Many new tobacco products are also not covered by existing state laws governing the manufacture, sale or use of other tobacco products.
- State excise taxes on smokeless and other tobacco products vary considerably from one state to another. For example, Florida has no tax on cigars; Pennsylvania has no tax on snuff, chewing or smoking tobacco, or large cigars; and South Carolina's tax on snuff, chewing or smoking tobacco and cigars is only 5 percent of the manufacturer's price. In contrast, the tax on snuff in Wisconsin is 100 percent of the manufacturer's price; and in Vermont, chewing tobacco, pipe tobacco and large cigars are taxed at 92 percent of the manufacturer's price.

The Solution

All tobacco products can cause disease and death, just like cigarettes, and therefore should be regulated like cigarettes to keep them away from children and discourage smokers from switching among tobacco products instead of cutting down on tobacco use or quitting altogether. In recent years, major cigarette manufacturers have been advocating for lower tax rates on smokeless tobacco products, diverting tobacco prevention and cessation funds toward harm reduction research, lobbying state legislatures to pass resolutions supporting harm reduction strategies and advocating to change warning labels on smokeless products to state they are less harmful than cigarettes. These so-called "solutions" are coming from the same manufacturers that violated civil racketeering laws and defrauded the American people with a decades-long conspiracy to deceive the public and target children with their deadly and addictive products. ACS CAN opposes these tobacco industry efforts to continue to deceive the public with claims their products are safe.

ACS CAN supports enacting evidence-based, comprehensive tobacco control policies that extend equally to all tobacco products, without any loopholes or exemptions. Specifically, we recommend:

- Eliminating price discrepancies between cigarettes and other tobacco products (OTPs) by increasing the tax on a package of OTPs to an equivalent percentage of the manufacturer's price as the tax on cigarettes.

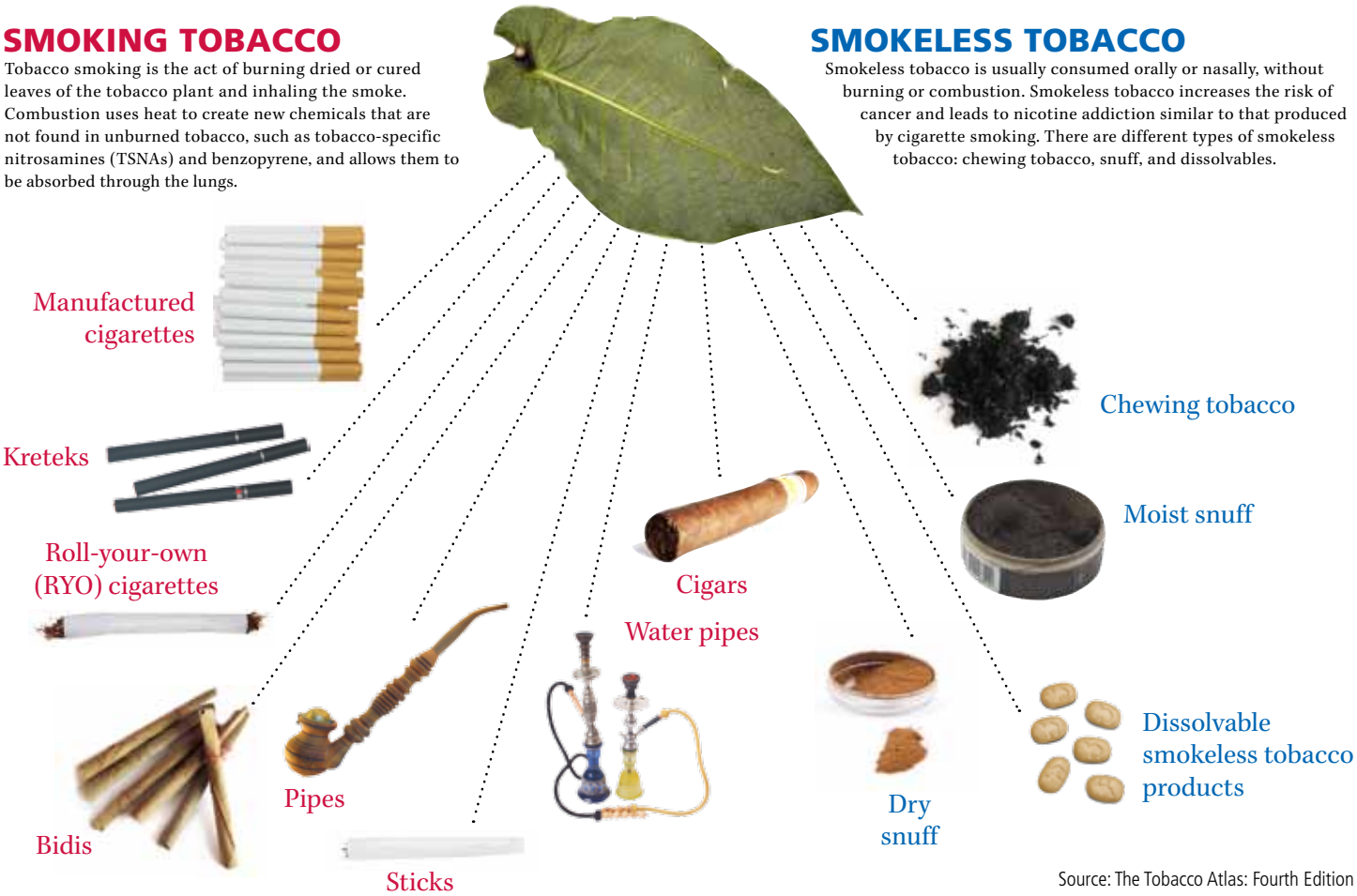
- Passing comprehensive smoke-free and tobacco-free laws and policies that do not provide exemptions for tobacco retail stores, cigar bars, hookah bars or any other retail or hospitality venue or for specific products such as electronic cigarettes. Secondhand smoke from cigars and hookah contains the same, or even greater, levels of toxic chemicals as secondhand smoke from cigarettes.[5, 6, 7, 8, 9, 10, 11] These products also are often smoked for longer periods of time than cigarettes, resulting in users of these products inhaling a much larger volume of smoke, along with its cancer-causing components.
- Ensuring that the definition of "tobacco product" in new laws is sufficiently broad to include all types of tobacco products, including dissolvable tobacco products and e-cigarettes. ACS CAN does not support exempting any type of smoked or smokeless tobacco product from smoke-free and tobacco-free laws and policies, tobacco tax increases or tobacco sales or marketing restrictions.
- Fully funding, promoting and providing access to all FDA-approved cessation treatments for all types of tobacco use.
- While the federal law giving the Food and Drug Administration (FDA) the authority to regulate tobacco products provides a number of restrictions on the manufacturing, marketing, labeling, distribution and sale of tobacco products, it also allows states to further restrict or regulate the time, place and manner (but not the content) of tobacco product advertising or promotions. While some of the regulations in the FDA law apply only to cigarettes, including restrictions on flavored cigarettes and minimum pack size requirements, ACS CAN supports extending these types of restrictions to all tobacco products.

SMOKING TOBACCO

Tobacco smoking is the act of burning dried or cured leaves of the tobacco plant and inhaling the smoke. Combustion uses heat to create new chemicals that are not found in unburned tobacco, such as tobacco-specific nitrosamines (TSNAs) and benzopyrene, and allows them to be absorbed through the lungs.

SMOKELESS TOBACCO

Smokeless tobacco is usually consumed orally or nasally, without burning or combustion. Smokeless tobacco increases the risk of cancer and leads to nicotine addiction similar to that produced by cigarette smoking. There are different types of smokeless tobacco: chewing tobacco, snuff, and dissolvables.



Source: The Tobacco Atlas: Fourth Edition

Tobacco Cessation Services

The Challenge

Public health experts have long supported proven strategies to prevent children and adults from smoking and to get smokers to quit. States with comprehensive tobacco control 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 than states that do not invest in these programs.

Only six states (Indiana, Massachusetts, Minnesota, Nevada, North Carolina and Pennsylvania) provide comprehensive cessation coverage for all Medicaid beneficiaries. Only nine states require private insurance plans to cover tobacco cessation treatments. While the Affordable Care Act (ACA) requires non-grandfathered private health plans to offer cessation coverage, at this time there are no guidelines or requirements for effective and comprehensive cessation coverage. Only five states offer comprehensive cessation coverage for their own employees.

State investment in telephone cessation counseling is far below what the CDC recommends as adequate funding for this valuable, proven resource. Only four states (Maine, North Dakota, South Dakota and Wyoming) fund telephone-based tobacco cessation services (quitlines) at the recommended levels.

Evidence shows that administrative barriers like co-pays, pre-authorization requirements and administrative "red tape" can deter people from utilizing preventive services such as cessation treatment. In 25 state Medicaid programs, co-pays are required for every cessation-related prescription filled or every cessation counseling visit. Twenty-three states restrict the number of quit attempts covered in a year and, in least 23 states, Medicaid programs limit the number of weeks the tobacco treatment programs are covered or the number of covered quit attempts per year. Nine states do cover all evidence-based cessation medications, but not counseling.

Affordable Care Act Cessation Provisions:

Starting in 2013, states can choose to include cessation services (graded "A" by the U.S. Preventive Services Task Force) in Medicaid benefits and receive a 1 percent increase in federal matching funds for these services.

The Facts

- Almost 70 percent of current smokers want to quit completely.[1]
- 52 percent of smokers make a quit attempt each year, but only about 6 percent of smokers will actually stop smoking.[2]
- Less than a third of smokers trying to quit will use evidence-based treatments to help. Including evidence-based cessation services as a covered health benefit increases quit rates by 30 percent.[3]
- Providing both medication and professional counseling in cessation treatments increases quit rates by 40 percent.[4]
- Smokers and other tobacco users need access to a range of treatments and combinations of treatments to find the most effective cessation tools that work for them.
- Quitlines can increase quit success more than 50 percent, compared to using no cessation intervention.[5]

The Solution

Implementing cessation benefits to all state employees, Medicaid beneficiaries and other smokers, and having these benefits cover a range of treatment options, will curb states' tobacco-related death and disease and save money. Covering all population groups through insurance plans is critical, especially for low-income populations that need it most. Throughout the implementation phase of the ACA, ACS CAN will be working to ensure that a full range of cessation services are covered at all levels of benefits and in all plans. State and local governments should also take advantage of Centers for Disease Control and Prevention Community Transformation Grants, which support community-level efforts to reduce chronic diseases such as heart disease, cancer, stroke and diabetes, as well as other funding opportunities to significantly increase resources for state-sponsored quitlines.

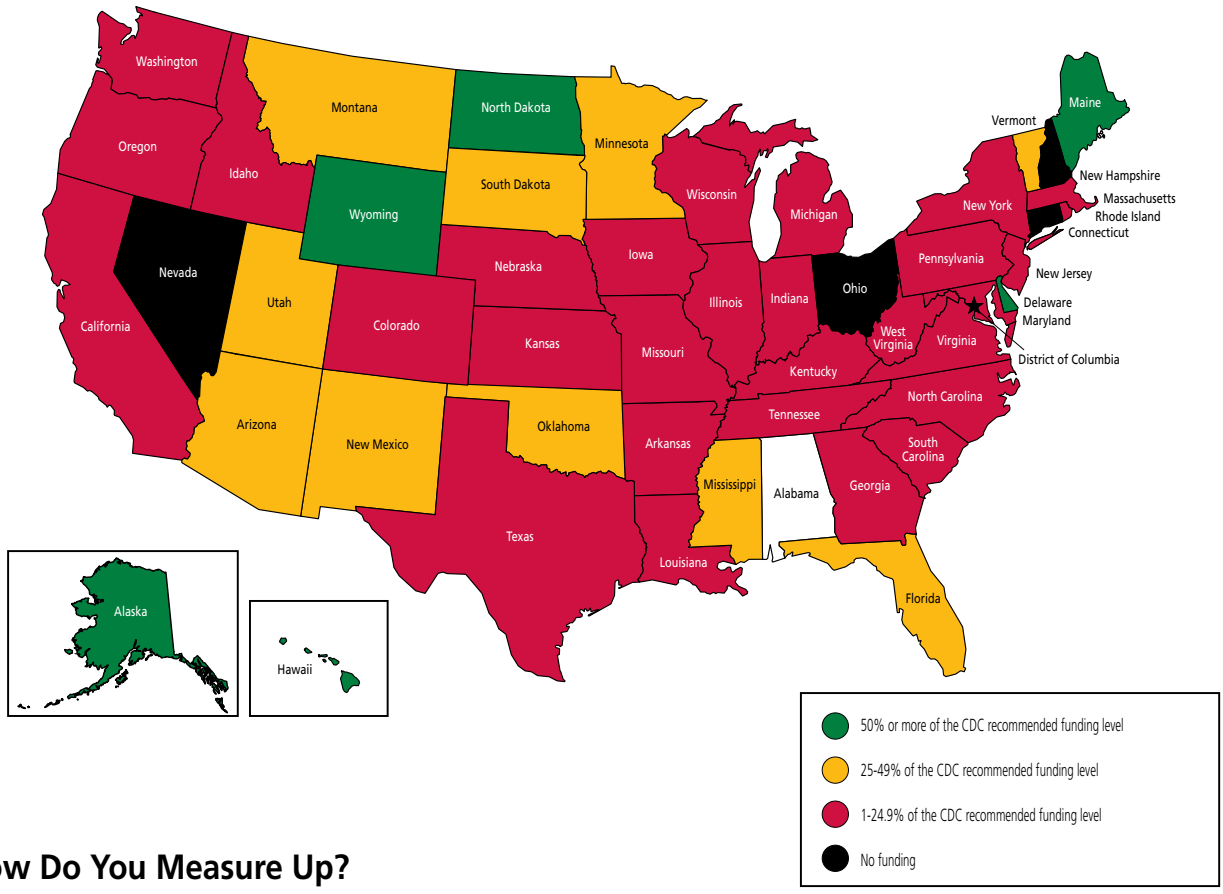
10-Year Retrospective:

FY 2011 state funding for tobacco prevention programs has declined by 23 percent since FY 2003, when funding levels were already inadequate. States have taken a short-sighted approach to tobacco control funding in times of fiscal crisis. We place public health at risk when we fail to recognize the health and long-term fiscal benefits of adequately funding state tobacco control programs.

The Challenge

The level of funding and the emphasis states place on proven prevention and cessation programs over time directly influence the health and economic benefits of their tobacco control interventions. Comprehensive, adequately-funded tobacco control programs reduce tobacco use and tobacco-related disease, resulting in reduced 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 on tobacco control programs.

FY 2012 State Funding for Tobacco Prevention



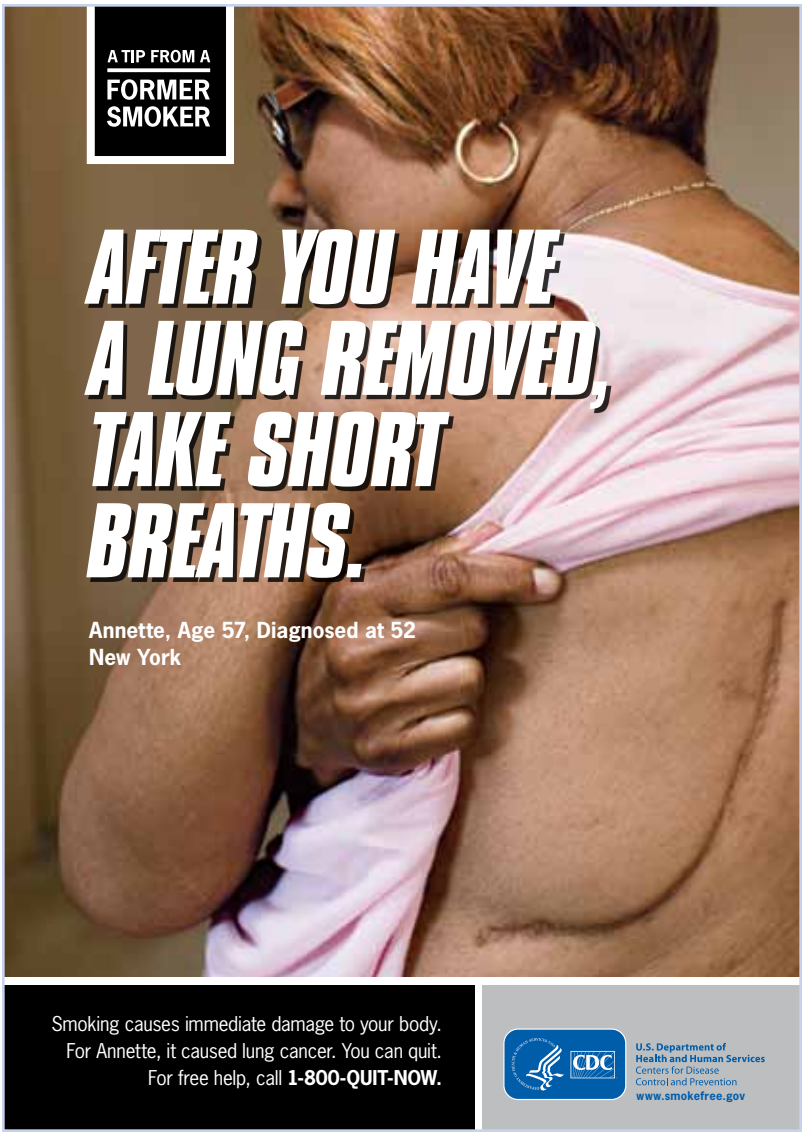
How Do You Measure Up?

Source: Robert Wood Johnson Foundation, Campaign for Tobacco-Free Kids, American Cancer Society Cancer Action Network, American Heart Association, and American Lung Association. A Broken Promise to Our Children: The 1998 State Tobacco Settlement 13 Years Later. November 2011 Available at http://www.tobaccofreekids.org/what_we_do/state_local/tobacco_settlement/ Current annual funding includes state funds for FY2012 and does not include federal funds directed to states. Alabama data not available, but 2011 funding was less than 25% of recommended level.

In fiscal year 2012, U.S. states as a whole budgeted $456.7 million for tobacco prevention and cessation programs.[1] While states will collect $25.6 billion in tobacco revenue this year, they will devote less than 2 percent of it, or $456.7 million, to support prevention and cessation efforts. States continued to cut funding for tobacco prevention and cessation programs for FY 2012, and at the same time, many states are facing deep cuts in tobacco control funding or the diversion of MSA dollars away from tobacco control programs. States have cut funding for tobacco prevention programs by 12 percent ($61.2 million) in the past year and by 36 percent ($260.5 million) in the past four years. Current funding is the lowest since 1999, when states first received tobacco settlement payments. The drop in 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.

The Facts

- Health care costs from tobacco-related disease total approximately $96 billion in the United States each year.[2]
- The $456.7 million that states budgeted for tobacco prevention and cessation programs in FY 2012 is only 1.8 percent of the $25.6 billion in revenue they are collecting from the tobacco settlement and tobacco taxes.[3]
- The Centers for Disease Control and Prevention (CDC) recommends states spend at least $3.7 billion per year on tobacco control programs. In total, states budgeted only 12.4 percent of the recommended funding in FY 2012.[4]
- Various agencies and programs have made available to states $91.2 million in federal grants to reduce tobacco use.[5]
- When federal and state funds are counted together, Alaska and North Dakota are the only two states currently funding their tobacco prevention programs above CDC-recommended levels. Only four additional states are funding at even half of the CDC's recommended spending levels.[6]
- If each state maintained target funding levels for five years, there would be an estimated five million fewer smokers in the United States.[7]



Source: Centers for Disease Control and Prevention

The Solution

The CDC's Best Practices for Comprehensive Tobacco Control Programs continues to be an effective guideline for state investment in tobacco control.[8] To succeed, these programs should consist of the following five components:

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.

State Tobacco Prevention Spending

State	State's FY2012 Tobacco Prevention Spending (millions)	CDC Recommended Spending (millions)	State Tobacco Prevention Spending % of CDC Recommended
Alaska	$10.8	$10.7	101.3%
North Dakota	$8.1	$9.3	87.0%
Hawaii	$10.7	$15.2	70.3%
Delaware	$9.0	$13.9	64.9%
Wyoming	$5.4	$9.0	60.0%
Maine	$9.4	$18.5	50.6%
Oklahoma	$21.2	$45.0	47.1%
South Dakota	$4.0	$11.3	35.4%
Montana	$4.7	$13.9	33.8%
Minnesota	$19.5	$58.4	33.4%
Vermont	$3.3	$10.4	31.8%
Utah	$7.2	$23.6	30.4%
Florida	$62.3	$210.9	29.5%
Arizona	$18.0	$68.1	26.4%
Mississippi	$9.9	$39.2	25.3%
New Mexico	$5.9	$23.4	25.3%
Arkansas	$7.4	$36.4	20.5%
West Virginia	$5.7	$27.8	20.3%
Oregon	$8.3	$43.0	19.3%
New York	$41.4	$254.3	16.3%
North Carolina	$17.3	$106.8	16.2%
California	$70.0	$441.9	15.8%
Louisiana	$8.4	$53.5	15.8%
Indiana	$10.1	$78.8	12.8%
Colorado	$6.5	$54.4	11.9%
Nebraska	$2.4	$21.5	11.0%
Pennsylvania	$13.9	$155.5	9.0%
Iowa	$3.3	$36.7	8.9%
Wisconsin	$5.3	$64.3	8.3%
Virginia	$8.4	$103.2	8.1%
South Carolina	$5.0	$62.2	8.0%
Maryland	$4.3	$63.3	6.8%
Illinois	$9.5	$157.0	6.1%
Idaho	$0.9	$16.9	5.2%
Massachusetts	$4.20	$90.00	4.6%
Kentucky	$2.20	$57.20	3.9%
Kansas	$1.00	$32.10	3.1%
Rhode Island	$0.40	$15.20	2.5%
Texas	$5.50	$266.30	2.0%
Georgia	$2.00	$116.50	1.7%
Michigan	$1.80	$121.20	1.5%
Washington	$0.80	$67.30	1.1%
New Jersey	$1.20	$119.80	1.0%
Tennessee	$0.20	$71.70	0.3%
Missouri	$0.10	$73.20	0.1%
Connecticut	$0	$43.90	0.0%
DC	$0	$10.50	0.0%
Nevada	$0	$32.50	0.0%
New Hampshire	$0	$19.20	0.0%
Ohio	$0	$145.00	0.0%
Alabama	N/A*	N/A*	N/A*

* Alabama data not available, but 2011 funding was less than 25% of recommended level.

2. State health communication interventions which deliver strategic, culturally appropriate and high-impact messages in sustained and adequately funded campaigns integrated into the overall state tobacco program effort.
3. Cessation interventions ensuring all patients seen in the health care system are screened for tobacco use and receive brief interventions to help them quit, are offered more intensive counseling services and FDA-approved cessation medications, as well as telephone-based cessation (quitline) counseling for all tobacco users who wish to access the service.
4. Surveillance and evaluation to monitor the achievement of overall 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 enables programs to plan their strategic efforts, provide strong leadership and foster collaboration between the state and local tobacco control communities.

ACS CAN challenges states to combat tobacco-related illness and death through sufficiently funded comprehensive tobacco control programs at the CDC-recommended level or above, implementing strategies to continue that funding over time, and applying the specific components delineated in the CDC's best practices guideline. ACS CAN urges legislators 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 the state's population.

Success Story

For the past four years, Colorado has faced fiscal challenges and has not been able to direct the full share of the revenues generated by a 2004 increase in the state's tobacco tax to its tobacco control programs. This year, through advocacy efforts such as a state lobby day and emails to lawmakers, Colorado volunteers and staff successfully encouraged lawmakers to finally restore $23.5 million in funding to the program. Restoration of these funds will make Colorado one of the state leaders in funding for tobacco control.

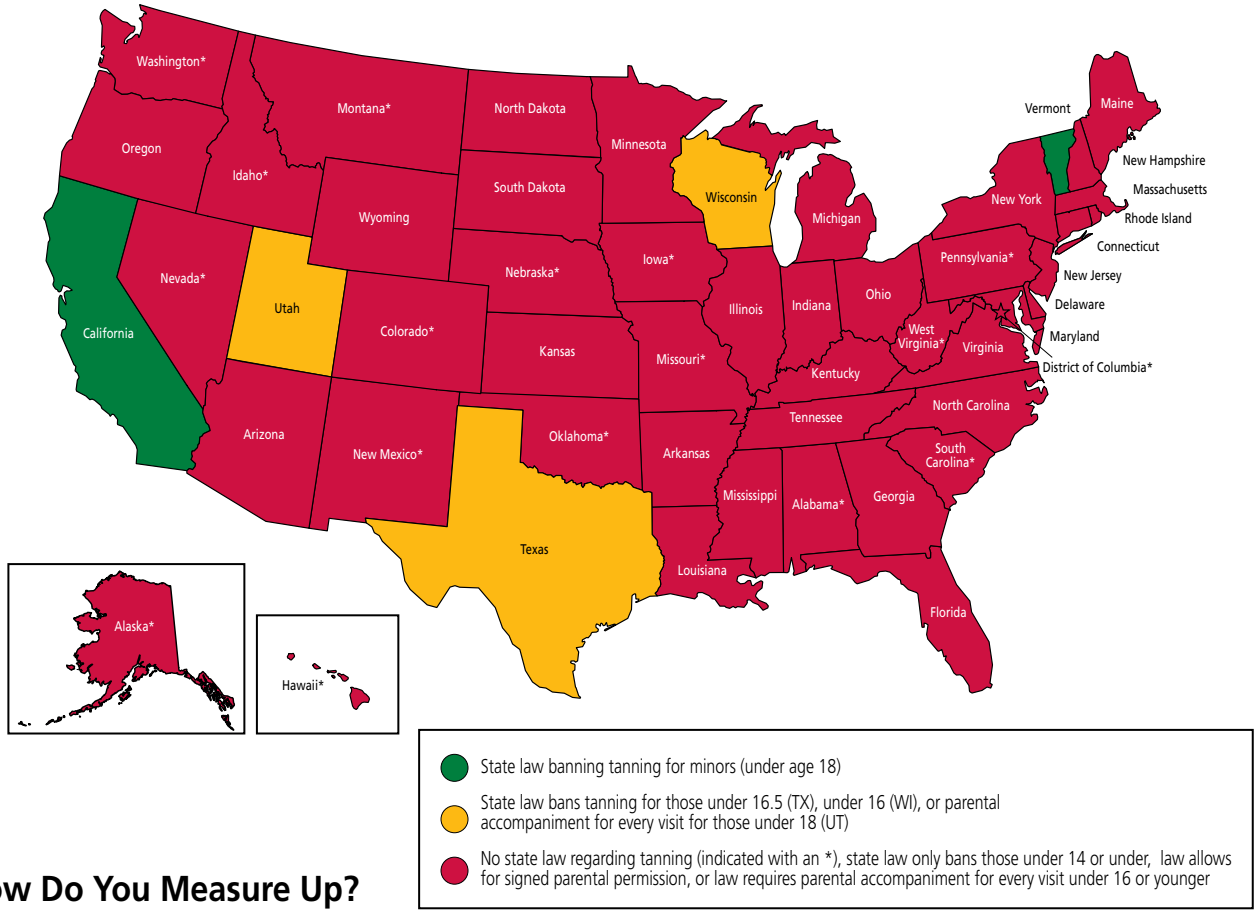
In addition to the tobacco education, prevention and cessation programs the tobacco tax revenues fund an expanded Child Health Plan program, community clinics across the state to serve the uninsured and medically indigent, and grants for prevention, early detection and treatment of cancer, cardiovascular and pulmonary diseases.

The Challenge

Skin cancer is the most prevalent type of cancer in the United States, with melanoma being one of the most commonly diagnosed cancers among young adults. Ultraviolet (UV) radiation exposure from the sun is a known cause of skin cancer and excessive UV exposure, particularly during childhood and adolescence, is an important predictor of future health consequences. The link between UV exposure from indoor tanning devices and melanoma is consistent with what we already know about the association between UV exposure from the sun and skin cancer. This is why the International Agency for Research on Cancer (IARC) in 2009 elevated tanning devices to its highest cancer risk category – "carcinogenic to humans."

There has been a drastic increase in rates of melanoma in young, white women during the past few decades. The increase is widely thought to be a consequence of elevated use of indoor tanning devices and exposure to solar UV radiation. Compounding this risk is the popularity of indoor tanning among young adults – especially girls. There is a general misconception among teens and adults that a so-called "base tan," obtained by using indoor tanning devices, will have a protective effect from excessive sun exposure. Also, the tanning bed industry is not regulated as well as it should be in terms of exposure times and frequencies, education of employees and information given to consumers. For instance, a recent survey of tanning salons showed that 71 percent of facilities would allow a teen to tan more often than the government's recommended limit of three times per week.[1]

State Tanning Bed Bans



State law banning tanning for minors (under age 18)

State law bans tanning for those under 16.5 (TX), under 16 (WI), or parental accompaniment for every visit for those under 18 (UT)

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

How Do You Measure Up?

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

New FDA guidelines on sunscreen will require better labeling of sunscreen products designed to make it easier for consumers to read and understand what they are purchasing. The guidelines will go into effect in 2013. Sunscreens will now be tested for both UVA and UVB rays and those that pass a standard test will be labeled as broad spectrum. Non broad-spectrum sunscreens and those that have a rating below SPF 15 will have a warning attached. Also, since the amount of protection beyond SPF 50 is minimal, sunscreens above SPF 50 will be labeled as 50+.

- Melanoma is the most deadly of all skin cancers, with more than 9,100 deaths expected to occur in 2012.[2] It is estimated that 76,250 people will be diagnosed with melanoma in 2012 alone.[3]
- People who use indoor tanning booths in their teens and 20s have a 75 percent increased melanoma risk, and a 69 percent increased risk of early onset basal cell carcinoma, than individuals who never use indoor tanning devices.[4, 5, 6]
- Since 1988, teens reporting use of tanning beds has increased from 1 percent to 27 percent.[7]
- In 2009, more than 25 percent of girls ages 13-17 reported using an indoor tanning device in the past year.[8] This number decreases to 15 percent when asking adults 18 and over.[9]
- Among kids who reported using indoor tanning devices, more than half (57.5 percent) reported burns from use.[10]

The Solution

To help reduce the incidence of and mortality from skin cancer in the United States, ACS CAN supports state and local initiatives to prohibit the use of indoor tanning devices by those under the age of 18, to ensure all consumers are properly informed of their risk prior to use and to require all indoor tanning devices to be properly regulated with effective enforcement provisions in place. ACS CAN also urges the FDA to reclassify indoor tanning devices to provide the restrictions and oversight necessary to protect the public from the dangers of indoor tanning.

ACS CAN is not alone in wanting to change behaviors and attitudes about tanning beds among youth. Thirty-three states across the nation have implemented laws which restrict minors' use of tanning beds; however, many state laws do not go far enough in protecting youth from melanoma. Laws which require parental consent, parental accompaniment, or ban use at any age less than 18 could do more to ensure that minors are protected. ACS CAN strongly encourages states to pass bans on tanning for all minors.

Success Story

ACS CAN has recorded multiple big wins on the tanning bed issue this year. The momentum started in 2011 when Society and ACS CAN volunteers and staff in Howard County, Maryland worked to pass a total ban on tanning bed use for minors under the age of 18. This ban would help to protect young people from skin cancers, including melanoma, and was the first ban of its kind in the United States.

In January of this year, Society and ACS CAN volunteers and staff in California helped send a resounding message to the rest of the country regarding tanning bed use by minors when our most populous state passed the same ban. California was the first state to pass such a ban and we knew others would soon follow. In May, Vermont spearheaded a legislative campaign that made the Green Mountain state the second state in the nation to pass such a law, and in June, Chicago became the first major U.S. city to ban tanning for all minors.

With the evidence clear and the momentum building in all parts of the country, ACS CAN stands willing and able to work with all legislators who share the desire to protect our children from the devastating effects of tanning bed usage.

The Challenge

For the majority of Americans who do not use tobacco, the greatest modifiable determinants of cancer risk are weight control, dietary choices and physical activity. One in three cancer deaths are due to factors relating to nutrition and physical activity, including overweight and obesity.[1] Being overweight or obese increases one's risk for many cancers, including cancers of the breast (postmenopausal), colon, rectum, endometrium, esophagus, kidney, pancreas and probably the gallbladder.[2] There is also highly suggestive evidence of a link between overweight and obesity and cancers of the liver, ovary and cervix, and for multiple myeloma, Hodgkin lymphoma and aggressive prostate cancer.[3]

Approximately two in three adults and one in three youth in this country are overweight or obese – more than double the rate from just 20 years ago. Only half of adults are meeting recommendations for 150 minutes of moderate physical activity or an equivalent amount of vigorous physical activity per week,[4] and nearly 25 percent of high school students do not get the recommended daily hour of physical activity on any day of the week.[5] Americans also consume too few fruits and vegetables and whole grains and too many refined grains, added sugars, unhealthy fats and calories overall.[6]

The rapid increase in overweight and obesity during the past two decades is attributable primarily to environmental and social changes. Many communities lack pedestrian-friendly infrastructure, such as sidewalks and parks, which can facilitate daily physical activity among children and adults. Additionally, far too many communities fail to provide access to supermarkets with healthy, affordable food options, and instead have an overabundance of fast food restaurants with inexpensive, unhealthy foods. Also, due to technological advances, fewer jobs require physical activity, and Americans are spending more leisure time in front of computers, televisions and other electronic devices. Together, all of these environmental and social factors have contributed to the overweight and obesity epidemic in our country. Increasing opportunities for physical activity and healthy eating and promoting good choices offer a critical opportunity for cancer prevention.

The Facts

- 68.8 percent of adults age 20 and older are overweight or obese, including 35.7 percent of adults who are obese.[10]
- Overweight and obesity rates vary among racial and ethnic groups. Among African Americans, 76.7 percent are too heavy, including 49.5 percent who are obese. Among Hispanics, 78.8 percent are overweight or obese, including 39.1 percent who are obese. This is compared with 66.7 percent of non-Hispanic whites who are overweight or obese and 34.4 percent who are obese.[11]

New American Cancer Society Nutrition and Physical Activity Guidelines:

In 2012, the American Cancer Society released two sets of nutrition and physical activity guidelines – one focused on cancer prevention and the other focused on cancer survivorship. The American Cancer Society Guidelines on Nutrition and Physical Activity for Cancer Prevention recommends individuals achieve and maintain a healthy weight, adopt a physically active lifestyle, consume a healthy diet with an emphasis on plant sources and limit consumption of alcoholic beverages.[7] The Nutrition and Physical Activity Guidelines for Cancer Survivors, which cover the active treatment and recovery phase, life after recovery and advanced cancer and end of life, also stress the importance of achieving and maintaining a healthy weight, being physically active and consuming a nutrient-rich diet as much as possible at all points during the cancer survivorship trajectory.[8] The cancer prevention 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, worksites and schools; decrease access to and the marketing of foods of low nutritional value, particularly to youth; and provide safe, enjoyable and accessible environments for physical activity in schools, worksites and communities.[9] Both the individual and community recommendations in the prevention guidelines are consistent with the 2010 Dietary Guidelines for Americans, developed by the U.S. Department of Agriculture and the U.S. Department of Health and Human Services.

- Currently 31.8 percent of youth ages 2-19 are overweight or obese, including 16.9 percent who are obese.[12] Childhood obesity rates have more than tripled in the past four decades.[13] These statistics are especially concerning because childhood overweight and obesity increases the risk for overweight and obesity in adulthood.
- 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.[14]

A May 2012 Institute of Medicine report, Accelerating Progress in Obesity Prevention: Solving the Weight of the Nation,[27] takes a comprehensive, systems approach to the obesity problem and identifies recommendations that are important individually, but when implemented collectively would further strengthen efforts to prevent obesity. The five main goals and key strategies for each are:

- Make physical activity an integral and routine part of life.
  - Make physical activity an integral and routine part of life.
  - Provide and support community programs designed to increase physical activity.
  - Adopt physical activity requirements for licensed child care providers.
  - Provide support for the science and practice of physical activity.
- Create food and beverage environments that ensure that healthy food and beverage options are the routine, easy choice.
  - Adopt policies and implement practices to reduce overconsumption of sugar-sweetened beverages.
  - Increase the availability of lower-calorie and healthier food and beverage options for children in restaurants.
  - Utilize strong nutritional standards for all foods and beverages sold or provided through the government, and ensure these healthy options are available in all places frequented by the public.
  - Introduce, modify and utilize health-promoting food and beverage retailing and distribution policies.
  - Broaden the examination and development of U.S. agriculture policy and research to include implications for the American diet.
- Transform messages about physical activity and nutrition.
  - Develop and support a sustained, targeted physical activity and nutrition social marketing program.
  - Implement common standards for marketing foods and beverages to children and adolescents.
  - Ensure consistent nutrition labeling for the front of packages, retail store shelves and menus and menu boards that encourage healthier food choices.
  - Adopt consistent nutrition education policies for federal programs with nutrition education components.
- Expand the role of health care providers, insurers and employers in obesity prevention.
  - Provide standardized care and advocate for healthy community environments.
  - Ensure coverage of, access to and incentives for routine obesity prevention, screening, diagnosis and treatment.
  - Encourage active living and healthy eating at work.
  - Encourage healthy weight gain during pregnancy and breastfeeding and promote breastfeeding-friendly environments.
- Make schools a national focal point for obesity prevention.
  - Require quality physical education and opportunities for physical activity in schools.
  - Ensure strong nutritional standards for all foods and beverages sold or provided through schools.
  - Ensure food literacy, including skill development, in schools.

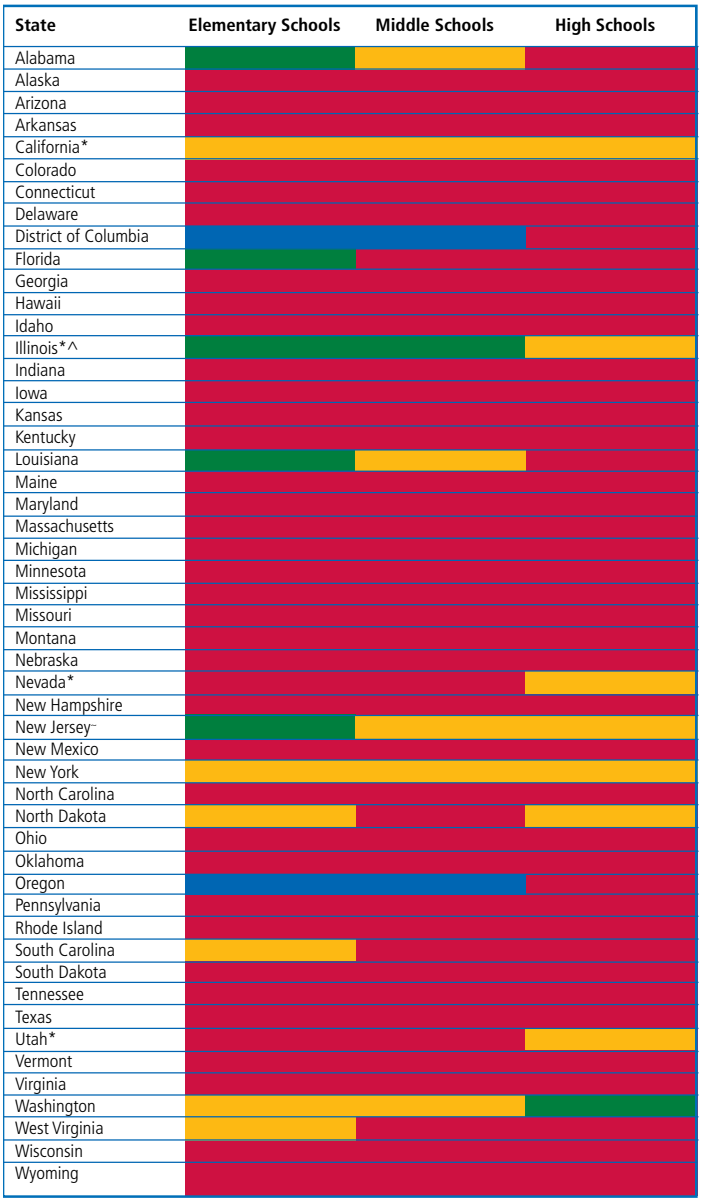
The Solution

Experts agree that policies promoting healthier communities through activity accessibility and dietary choices are the most promising methods for reducing the high rates of overweight and obesity. Guidelines and recommendations from government and non-governmental entities, including the American Cancer Society, the CDC,[15] the Institute of Medicine,[16, 17] the White House[18] and the U.S. Department of Agriculture and U.S. Department of Health and Human Services Dietary Guidelines for Americans 2010,[19] recommend making healthy choices easier – meaning healthy foods should be more available and affordable and physical activity should be more easily incorporated into one's daily life.

While the federal government has been active in setting laws and regulations focused on making healthy food and physical activity choices easier – and environments, such as schools, healthier – there are still significant opportunities for states and local governments to pass and implement their own policies. The federal Healthy, Hunger-Free Kids Act, which became law in December 2010, reauthorized the child nutrition programs and made numerous changes to improve school nutrition. The law required the USDA to update the federal nutrition standards for school meals, which they released earlier this year and which will begin to go into effect in the 2012-2013 school year. It also required the USDA to set minimum nutrition standards for all foods sold in schools during the school day outside of the school meal programs, such as in a la carte lines, vending machines and school stores. However, states or localities may still set stronger nutrition standards and/or extend the existing standards beyond the length of the school day. The law also requires school districts to update and strengthen their wellness policies. Local wellness policies must include goals for nutrition education, physical activity, nutrition standards for foods sold in schools and other school-based wellness activities; must be developed with input from a broad group of stakeholders; and must be widely disseminated throughout the community.

State and local community leaders and policymakers play a critical role in improving nutrition, increase physical activity and reduce obesity. One area in particular where states can implement strong policies is through physical education in schools. The *Physical Activity Guidelines* for Americans recommends children and adolescents engage in at least one hour of physical activity daily,[20] and the Institute of Medicine recommends they have opportunities to engage in this amount of physical activity within the school day.[21] Quality physical education is the best way for youth to get a significant portion of their recommended physical activity, improve their physical fitness and obtain the knowledge and skills they need to be

Physical Education Time Requirements



Key:

- State requires at least 150 minutes per week of physical education at the elementary school level or at least 225 minutes per week at the middle and high school levels, for all grades
- State requires at least 90 minutes per week of physical education for all grades, but less than the recommended 150 or 225 minutes per week
- State requires less than 90 minutes per week of physical education or does not require physical education at all
- Requirement is not yet in effect as of 7-1-12

Footnotes:

* Physical education required for 2 or more years in high school, but not all 4 years, or an exemption from physical education permitted for up to 2 years in high school

^ Daily physical education required at all school levels, but a specific number of minutes has not been set

~ Required number of minutes also includes time for health and safety education

Sources:

National Cancer Institute. Classification of Laws Associated with School Students (CLASS) Database. 2010. Available at http://class.cancer.gov.

American Heart Association and National Association for Sport and Physical Education. *2012 Shape of the Nation Report: Status of Physical Education in the USA.* Reston, VA: NASPE.

Additional research by ACS CAN.

physically active throughout their lifetimes.[22, 23] Physical education may even increase students' academic achievement.[24, 25, 26] 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.

ACS CAN recommends that states require all school districts to develop and implement a planned K-12 physical education curriculum that adheres to national and state standards for health and physical education for a minimum of 150 minutes per week in elementary schools and 225 minutes per week in middle and high schools. In addition to increasing the quantity of physical education, there are a number of strategies to improve the quality of physical education in schools that are important for states to implement, regardless of how frequently physical education must be offered:

- Require students to engage in moderate to vigorous physical activity for at least 50 percent of physical education class time.
- Disallow automatic waivers or substitutions for physical education and prohibit students from opting out of physical education to prepare for other classes or standardized tests.
- Hire a state-level physical education coordinator to provide resources and offer support to school districts throughout the state and a district-level coordinator to provide support to physical education teachers.
- Require school districts or schools to complete comprehensive self-assessments of their physical education programs; report their findings to parents, community members and the school board; and integrate the results into the district or school's long-term strategic planning, improvement plan or wellness policy.
- Offer regular professional development opportunities to physical education teachers that are specific to the field and require physical education teachers to be highly qualified and certified.
- Add valid fitness, cognitive and affective assessments in physical education based on student improvement and knowledge gain.
- Provide physical education programs with appropriate equipment and adequate facilities and require class size consistent with other subject areas.

Multifaceted 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.

The Challenge

The Affordable Care Act (ACA), which became law in 2010, empowers states to reshape and improve their health delivery systems to fit the needs of their citizens. It is imperative that legislators and policymakers focus on issues that are most critical to improving access to quality, affordable health care for their citizens, particularly those with life-threatening chronic diseases such as cancer, and creating a fair and competitive market for health services.

The initial focus of activity in many states has been on the establishment of health benefit exchanges and Small Business Health Options Program (SHOP) exchanges. The exchanges will serve as marketplaces where consumers in the individual and small-group markets can compare health plans and choose the one that is best for them. To date, 15 states have established exchanges through legislation or executive order, and many other states have considered proposals to create exchanges.

Exchanges provide states with an extraordinary opportunity to make the process of choosing a health plan easier, more transparent, and more empowering for patients and other consumers. The U.S. Department of Health and Human Services (HHS) requires certification of state exchanges by January 1, 2013, in order that they are fully operational by January 2014. Should a state choose not to create an exchange, the federal government will run an exchange in that state.

In March, HHS issued three final regulations for state exchanges:

- Requirements for exchanges - The final exchange regulation, consistent with the intent of the law, clearly provides the states with considerable flexibility in creating their exchanges
- Medicaid eligibility and determination standards - The final regulation for Medicaid standardizes many of the program's rules and practices to align better with what will be done in the exchange.
- Risk adjustments, reinsurance and risk corridors ("3Rs") - The 3Rs regulation, though very technical, is extremely important to the viability of many of the insurance reforms, including no pre-existing condition restrictions and guaranteed issue.

The states now have the direction they need to fully and successfully implement exchanges and other reforms to achieve a truly consumer-oriented, competitive market for health insurance – one that can both lower costs and improve health care quality.

The Facts

Enactment of the ACA will provide cancer patients and survivors will significant improvements in access to care:

- More than 20 million people under age 65 are expected to purchase their health insurance through the state exchanges.[1]
- A majority of individuals – 65 percent – who are expected to purchase health insurance through an exchange will have previously been uninsured.[2]
- Approximately 29 million Americans are underinsured – that is, their insurance has inadequate coverage to treat their condition fully and appropriately, and as a result, they are exposed to unaffordable medical costs. This number could drop by up to 70 percent with the implementation of the ACA.[3]
- Twice as many underinsured people forgo care, such as not filling prescriptions or not following up on recommended treatments, as those that are more adequately insured.[4]

Next Steps for the States

As the nation moves closer to full implementation of the ACA in 2014, states must take critical steps to ensure they have a strong, functioning and consumer-based competitive health care system.

Establishing An Effective Health Benefits Exchange

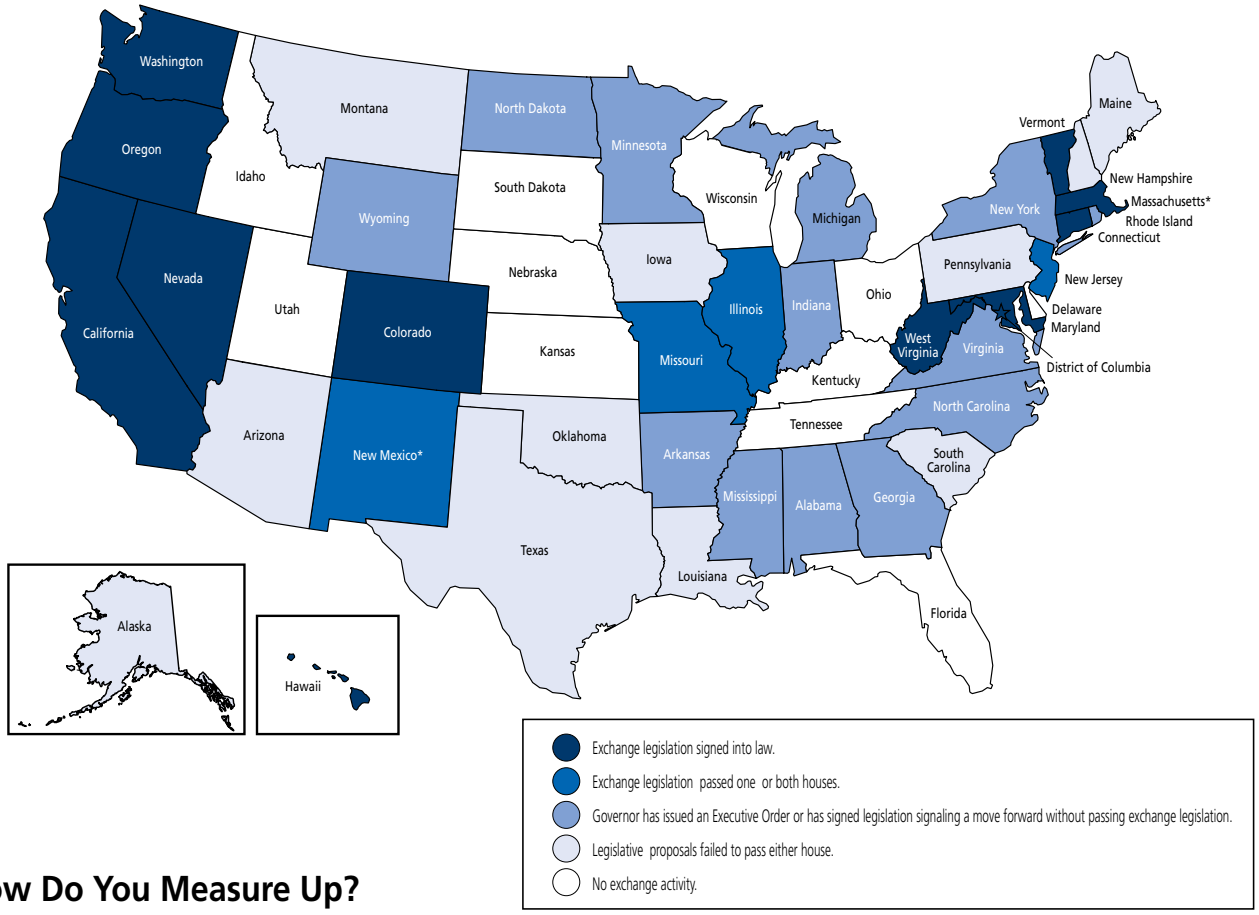
Five key issues must be addressed to ensure the exchange is an effective marketplace for consumers, especially those with chronic diseases such as cancer. These issues are relevant for states still considering how to enact an exchange as well as for those that are in the initial stages of implementing one. ACS CAN has developed the following threshold questions to determine whether an exchange will be effective in providing the consumer protections intended by the ACA.

1. ***Is the exchange governance board properly structured to ensure that its decisions serve the best interest of consumers, patients, workers and small employers?***
   The governance board in each state will make the critical management and policy decisions that determine the direction and success of the exchange. It is important that members of these boards have the authority to appropriately and successfully manage the many critical administrative decisions that must be made by 2014. It is also imperative board members not have a conflict with their business or professional interests.

2. ***Do the rules for the insurance market outside the exchange complement those inside the exchange to mitigate adverse selection?***
   States need to act to ensure insurance rules are comparable for plans inside and outside of the exchanges, thus promoting a level playing field. If plans outside the exchanges can sell products under more favorable terms, those plans can cherry-pick the healthiest consumers, making the exchanges ultimately an insurance pool of primarily high-risk individuals. This would result in high and potentially unaffordable insurance premiums for those consumers who need care the most.

3. ***Is the Medicaid program well integrated with the exchange?***
   The federal regulations released earlier this year provide states with considerable flexibility in how Medicaid eligibility determinations will be made.

Benchmarking State Health Exchange Laws



How Do You Measure Up?

The map depicts state health exchange activity through May 2012.
Sources: Health Policy Tracking Service & Individual state bill tracking services
*Both Massachusetts and Utah established health benefit exchanges prior to 2011. The Massachusetts exchange is very similar to what is required by the Affordable Care Act, however the Utah exchange will need to make legislative changes in order to be certified as an ACA exchange.

HHS is working with states and private vendors to develop information technology that will simplify and expedite information collection and dissemination for eligibility purposes, including Medicaid and premium subsidies. However, under the federal regulations, states have numerous options for making eligibility determinations, including through the exchanges, state Medicaid agencies or through the use of private vendors. It is critical the state consider all ramifications of this decision to ensure a seamless experience for the consumer and to minimize administrative costs and burdens for the exchanges and the state.

4. ***Is the exchange structured to emphasize administrative simplicity for consumers?***
   Consumers must be able to easily access not only information such as premium rates and enrollment forms, but also critical additional information such as each plan's benefits, provider networks, appeals processes and consumer satisfaction measures. This information should be available in multiple languages and literacy levels.

5. ***Does the exchange have a continuous and stable source of funding?***
   To facilitate good management and planning, it is important the exchanges have a predictable and steady source of funding, otherwise there is a risk funding will become vulnerable to the often unpredictable legislative appropriations process. Further, funding sources should be generated from both plans inside and outside the exchange so carriers outside the exchange are not afforded an unfair financial advantage that could lead to adverse selection.

6. ***Does the exchange have the authority to be an active purchaser?***
   To best promote high-quality care, innovative delivery system reforms and for slowing the rate of growth of health care costs, exchanges should have the authority to be "active purchasers" when selecting participating health plans, as opposed to being required to allow every health plan that can meet the minimum requirements to participate. With this authority, exchanges could use their considerable market power and certification authority to limit exchange participation only to plans with a high level of quality and/or value when market conditions permit.

Choosing a State's Essential Health Benefits

Under the ACA, health plans in the individual and small-group markets will have to offer "essential health benefits" that meet the basic health benefit needs of someone with a serious chronic condition such as cancer. In December 2011, HHS released a bulletin that outlined the process for states to choose one of 10 "benchmark plans." The benefits offered in the benchmark plan will become the essential benefits for that state for at least several years.

The 10 options for a benchmark plan are the following:

- The three largest plans offered through the Federal Employees Health Benefit program
- The three largest state employee health plans
- The three largest health plans in the state's small group market
- The state's largest HMO plan

HHS has indicated that if a state does not make a decision by September 30, 2012, the state's largest plan in the small group market will be the default essential health benefit plan.

The decision about which plan to choose as a benchmark plan provides a unique opportunity for state leaders to decide what is "essential" coverage. If we are to improve our health care system and control our nation's rising health care costs, we need to look more closely at how we utilize care, especially for high-cost chronic conditions such as cancer. The problem of underinsurance – inadequate coverage among those with health insurance – has been well documented.[5] Other research has shown that when cancer is detected at earlier stages and treated in accordance with evidence-base care, survival rates increase and long-term costs are mitigated.[6] Now is the opportunity to wisely and fully address the level and extent of benefits necessary to treat the most serious medical conditions that are the primary drivers of health care costs.

Legislators can contribute significantly to a robust debate about what is essential coverage. Critical steps in this process are:

1. ***Identifying benchmark plan options:*** The state's insurance department should quickly identify the three largest plans in the state's small group market as well as the largest HMO. The department should also work with the appropriate state agency in identifying the three largest state employee plans. This information should be posted prominently on the department's Web site and other public forums.

2. ***Providing plan documents:*** For consumers and policymakers to make an informed assessment of the benchmark plan options, it is absolutely essential the insurance department publicly disclose the summary of plan description, the certificate of coverage or the insurance contract for each benchmark plan option. The summary of benefits typically provided to consumers is not acceptable because such documents do not provide sufficient information on which to make such an important decision.

3. ***Establishing standards for benchmark selection:*** The appropriate state agencies need to work in concert to establish the substantive criteria the state will use when selecting the benchmark plan, such as the comprehensiveness of the benefits, cost considerations, balance among the benefit categories and interactions with existing markets.

4. ***Aiding public understanding of the benefits:*** The state insurance department and other relevant agencies should develop and make publicly available a comparative analysis between the potential benchmark plans and the state's mandated benefits, as the Maine Bureau of Insurance recently did. This type of comparative analysis can help the public understand what's really covered under various policies and aid an informed selection process.

5. ***Engaging the public on benchmark selection:*** Legislators should help lead a state effort to engage the public on the selection of an appropriate benchmark plan by conducting hearings or stakeholder meetings and allowing for public input on both the substantive standards for selecting a benchmark and the selection itself. The process should be open, transparent and allow time for public review and comment.

6. ***Advocating for very limited or no insurer flexibility in the first few years:*** The year 2014 will see very significant changes in the health insurance landscape. In addition to the essential health benefits requirements, there will be numerous other dramatic changes in health insurance such as the new health exchanges and significant changes in insurance rules and premium setting. Therefore, commissioners should strongly discourage insurer flexibility in changing the benefits in the benchmark plan until at least 2016. While there may be shortcomings in any benchmark plan, consumers will be facing the newness of the essential health benefits concept along with new rules regarding cost-sharing, actuarial value and, in some cases, premium subsidies. Limiting insurer flexibility for several years will provide greater market stability, enhance consumer confidence in the changes and lessen the potential for market segmentation by insurers that might result if they are able to adjust benchmark plan benefits.

7. ***Monitoring impact on patients, particularly vulnerable populations:*** This is perhaps the most important role insurance commissioners can play in the next few years. In order to control costs and improve health outcomes, states must monitor closely the actual impact of the benchmark plan decision. Special focus should be on chronic diseases, the disabled and other vulnerable populations. These groups often have unmet needs for specific health services as well as high out-of-pocket costs that can cause financial problems. State mandated benefits that protect these populations should be conserved. These are the areas that offer the most promise for improving health outcomes and containing costs, but improvements can only be achieved if we better understand the utilization of services and the outcomes associated with them. Insurance departments should use the powers they have under state law and the ACA to collect and disseminate claims and other pertinent information that can inform decisions in the future.

8. ***Protecting the integrity of the 2014 essential health benefit concept:*** Once the rules for the essential health benefits are established, the insurance commissioners must be vigilant that any changes proposed by insurers are based on evidence and actuarial standards. "Flexibility" cannot become a euphemism for discrimination or adverse risk selection. We are particularly concerned about the trend toward "inside benefit limits" – e.g., arbitrary numerical limits on such benefits as doctor visits or lab tests that may impair the proper treatment of serious medical conditions like cancer. The ACA establishes a sound foundation for a consumer-driven market, but the insurance commissioners have a vital role to play in ensuring the essential benefits truly achieve that goal.

Finally, it is important to discuss the issue of state mandates. Mandates vary significantly in number and

scope among the states. If a state chooses one of the small group market plan options, then the state mandates will be covered in the essential benefit package. If a state chooses one of the federal employee health plan options, then it is likely the mandates addressing major health services will also be covered, though there may be some exceptions. However, there is concern that some state employee plans have limited benefits for potentially serious medical conditions.

The Society and ACS CAN have long advocated for a variety of mandates for cancer coverage at the state level, particularly for evidence-based prevention screenings that have been proven effective in the fight against cancer. If a state engages in a debate about the merits of including mandates in its essential health benefits, we strongly encourage lawmakers to focus on the evidence for mandates and the role the mandated benefits play in providing truly essential coverage for serious medical conditions.

Network Adequacy

One of the important emerging issues for all consumers is network adequacy. Insurers are increasingly relying on contracts with specific providers – hospitals, doctors, labs and others – as a means of controlling costs and competing for market share. The insurers seek preferable rates and providers receive better access to a plan's participants. The consumer may benefit from lower costs, but an important issue is the quality of the network. For example, does a plan's network have an adequate supply of doctors to ensure access to primary care or specialist physicians when needed? What are the waiting times to get an appointment, or how far must one travel to actually receive care?

For cancer patients, there may be less common but critical needs for benefits, such as the need to consult a specialist for a rare cancer or seek treatment at an out-of-network specialty facility because it is much more experienced and skilled at dealing with the condition. The ability to identify and receive the best care may be out-of-network, but the cost difference for the patient if they go out of the insurer's network can be overwhelming.

Under the ACA, exchanges are required to develop network adequacy standards. The standards can be important tools for improving quality as well as controlling costs, if developed and implemented properly. But states should also adopt comparable standards for plans outside the exchange to ensure a market that promotes quality care. Insurers are increasingly looking to develop networks as a means of controlling costs and enhancing market share, but if not properly regulated, the result could be detrimental to improved health.

In 1997, Diane Bekesh was diagnosed with stage II breast cancer and had seven lymph nodes removed and 38 radiation treatments. In 2010, she was again diagnosed with breast cancer. Following this recurrence, Diane began having severe lymphedema episodes. Lymphedema is characterized by fluid retention in a limb due to blockages that prevent lymph fluid from draining. It is most often caused by damage to the lymph system through removal or damage of lymph nodes as part of cancer treatment. It is often a chronic condition, but can be managed with the correct treatment.

Unfortunately, Diane struggles with her insurance company to access adequate care for her condition. Diane's lymphedema reoccurs every one to two months and requires IV therapy to treat. While her doctors would prefer she have the IV therapy in the hospital due to her seizure disorder, the insurance company refuses to pay for inpatient treatment. In addition, her doctors say she needs multiple compression sleeves to properly fit her arm as her arm size fluctuates significantly over time due to changes in her lymphedema. Yet the insurer has said it will only cover one compression sleeve every 12 months. Diane said, "It makes me feel really depressed. It's like these insurance companies don't understand what people go through."

Limits like these are termed "inside limits" and may be part of the essential benefits package if they currently exist in the benchmark plan chosen by the state. Inside limits are often arbitrary and can undermine the goal of providing adequate coverage to patients based on evidence-based medicine. It is important that state policymakers carefully review the proposed benchmark plan options to identify inside limits that may affect the needs of patients with chronic diseases such as cancer.

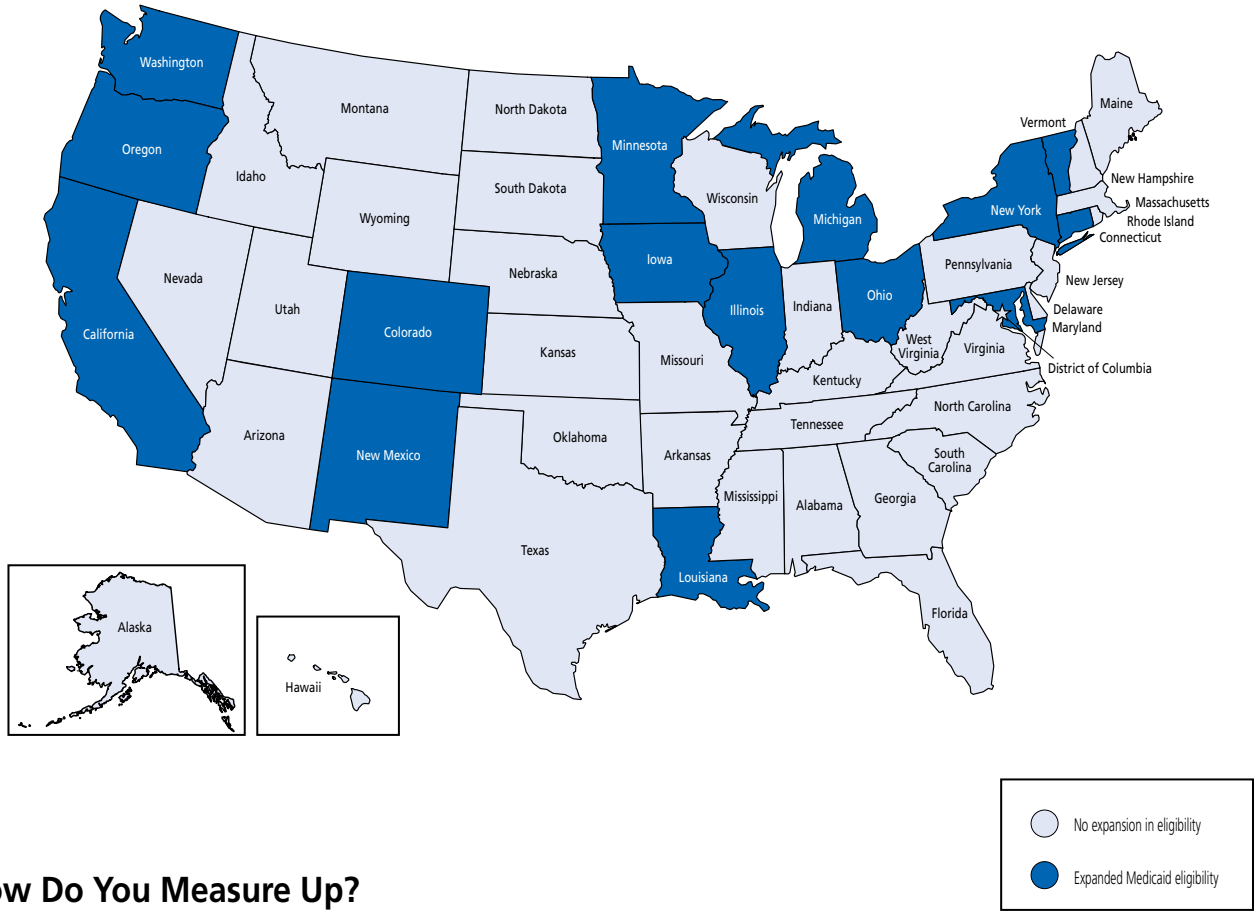
The Challenge

Medicaid is free or low-cost public health coverage for certain low-income people, and is jointly financed and administered by federal and state governments. The federal government matches dollars spent by each state and, in return, states cannot restrict coverage or establish waiting lists. For many low-income uninsured or underinsured people under the age of 65, Medicaid is the only source of coverage for regular cancer care. The federal government requires Medicaid programs to cover a number of mandatory benefits, but states largely decide the breadth of optional benefits and services that are vital for many cancer patients. In an effort to balance budgets and reduce Medicaid spending, many state legislatures attempt to cut the program by reducing the availability, affordability, adequacy and administrative simplicity of Medicaid coverage. This is done by limiting who is eligible for the program, when they can enroll, what benefits are covered for patients and what out-of-pocket expenses are required to receive coverage.

In 2014, states may choose to cover individuals at or below 133 percent of the federal poverty level (FPL) in their Medicaid programs. As part of this Medicaid expansion under the ACA, states will have to choose a benchmark plan to define the benefits for this "newly eligible" population. States can choose their Medicaid benchmark plan from the benchmark options that were established for the program in 2006:

- The largest HMO in the state (based on enrollment figures)
- The state employee health plan

Expansion of Medicaid Eligibility, 2011-2012



How Do You Measure Up?

Source: Kaiser Commission on Medicaid and the Uninsured. October 2011. *Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage, and Policy Trends, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012.*

- The Federal Employee Health Benefit Plan (FEHBP) Blue Cross Blue Shield (BSCB) plan
- Or "Secretary-approved" coverage.

States also have the option to choose the benefits and services offered in their traditional Medicaid program, as the benchmark plan for newly eligible individuals. If states choose the benefits and services in their traditional Medicaid program and it does not contain services for the 10 Essential Health Benefit (EHB) categories specified in ACA, then the state must supplement the benchmark plan. It should also be noted that states are not required to select the same benchmark plan and EHB for Medicaid as they select for the individual and small group markets that will purchase their plan through the exchange.

ACS CAN believes every eligible American deserves adequate, affordable health coverage in Medicaid. As states choose their Medicaid benchmark plan, it is critical they adopt plans that will meet the health care needs of all individuals eligible for coverage. Should a state consider choosing the benefits and services provided in traditional Medicaid, thought should be given to the health care needs of cancer patients and individuals with other chronic diseases. Traditional Medicaid can have some very low limits on the number of benefits and services an individual can utilize. For example, some states limit physician services to 12 office visits a year, which is insufficient for an individual being treated for cancer. Many of the newly eligible individuals from the Medicaid expansion will be older and sicker than the traditional Medicaid enrollees (pregnant women and children) and such limits could prove to be inadequate for their health care needs.

In addition to the need for adequate coverage of benefits and services for cancer patients and those with chronic conditions, states must consider the need for continuity of care delivered in Medicaid and the plans offered in the state exchange. Income fluctuations are expected to disrupt coverage for individuals newly eligible for Medicaid and those who qualify for subsidies in the exchange. States must consider how the two plans and the EHB will coordinate, providing individuals with continuity of care between benefits, providers networks and delivery systems.

Research suggests income fluctuations will cause considerable shifting of consumers between Medicaid and private insurance. These fluctuations and related coverage disruptions could make it difficult for patients to maintain treatment and care coordination plans as they move between Medicaid and the private insurance plans in the exchange, also known as "churning." A lack of coordination between Medicaid and the state exchanges could interrupt the cancer care of current patients, resulting in harmful, adverse effects on chemotherapy or radiation treatment and negatively impact one's ability to treat a future cancer reoccurrence.

Finally, states should consider the need for a benchmark plan that is also affordable for newly eligible individuals. Research shows that even nominal co-payments can deter lower-income patients from seeking cancer care, resulting in delayed screenings and treatment. Coverage of recommended cancer screenings in Medicaid is not guaranteed and individuals who are newly eligible for coverage may incur an out-of-pocket cost to receive these early detection services that we know can help save lives. Timely and appropriate access to recommended cancer screenings prevent certain types of cancer and detect cancer early allowing for more effective and cost-efficient treatment. A late-stage cancer diagnosis often includes more severe or limited treatment options, as well as diminished odds of survival.

The 10 Essential Health Benefits

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Mandatory and Optional Benefits in State Medicaid Programs:

The federal government allows states to establish and administer their own Medicaid programs. The federal government requires states to cover certain "mandatory benefits," and allows states to provide other "optional benefits" such as prescription drugs, dental and vision services. States have the discretion to determine the type, amount, duration and scope of both mandatory and optional benefits and services, within broad federal guidelines, to provide in their Medicaid program. The following table highlights the mandatory and optional benefits that can be offered in state Medicaid programs:

Mandatory Benefits	**Optional Benefits**
NOTE: States have the discretion to determine the type, amount, duration and scope of both mandatory and optional benefits and services, within broad federal guidelines, to provide in their Medicaid program.	
Inpatient hospital services	Prescription drugs
Outpatient hospital services	Clinic services
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services (for children only)	Physical therapy
Nursing facility services	Occupational therapy
Home health services	Speech, hearing and language disorder services
Physician services	Respiratory care services
Rural health clinic services	Other diagnostic, screening, preventive and rehabilitative services
Federally qualified health center services	Podiatry services
Laboratory and X-ray services	Optometry services
Family planning services	Dental services
Nurse midwife services	Dentures
Certified pediatric and family nurse practitioner services	Prosthetics
Freestanding birth center services (when licensed or otherwise recognized by the state)	Eyeglasses
Transportation to medical care	Chiropractic services
Tobacco cessation counseling for pregnant women	Other practitioner services
	Private duty nursing services
	Personal care
	Hospice
	Case management
	Other services approved by the Secretary

Challenges and Opportunities in Medicaid

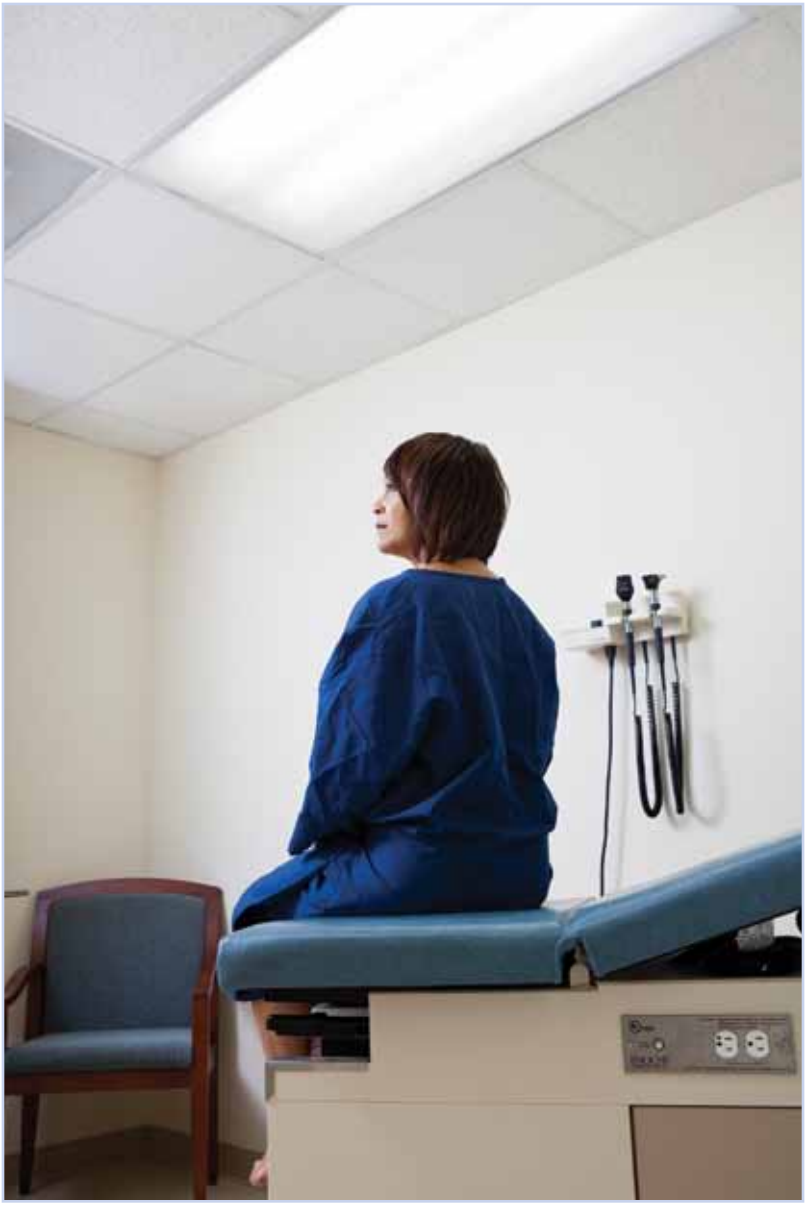
With the nation's economy still struggling, states continue efforts to control spending in their Medicaid programs. Although some states have expanded eligibility during the past several months in anticipation of the ACA's expansion of the program in 2014, several others have reduced or eliminated benefits and services in their Medicaid programs as a short-sighted, cost-cutting measure. The ACA provides states with a number of incentives to act in advance of the 2014 deadline by updating their information technology (IT) systems, beginning to phase in the newly eligible population, streamlining eligibility systems and implementing coordinated care programs for individuals with chronic conditions. However, states continue to struggle with budget shortfalls, and the more than 1 million cancer patients who rely on Medicaid are being affected as states restrict access to prescription drugs, limit physician visits and hospital stays and reduce access to optional benefits such as non-emergent transportation and therapy services in order to reduce costs.

Some state policymakers believe they can resolve their budgetary problems by converting to block grants or repealing the maintenance of effort (MOE) provisions of the ACA to gain extra flexibility in how to control Medicaid expenditures by reducing the number of people eligible for or enrolled in the program. However, this approach simply shifts costs to taxpayers in other forms rather than fundamentally reducing costs or improving outcomes. Furthermore, because block grants are fixed payments that do not automatically adjust for increases in health care expenses, they are unlikely to result in cost savings. The ACA maintenance of effort provisions ensure coverage for all Medicaid beneficiaries through January 2014 or until the health insurance exchanges are fully operational. Coverage and for children in the Children's Health Insurance Programs (CHIP), is ensured until September 30, 2019. An elimination of the MOE will reverse efforts to secure access and exacerbate coverage barriers in Medicaid or CHIP.

Federal law allows states to reduce eligibility or enrollment for certain low-income individuals if they certify to the U.S. Department of Health & Human Services (HHS) they are in a budget crisis.

The Facts

- Medicaid and CHIP cover approximately 25 percent of children with cancer and 9 percent of adults with cancer.
- Overall, only 28 percent of adults living in poverty are covered by Medicaid. Meanwhile, 45 percent of adults living in poverty are uninsured.[1]
- The federal government provides matching funds from 50 percent to 85 percent of costs. Thus, a $1 cut in state dollars can mean a $1 to $3 cut in federal aid.[2]
- Among adults expected to enroll in the exchanges, 13 percent report they are in fair or poor physical health compared to 6 to 7 percent of currently privately-insured individuals.[3]
- Out-of-pocket expenses for Medicaid beneficiaries rise twice as fast as their income. Through 1997-2002, out-of-pocket medical expenses for Medicaid beneficiaries without dependent children rose on average by 9.4 percent per year.[4]



The Solution

Ensuring access to care for our nation's most vulnerable populations is essential to the fight against cancer. Coverage reductions and changes to the Medicaid entitlement nature and financial structure have major implications for Medicaid beneficiaries. States have an opportunity in the choice of their Medicaid benchmark plan to ensure adequate health care coverage for low-income populations facing chronic disease. The Medicaid benchmark plan should:

- Ensure an adequate scope of services for chronic disease patients
- Coordinate benefits with the Essential Health Benefits benchmark in the private insurance market
- Limit the use of nominal co-pays to ensure timely access to necessary care

Additionally, rather than resorting to drastic cuts, states should first take full advantage of the flexibility already provided in Medicaid. For instance:

- Improve Medicaid health systems. States are eligible to receive more money to develop simpler and more efficient information technology systems to modernize Medicaid enrollment.
- Design coordinated primary and specialty care programs. These programs are eligible to receive additional federal funding to improve quality and disease management for patients at risk or with serious and expensive chronic conditions, such as cancer.
- Purchase drugs more efficiently. The ACA allows states to take advantage of federal drug rebates. As an example, participation in such opportunities would allow states to provide full coverage of FDA-approved prescription tobacco cessation treatments.

ACS CAN believes participating in these initiatives will ensure that all Americans living in poverty and who qualify for Medicaid will have routine access to cancer prevention, early detection and treatment services, which may allow them to live longer and healthier lives.

10-Year Retrospective:

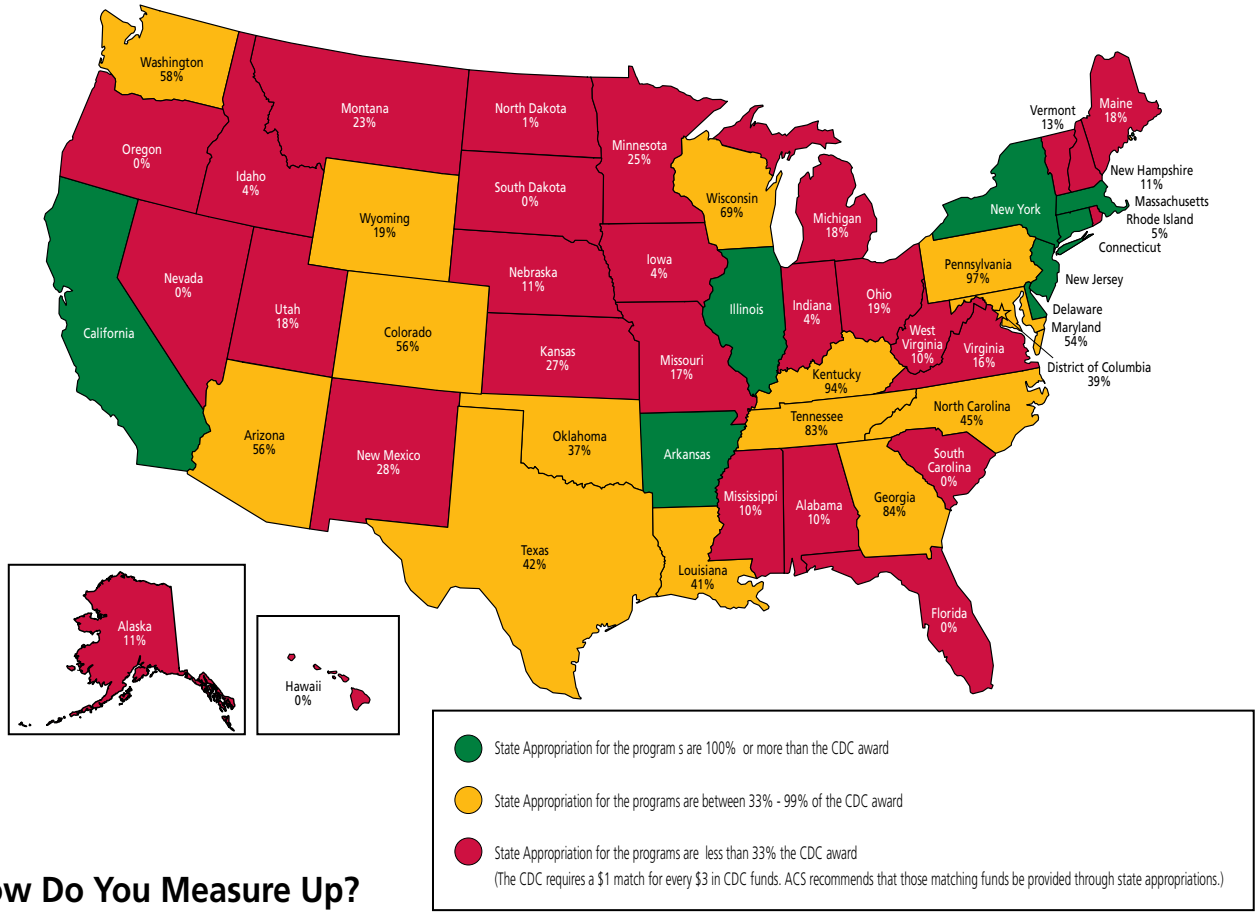
- The Breast and Cervical Cancer Prevention and Treatment Act passed in 2000 and all states began accepting the Medicaid option in 2003.
- Since 2006, nearly 50,000 cancers have been detected and those women were provided with a pathway to comprehensive treatment services through their state Medicaid programs.

The Challenge

Research shows that early detection of breast and cervical cancer saves lives. That is why the Society recommends that women age 40 and older have yearly mammograms and that all adult women get regular Pap tests.

With the economic downturn straining family finances and prompting some Americans to forgo preventive care and visits to the doctor, the need to protect women's access to preventive health services and to provide timely and appropriate access to breast and cervical cancer screenings, is greater than ever. Today, more

State Appropriations for Breast and Cervical Cancer Screening Programs - Fiscal Year 2011-2012



How Do You Measure Up?

American Cancer Society Cancer Action Network Updated June 1, 2012
Source: 2011-2012 data from the Centers for Disease Control and Prevention and unpublished data collected from ACS CAN and ACS Divisions, including input from NBCCEDP directors.

women are uninsured and as a result are cutting back on routine cancer screenings and examinations designed to protect their health. A recent ACS CAN survey found that 1 in 7 individuals who have had a history of cancer and earn less than $30,000 annually needed to delay preventive testing or treatment for cancer at some point due to cost.

The Facts – Breast Cancer

- Excluding skin cancer, breast cancer is the most frequently diagnosed cancer among U.S. women – an estimated 226,870 new cases of invasive breast cancer and 63,300 new cases of non-invasive breast cancer will occur this year.[1]
- In 2012, an estimated 39,920 women will die from the disease, making it the second-leading cause of cancer death among women in the United States.[2]
- A mammogram is the most accurate and cost-effective tool available to find breast cancer before symptoms appear. However, mammogram rates continue to be lower among Hispanic and Asian women, compared to white and African American women, as well as those who lack health insurance.[3]
- When breast cancer is diagnosed at the localized stage, the five-year survival rate is 99 percent; however, when it is diagnosed after spreading to distant organs, the five-year survival rate decreases drastically to 24 percent.[4]

The Facts – Cervical Cancer

- An estimated 12,170 new cases of cervical cancer will be diagnosed among women in the United States this year and 4,220 women will die from the disease.[5]
- Pap tests detect precancerous lesions that can be treated before they become cervical cancer, resulting in a nearly 100 percent survival rate.[6]
- When detected at an early stage, cervical cancer has a five-year survival rate of 91 percent. However, when cervical cancer is diagnosed at an advanced stage, survival rates plummet to 16 percent.[7]

The Changing Health Care Environment: Cancer Screening and the Uninsured

In partnership with state-administered breast and cervical cancer screening programs, the U.S. Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) provides low-income, uninsured and underinsured women with access to lifesaving breast and cervical cancer screenings and follow-up care. In 2011, the program celebrated its 10 millionth screening exam. Serving more than four million women since 1991, the program has been able to detect more than 51,891 breast cancers, 2,982 invasive cervical cancers and 142,443 premalignant cervical lesions.[8] In addition, women diagnosed through the program have access to treatment services through state Medicaid programs because of the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) of 2000. BCPPTA allows all 50 states and the District of Columbia to provide Medicaid services to women diagnosed with breast or cervical cancer through the NBCCEDP.[9]

The NBCCEDP awards annual grants to states with breast and cervical cancer early detection programs that provide in-kind or monetary matching funds – at least $1 for every $3 in federal money. However, a shortage of state and federal funding currently allows for fewer than 20 percent of eligible women nationwide to receive these lifesaving

New Cervical Cancer Screening Guidelines

The American Cancer Society released new cervical cancer screening guidelines for average risk women in March 2012. The guidelines recommend average-risk women aged 21-65 be screened using the following methods and frequencies:

- Women age 21-29 should receive a Pap test every three years (liquid or conventional).
- Women age 30-65 should receive co-testing with the HPV test and the Pap test every five years (preferred), or every three years with the Pap test alone.
- Women over the age of 65 who have had normal results should discontinue screening.

cancer screenings. Consequently, millions of eligible women are going without these critical early detection services. Funding is essential, both now and in the future, to give underserved women the opportunity to receive vital screening services.

Last year, The George Washington University, in collaboration with ACS CAN, the Society and the CDC, developed a model to explore the continued need for the CDC's cancer screening programs. This analysis indicated that there will be a continued need for the NBCCEDP, even after the ACA is fully implemented in 2014. While a vast majority of the population will have access to affordable health insurance in 2014, there are a number of individuals who will lack coverage, including those who will not be required to have insurance, those who may not be able to afford a plan, or those who have selected a plan that does not cover preventative screening services. In many states, if the current level of funding for NBCCEDP was maintained beyond 2014, they would still not be able to screen all women who would remain eligible for the program. This shows there will be a continued need for the program and for adequate funding, even after the ACA is fully implemented in 2014, in order to reach those women who are eligible and lack access to preventative screening services.

Program Cuts Putting Women at Risk

Nearly half of all states reduced state funding for their BCCEDP and these funding reductions are affecting low-income women in a number of different ways.

The Solution

Early breast cancer detection is the single most important factor in achieving a good health outcome when facing the disease. However, lack of adequate insurance coverage makes people less likely to be screened for cancer and puts them at significantly greater risk for late-stage diagnosis of disease and poorer prognosis.[10] Research shows mammograms can be covered for little or no additional cost to insurers, employers or employees, when compared to the cost of treatment.[11] Laws that require coverage for all recommended breast cancer screening options help save lives.

State policymakers must ensure neither income nor insurance status are barriers to cancer screenings. State policies supporting education and screening along with well-funded programs are critical to ensuring all eligible women receive these lifesaving services.

In 2007, the NBCCEDP was reauthorized, allowing for greater flexibility in the program to enable it to reach more uninsured and

Program Cuts Putting Women at Risk

State	Have Reduced State Funding or Provide No Funding	Implemented Waiting Lists or Other Means of Limiting Access	Routine Mammogram for Women 40-49 Not Covered
Alabama	X		X
Alaska			
Arizona	X	X	
Arkansas		X	
California			
Colorado	X		X
Connecticut	X	X	
Delaware	X		
District of Columbia	X		
Florida	X	X	X
Georgia			
Hawaii	X		X
Idaho	X	X	X
Illinois	X	X	
Indiana		X	X
Iowa		X	
Kansas		X	X
Kentucky			
Louisiana		X	
Maine			
Maryland	X	X	
Massachusetts			
Michigan			
Minnesota			
Mississippi			
Missouri			X
Montana			
Nebraska	X		
Nevada	X		X
New Hampshire	X		X
New Jersey	X	X	
New Mexico		X	
New York			
North Carolina		X	
North Dakota	X		
Ohio		X	X
Oklahoma	X		X
Oregon	X	X	
Pennsylvania	X	X	
Rhode Island	X		
South Carolina	X	X	*
South Dakota	X		
Tennessee		X	X
Texas			
Utah			X
Vermont			
Virginia		X	
Washington		X	
West Virginia			X
Wisconsin	X		**
Wyoming	X		X

* Screens only women over 47
** Screens only women over 45

Note: Funding amounts are those that are lower in fiscal year 2012 than in fiscal year 2011.

other medically underserved women. The reauthorization also set increased funding targets for the program from the previous $202 million per year to $275 million per year during the course of five years. After a decrease in funding in 2011, from $215 million to $206 million, ACS CAN is advocating for Congress to increase annual funding for this program to the full $275 million authorized. Providing sustained funding increases for the NBCCEDP will mean that it can provide high-quality screening services to more low-income, uninsured and underinsured women.

However, the program continues to need additional funds, which makes state legislative action critical. Several states have appropriated funds above the required match to expand their screening program capacities and thus serve more eligible women. Recognizing their fiscal constraints, a few states have leveraged funding from other public and private sources to expand the program's reach.

Reductions in state appropriations for NBCCEDP means that fewer eligible women across America have access to lifesaving screenings. Even after the ACA is fully implemented in 2014, there will still be many women in need of screening services through the NBCCEDP Program. This is not the time to cut or reduce funding. In order to reach as many eligible women as possible, ACS CAN urges state legislators to continue appropriating dollars for this underfunded program and, when faced with budgetary shortfalls, to continue identifying alternative funding sources.

ACS CAN also urges state legislators to maintain laws that protect access to breast cancer screenings and to expand coverage for all eligible women. It is critical that patient protection laws specify that coverage for annual mammograms be guaranteed for all women age 40 and older. Currently, provisions in the ACA require that all new plans and Medicare now cover mammograms for women age 40 and older. However, there are still many private insurance plans that do not ensure this coverage. Grandfathered plans – plans that existed at the time the law was enacted – are not required to cover these services, and plans participating in state health insurance exchanges required by the ACA will not be required to cover this group until 2014. State legislative action is required in many states to ensure this coverage for all women.

Success Story

Florida had long suffered the unenviable distinction of being one of the very few states to never have invested state dollars in screening through the NBCCEDP program. That finally changed, however, with a concerted effort by Society advocates, who convinced the Florida legislature this year to appropriate $1.24 million in matching state funds to screen more medically-underserved women. A committed contingent of 150 volunteers converged upon Tallahassee early in the session, led by a number of breast cancer survivors. An enthusiastic rally on the steps of the Capitol, strategically-timed meetings with members and staff, and grassroots follow-up all built momentum for the important women's health initiative. State Representative Chris Dorworth, a rising member of House leadership, ultimately took up the cause and championed the measure during the legislature's budget conference committee deliberations.

Despite the Society's successful legislative campaign in Florida to secure state funding for its BCCEDP program, advocates also had to overcome a potential veto of the new appropriation. Thousands of grassroots contacts were generated to encourage Florida Governor Rick Scott to keep this mission-critical line item in the budget, which he ultimately signed with the first-ever state screening dollars intact.

This outcome underscores the power of advocacy. The Society's advocacy volunteers and staff in Florida made the issue their top priority in Tallahassee this year, understanding the significance of such a win in a state with a high rate of incidence and mortality. To be sure, this victory means more cancers will be detected earlier at more treatable stages, and lives will be saved.

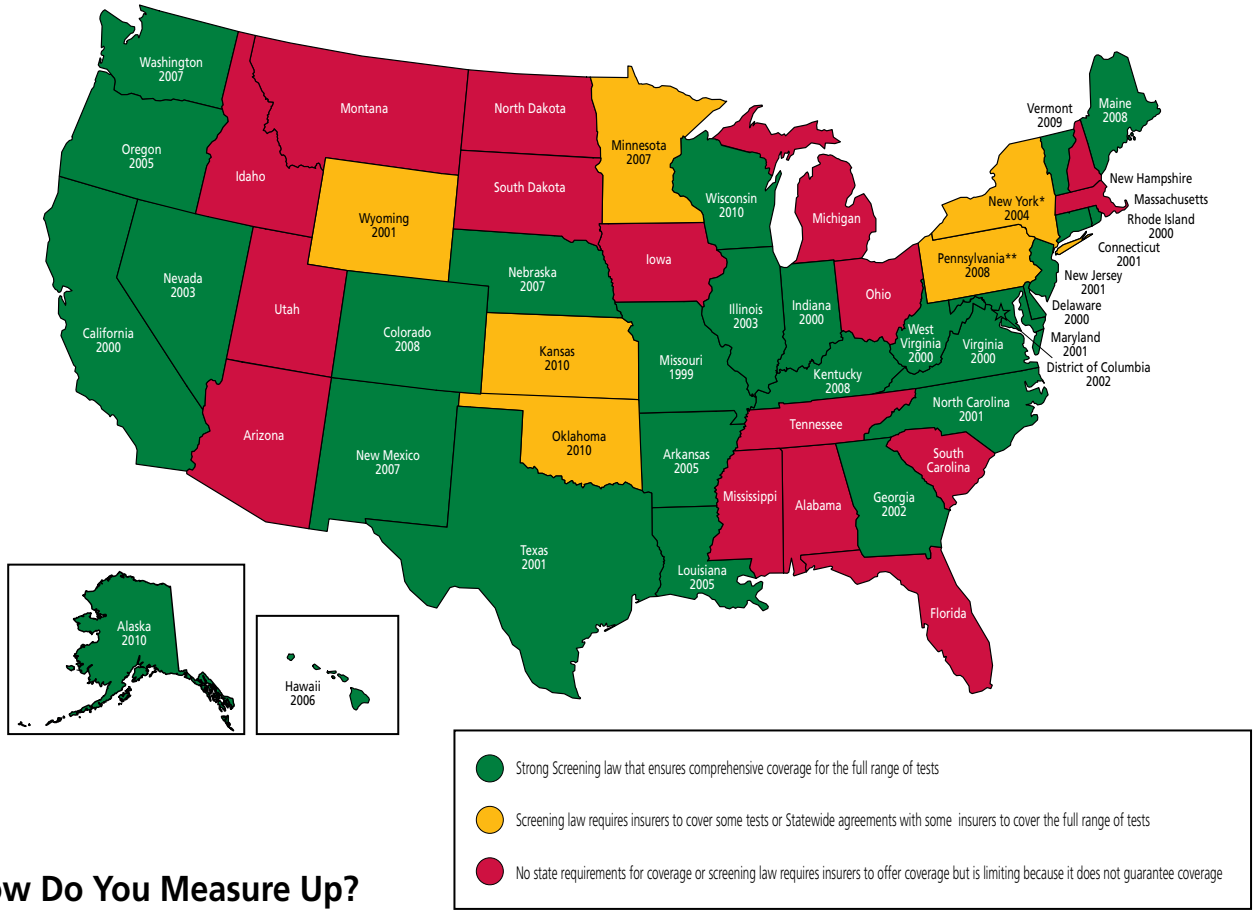
Legislative Call to Action

ACS CAN strongly urges states to follow the science when developing new screening and coverage legislation. Over the past several months, a number of breast cancer bills have been introduced mandating specific insurance coverage and/or dictating how physicians should practice medicine based on research and data that has not been scientifically proven to be accurate or effective. While some of these efforts may be well-intended, implementing these types of mandates could result in overuse of tests that have not been shown to be effective and lead to increased anxiety among those undergoing them. Additionally, we urge policy makers to perform a comprehensive analysis of the subject matter and impact of legislation dictating how medical professionals should practice medicine. ACS CAN recommends that state mandates be consistent with Society screening guidelines.

10-Year Retrospective:

In 2003, 16 states and the District of Columbia were considered "green" on the colorectal cancer map. Today, 27 states and the District of Columbia are "green."

Benchmarking Insurance Coverage for Colorectal Cancer Screening



Strong Screening law that ensures comprehensive coverage for the full range of tests

Screening law requires insurers to cover some tests or Statewide agreements with some insurers to cover the full range of tests

No state requirements for coverage or screening law requires insurers to offer coverage but is limiting because it does not guarantee coverage

How Do You Measure Up?

Sources: Health Policy Tracking Service & Individual state bill tracking services
*Pennsylvania passed its law in 2008 but restricted the mandate to employers with greater than 50 employees.
*The New York Health Plan Association, which serves 6 million New Yorkers, covers the full range of colorectal cancer screening tests, as a part of a voluntary collaborative with ACS.

States that have colorectal cancer screening mandates which are more comprehensive than those recommended by the United States Preventative Services Task Force (USPSTF) will be able to have those services covered and paid for in the state health insurance exchanges required by the ACA. Patients in states that mandate coverage consistent with the American Cancer Society's recommended guidelines for colorectal cancer screening have access to additional screenings, such as CT colonoscopy and expanded age guidelines. The following states mandate colorectal cancer screenings consistent with Society guidelines:

- Alaska
- Arkansas
- Connecticut
- District of Columbia
- Delaware
- Georgia
- Indiana
- Illinois
- Kentucky
- Louisiana
- Maryland
- Missouri
- Nevada
- New Jersey
- North Carolina
- Oregon
- Rhode Island
- Virginia
- Wisconsin

The Challenge

Laws requiring coverage for all recommended colorectal cancer screening options have helped save lives of countless Americans. Early detection is one of the most fundamental factors in diagnosis, successful treatment and reduced mortality for colorectal cancer. However, lack of health insurance coverage is one of the greatest barriers to timely and appropriate cancer screening services and puts individuals at higher risk of late-stage diagnosis.[1]

To address this problem, 28 states and the District of Columbia have implemented comprehensive colorectal cancer screening laws during the past 20 years to ensure their residents receive access to vital screening services. Thanks to the commitment and dedication of many state lawmakers to prevention, many patients now have access to comprehensive colon cancer screening services, and have therefore avoided unnecessary late-stage colorectal cancer diagnoses and worse prognoses.

Today, an overwhelming number of Americans, not just those who reside in a state with mandates, have access to no-cost cancer screening services due to provisions in the ACA. Because of the law, these services, which include colonoscopy, sigmoidoscopy and fecal occult blood tests, are currently available under all new health plans and Medicare at no cost to patients. Plans participating in state health insurance exchanges will also be required to cover such services in 2014.

Even with expanded insurance access, there will still be a significant number of individuals who will lack access to colorectal cancer screening. As mentioned in the previous section, in 2011, The George Washington University, in collaboration with ACS CAN, the Society and the CDC, developed a model to explore the continued need for the CDC's cancer screening programs. The analysis indicated that in 2014 there will still be a number of individuals who will lack insurance coverage, including those who will not be required to have insurance, those who may not be able to afford a plan, or those who have a plan that does not cover preventative screening services. There will be a continued need for and adequate funding of state colorectal cancer control programs to reach those individuals who have fallen through the cracks.

Education, outreach and access to timely and appropriate screening services are critical tools in the fight against colorectal cancer. The elimination of these barriers to cancer screening and treatment can save the lives of thousands of Americans between 50 and 75 years of age.

The Facts

- This year, an estimated 143,460 people will be diagnosed with colorectal cancer in the United States and about 51,690 will die from the disease.[2]
- The rate of colorectal cancer screening is much lower among racial minorities and the medically underserved.[3]

- Less than 20 percent of those without health coverage in the United States have been screened for colorectal cancer, compared to more than 62 percent among those with insurance coverage.[4]

Emerging Issues

The ACA requires all USPSTF "A" and "B" recommended services be covered without cost sharing (co-payments/deductibles) in Medicare and new health plans. The USPSTF gives an "A" recommendation for colorectal cancer screening using either fecal occult blood testing, sigmoidoscopy or colonoscopy for people age 50-75. An unintended loophole in the ACA has resulted in some patients experiencing costs sharing when going in for their colorectal cancer screening. If polyps are identified during a colonoscopy, it is common practice to remove them during the screening colonoscopy, minimizing the need for a secondary procedure. However, once a polyp is removed, the procedure may result in patients having to pay cost sharing.

ACS CAN is monitoring this concern and has developed draft legislation that can be used to address the cost barrier at the state level. In addition, the Removing Barriers to Colorectal Cancer Screening Act (H.R. 4120), which was introduced in March 2012, would ensure that screening colonoscopy is free to all Medicare beneficiaries, regardless of whether a polyp or other tissue is removed.

The American Cancer Society recommends average-risk adults age 50 and older begin screening for colorectal cancer using the following methods and frequencies:

Tests that find polyps and cancer

- Flexible sigmoidoscopy every five years, or
- Colonoscopy every 10 years, or
- Double-contrast barium enema (DCBE) every five years, or
- CT colonography (CTC) every five years.

Tests that mainly find cancer

- Annual fecal occult blood test (FOBT) with at least 50 percent test sensitivity for cancer, or
- Annual fecal immunochemical test (FIT) with at least 50 percent test sensitivity for cancer, or
- Stool DNA test (sDNA), with high sensitivity for cancer, interval uncertain.

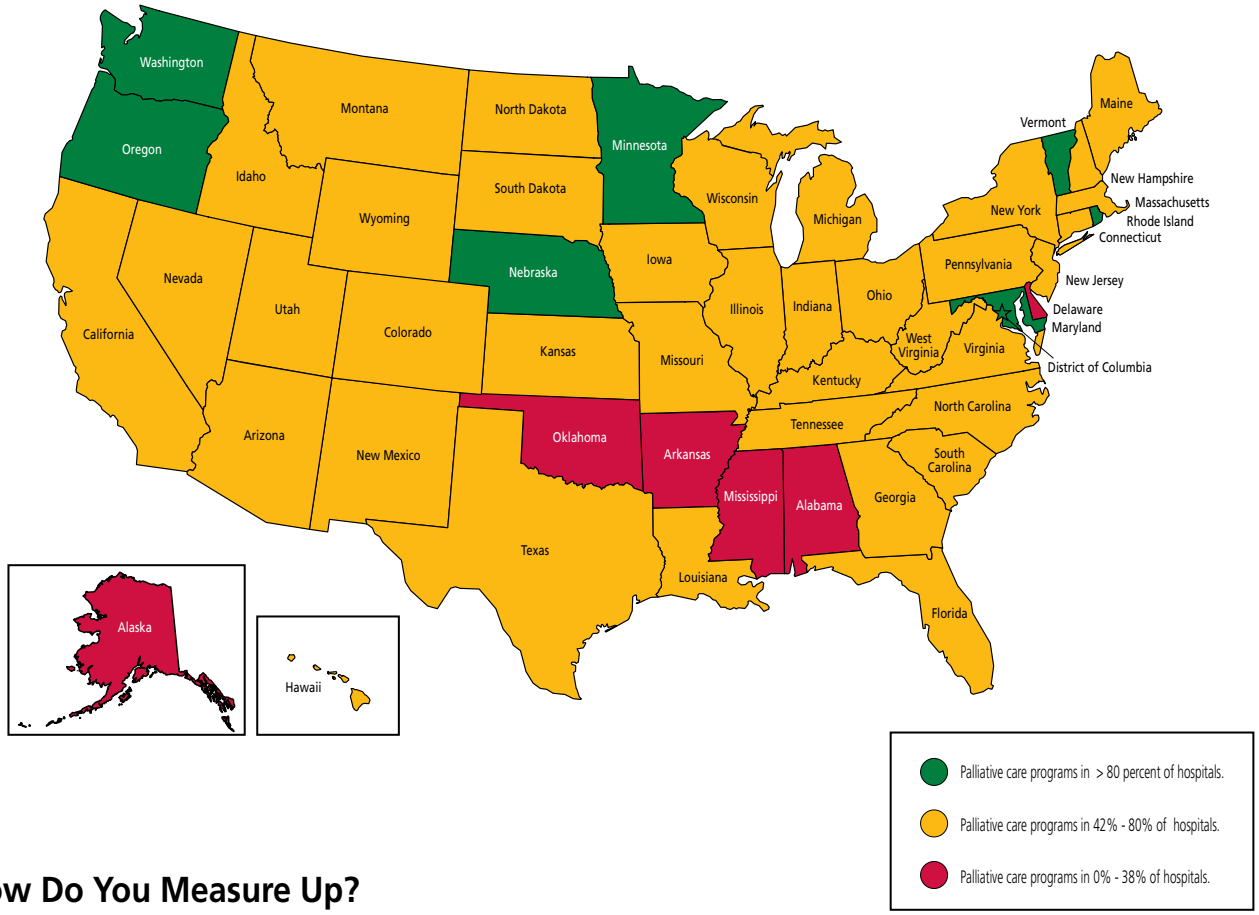
A Team-Based Approach That Focuses on the Patient

The Challenge

In the United States today, more than 90 million people are living with at least one chronic illness. This number will grow rapidly as our nation's baby boomers live longer with multiple, long-term medical conditions such as congestive heart failure, chronic lung disease, cancer, coronary artery disease, renal failure, peripheral vascular disease, diabetes, chronic liver disease and dementia – the collection of chronic illnesses currently responsible for nine of 10 deaths among the Medicare population.[1]

In addition, 500,000 children and their families cope with serious illness in the United States each year -- many enduring distressing symptoms because considerations of the toxicity of therapy, quality of life and growth and development often take a back seat to the primary goal of achieving a cure.[2] To preserve quality of life and

Access to Palliative Care in the Nation's Hospitals



How Do You Measure Up?

Source: Center to Advance Palliative Care / National Palliative Care Research Center. (2011). America's Care of Serious Illness: A State-by-State Report Card on Access to Palliative Care in Our Nation's Hospitals. New York, New York. Retrieved from http://reportcard-live.capc.stackop.com/pdf/state-by-state-report-card.pdf.

prevent suffering for these adults and children, it is very important that all people living with serious illness receive palliative care from the point of diagnosis to:

- Assess and manage physical, psychological and spiritual symptoms.
- Establish patient-centered goals of care.
- Support patient and family caregivers and
- Manage transitions across care sites.

Treating the whole person – not only the disease but also the physical and emotional consequences of treatment – is the key to both extending life and enhancing the quality of the time gained. The good news is that palliative care, which aims to treat the whole person, has emerged as the new patient-centered and family-focused paradigm for managing serious illness, and the number of teams available in hospitals has more than doubled during the past 10 years.[3]

Palliative care is a form of health care focused on maximizing quality of life during serious illness and is delivered at the same time as all other beneficial treatments. Several studies have now shown that patients who receive palliative care not only live better but also tend to live longer.[4] For example, a recent study in the New England Journal of Medicine showed that receiving palliative care early in the treatment of advanced lung cancer led to significant improvements in both quality of life and mood. In addition, as compared with patients receiving only disease-directed care, patients receiving early palliative care required less emergency hospital and intensive care and survived nearly three months longer.[5]

Despite the recent growth of palliative care, some areas of the United States are better equipped than others, and some hospitals are more committed than others to providing these services. Availability of palliative care varies considerably by region and by state, so millions of adults and children with serious illness do not have access to palliative care from the point of diagnosis throughout the course of illness.[6]

The Facts

- Once informed about palliative care,[7] 92 percent of the American public is highly likely to consider palliative care for themselves or their families if they have a serious illness. This endorsement did not vary by political affiliation, geographic location, sex, age or prior caregiving experience of the respondents.[8]
- 92 percent also say it is important that palliative care services be made available at all hospitals for patients with serious illness and their families throughout the United States.[9]
- Only 54 percent of public hospitals offer palliative care teams, and fewer than 40 percent of sole community provider hospitals offer them. These settings typically provide medical care for the nation's most vulnerable populations, such as the uninsured and those who are geographically isolated.[10]
- Policy initiatives that address palliative care workforce improvements, research into palliative care, and patient access to such care could significantly improve the care and treatment of the nation's sickest children and growing population of seniors living with long-term chronic conditions.
- If palliative care teams were fully integrated into the nation's hospitals, total savings could exceed $6 billion per year.[11]

Key Palliative Care Benefits:

- Relieves suffering and provides the best possible quality of life for the patient and the patient's family.
- Offers a team-based approach, involving doctors, nurses and other specialists, to help the patient and their family understand their treatment options and goals.
- Appropriate at any age and any stage of a serious illness.
- Manages pain and other symptoms.
- Improves communication and coordination of a patient's care.
- Prolongs life and reduces healthcare costs.

The Solution

The ultimate goal of palliative care is to improve overall quality of life and quality of care for patients experiencing serious and chronic illnesses and their families. In order to benefit from palliative care, however, patients 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 palliative care teams.

To the public, the benefit of this added layer of support from a palliative care team focused on quality of life is obvious. The holistic information and clear communication these teams provide are essential for patients and families so they can share in the important decisions they need to make as a result of the illness and treatment options. To help save lives and stop suffering for all people living with serious illness like cancer, ACS CAN urges legislators to partner with us and other key stakeholders in enacting policies that will increase the availability of palliative care services for all adults and children – with special attention needed in small, rural and public hospitals – through initiatives that:

- ***Educate the public about palliative care:*** In partnership with state departments of health and others, implement communication and awareness strategies to make sure the public knows what palliative care is and encourage them to ask their doctors for it under appropriate circumstances. Media coverage of studies demonstrating gain in both quality and quantity of life in association with palliative care has already helped change patient and family behavior in this direction.

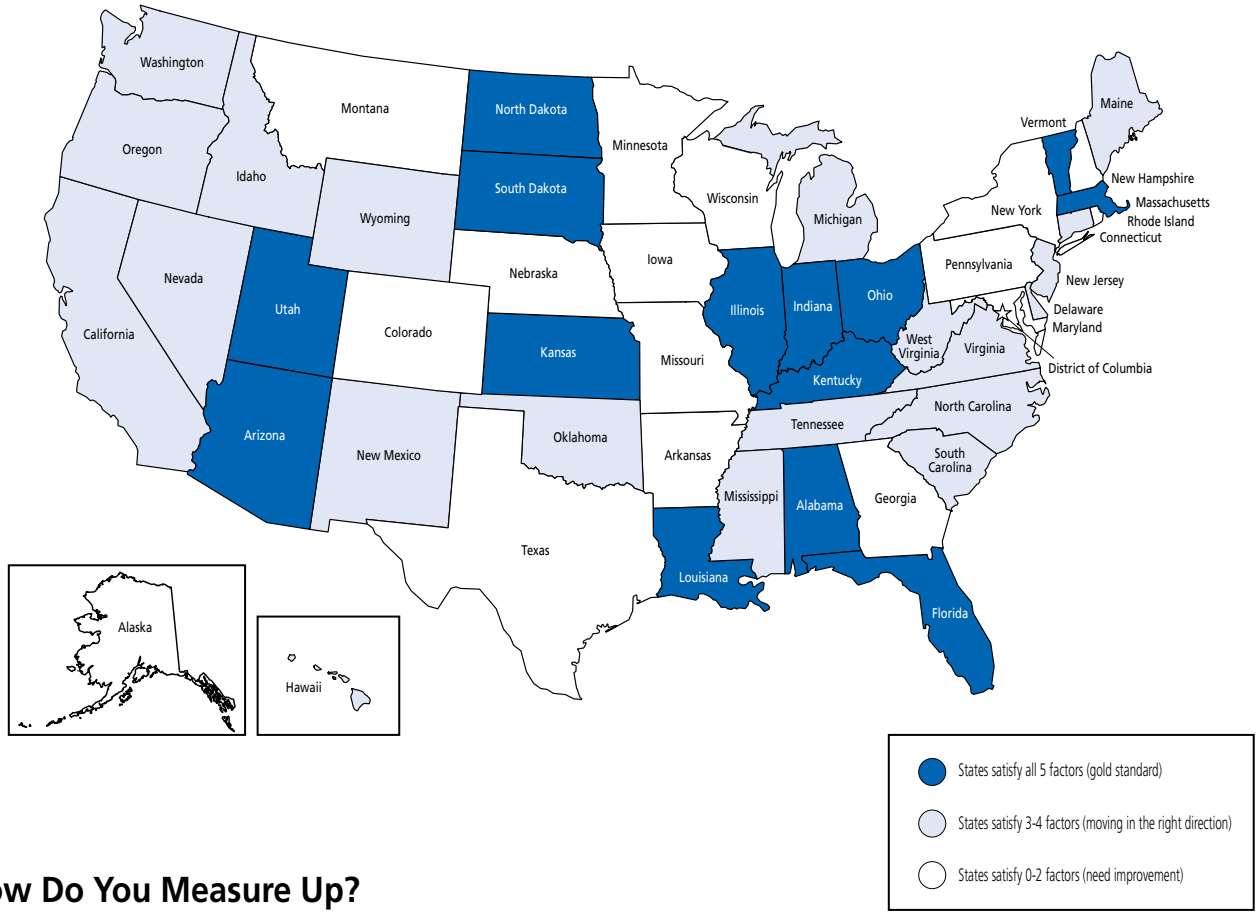
- ***Make palliative care a key measure of quality and a core component of available services:*** Frame palliative care as a core component of quality care and require that health care settings serving the seriously ill – hospitals, nursing homes, assisted living facilities, home care agencies – routinely screen their patients for palliative care needs, such as poorly controlled pain, depression or other symptoms, lack of clarity about medically achievable goals for care, what to expect in the future and how to plan for it and family caregiver exhaustion and stress. Requiring identification of these needs would trigger care protocols and associated payment models that reward whole person, promote interdisciplinary care and address current care gaps. In addition, compensation for advanced practice nurses delivering palliative care services should be standardized so billing for these services is permitted in every state.

- ***Boost health professional training in palliative care core competencies:*** Implement strategies to enhance fundamental palliative care clinical skills among health professionals and students of medicine, nursing and other professions to align educational requirements and professional practices with the current evidence demonstrating the importance of integrating palliative care alongside disease-directed treatment. In addition, having palliative care teams that meet quality standards should be a condition of accreditation for all U.S. hospitals and nursing homes.

- ***Preserve access to pain medications for people in pain:*** Implement balanced prescription monitoring programs and other policy initiatives that preserve access to pain medications for seriously or chronically ill people with pain and enhance workforce training in pain assessment, management and responsible prescribing. At the same time, promote public awareness programs and other strategies encouraging safe use, storage and disposal of prescription medicines together with evidence-based interventions for preventing their misuse and abuse.

A Team-Based Approach That Focuses on the Patient

State Prescription Monitoring Programs



How Do You Measure Up?

American Cancer Society Cancer Action Network
Map based on five criteria on page 46 of this report. Sources of five criteria - Alliance of States with PMPs (<http://www.pmpalliance.org/>) and Univ. of Wisconsin PPSG (<http://www.painpolicy.wisc.edu/domestic/pmp.htm>).

The Challenge

Pain remains one of the most feared and burdensome symptoms for adults and children facing cancer. The need to manage pain can persist for years after cancer treatment concludes and can become a disabling condition that causes great suffering and diminished quality of life for survivors and their families. While nearly all cancer-related pain can be relieved, its prevalence and its under-treatment have remained consistently high and largely unchanged for more than four decades.[1]

The situation is even worse for approximately 100 million American adults suffering chronic non-cancer pain – particularly among our nation's medically underserved populations experiencing significant documented health disparities in access and care.[2]

Curtailing illegal use and diversion of prescription drugs is necessary and very important. But policy initiatives intended to keep these medications out of the wrong hands must be balanced to ensure that prescription pain medicines remain available and accessible to people who need them to relieve their suffering.

The Facts

- Nearly every state has adopted laws establishing a Prescription Monitoring Program (PMP), with a large majority of these PMPs now operational.
- Properly implemented PMPs can help prescribers and pharmacists with informed and responsible prescribing and dispensing of controlled substances, including opioid analgesics, benzodiazepines and other types of prescription medicines used to control pain, anxiety and nausea for cancer patients, as well as cancer survivors and other people with chronic pain.
- PMPs identify patients who are obtaining prescriptions from multiple sources and assist in detecting illicit prescribing and dispensing. But they do not target other key sources of the problem such as non-medical prescription drug use, theft from household medicine cabinets, or pharmacies or other illicit diversion activities outside the scope of prescribing practices.

The Solution

PMPs can be one important tool as part of broader state drug control and abuse prevention strategies addressing safe prescription medication use, storage and disposal. States should address the following five essential elements in their efforts to enhance and implement balanced PMPs to ensure they achieve stated drug control objectives without inadvertently impeding patient care:

1. ***Interoperability:*** Each state PMP must be able to share electronically reported prescription information with other state PMPs.
2. ***Real-time reporting:*** Data should be reported by pharmacies to the PMP no less often than every seven days; in the future, this reporting should strive to be at point-of-sale.
3. ***Electronic reporting via internet access:*** Prescribers and dispensers should be able to obtain reports on their patients via the internet, as opposed to through regular mail or fax requests, which are more time-consuming.
4. ***Proactive reports:*** PMPs should proactively notify prescribers and dispensers if the program becomes aware of aberrant and potentially illegal behavior on the part of those practitioners' patients.
5. ***Advisory Council:*** PMPs should establish multidisciplinary advisory councils to integrate health professional and patient advocate stakeholder expertise in efforts to develop, implement and evaluate the PMP.

Legislative Successes Working to Improve Patients' Quality of Life

Scientific advancements during the past several years have increased the availability and effectiveness of oral medications for cancer treatment. More than 40 oral medications have now received approval from the U.S. Food and Drug Administration (FDA), adding new and less invasive alternatives to traditional intravenous (IV) chemotherapy infusions for treatment of at least 54 different types of cancer.

In many instances, oral chemotherapy offers advantages important to overall quality of life for patients and their family caregivers, including the convenience of not having to travel to a doctor's office or cancer treatment center as often as several times a week for IV infusions that can take several hours each time. This flexibility is particularly important for people living in rural areas, who otherwise 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. When taken as directed and with appropriate counseling about their use, some of these medicines also offer the benefit of reduced and more manageable side effects.

To date, 20 states and the District of Columbia have passed oral chemotherapy parity legislation to help equalize patient out-of-pocket costs for oral chemotherapies and IV chemotherapies. Many of these laws generally require state-regulated health insurance companies and group health plans to cover orally administered anticancer drugs "on a basis no less favorable than" IV administered ones. Over time, states have tightened their legislative language, resulting in holding health insurers to charging the lower cost share for an oral chemotherapy of either the oral anticancer treatment under the patient's prescription drug benefit or the IV chemotherapy.

Cancer patients' access to anticancer oral drugs has improved as a result of these states' legislative efforts and successes. ACS CAN applauds these state initiatives focused on improving access to this fuller range of lifesaving and life-enhancing cancer treatments.

Ensuring access to adequate and affordable coverage remains a primary goal of ACS CAN, and are now actively engaged in trying to shape an evidence-based package of essential benefits through the federal regulatory process and state activity related to benchmark plan selection this year. The initiative shown by these 20 states and D.C. strengthens our ability to advocate for better coverage at the federal level.

State in which Oral Parity Passed	Year Legislation Passed	State in which Oral Parity Passed	Year Legislation Passed	State in which Oral Parity Passed	Year Legislation Passed
Oregon	2007	District of Columbia	2010	Texas	2011
Hawaii	2009	Minnesota	2010	Washington	2011
Indiana	2009	New Mexico	2011	Delaware	2012
Iowa	2009	Illinois	2011	Louisiana	2012
Vermont	2009	Kansas	2011	Maryland	2012
Colorado	2010	New Jersey	2011	Nebraska	2012
Connecticut	2010	New York	2011	Virginia	2012

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