Cancer Action Network℠
American Cancer Society®

How Do You Measure Up?

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

2017 15th Edition

What is the American Cancer Society Cancer Action Network (ACS CAN)?

The American Cancer Society Cancer Action Network (ACS CAN) is the nation's leading cancer advocacy organization, working to save lives and eliminate death and suffering from cancer through involvement, influence and impact. As the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, ACS CAN educates the public, elected officials and candidates about cancer's toll on public health and encourages them to make cancer a top priority.

Reducing suffering and death from cancer relies as much on public policy as it does on proven medical research. Lawmakers and policymakers at all levels of government play a critical role in making decisions that can help save more lives from cancer. ACS CAN's work has resulted in enormous progress through increased funding for cancer research and prevention programs, stronger tobacco control policies nationwide and improved access to the full range of cancer care for people diagnosed with the disease as well as their families. By focusing the public's attention on the cancer fight, raising funds, educating voters and rallying others to join the fight, ACS CAN unites and empowers people with cancer, along with their families, to help save lives.

ACS CAN ensures that cancer patients, survivors, their families and experts on the disease have a voice in public policy matters relevant to cancer at all levels of government. We mobilize our large, powerful grassroots network of cancer advocacy volunteers to make sure lawmakers are aware of cancer issues that matter to their constituents.

Working closely with the American Cancer Society's research and cancer control leadership, ACS CAN staff identify and develop key public policies firmly rooted in scientific evidence that promote prevention and access to early detection, treatment and follow-up care. ACS CAN uses our expert lobbying, policy, grassroots and communications capacity to advance evidence-based solutions that help save more lives from cancer.

ACS CAN is strictly nonpartisan and does not endorse, oppose or contribute to candidates or political parties. As a result, we are viewed as a trusted source of health policy information by legislators, policymakers and opinion leaders. The only side ACS CAN takes is the side of cancer patients.

To become a member visit www.acscan.org/donate.

Table of Contents

15th Edition

How Do You Measure Up?

How Do You Measure Up?

Our 15th Edition

The 15th edition of *How Do You Measure Up?* illustrates where states stand on issues that play a critical role in reducing cancer incidence and death. The goal of every state should be to achieve "green" in each policy area delineated in the report. By implementing the solutions set forth in this report, state legislators have a unique opportunity to take a stand and fight back against cancer. In many cases, it costs the state little or nothing to do the right thing. In most cases, these solutions will save the state millions and perhaps billions of dollars through health care cost reductions and increased worker productivity.

Looking back on how far we've come since the first report was released in 2003 shows just how much progress can be made in 15 years when ACS CAN staff and volunteers work with lawmakers to make ending cancer a local, state and federal priority.

Since 2003, we've seen major breakthroughs in cancer research, significant reductions in tobacco use and, in the last two decades, a 25 percent drop in the cancer death rate which translates to more than 2.1 million fewer cancer deaths.[1] There are 15.5 million cancer survivors alive today, thanks, in part, to better screening and treatment options and improved access to this type of care over the last 15 years.[2] The progress made since that first report is proof that when research is put to action, we can save more lives from cancer.

Yet, just this year, nearly 1.7 million Americans will hear the words "you have cancer" and more than 600,000 will die from this disease.[3] That's why it is critical we continue to leverage the progress we've made to catapult our nation closer to a day when a cancer diagnosis is no longer life threatening. To get there, local, state and federal lawmakers must continue passing and implementing proven public health policies to prevent tobacco use and help those already addicted to quit, to make the healthy choice the easy choice, to protect youths from skin cancer, increase access to affordable and adequate health coverage and

promote patient access to palliative care to improve quality of life during and after treatment. ACS CAN has made great progress in all of our priority areas.

Tobacco:

When the first edition of *How Do You Measure Up?* was released, the national adult smoking rate was 21.6 percent.[4] Since then, the rate has dropped to 15.1 percent.[5] This drop was largely a product of calculated, strategic, evidence-based policy changes.

For example, in 2003 only two states had smoke-free laws and 74 municipalities had passed smoke-free ordinances. Today, 25 states, Puerto Rico, the U.S. Virgin Islands, the District of Columbia and 891 municipalities across the country have laws in effect that require 100 percent smoke-free workplaces, including restaurants and bars. As a result, nearly 60 percent of the population is now protected from secondhand smoke while at work.

Furthermore, in 2003, the average cigarette tax was just 70.5 cents, but today, ACS CAN, along with its partners, has worked successfully to increase that average tax rate, which now sits at $1.69 per pack. Most recently, California increased the tax on tobacco by $2.00 per pack.

For these policies to be as effective as possible, it's important that as smoke-free laws and increased tobacco taxes encourage tobacco users to quit, individuals have access to cessation services to help them succeed. At the time of the first edition of *How Do You Measure Up?*, 14 states were funding their tobacco prevention and cessation programs at a minimum of 50 percent of what the Centers for Disease Control and Prevention (CDC) recommends as effective. Given that money spent on prevention takes time to demonstrate results, these funding levels likely played a major role in the reductions experienced in smoking rates in recent years.

While we've made progress in many areas in tobacco control, constricting state budgets have resulted in a backslide on tobacco control efforts. Today, just four states fund tobacco prevention and cessation programs at more than half of what CDC recommends, even though states are estimated to collect $26.6 billion in revenue from tobacco taxes and the Master Settlement Agreement this year.[6] Additionally, while the average state tobacco tax rate has increased in the last 15 years, research shows these increases must be significant and happen on a regular basis to continue being effective. In 2003, 31 states had increased their cigarette tax in the past two years, but today, only three states have significantly increased their cigarette tax by $1 or more in the last three years. Momentum is stalling and if lawmakers don't make reducing tobacco use a priority at the local, state and federal levels, smoking rates will likely increase among adults and youth. This comes with a hefty price tag, too. At the current rate, tobacco costs the nation approximately $170 billion in health care expenditures annually – a number that will only rise if progress reverses in tobacco use rates.[7]

Prevention:

In the last 15 years, we've learned a lot about cancer prevention, including the significant role living a healthy, active lifestyle and avoiding the risks associated with indoor tanning devices can play in reducing cancer diagnoses and deaths. Lawmakers have a unique opportunity today, with the knowledge we have of cancer prevention, to spare our loved ones, and maybe even one day ourselves, from hearing the words, "you have cancer." By helping to make the healthy choice the easy choice through establishing science-based nutrition standards for all foods and beverages sold or served in schools, and increasing and strengthening physical education requirements, among other evidence-based strategies, lawmakers can help young people develop lifelong healthy habits to reduce cancer risk. Additionally, by passing simple, common-sense legislation to protect young people from the cancer-causing UV rays of indoor tanning devices, without any exceptions, lawmakers can reduce skin cancer diagnoses, the most commonly diagnosed cancer in the US.[8]

Access:

The progress that's been made in the science around cancer prevention and the improvements made to cancer screenings and treatments mean little if patients don't have access to these services. Ensuring access is paramount in reducing cancer deaths and saving health care dollars. This was clear even in 2003, when

How Do You Measure Up?

one of ACS CAN's priority issues was working with states to ensure private insurance plans cover the full range of screening tests for colon cancer. At the time of the first *How Do You Measure Up?* report, 16 states and the District of Columbia required these screenings to be covered. Today, current law guarantees individuals on private plans have full coverage, without cost-sharing, for colon cancer screenings. Additionally, ACS CAN is collaborating with partners to increase screening rates to 80 percent by 2018 by working with lawmakers to appropriate funds to establish or invest in the state's colorectal cancer screening and control programs, to ensure plans cover follow-up colonoscopies, and other evidence-based strategies to remove barriers to colorectal cancer screenings. By ensuring individuals have access to these lifesaving screenings and increasing screening rates to 80 percent, we could save more than 200,000 lives from colorectal cancer.

But access to screenings isn't enough. Lawmakers need to ensure those who are diagnosed with cancer have access to the treatment they need to save their lives. In 2000, Congress passed the Breast and Cervical Cancer Treatment Act, creating an option for states to provide treatment for women whose cancer was detected through the National Breast and Cervical Cancer Early Detection Program. By 2003 when the first *How Do You Measure Up?* report was released, there was great momentum from states to take advantage of this program. At that time, 48 states and the District had taken all necessary steps to implement these new programs and receive federal funding for the first time. But the 2003 report warned that constricting budgets may stifle this progress. Unfortunately, that warning has become reality. Today, ACS CAN urges states to contribute just $1 for every $3 the federal government contributes to these programs, yet, 24 states aren't doing even that, with Hawaii, Nevada, South Dakota and Vermont, contributing $0.

Many states have increased access to care for some of their most vulnerable residents by extending eligibility for Medicaid enrollment under current law. By accepting the federal funds available to them, lawmakers have reduced the number of uninsured individuals in their states, and in doing so, increased the likelihood for these individuals to survive cancer if diagnosed. To date, 32 states and the District of Columbia have taken this lifesaving step. Unfortunately, as many states consider new approaches to covering residents through Medicaid, unintended barriers are being created, putting coverage at risk for 14 million low-income individuals across the country. Research shows people without insurance are more likely to be diagnosed with a later stage cancer, and are more likely to die from the disease.[9] Ensuring access to cancer prevention, screening and treatment is paramount to reducing suffering and death from cancer and the economic toll the disease puts on state and local budgets.

In addition to ensuring vulnerable populations have access to health coverage, it's important lawmakers pass policies to ensure that available health plans cover the drugs and oncology providers cancer patients need. Furthermore, lawmakers must ensure it is easy for consumers shopping for coverage to identify health plans that cover the benefits and services they need at a cost they can afford.

As we examine how far we've come in preventing, screening and better treating cancer in the last 15 years, it's important to closely examine where we are today and where we can go. In 2017, there has been much discussion about giving states more flexibility in how they approach public health. As a result, more responsibility is being put on states to reduce the burden of chronic disease. Therefore, now more than ever, it is critical that lawmakers take advantage of the opportunities proven to successfully reduce the physical impact diseases like cancer have on our families, friends and neighbors. Not only will these policy changes save lives, but they'll also reduce the fiscal impact on personal and state budgets. The 2017 *How Do You Measure Up?* report lays out a blueprint for state and local lawmakers to follow to help prevent cancer, and ensure patients have access to the screening and treatment they need. ACS CAN staff and volunteers will continue to work in every state and at the federal level to make reducing suffering and death from cancer a priority.

To learn more about ACS CAN's model policies or inquire about a topic not covered in this report, please contact the ACS CAN State and Local Campaigns Team at measure@cancer.org. We want to put you in contact with ACS CAN staff in your state. You can also visit us online at acscan.org.

How does your state measure up?

Tackling Tobacco Use

15th Edition

Tobacco use places a staggering burden on the United States. According to the U.S. Surgeon General, more than 20 million premature deaths over the past half century can be attributed to cigarette use.[1]

We have made progress in the last few decades by implementing comprehensive tobacco control strategies. The most recent data available suggests 9.3 percent of youths[2] and 15.1 percent of adults[3] nationwide smoke cigarettes – lower rates than ever before. Increasing the price of tobacco products, implementing comprehensive smoke-free policies and funding evidence-based tobacco prevention and cessation programs are proven ways to reduce tobacco use and exposure to secondhand smoke. Additionally, increased access to cessation coverage in Medicaid and private insurance plans, as well as hard-hitting media campaigns like the Centers for Disease Control and Prevention's (CDC) national *Tips from Former Smokers* campaign, have supported tobacco users in quitting permanently.[4, 5]

However, the low rate of cigarette smoking among the general population is only half the story. In 2015, about 7 percent of middle school students and 25 percent of high school students used some type of tobacco product.[6] Additionally, smoking remains high among certain populations. For those below the federal poverty level (FPL), a measure of income issued annually by the Department of Health and Human Services to determine eligibility for certain programs such as Medicaid, the smoking rate is 26.1 percent, nearly twice the rate of those individuals at or above the FPL (13.9%).[7] Also, 36 percent of people in the United States with a mental health condition smoke cigarettes.[8]

In order to achieve a tobacco-free generation, lawmakers must continue to utilize the evidence-based solutions they have at their fingertips to reduce use of all tobacco products by all populations. The American Cancer Society Cancer Action Network (ACS CAN) supports a comprehensive approach to tackling tobacco use through policies that:

1. Increase the price of all tobacco products through regular and significant tobacco tax increases of at least $1.00 per pack of cigarettes and on other tobacco products equivalent to the state's tax on cigarettes;

2. Implement comprehensive smoke- and tobacco-free policies that apply to all tobacco products; and

3. Fully fund and sustain evidence-based, statewide tobacco prevention and cessation programs and increase comprehensive insurance coverage for cessation.

Like a three-legged stool, each component works in conjunction with the others, and all three are necessary to overcome this country's tobacco epidemic. In addition to these three proven tobacco control policy interventions, ACS CAN pursues other evidence-based policies that will prevent and reduce tobacco use. Some of these additional policies include raising the age of sale for tobacco products to 21, restricting the sale of flavored tobacco products and limiting the quantity and location of tobacco retailers.

Did You Know?

An Institute of Medicine (IOM) report stated that the Department of Defense spends more than $1.6 billion per year on tobacco-related medical care, increased hospitalizations and lost days of work.[9]

Tackling Tobacco Use

Success Story

The District of Columbia made extraordinary progress in the fight against tobacco this past year, implementing three laws to reduce tobacco use.

The Prohibition Against Selling Tobacco Products to Individuals Under 21 Amendment Act will raise the age of sale for tobacco products from 18 years old to 21. If funded and fully implemented, this law will help to reduce the number of people who start using tobacco at a young age by restricting the sale of and exposure to these products. ACS CAN calls on the DC Council to appropriate the necessary funds to fully implement this legislation.

The Electronic Cigarette Parity Amendment Act, which passed the DC Council and was signed by the mayor in November, prohibits the use of e-cigarettes in workplaces, including restaurants and bars, so that the public health benefits that have been achieved by the smoke-free law passed in 2007 are not undermined.

Finally, the Sporting Events Tobacco Products Restriction Amendment Act, prohibited the use of tobacco products at organized sporting events in the District of Columbia, including baseball games at Nationals Park, now one of 14 tobacco-free major league stadiums across the country. Where cities and states already have a strong tobacco tax, a comprehensive smoke-free law and a robust tobacco control program, measures like these can bolster their effects and further decrease tobacco use.

Tobacco Excise Taxes

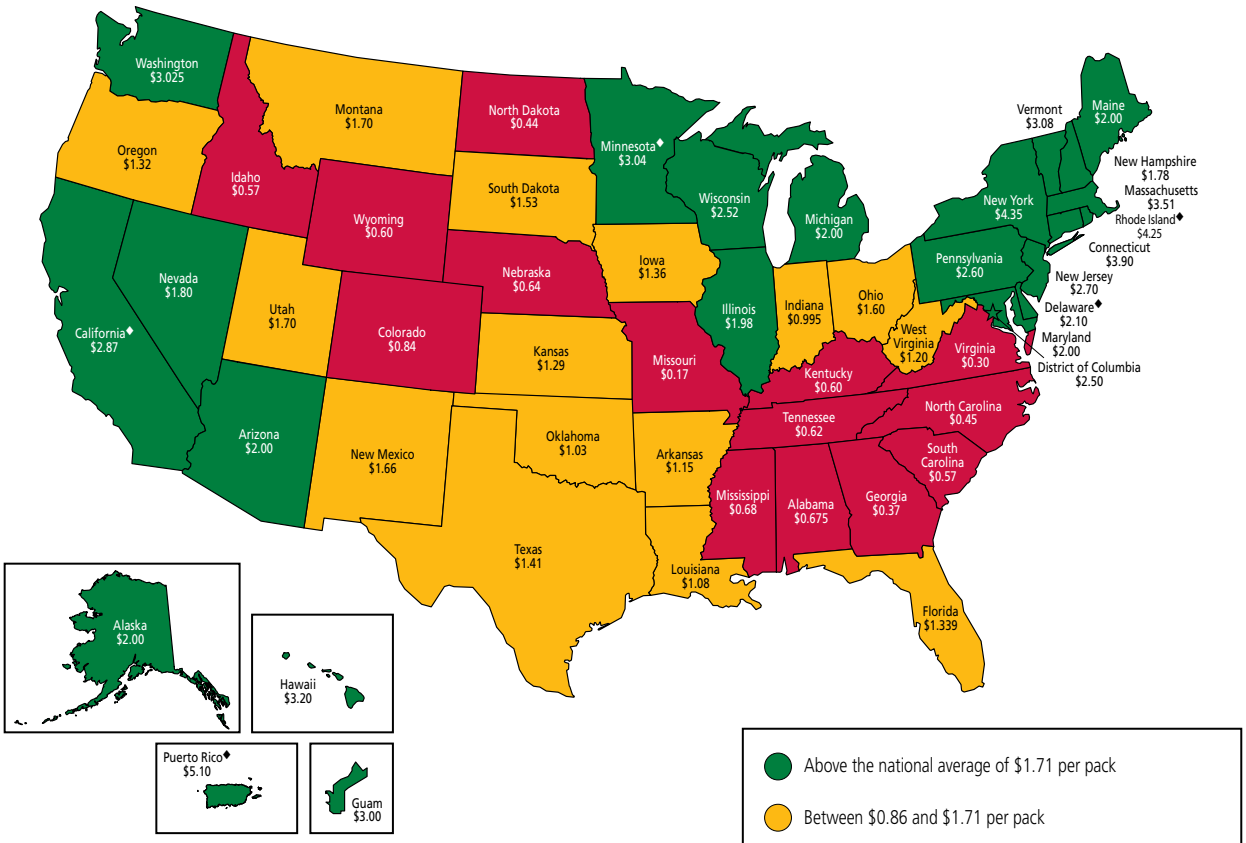
15th Edition

The Challenge

While the personal toll of tobacco is high, this deadly product also costs the U.S. economy billions of dollars in health care and lost worker productivity. Total health care spending, public and private, is around $170 billion each year.[1] In fact, smoking-related health costs and productivity losses in the U.S. amount to roughly $19.16 per pack of cigarettes sold.[2] Despite this, the average retail price of a pack of cigarettes in the U.S. remains at $6.16.[3]

Research clearly shows regularly and significantly increasing taxes on cigarettes, cigars, smokeless tobacco and all other tobacco products (OTP) is one of the most effective ways to reduce tobacco use, save lives and reduce health care costs. Furthermore, tax increases on tobacco products generate needed revenue for states.

2017 State Cigarette Excise Tax Rates



Only taxes in the 50 states and DC in effect as of 9/1/17 are included in the national average.
♦ Legislative or regulatory changes made in 2017

How Do You Measure Up?

Tobacco Excise Taxes

A Win-Win-Win for States

Regular increases of $1 per pack or more in the price of cigarettes – and parallel increases in the price of other tobacco products – are a win-win-win for states.

Saves Lives – Regular and significant tobacco tax increases are one of the most effective ways to reduce tobacco use and, therefore, suffering and death from tobacco-related diseases like cancer.

Saves Money – Significant increases to cigarette and tobacco taxes result in substantial revenue increases for states and health care cost savings.

Voters Approve – National and state polls consistently have found overwhelming public support for tobacco tax increases. In fact, many polls have shown voters are more likely to support a candidate that supports increasing the price of tobacco.

As of July 1, 2017, the average state cigarette excise tax was $1.69 per pack, but state cigarette excise tax rates vary widely, from a high of $4.35 per pack in New York to a low of 17 cents per pack in Missouri. Since 2000, all but two states – Missouri and North Dakota – have raised their cigarette taxes in at least 135 separate instances.[4]

However, progress increasing cigarette and OTP tax rates has stalled. Since August 2014, only three states – California, Nevada and Pennsylvania – have increased their tax on cigarettes by $1 or more per pack. Low prices on tobacco products make it easy for young people to afford to start and continue to use, make it harder for individuals addicted to quit and do little to defray the societal cost for state and federal governments.

The tobacco industry knows how effective significant tobacco tax increases are and works hard to keep taxes low – oftentimes going as far as proposing small tax increases, they know are too insignificant to have any effect on tobacco sales, consumption, or incidence of tobacco-related diseases. For example, in Missouri in 2016, the tobacco industry spent millions of dollars pushing two statewide ballot measures to increase the cigarette tax by only a few cents. The American Cancer Society Cancer Action Network (ACS CAN) educated voters on the deceptive tobacco industry practices and in the end, both ballot measures were defeated.

Missed Opportunity

New Mexico was one state among several in 2017 that proposed a particularly strong cigarette tax increase of $1.50 per pack, plus an equivalent increase on all other tobacco products. After a strong start in the Senate which passed the measure with bipartisan legislative support, Governor Susana Martinez reiterated her promise to veto any tax increase, and the House Taxation and Revenue Committee then voted the bill down in response to opposition from tobacco industry lobbyists. This squandered opportunity will result in another year of cheap tobacco prices, higher tobacco use rates, cancer-related suffering and preventable death in the state. ACS CAN in New Mexico plans to strengthen its efforts to urge House lawmakers and Governor Susana Martinez to support this critical disease prevention policy during the next legislative session.

The Importance of Tax Parity for All Tobacco Products

As states increase taxes on cigarettes and smoking rates decline, increasing taxes on all other tobacco products to achieve tax parity takes on greater importance.

Flavored Cigars

In 2014, among middle and high school students who used cigars in the past 30 days, 63.5% reported using a flavored cigar during that time.*

Smokeless Tobacco

Smokeless tobacco, consumed orally or nasally, increases the risk of cancer and leads to nicotine addiction.

Electronic Cigarettes

Electronic cigarettes, or e-cigarettes, allow users to inhale an aerosol filled with nicotine, flavors and other chemicals.

Cigarettes

Cigarettes are often taxed at a much higher rate than other tobacco products (OTP). ACS CAN urges states to raise taxes on all tobacco products regularly and significantly, as research shows this is the best way to curb tobacco use.

All OTP should be taxed at the same rate as cigarettes to encourage smokers to quit rather than switching to lower-priced alternatives.

Recent research shows cigarette taxes must increase by a minimum of $1.00 per pack to have a meaningful public health impact.

By increasing taxes on all tobacco products, states can save lives, reduce health care costs and generate much needed revenue.

Little Cigars

Lower tax rates make little cigars appealing to young smokers.

Large Cigars

Manufacturers can manipulate weight to evade higher taxes.

Hookah

Secondhand hookah smoke poses equal or greater danger than secondhand cigarette smoke.**

* Corey CG, Ambrose BK, Apelberg BJ, and King BA. Flavored Tobacco Product Use Among Middle and High School Students — United States, 2014. *MMWR* 2015;64:1066-1070.
**Barnett TE, Curbow BA, Soule EK, et al. "Carbon Monoxide Levels Among Patrons of Hookah Cafes". American Journal of Preventive Medicine 2011; 40(3): 324-328.

Tobacco Excise Taxes

The Solution

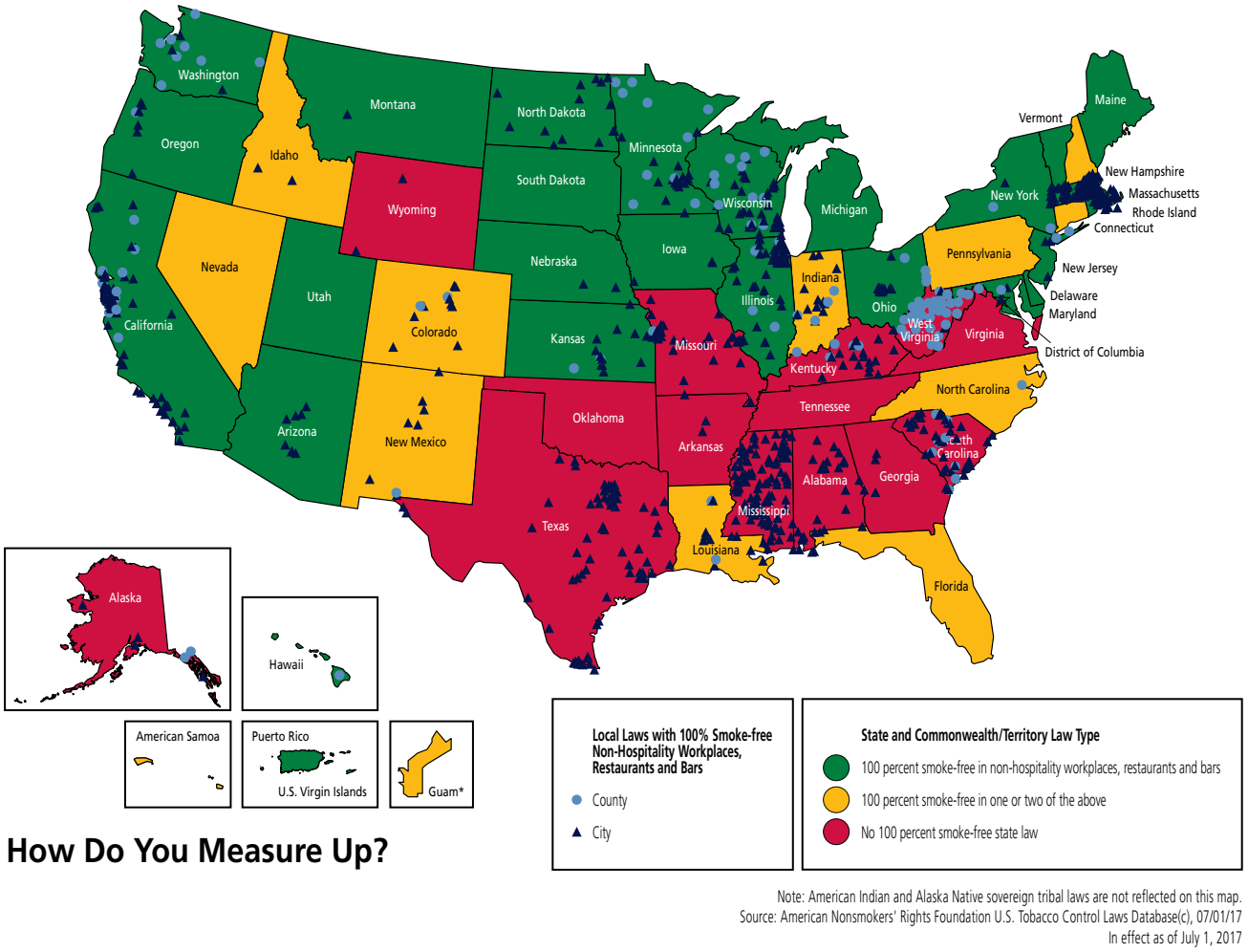
ACS CAN recommends regularly increasing cigarette taxes by a minimum of $1 per pack to have a meaningful public health impact. States should also regularly increase the tax on OTP at a rate equivalent to the state's tax on cigarettes. Additionally, dedicating tobacco tax revenues to tobacco prevention and cessation programs, along with other programs that help prevent cancer and benefit cancer patients, can help amplify the benefits of a tax increase and further reduce suffering and death from tobacco-related diseases. In 2016, California passed a $2 per pack increase approved by voters at the ballot. This increase took effect April 1, 2017.

ACS CAN, in partnership with the Campaign for Tobacco-Free Kids, has developed a model to estimate the public health and economic benefits produced by meaningful increases in state cigarette excise taxes. State-specific projections, as well as technical assistance in the development of strong tax policy, are available by contacting ACS CAN.

Unfinished Business

In 2016, Oklahoma found itself in a position where Governor Mary Fallin and recent Republican-controlled legislatures in the state had been increasingly supportive of tobacco tax proposals. The coalition supporting the tobacco tax increase worked tirelessly throughout the interim to further educate legislators on the positive health and financial impact of increasing the cost of cigarettes. This year, Governor Fallin teamed up with House and Senate budget leadership to uniformly express support early in the session for increasing the price of cigarettes by $1.50 per pack, in large part because of the severe economic toll that tobacco renders on the state of Oklahoma. Late in the session, revised legislation was crafted to levy a price increase of $1.50 on all packs of cigarettes. The legislation captured the majority of votes in both chambers the last week of the legislative session, helping to support a newly-created health care enhancement fund intended to benefit Oklahomans for generations to come. In addition, Oklahoma maintained funding for comprehensive tobacco prevention and cessation programs. Unfortunately, the tobacco industry and its allies have filed a legal challenges, placing the viability of this price increase at risk. ACS CAN nonetheless applauds Governor Fallin and those legislative leaders, along with our dedicated ACS CAN volunteers and coalition partners, who fought in 2017 and will continue to fight to ensure implementation of a $1.50 per-pack increase in the price of cigarettes in Oklahoma.

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



How Do You Measure Up?

Note: American Indian and Alaska Native sovereign tribal laws are not reflected on this map.
Source: American Nonsmokers' Rights Foundation U.S. Tobacco Control Laws Database(c), 07/01/17
In effect as of July 1, 2017

The Challenge

According to the U.S. Surgeon General,[1,2] there is no safe level of exposure to secondhand smoke, which contains approximately 70 known or probable carcinogens[3] and more than 7,000 substances, including formaldehyde, arsenic, cyanide and carbon monoxide.[4]

Each year in the United States, secondhand smoke causes nearly 42,000 deaths among nonsmokers, including up to 7,300 lung cancer deaths.[5,6] It can also cause or exacerbate a wide range of other adverse health issues, including cardiovascular disease, stroke, respiratory infections and asthma.

Smoke-Free Laws

As of July 1, 2017, 25 states, Puerto Rico, the U.S. Virgin Islands, the District of Columbia and 891 municipalities across the country have laws in effect that require 100 percent smoke-free workplaces, including restaurants and bars.[7] Seventeen of these states, as well as Puerto Rico and the U.S. Virgin Islands, also include gaming facilities in their comprehensive smoke-free laws. Nationwide, nearly 60 percent of the U.S. population lives in a place with a comprehensive smoke-free law covering workplaces, including restaurants and bars.[8]

Certain segments of the population, such as hospitality and gaming facility workers in states or communities without comprehensive laws, continue to be denied their right to breathe smoke-free air. The American Cancer Society Cancer Action network (ACS CAN) believes everyone has the right to breathe smoke-free air and no one should be forced to choose between their health and a paycheck.

The Solution

The best way to reduce exposure to secondhand smoke is to make all public places, including all non-hospitality workplaces, restaurants, bars and casinos, 100 percent smoke-free. Smoke-free laws reduce exposure to secondhand smoke, encourage and increase smoking cessation among adults trying to quit and reduce health care, cleaning and lost productivity costs.[9,10,11] Smoke-free laws also have been proven to reduce the incidence of coronary events among people under the age of 65.[12]

ACS CAN urges state and local officials to pass and protect comprehensive smoke-free laws in all workplaces, including restaurants, bars and gaming facilities, in order to protect the health of all employees and patrons. Lawmakers are encouraged to reject legislation that weakens smoke-free laws. ACS CAN adamantly opposes legislation that restricts a lower level of government from enacting stronger smoke-free laws than exist at a higher level of government. These preemption laws slow and prevent future progress to protect all workers from the cancer-causing toxins in secondhand smoke.

Electronic cigarettes, or e-cigarettes, should be included in smoke-free laws. E-cigarettes are typically battery-operated devices that allow users to inhale an aerosol produced from cartridges filled with nicotine, flavors and other chemicals. A recent Surgeon General's report stated that e-cigarette aerosol is not harmless and can contain harmful and potentially harmful chemicals. In addition, e-cigarettes often resemble traditional cigarettes, making it difficult for business owners to distinguish between the two, making enforcement of smoke-free laws tougher.

As a result, ACS CAN advocates that states prohibit the use of e-cigarettes in all venues where smoking is prohibited – including workplaces, restaurants, bars and gaming facilities.

Success Story

Texas lags behind the majority of the country by not having a statewide smoke-free law, but that hasn't stopped advocates in the state from making huge progress to protect the workforce of Texas from secondhand smoke. With the help of a statewide coalition of stakeholders, including ACS CAN staff and volunteers, 73 cities in Texas have comprehensive smoke-free ordinances on the books. In 2016 and 2017, momentum for smoke-free measures has surged, with 20 cities adopting comprehensive ordinances from June 2016 to June 2017. With 10.5 million Texans now covered, only four states – California, New York, Illinois, and Ohio – protect more residents from the dangers of secondhand smoke.

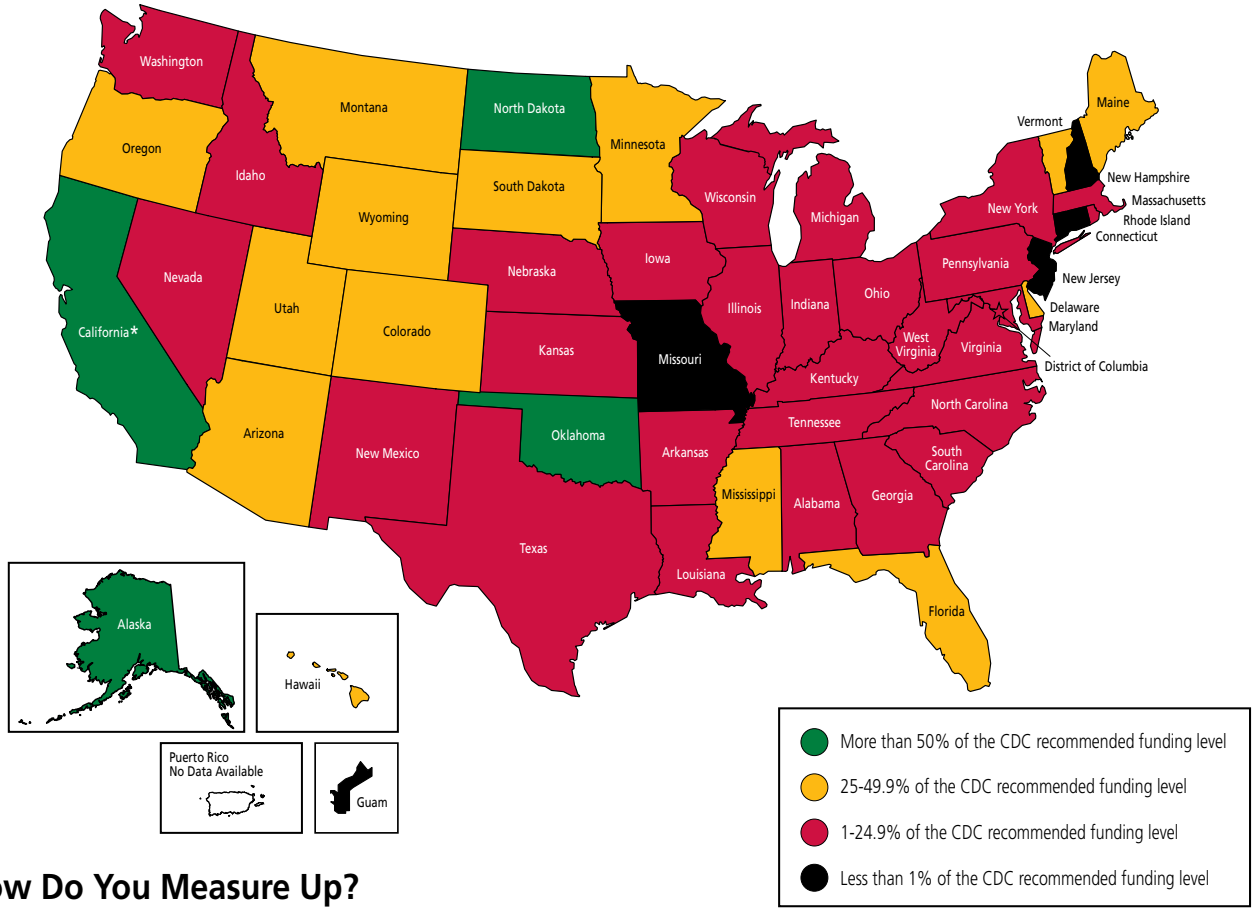
Victories range from the small town of Universal City (pop. 2,400) to the growing city of New Braunfels (pop. 66,000). All major cities in Texas are now included, with the exception of Ft. Worth (pop. 812,000), where an active campaign is ongoing. ACS CAN strongly urges local Ft. Worth lawmakers to follow the lead of other major cities in the state and do the right thing for the health of their residents and visitors. In March of 2017, Texas was awarded Americans for Nonsmokers Rights' Smokefree Indoor Air Challenge Award, its top public health award, for enacting the greatest number of local smoke-free workplace protections in any US state.

Did You Know?

- There is no risk-free level of secondhand smoke, and even brief exposure can cause immediate harm.[13]
- Establishing a 100 percent smoke-free environment is the only effective way to fully protect nonsmokers from secondhand smoke.[14]
- Separating smokers from nonsmokers, cleaning the air, and ventilating buildings cannot eliminate exposure of nonsmokers to secondhand smoke.[15]
- Everyone has the right to breathe smoke-free air.

Tobacco Control Program Funding

Fiscal Year 2017 State Funding for Tobacco Control



How Do You Measure Up?

Sources: Robert Wood Johnson Foundation, Campaign for Tobacco-Free Kids, American Cancer Society Cancer Action Network, American Heart Association, American Lung Association, and Americans for Nonsmokers' Rights. *Broken Promises to Our Children: A State-by-State Look at the 1998 State Tobacco Settlement 18 Years Later*. December 2016. Available at http://www.tobaccofreekids.org/microsites/statereport2017/. Centers for Disease Control and Prevention (CDC). *Best Practices for Comprehensive Tobacco Control Programs — 2014*. Atlanta: U.S. Department of Health and Human Services, CDC, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014. Current annual funding includes state funds for FY2017 and does not include federal funds directed to states.
*Tobacco tax increase (April 1, 2017) generated additional ~ $120 million, making annual spending 56% of CDC recommendation

The Challenge

One of the most effective ways to reduce tobacco use is to prevent it from happening in the first place. While smoking rates have declined overall in recent years, 95 percent of smokers still began using tobacco before the age of 21 and 99 percent of adults who use tobacco started before age 26. Furthermore, as some young people are turning away from traditional cigarettes, use of other tobacco products has increased. For example, the most recent data available show that 13.6 percent of young adults, ages 18 to 24, (2014) and 16 percent of high school students (2015) have used e-cigarettes in the past 30 days.[1] It's imperative that steps are taken to ensure programs are in place to protect the next generation from a lifetime of addiction.

In a disturbing trend, state legislatures have gutted tobacco control funds across the country. Seventeen states and the District of Columbia experienced a decline in tobacco control funding in fiscal year 2017. Wyoming and Maine fell below 50 percent of the CDC-recommended funding level, while New Mexico and Arkansas fell below 25 percent. Funding was zeroed out entirely in Connecticut.

The 2014 U.S. Surgeon General's report on tobacco concluded that comprehensive statewide and community tobacco control programs prevent and reduce tobacco use by keeping young people from becoming addicted and helping individuals who use tobacco to quit.[2] The report called for states to fully fund these programs at levels recommended by the Centers for Disease Control and Prevention (CDC) as part of a comprehensive strategy to accelerate progress in eliminating death and disease caused by tobacco use.

Despite this well-established link between comprehensive tobacco prevention and cessation programs and reductions in tobacco use, most states are falling behind when it comes to adequately funding these programs. Although states are estimated to collect $26.6 billion this year in tobacco taxes and Master Settlement Agreement (MSA) payments (billions of dollars in yearly installments the tobacco companies agreed to pay states and territories as compensation for costs associated with tobacco-related diseases), they are slated to spend only 1.8 percent of that revenue as intended - on programs to reduce tobacco use.

In fiscal year 2017, states budgeted a total of $491.6 million[3] for tobacco prevention and cessation programs. This means the states are spending less than two cents of every dollar in tobacco revenue to fight tobacco use.[4] When state and federal funds are taken together, only one state – North Dakota – funds their program at the CDC-recommended level. Only three states – California, Alaska and Oklahoma – fund their programs at over half the CDC-recommended level based on state funding alone. It would take less than 13 percent of annual state tobacco tax and settlement revenue to fund all state programs at CDC-recommended levels.[5]

Tobacco Control Program Funding

The Solution

Comprehensive, adequately-funded tobacco control programs reduce tobacco use and related diseases, resulting in lower health care costs. To help states implement effective tobacco control programs, the CDC laid out its evidence-based recommendations for state investment in tobacco control in the recently-updated edition of *Best Practices for Comprehensive Tobacco Control Programs*.[6] The CDC recommends that comprehensive tobacco control programs consist of the following five components:

1. **State and community interventions**, which include programs and policies that encourage and support individuals to make behavior choices consistent with tobacco-free norms.
2. **Statewide health communication interventions**, which deliver strategic, culturally-appropriate and high-impact messages about the health impact of tobacco use and promote cessation resources.
3. **Cessation interventions**, which focus on promoting health systems change, expanding insurance coverage of proven cessation treatments and supporting state quitline capacity.
4. **Surveillance and evaluation**, which monitor attitudes, behaviors and health outcomes over time, as well progress on overall program goals.

5. **Infrastructure, administration and management**, which ensure sufficient capacity for program sustainability, efficacy and efficiency to plan their strategic efforts, provide strong leadership and foster collaboration between the state and local tobacco control communities and make available an adequate number of skilled staff to provide program oversight, technical assistance and training.

Funding statewide tobacco control programs as outlined in the CDC's best practices guide and at CDC-recommended levels will result in many fewer tobacco users and increase lives saved from premature tobacco-related deaths.

The American Cancer Society Cancer Action Network (ACS CAN) challenges states to combat tobacco-related illness and death by sufficiently funding comprehensive tobacco control programs at CDC-recommended levels or above; implementing strategies to continue that funding over time; and applying the specific components delineated in the CDC's best practices guide. When considering tax increases on cigarettes and other tobacco products, states should always dedicate a portion of the funds to state tobacco prevention and cessation programs.

Did You Know?

Funding tobacco prevention and cessation programs is good for a state's bottom line. California, the state with the nation's longest-running tobacco control program, has reduced lung and bronchus cancer rates four times faster than the rest of the United States.[7] From 2009 to 2015, smoking among North Dakota's high school students fell by 48 percent, from 22.4 percent to 11.7 percent.[8] In Florida, the high school smoking rate fell to just 6.9 percent in 2015, far below the national rate.[9] All of these states have made significant, long-term investments in their state's tobacco control programs.

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

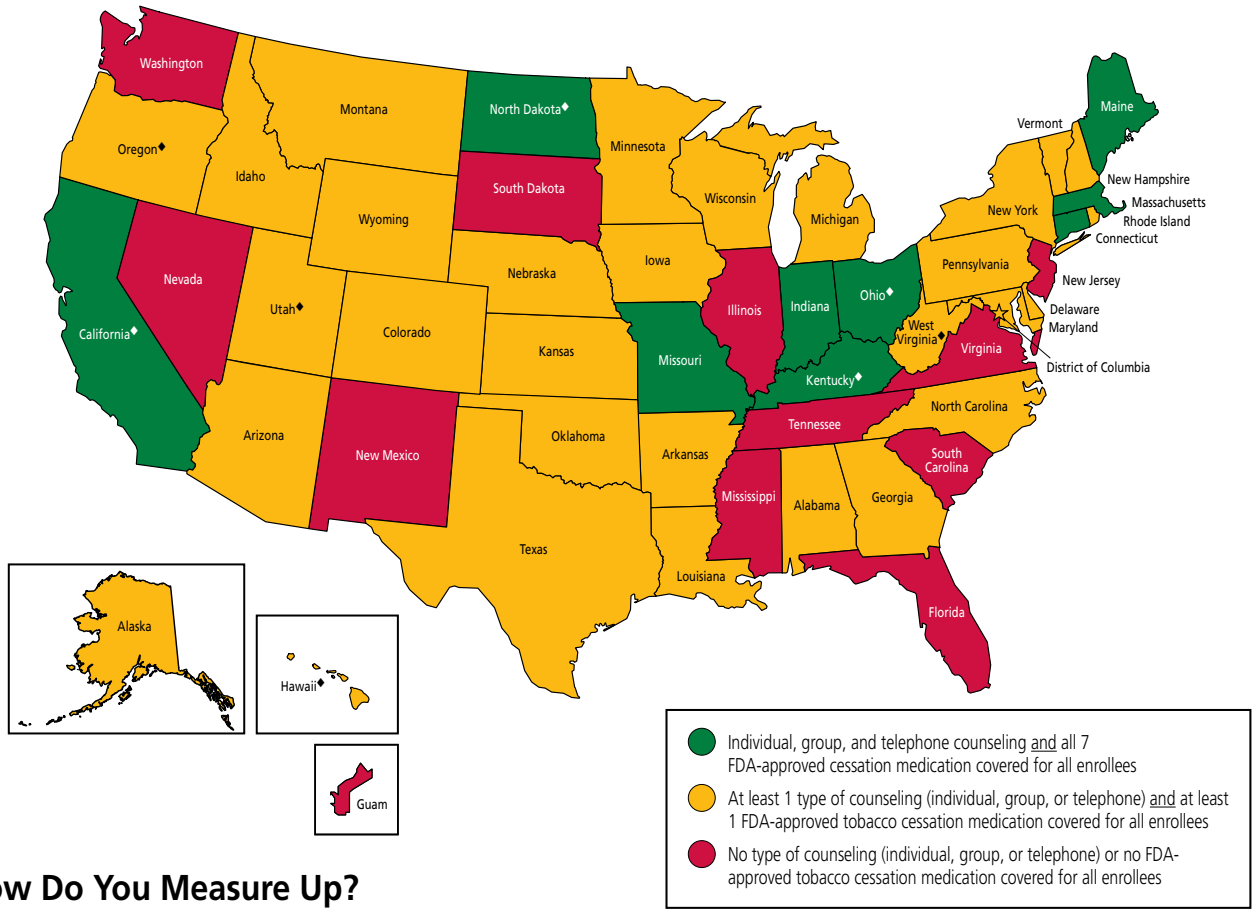
State Tobacco Control Funding – FY 2017

State	State Tobacco Prevention Funding Allocations (FY17)*	CDC Recommended Spending	Tobacco Prevention Spending % of CDC Recommended
North Dakota	$9.9 million	$9.8 million	100.9%
Alaska	$9.5 million	$10.2 million	93.0%
California	$195.7 million	$347.9 million	56.2%
Oklahoma	$23.5 million	$42.3 million	55.6%
Wyoming	$4.2 million	$8.5 million	49.4%
Maine	$7.8 million	$15.9 million	49.1%
Delaware	$6.4 million	$13.0 million	48.9%
Montana	$6.4 million	$14.6 million	44.1%
Colorado	$23.2 million	$52.9 million	43.8%
Minnesota	$22.0 million	$52.9 million	41.7%
Vermont	$3.4 million	$8.4 million	40.2%
Utah	$7.5 million	$19.3 million	38.9%
Hawaii	$5.3 million	$13.7 million	38.6%
South Dakota	$4.5 million	$11.7 million	38.5%
Florida	$67.8 million	$194.2 million	34.9%
Mississippi	$10.7 million	$36.5 million	29.4%
Arizona	$18.4 million	$64.4 million	28.6%
Oregon	$9.8 million	$39.3 million	25.0%
New Mexico	$5.7 million	$22.8 million	24.9%
Arkansas	$9.0 million	$36.7 million	24.5%
Maryland	$10.6 million	$48.0 million	22.0%
New York	$39.3 million	$203.0 million	19.4%
Idaho	$2.9 million	$15.6 million	18.4%
Iowa	$5.2 million	$30.1 million	17.4%
Nebraska	$2.6 million	$20.8 million	12.4%
Louisiana	$7.0 million	$59.6 million	11.7%
West Virginia	$3.0 million	$27.4 million	11.1%
Ohio	$13.5 million	$132.0 million	10.3%
Pennsylvania	$13.9 million	$140.0 million	9.9%
South Carolina	$5.0 million	$51.0 million	9.8%
District of Columbia	$1.0 million	$10.7 million	9.3%
Wisconsin	$5.3 million	$57.5 million	9.2%
Virginia	$8.2 million	$91.6 million	9.0%
Indiana	$5.9 million	$73.5 million	8.0%
Illinois	$9.1 million	$136.7 million	6.7%
Massachusetts	$3.9 million	$66.9 million	5.8%
Kentucky	$2.4 million	$56.4 million	4.2%
Texas	$10.2 million	$264.1 million	3.9%
Washington	$2.3 million	$63.6 million	3.6%
Nevada	$1.0 million	$30.0 million	3.3%
Kansas	$847,041.00	$27.9 million	3.0%
Rhode Island	$375,622.00	$12.8 million	2.9%
Alabama	$1.5 million	$55.9 million	2.7%
Georgia	$1.8 million	$106.0 million	1.7%
Tennessee	$1.1 million	$75.6 million	1.5%
Michigan	$1.6 million	$110.6 million	1.4%
North Carolina	$1.1 million	$99.3 million	1.1%
New Hampshire	$125,000	$16.5 million	0.8%
Missouri	$109,341	$72.9 million	0.1%
Connecticut	$-	$32.0 million	0.0%
New Jersey	$-	$103.3 million	0.0%
Guam***			N/A

Source for Tobacco Prevention Funding, unless otherwise noted: Robert Wood Johnson Foundation, Campaign for Tobacco-Free Kids, American Cancer Society Cancer Action Network, American Heart Association, American Lung Association, and Americans for Nonsmokers' Rights. *Broken Promises to Our Children: A State-by-State Look at the 1998 State Tobacco Settlement 18 Years Later.* December 2016. Available at http://www.tobaccofreekids.org/microsites/statereport2017/
Source for Funding Recommendations: Centers for Disease Control and Prevention (CDC). *Best Practices for Comprehensive Tobacco Control Programs - 2014*. Atlanta, GA: U.S. Department of Health and Human Services, CDC, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.
*Only state government allocations are included in this chart.
**Source for IL funding: IL Public Act 099-0491. Available at http://www.ilga.gov/legislation/publicacts/99/PDF/099-0491.pdf.
***Data for Guam provided by local ACS CAN staff.

Tobacco Cessation Services In Medicaid

Medicaid Coverage of Tobacco Cessation Treatments (Traditional Medicaid)



How Do You Measure Up?

Source unless otherwise noted: Singleterry J, Jump Z, DiGiulio A, et al. State Medicaid Coverage for Tobacco Cessation Treatments and Barriers to Coverage – United States, 2014-2015. *MMWR* 2015; 64(42): 1194-9. Updates provided through correspondence with the American Lung Association.
*Coverage in only some plans or only for pregnant women does not count as coverage for all enrollees.
♦ Legislative or regulatory changes made in 2017

The Challenge

Public health experts have long supported proven strategies to prevent children and adults from using tobacco products and to help current tobacco users quit. But quitting isn't easy. Among all current U.S. adult cigarette smokers, nearly seven out of every 10 (68 percent) reported in 2015 that they wanted to quit completely.[1]

Medicaid beneficiaries have a smoking rate that is more than 50 percent higher than the overall adult smoking rate and more than double that of individuals with private insurance – 29 percent of adult Medicaid beneficiaries smoke, compared with 17 percent of adults overall and 13 percent of adults with private insurance.[2] Despite this high smoking rate, in 2013, only 23 percent of Medicaid enrollees who smoked received cessation

medications.[3] All tobacco users, including those enrolled in Medicaid, need access to a range of treatments to find the most effective cessation tools for them. Research shows that the most effective tobacco cessation treatments combine cessation counseling and medications approved for that purpose by the Food and Drug Administration (FDA).

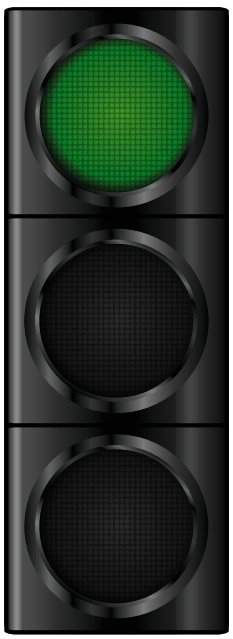
While Medicaid programs in all 50 states and the District of Columbia provide access to some tobacco cessation coverage, many gaps in coverage exist. Currently, only nine states – California, Connecticut, Indiana, Kentucky, Ohio, Maine, Massachusetts, Missouri and North Dakota – provide comprehensive tobacco cessation coverage in Medicaid that includes individual, group and telephone counseling and all seven FDA-approved tobacco cessation medications.

Even when state Medicaid programs cover cessation services, they often put procedures in place that limit a patient's access to the medication and counseling they need to quit. When tobacco users have access to more cessation medication and counseling options they are more likely to be able to take advantage of proven cessation services.

The Solution

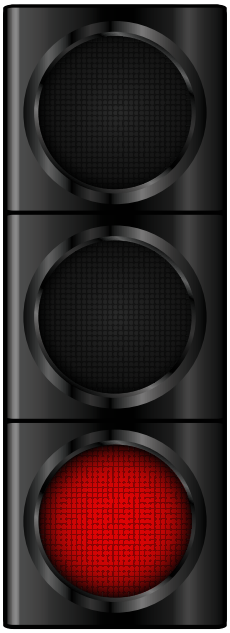
As of April 2017, federal law requires Medicaid expansion plans, marketplace plans on state or federal health insurance exchanges and most private plans, including employer-offered plans, to cover without any cost-sharing, tobacco use screening and cessation services. "Grandfathered plans" created before the existing health care law was signed are exempt. States are incentivized to cover tobacco cessation and other preventive services in traditional Medicaid through an increase in the federal matching rate. Given the great need for cessation services in the Medicaid population, the American Cancer Society Cancer Action Network (ACS CAN) advocates that

Comprehensive Cessation Benefits Should Include Coverage for:



- Individual counseling
- Group counseling
- Phone counseling
- NRT Gum
- NRT Patch
- NRT Lozenge
- NRT Inhaler
- NRT Nasal Spray
- Bupropion
- Varenicline

A Comprehensive Cessation Benefit Poses No Barriers to Accessing Services:



- Co-payments
- Prior Authorization Requirements
- Limits on Treatment Duration
- Yearly or Lifetime Dollar Limits
- "Stepped Care" Therapy
- Counseling Required for Medications

Tobacco Cessation Services In Medicaid

Success Story

During the 2017 legislative session, Kentucky passed a law to require all Kentucky insurers, including Medicaid and private insurers, to cover the treatments recommended by the United States Preventive Services Task Force (USPSTF) for tobacco cessation, including all seven Food and Drug Administration (FDA)-approved medications and all three forms of counseling. This coverage is required without cost-sharing or prior authorization. Prior to this law, many Kentucky insurers imposed complicated barriers such as step therapies and prior authorizations, making it difficult for individuals to access the services they need to quit tobacco. No Medicaid Managed Care Organization (MCO), a third-party administrator of Medicaid health benefits and services, covered any form of cessation counseling before now.

Thanks to the efforts of a broad coalition of health organizations, advocates and volunteers, as well as legislative leadership from Senator Julie Raque Adams, the measure passed both the Kentucky House and Senate with overwhelming bipartisan support. This law will ensure that all Kentuckians on Medicaid or private insurance have access to proven cessation treatment, without barriers, when they try to quit.

Medicaid programs ought to provide this benefit equal to what is required in the private market. All insurance plans, including state Medicaid programs, should provide a comprehensive cessation benefit that covers individual, group, and telephone-based counseling and all FDA-approved tobacco cessation medications without cost-sharing or other barriers to accessing care. In addition, state and local governments can use tobacco tax revenue to increase access to and promote cessation services. Covering tobacco cessation services for all tobacco users in all health plans, especially those enrolled in Medicaid, is critical to reducing tobacco use, saving lives and ultimately saving money.

In addition to providing all FDA-approved tobacco cessation medications and all three types of counseling, ACS CAN advocates that state Medicaid programs reimburse state quitlines for the telephone counseling services they provide to their patients. Ensuring that Medicaid covers phone counseling provided by quitlines increases the capacity of a state's quitline and provides an added layer of sustainability, insulating it from state budget cuts. Additionally, state Medicaid dollars receive a federal match, so allocating Medicaid dollars to reimburse quitlines, means more funding for this vital service.

Healthy Eating and Active Living Environments

15th Edition

Why are healthy eating and active living environments important for cancer prevention?

Research shows that achieving and maintaining a healthy weight, eating a healthy diet and being physically active reduces the long-term risk of cancer and may help reduce the risk of recurrence and improve quality of life for cancer survivors. That is why the American Cancer Society Cancer Action Network (ACS CAN) is focused on changing policies to create environments that make it easier for people to consume a healthy diet and lead a more physically active lifestyle.

The Challenge

For the majority of Americans who do not use tobacco, the greatest behavioral risk factors for cancer are weight, diet and physical activity levels. In fact, 20 percent of all cancers are tied to poor nutrition, physical inactivity, excess weight and excess alcohol consumption.[1] Excess weight increases the risk for many cancers in both men and women, including cancers of the colon and rectum, kidney, pancreas, liver, gall bladder, and thyroid, as well as for meningioma, gastric cardia, multiple myeloma, adenocarcinoma of the esophagus, and cancers of the uterus, ovary and breast (postmenopausal) in women.[2]

While rates of excess weight and obesity have begun to level off over the past decade, currently 69 percent of adults[3] and 32 percent of young people ages 2 - 19[4] are overweight or obese. These high rates of childhood obesity and excess weight are particularly troubling because children who are overweight and obese are much more likely to remain so as adults. Increasing opportunities for physical activity and healthy eating are critical for cancer prevention.

The Solution

The American Cancer Society's Guidelines on Nutrition and Physical Activity for Cancer Prevention recommend that individuals:

- Achieve and maintain a healthy weight;
- Adopt a physically active lifestyle;
- Consume a healthy diet with an emphasis on plant-based foods, like whole grains, legumes, fruits and vegetables; and
- Limit consumption of alcoholic beverages.[5]

The guidelines also recommend that public, private and community organizations work collaboratively at all levels of government to implement policy and environmental changes that:

- Increase access to affordable, healthy foods in communities, schools and workplaces;
- Decrease access to and marketing of foods with low nutritional value, particularly to youths; and
- Provide safe, enjoyable and accessible places for physical activity in schools, workplaces and local communities.[6]

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

Various state and local policies working together will create an environment that makes the healthy choice the easy choice.

Funding for Research and Programs: Protect and increase government investments in policies and interventions to reduce overweight and obesity, improve nutrition, increase physical activity and reduce inactivity, with the ultimate goal of reducing cancer incidence and mortality.

School Nutrition: Establish, maintain, strengthen and implement evidence-based nutrition standards for all foods and beverages sold, served or marketed in schools, before, during and after regular school hours.

Healthy Eating and Active Living Environments

Broad Range of Policies Required to Create Healthy Eating and Active Living Environments

Physical Education and Physical Activity in Schools: Increase the quantity and improve the quality of K-12 physical education, supplemented by additional opportunities for school-based physical activity.

Active Transportation and Recreation: Provide funding for infrastructure and programs such as Safe Routes to School and Complete Streets to build in additional opportunities for physical activities. This also includes establishing shared-use agreements for community members to share physical activity facilities.

Sugary Drink Taxes: Increase the price of sugary drinks relative to healthy beverages through excise taxes, and dedicate the revenue to healthy eating and active living interventions and other public health initiatives.

Healthy Public Places: Establish nutrition guidelines for foods and beverages that are provided or sold in government buildings and other public service venues to increase access to healthy options.

Food Marketing: Reduce the marketing of unhealthy foods and beverages, particularly to young people, through setting, and encouraging companies to comply with strong nutrition standards.

Healthy Food Access and Affordability: Enact policies and incentives to encourage retailers to offer healthy food and beverage options and locate healthy food retailers in underserved areas.

Healthy Restaurant Meals: Improve the nutritional quality of food and beverage options in restaurants, particularly for children's meals, and promoting healthier options.

Insurance Coverage for Weight Management: Provide access to adequate insurance coverage for recommended prevention, screening, diagnosis and treatment of overweight and obesity for both cancer prevention and survivorship. As a preventive service, access to these services should be provided without cost sharing. Cancer survivors should also have access to nutrition and physical activity support services by a qualified health professional both during and after treatment.

The Problem with Preemption

While some states and localities have advanced policies aimed at promoting healthier foods and beverages, other states have passed laws that would prevent localities within their state from doing so. It is important for localities across the country to have the opportunity to put their own innovative initiatives in place that have the potential to improve nutrition, increase physical activity and promote a healthy weight in order to promote the health of residents and reduce their long-term risk of cancer and other chronic diseases. Just as is the case with tobacco control, ensuring local control exists to pass laws that are stronger than state and federal laws is essential for good public health. This year in New Mexico's House of Representatives, a last minute substitution to a massive tax overhaul bill included a change to prohibit municipalities from imposing taxes on food or beverages. The change would have barred local governments from taxing sugar-sweetened beverages, which state lawmakers knew was a real prospect in Santa Fe. The bill passed the House unanimously before moving to the Senate.

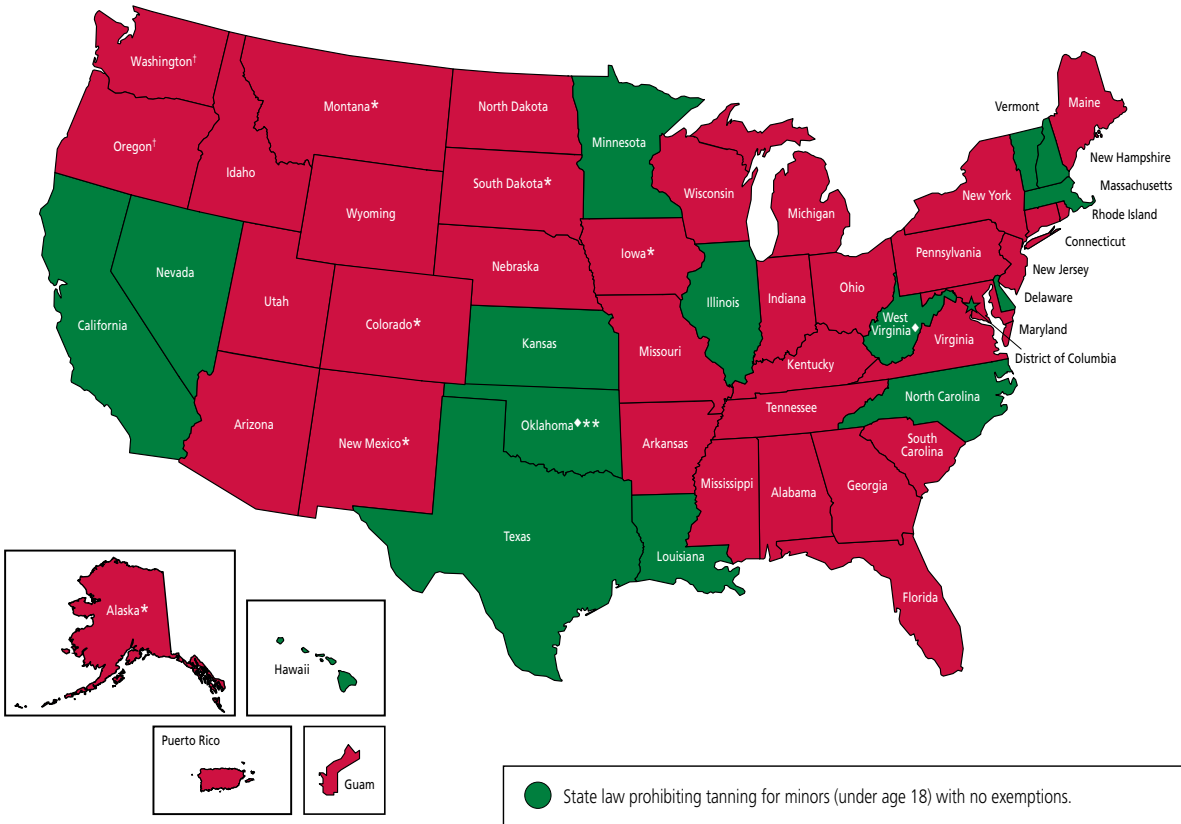
ACS CAN worked with partners to educate members of the Senate on the detrimental impact preemption would have on local efforts, which often provide state lawmakers with valuable lessons about policy implementation and efficacy. We garnered sufficient support to remove preemption in the Senate bill. Before the preemption was removed, however, the bill died in committee.

Did you know?

In addition to increasing the risk of cancer and other chronic diseases, overweight and obesity place a huge financial burden on the health care system in the United States. Obesity alone costs the nation $147 billion in direct medical costs each year, approximately half of which is paid for by federal and state governments through Medicaid and Medicare and the other half by individuals and private payers.[7]

Indoor Tanning

State Laws Prohibiting Minors from Using Tanning Devices



How Do You Measure Up?

Sources: Health Policy Tracking Service & Individual state bill tracking
† There is no medical indication for the use of a tanning device in the diagnosis or treatment of a disease.
♦ Legislative or regulatory changes made in 2017
** Effective Nov. 1, 2017

The Challenge

Skin cancer is the most commonly diagnosed cancer in the United States and rates have continued to rise over the past 30 years.[1] In 2017, an estimated 95,400 cases of invasive skin cancer (the majority being melanoma) will be diagnosed. Millions more cases of basal and squamous cell skin cancers will also be diagnosed.[2] In total, more than 13,600 men and women are expected to die of skin cancer this year in the United States, and over 9,700 of those deaths will be from melanoma.[3]

Exposure to UV radiation, through sunlight and indoor tanning devices, is the most avoidable risk factor for skin cancer. In fact, the effects of UV radiation are so harmful that they have drawn local, state, national and international attention resulting in additional restrictions being placed on the use of tanning devices, especially among young people under the age of 18. The World Health Organization's International Agency for Research on Cancer (IARC) categorizes tanning devices into its highest

Indoor Tanning: Myth vs. Fact

Myth:
UV rays are important for producing Vitamin D, an essential nutrient for good health.

Facts:
- Vitamin D is an essential vitamin needed for bone health.
- While the amount of UV light needed to produce enough vitamin D is minimal, it still puts a person at risk for skin cancer.
- Supplements and food are the preferable sources for vitamin D over UV radiation.*

Facts:
- There is no medical reason to use a tanning device in the diagnosis or treatment of a disease.
- When medical treatment is deemed appropriate, doctors may use phototherapy for medical skin conditions, employing an FDA-approved medical device that emits concentrated UV radiation.

Myth:
Tanning devices are sometimes used for medical purposes.

* American Cancer Society. "Cancer Prevention and Early Detection Facts and Figures 2015". Atlanta: American Cancer Society; 2015.

Missed Opportunity

For the last two years the Mississippi Legislature has failed to hear the concerns of a coalition of local, state and national partners laboring to protect teens from the dangers of indoor tanning devices. Serving as a key spokesperson is Gayle Wicker, wife of U.S. Sen. Roger Wicker and a long-time member of the Congressional Families Cancer Prevention Program. Mrs. Wicker is a conservative mother of three who believes everyone has a role in protecting children. "Sometimes as a parent, it's easier to say 'You cannot do this because you'll actually be breaking the law' and so to me, a law protecting Mississippi's teens from the dangers of indoor tanning devices would be something parents could use to help keep their kids safe." Despite support from key legislators, strong media coverage, and the testimonies of Mrs. Wicker and skin cancer survivors, the bill was never brought up for a vote. ACS CAN advocates will continue to push the Mississippi Legislature to pass this lifesaving bill.

Indoor Tanning

Volunteer Story

My mother would take me to a tanning salon three to four times a week when I was 14. I wanted to tan because my friends were doing it. It was the cool thing to do — the dumbest thing I ever did. Our parents would take us because we weren't old enough to drive. As I got older, I started to use indoor tanning devices five to six times a week, and I'm ashamed and embarrassed to admit that I would sometimes tan twice a day to get dark enough for a trip or to have a "base tan" so I wouldn't "burn."

At age 32, I was diagnosed with melanoma. I even tanned before I got my stitches out and received my cancer diagnosis. Then two years later, at age 34, I was diagnosed with metastatic melanoma. I had stopped indoor tanning, but the damage was done. During my treatment, my mom would say, "If I had known how dangerous indoor tanning was, I would have never taken you."

Traci Stackhouse, Edmond, Oklahoma

cancer risk category – "carcinogenic to humans."[4] In 2014, the Food and Drug Administration (FDA) reclassified tanning devices to a higher risk category as a class II device, resulting in improved safety measures and regulatory requirements for manufacturers, including warning labels on every device.

Despite the serious risks, misconceptions about indoor tanning exist, due in large part to misleading advertising and health claims put forth by the tanning industry.[5,6] Young people are especially susceptible to the tanning industry's manipulative marketing tactics aimed directly at this impressionable group (i.e. back-to-school, prom and homecoming specials).[7] This is a serious cause for concern, as teens continue to tan at high rates despite the risks.

The most recent data indicates that one in nine high school girls used a tanning device, with numbers increasing to one in six high school girls by their senior year.[8] Studies show using an indoor tanning device before the age of 35 increases the risk of melanoma by 59 percent, squamous cell carcinoma by 67 percent and basal cell carcinoma by 29 percent.[9,10] Among teens who tan, 58 to 75 percent report at least one sunburn within the past year, further increasing their risk of developing skin cancer.[11,12] Risk for melanoma increases with the number of total hours, sessions and years that indoor tanning devices are used.[13,14,15] Melanoma is currently the second most common cancer among females aged 15-29 and the second most common cancer among females aged 25-29.[16]

The Solution

Age restriction laws that prohibit the use of indoor tanning devices for individuals under the age of 18 are effective in deterring minors from using tanning devices and can help to reduce skin cancer incidence and mortality rates across the country.[17,18,19,20] Conversely, research has found that parental consent laws are not sufficient in effectively deterring minors from using tanning devices.[21,22,23,24,25] Therefore, to protect young people from the harmful effects of UV radiation, laws should be passed that prohibit individuals under 18 from using tanning devices, without exceptions. With usage rates increasing as teens get older, it is critical to protect all minors under the age of 18, not just younger teens. States need to ensure enforcement measures and oversight mechanisms are in place to guarantee that young people are not gaining access to these harmful devices.

Did You Know?

- A recent Centers for Disease Control and Prevention (CDC) study following a group of 61.2 million young people in the United States, found that restricting indoor tanning among minors younger than 18 years old was estimated to prevent 61,839 melanoma cases, prevent 6,725 melanoma deaths and save the United States $342.9 million in treatment costs over the group's lifetime.[26]

- A recent Minnesota Department of Health survey found that, since the state's law to prohibit minors under the age of 18 from using indoor tanning devices was implemented, the number of 11th grade white females that used indoor tanning devices decreased over 70 percent – from 33 percent in 2013 to 9 percent in 2016.[27]

Success Story

In the 2017 legislative session, West Virginia passed a law to prohibit those under the age of 18 from using indoor tanning devices, protecting young people from the cancer-causing UV rays emitted by indoor tanning devices. Delegate Amy Summers sponsored the legislation and was a powerful voice in support of the bill. Being a melanoma survivor and nurse, and having lost her brother at a young age to melanoma, she has been a passionate ally in efforts to reduce the risk of skin cancer among young people in West Virginia. The American Cancer Society Cancer Action Network Government Relations Director, Juliana Frederick Curry, is also a melanoma survivor who worked tirelessly to pass this bill. With the added help of partners and ACS CAN volunteers, the legislation gained overwhelming bi-partisan support. The bill was signed into law and will take effect in July of 2017.

Exposure to UV radiation, through sunlight and indoor tanning devices, is the most avoidable risk factor for skin cancer.

Access to Care

In 2017, the American Cancer Society Cancer Action Network (ACS CAN) is focused on improving access to care through state policies that improve transparency of health plan information for consumers; ensure adequate access to the providers cancer patients need; improve access to cancer preventive services, make oncology medications more affordable; and increase access to Medicaid.

ACCESS TO PRESCRIPTION DRUGS

The Challenge

When someone is diagnosed with cancer, prescription drugs are generally a key part of the treatment regimen. Consumers need to choose a health plan based, in part, on the plan's prescription drug coverage, but not all health plans cover every prescription drug. Unfortunately, due to a lack of transparent drug coverage and cost-sharing information, patients often have to buy plans without knowing whether their drug is covered or affordable. It is especially difficult for cancer patients to determine coverage for drugs provided under their medical benefits because they are often not included on lists of drugs covered by their insurance, known as formularies. Even if patients could easily find drug coverage and cost-sharing information, affordability can be an issue for some patients. Research shows that many plans assign a high cost-sharing responsibility to cancer medications, leaving patients with few plan options that cover their cancer drug at a cost they can afford.[1]

Access to Prescription Drugs

Affects of Lack of Transparency and High Cost-Sharing

Transparency

Wendy

Wendy recently received a cancer diagnosis and is shopping for a health plan.

She searches available plans but the plans don't disclose covered drugs, drug costs or cost-sharing information.

After Wendy purchases a plan, she discovers the drug her doctor says she needs is not covered by the insurance plan she chose.

High Cost-Sharing

Tom

Tom's generally healthy. His plan covers his blood pressure prescription with a low, $10 copay.

When diagnosed with cancer, the drug prescribed for his treatment is expensive, with high cost-sharing for Tom.

Tom leaves the pharmacy without his prescription because of the high cost.

Success Story

Arkansas Passes Oral Chemotherapy Fairness Law

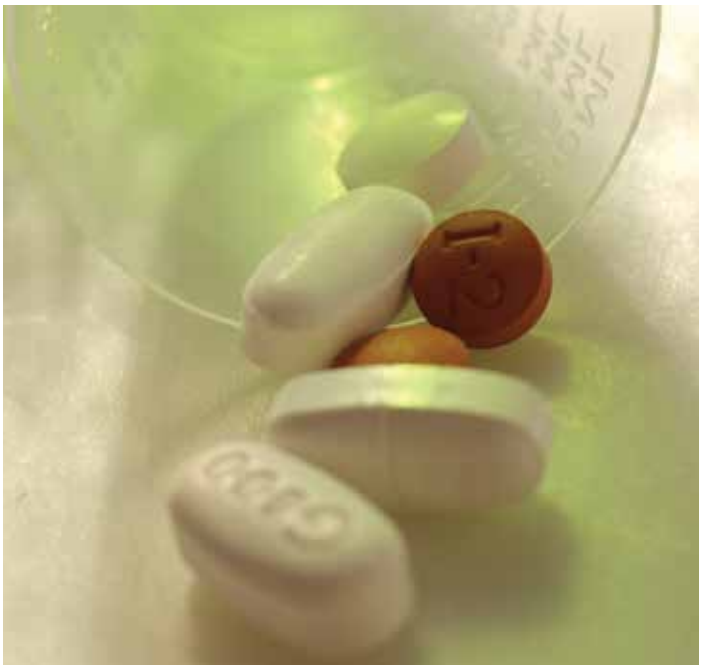
This year, Arkansas joined 42 states and the District of Columbia in passing oral chemotherapy fairness legislation to improve affordability for oral chemotherapy medications.

ACS CAN staff and volunteers worked with partners at Susan G. Komen and the Leukemia and Lymphoma Society to advocate that decisions around which chemotherapy is best for a patient should be based on their physician's direction, not the direction or design of their insurance plan. Thanks to the leadership of Representative Deborah Ferguson, Representative Joe Jett, Representative Greg Leding, and Senator Greg Standridge, the oral chemo bill passed during the 2017 legislative session with unanimous support in both the House and the Senate. The governor signed the bill into law during a signing ceremony on March 30. Thanks to this work, cancer patients in Arkansas who need oral chemotherapy will have the same access to it as they would for intravenous chemotherapy.

The Solution

Examples of state policies to improve access to prescription drugs (examples of each type of legislation can be found at www.acscan.org/billexamples):

- Legislation/regulation that requires health insurers to make publicly available all drugs covered under each plan, including those administered in a provider's office, and the dollar cost an enrollee would have to pay for each drug.[2]
- Legislation/regulation that requires health insurers to offer a certain number of plans that only apply a reasonable flat dollar copayment to covered prescription drugs, even if the deductible is not yet met.
- Legislation/regulation that would limit the monthly amount a patient pays through copays or coinsurance applied to prescription drugs per prescription.
- Legislation/regulation that would prohibit insurers from making changes to a plan's drug coverage that would impact a patient's access, such as removing drugs from the formulary or changing cost-sharing in the middle of a plan year.
- Legislation that would require insurers to cover oral chemotherapy medication at a cost no greater than what a patient would pay for intravenous (IV) chemotherapy medication under their health plan.



Access to Care

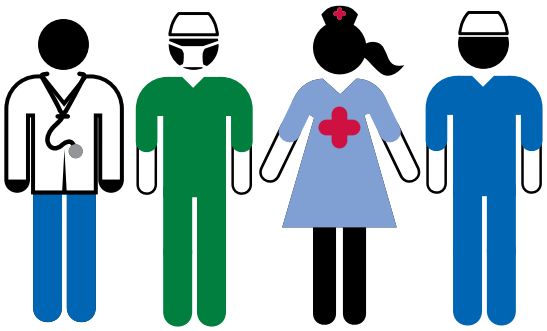
ACCESS TO CANCER CARE PROVIDERS

Cancer patients often require highly specialized care to treat their specific form of cancer. When patients visit a specialist who is not included in their plan's coverage network, their health insurance plan may pay for little or none of the cost of that care. In order to lower premiums, some insurance companies offer products that limit the range of doctors and specialists available—a practice that results in what are known as "narrow networks."

ACS CAN conducted a study that found it is very difficult for cancer patients to accurately identify which marketplace plans cover their oncologist based on the information health plans provide during open enrollment.[3] In addition, among the plans reviewed by ACS CAN in this study, 43 percent offered no out-of-network coverage. Plans that have narrow networks or no coverage for out-of-network providers leave cancer patients vulnerable to higher costs and surprise billing.

As cancer care becomes more specialized, it is imperative that patients have access to the oncology providers best equipped to deliver their care. The first step in ensuring provider access is making provider network information available and transparent for patients shopping for a health plan. Accurate provider network information allows patients to choose a health plan that covers their current cancer providers and hospital facilities. Of equal importance is provider network adequacy.

Provider Directory Accuracy



Require that insurers make provider network directories available to the public

Provide accurate and inclusive information about the provider's specialty

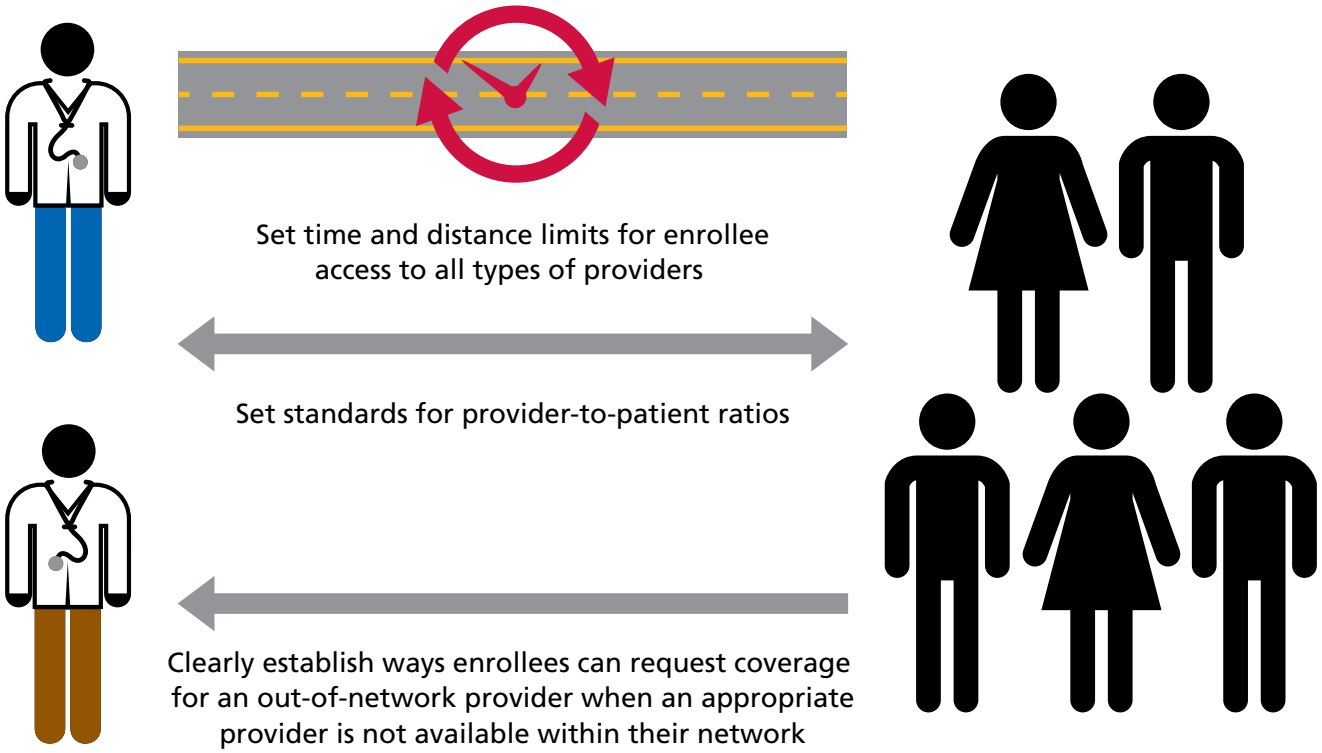
List hospitals with which providers are affiliated

Indicate whether provider is accepting new patients

When someone buys a health plan, and is subsequently diagnosed with cancer, that person should be assured coverage for appropriate cancer providers in their plan's network, without having to travel far distances or experience long wait times for an appointment. Finally, patients with health insurance should be protected from a practice known as surprise billing. This usually occurs when a patient seeks emergency services from a facility not included in their network, and is billed for the entire cost of the service. Surprise billing also occurs when a patient schedules a procedure at an in-network hospital or facility, and is, unbeknownst to them, treated by an out-of-network provider.

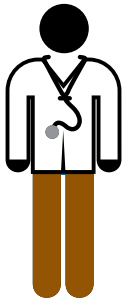
As cancer care becomes more specialized, it is imperative that patients have access to the oncology providers best equipped to deliver their care.

Network Adequacy



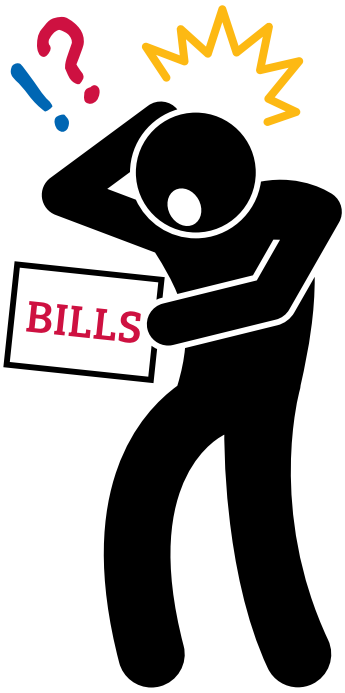
Access to Care

Protect Patients from Surprise Billing



Out-of-Network Doctor

Prohibit out-of-network providers from billing patients for excess costs when then patient did not consent or was not aware they were receiving out-of-network care



Emergency Care

Cost-sharing for emergency care should be billed to patient at in-network rates, regardless of where and from whom care was received

Success Story

This year, the Maine legislature passed L.D. 1557, a bill that will protect patients from surprise bills when they are treated at an in-network facility by an out-of-network provider. This legislation will ensure cancer patients only pay the anticipated in-network cost-sharing defined by their health plan, as long as they seek services at an in-network facility. This type of protection is particularly important to cancer patients, given the number of providers that contribute to their continuum of care. Specifically, cancer patients may utilize services from providers they never see, such as lab technicians or radiology analysts. L.D. 1557 was signed by Governor LePage and is effective on January 1, 2018.

Volunteer Story

In 2012, I was among dozens of advocates who attended the Florida Day at the Capitol event in Tallahassee and urged my legislators to support the Cancer Treatment Fairness Act. We talked about the importance of ensuring cancer patients had access to the most clinically appropriate treatment available, regardless of whether that treatment is delivered intravenously or taken in pill form. Much to my delight, the bill passed one year later and was signed by the governor.

Like most ACS CAN volunteers, I didn't get involved in the campaign to pass this bill thinking that I would eventually benefit. But as the statistics prove, a cancer diagnosis can happen to anyone – and, I am no exception.

A year after the bill passed, I was diagnosed with chronic lymphocytic leukemia (CLL). My treatment plan required a few different and very expensive drugs. As I continue my fight, I often wonder how things might have been different for me and my family had we not been successful in passing this law in Florida. Thankfully, that's not a reality I have to face.

Carol Tucker, Jacksonville, FL

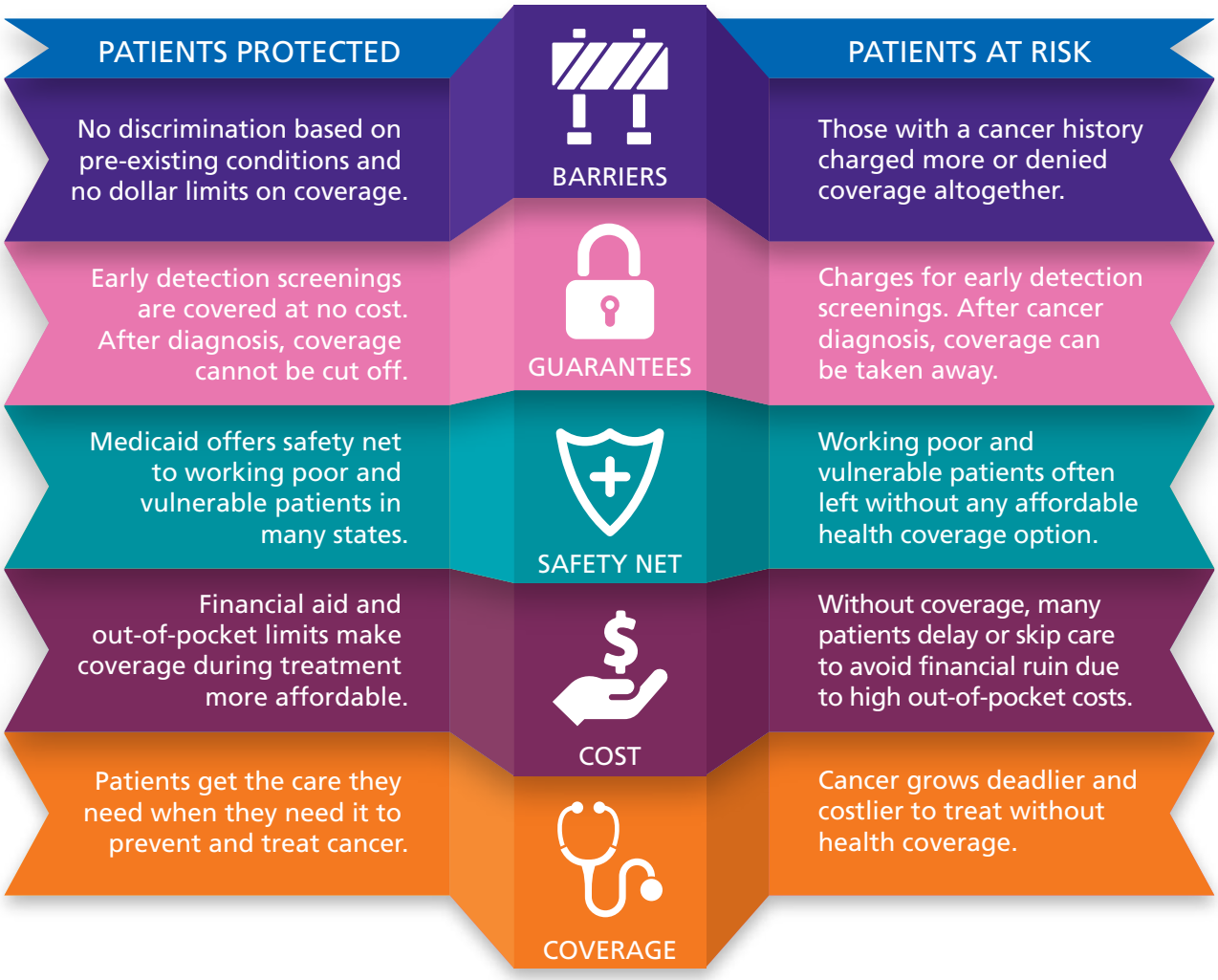
Carol Tucker started volunteering as part of the American Cancer Society's residential program, which involved walking door-to-door in her neighborhood asking for donations to support cancer patients. Over the years, she went on to serve as chair of the Florida Division board, be a part of the National Assembly and attend nearly every Day at the Capitol event in Tallahassee as well as Federal Lobby Day in Washington, D.C.

Access to Care

COVERAGE COUNTS IN THE CANCER FIGHT

Reducing the cancer burden depends on access to meaningful health coverage for all Americans. We cannot return to a health system that discriminates based on health history, blocks patients from lifesaving treatment or makes health coverage unaffordable.

That's why the American Cancer Society Cancer Action Network is urging Congress to keep patient protections in the health care law, while ensuring coverage is affordable. Any changes to the law should provide equal or better health insurance coverage of cancer prevention and treatment.



Access to Care: Increased Access to Health Coverage Through Medicaid

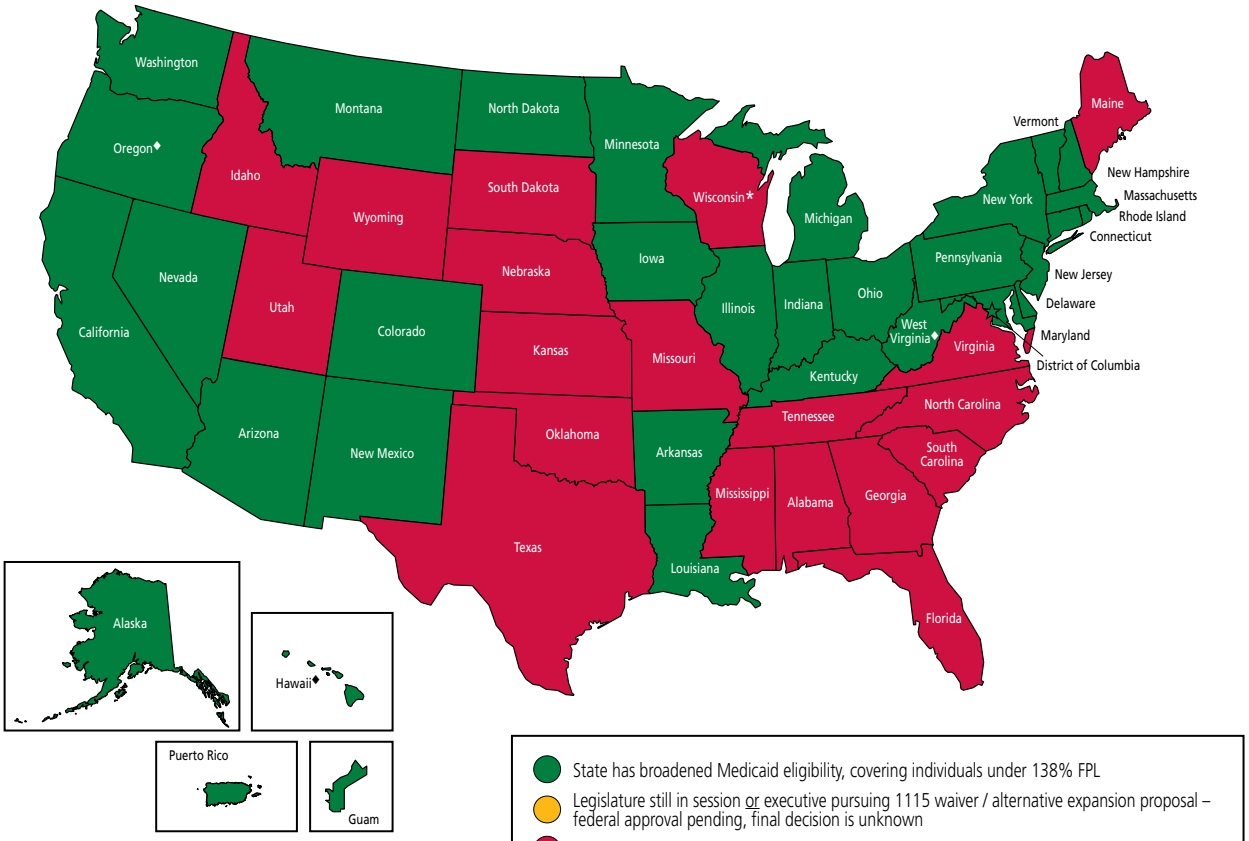
15th Edition

The Challenge

Evidence demonstrates that individuals with lower socio-economic status (income, education and insurance status) have higher cancer incidence and higher death rates.[4] Overwhelmingly, these populations have less access to quality and comprehensive health care coverage, including prevention and early detection services and treatment coverage.

Medicaid is the health insurance safety-net program for lower-income Americans. Currently, over 74 million people[4] – many of whom are cancer patients and survivors – rely on Medicaid for affordable health care coverage. States have broad flexibility in Medicaid to implement eligibility, coverage and cost-sharing policies that meet the diverse needs of their populations and satisfy state budgets. Thus, Medicaid programs vary widely state to state.

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



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

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

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

How Do You Measure Up?

Source: ACS CAN and Kaiser Family Foundation: New Estimates of Eligibility for ACA Coverage among the Uninsured
*State provides low income residents access to health care coverage, not consistent with the provisions of the federal health care law / ACA
As of July 1, 2017
♦ Legislative or regulatory changes made in 2017

Access to Care: Increased Access to Health Coverage Through Medicaid

Section 1115 Research and Demonstration Waivers: Flexibility in State Medicaid Programs

The Department of Health and Human Services (HHS) affords states the opportunity to test innovative or alternative approaches to health care coverage for their Medicaid populations through Section 1115 Research and Demonstration Waivers. HHS Secretary Tom Price and the Centers for Medicare & Medicaid Services (CMS) Administrator, Seema Verma, expressed their commitment to "providing states with more freedom to design programs that fit the needs of their Medicaid population."[8] The American Cancer Society Cancer Action network (ACS CAN) anticipates that 1115 Waivers will be one of the primary tools states use to pursue additional program flexibility.

ACS CAN has been actively involved in the review of 1115 Waivers, offering formal public comments at both the state and federal levels. Our comments have focused on the impact approaches, known as demonstration projects, could have on enrollees fighting cancer, cancer survivors and those individuals who might face a cancer diagnosis. We have emphasized that these alternative approaches should preserve access to care without creating barriers to coverage for Medicaid enrollees, especially cancer patients and survivors.

ACS CAN will continue to work closely with governors and state policymakers as they consider utilizing 1115 Waivers to test new approaches to providing care to low-income Americans. ACS CAN will strongly advocate for proposals that increase or preserve access to comprehensive, evidence-based treatment and prevention benefits; provide affordable coverage and include administratively simple processes for enrollees to gain or maintain eligibility for Medicaid.

Historically, the program has provided coverage to low-income children, pregnant women, seniors and the disabled. However, since 2014, states have had the option to increase eligibility to low-income adults earning less than 138 percent of the federal poverty level (about $16,643/year). This eligibility expansion has enabled over 14 million adults (nearly two-thirds of whom are working[6]) to obtain access to affordable, comprehensive health care coverage, making it possible for them to access a range of preventive and early detection services, diagnostic testing and cancer treatment therapies.[7] Such examples include services relating to inpatient and outpatient hospitals, early and periodic screening, diagnostic, and treatment, nursing facilities, home health, physicians, laboratory and x-ray tests, family planning, nurse midwives, transportation to medical care, and tobacco cessation counseling for pregnant women and more.

Federal and state policymakers are considering a number of Medicaid reform proposals that would significantly change the program, including changes to the federal financing of the program, modifying eligibility guidelines and eliminating or limiting access to benefits and services. These proposals have included increased out-of-pocket cost-sharing, penalties that could result in denying enrollees services, work requirements and waiving required Medicaid benefits (such as non-emergency medical transportation benefits).

The Solution

An estimated 2.3 million people ages 0-64 with a history of cancer will rely on the health care coverage provided by their state Medicaid program to help them fight and prevent recurrence of this disease.[9] In 2013 alone, 32 percent of pediatric cancer patients ages 0-19 had Medicaid as the payer at diagnosis.[10] The benefits and services provided by Medicaid span the cancer continuum – from prevention and early detection to diagnostic and treatment services through cancer survivorship or end-of-life care, all of which are important in the fight against cancer. Preserving Medicaid funding and eligibility is critical in that fight.

Medicaid Benefits and Services Necessary to Cancer Patients

Prevention	Early Detection	Diagnosis	Treatment	Survivorship	End-of-Life Care
• Tobacco control • Diet • Physical activity • Sun exposure • Alcohol use	• Colorectal cancer screening • Breast cancer screening • Cervical cancer screening	• Biopsy • Histological assessment • Pathology reporting • Tumor stage documented	• Chemotherapy • Hormone therapy • Pain management • Psychosocial care • Radiation • Surgery	• Surveillance • Psychosocial care • Management of long-term effects	• Hospice care • Palliation

Missed Opportunity

After several years with little meaningful action on Medicaid expansion in Kansas, the Alliance for a Healthy Kansas (the "Alliance") was formed in 2016, to build a grassroots and grasstops movement focused on advocating for the state expanding eligibility for KanCare (the state's fully privatized Medicaid program). ACS CAN has served as a leading member of the Alliance, which brought together dozens of community, health, religious, and patient advocacy organizations along with hospitals, chambers of commerce and other business groups. The Alliance held community forums and educational trainings around the state, resulting in thousands of Kansans being engaged and taking action in support of expansion. Subsequently, KanCare expansion became a major issue in many 2016 state legislative races, resulting in the election of a number of new state legislators, who vowed to support an expansion of KanCare. In the 2017 legislative session, a bill to expand KanCare passed both the Kansas House and Senate by large majorities. Grassroots support was backed up by polling from ACS CAN showing 82 percent of Kansas voters support expansion. Unfortunately, Governor Brownback vetoed the legislation. The Kansas House quickly took action to override the veto, but that effort fell three votes short.

Despite overwhelming opposition to the governor's veto, lawmakers were unable to get KanCare expansion passed again during the 2017 veto session. This is a huge missed opportunity for expanding access to care for 150,000 hard-working, low-income Kansans and ACS CAN along with its advocacy partners will continue to fight for KanCare expansion in 2018 and beyond.

Access to Care: Increased Access to Health Coverage Through Medicaid

Preserving the comprehensive benefits and services provided through state Medicaid programs allows millions of low-income, hard-working Americans to access primary care and preventive services that can stop some cancers from developing and detect many at earlier, more treatable stages. Timely and affordable access to diagnostic testing and cancer treatment therapies lowers the cost to treat the disease and improves rates of survival.[11,12] Finally, ensuring states have the funds to continue to provide these important benefits and services to the widest eligibility levels possible is critical in helping to reduce disparities and narrow the cancer incidence and mortality gap between those of higher and lower socio-economic status.

ACS CAN encourages state policymakers to support federal and state reform proposals that protect or expand the current Medicaid funding levels so patients have access to the crucial safety net the program provides. Additionally, we urge state policymakers to support Medicaid reform proposals that are aimed at improving or preserving access to quality, affordable and comprehensive health care coverage for low-income Americans, rather than limit those protections. As states consider reform proposals, we ask that policymakers weigh the impact such policies may have on individuals accessing health care coverage, particularly those individuals with cancer, cancer survivors, and those who will be diagnosed with cancer during their lifetime. Ensuring these groups have access to uninterrupted, affordable and meaningful coverage will reduce suffering and death from cancer.

Volunteer Story

I am a mother, wife, Clevelander and warrior in the fight against cancer. In October 2015, I lost my job due to a corporate downsize – at the time I was also the sole provider for my three young children, including my son who is on the autism spectrum. Because of my loss of income, I knew that paying for private coverage or COBRA would not be an affordable option, while searching for a new job. I was able to sign my children up for our state Medicaid program and during their enrollment, I was told that I was also eligible to receive Medicaid.

In December 2015, I noticed a hardening in my left breast and because I knew that I had coverage, I went to the doctor. After several tests were performed, we received the devastating news – I had Stage 3b breast cancer. I was told that I would be facing at least 18 months of cancer treatment. My doctors urged me to focus on my treatment, advising me to suspend my job search until I was healthy. Since my initial diagnosis, I have had 16 rounds of chemotherapy, a bilateral mastectomy, 33 rounds of radiation and three additional hospitalizations for infections. I am currently on an oral chemotherapy regimen, I have numerous follow up exams and tests and every day I struggle with side effects from my cancer treatment.

I believe that the only reason that I am able to tell my story, is because Ohio expanded eligibility for its Medicaid program – which allowed me to access the necessary diagnostic tests and quickly begin my cancer treatment. No one should have to battle a life-threatening disease like cancer, while also facing the anxiety of not having or losing health care coverage. Thankfully, as an Ohioan, I did not experience this anxiety.

Through my cancer battle, I have learned that I must not only fight for myself and my loved ones, but that I also have to fight to preserve and broaden access to health care for my fellow Ohioans and cancer patients and survivors across this country. Today, I am a better mother, a joy-filled newlywed, a loud and proud supporter of the Indians, Cavs, Buckeyes and Browns and vocal advocate for health care for every American.

Laurie Merges, Cleveland, OH

Access to Care: Medicaid Breast and Cervical Cancer Treatment Programs

15th Edition

The Challenge

In 2000, Congress authorized states to provide women diagnosed with breast or cervical cancer through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) access to comprehensive cancer treatment services through their state Medicaid program. (See pages 46 - 49 for more information on the companion screening program.) Every year, thousands of low-income, uninsured women access lifesaving health care and cancer treatment services because of this Medicaid eligibility option.

Over the past several years, many states have considered proposals that would eliminate funding for their state's breast and cervical cancer treatment program, based on the assumption that alternative coverage options provided through existing law would provide eligible women the care they need. However, because many states have not expanded access to their state Medicaid program for low-income adults, millions of women remain uninsured without adequate, affordable and comprehensive health care coverage. For many women, the coverage provided through the state's breast and cervical cancer treatment program is still the only option to receive the cancer treatment they need. Any attempts to eliminate this program by a state is a short-sighted approach that often results in increased long-term costs and threatens the lives of these vulnerable women. Women residing in 31 states that have expanded Medicaid eligibility also continue to face barriers to care and the need to preserve funding and eligibility for this cancer screening and treatment programs is critical.

The Solution

The treatment services provided by the state's Medicaid program allow women to start treatment faster, at earlier stages of cancer when the disease is easier and less costly to treat – and typically results in better outcomes for the patient.[13] It is imperative that state lawmakers protect eligibility and maintain adequate funding for the lifesaving breast and cervical cancer treatment eligibility option in Medicaid. The American Cancer Society Cancer Action Network (ACS CAN) strongly opposes any attempts to eliminate these programs in Medicaid as premature. Prior to considering any proposals that would reduce eligibility for breast and cervical cancer treatment coverage in the state's Medicaid program, ACS CAN encourages states to evaluate the demand and continued need for the services.

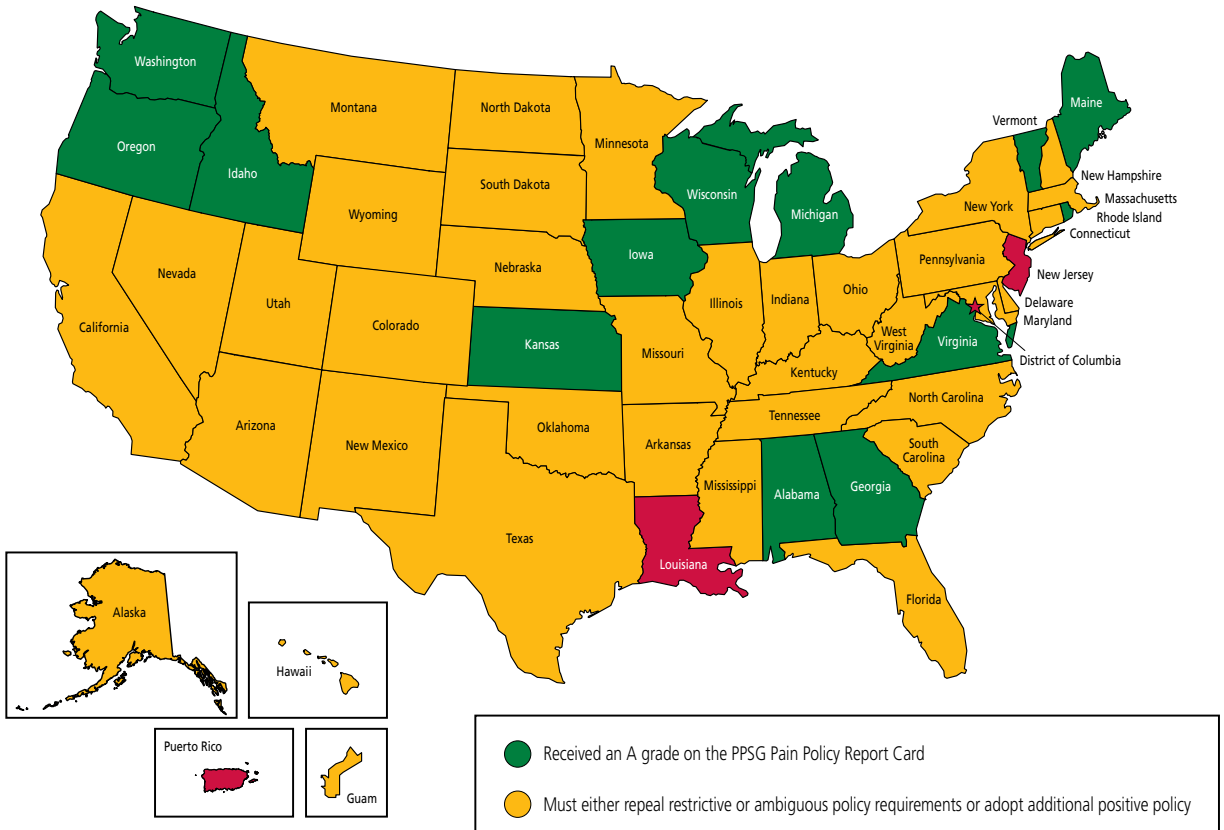
Cancer Pain Control:
Advancing Balanced State Policy

The Challenge

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

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

2017 Pain Policy in the States



How Do You Measure Up?

Source: Pain Policy Studies Group (PPSG) at the University of Wisconsin. For more information on this report card, please visit: www.acscan.org/painreportcard

Centers for Disease Control and Prevention Guideline for Prescribing Opioids

In 2016 the Centers for Disease Control and Prevention (CDC) issued a guideline on when and how opioid analgesics should be prescribed to treat pain. While still in draft form, the American Cancer Society Cancer Action Network (ACS CAN) provided feedback to CDC on the guideline, expressing concern for the lack of evidence supporting the recommendations it contained, as well as for its potential impact on cancer patients. The CDC guideline itself stresses that the recommendations are meant to be voluntary, but one of ACS CAN's major concerns was that these voluntary recommendations would be formalized by state legislatures and regulatory agencies and be given the mandatory force of law. Unfortunately, not only has this concern been realized with the passage of state laws based on the CDC guideline, but many of the caveats of the original guideline, for example, that it should not apply to cancer patients, have often been lost when written into state law. As states continue to seek policy changes regarding the medical use of opioids, it will continue to be important that state legislators fully understand the true intent and applicability of the CDC guideline, along with the lack of evidence on which it was based, to protect appropriate access by cancer patients and survivors to pain treatment.

ACS CAN has several specific concerns with the CDC guideline. First, the guideline recommends non-opioid treatments are preferred over opioids. For many cancer patients, opioids are the only effective means of alleviating pain and they play a critical role in pain management related to cancer. CDC's guideline sets a top recommended dosage limit. That decision should be left between doctor and patient based on a patient's unique circumstances and pain needs. The CDC also suggests limits on initial prescription lengths, which create a hardship for any patient needing medication for longer than the recommendation. The CDC does specifically exempt cancer patients, children and those in hospice care in its guideline, but those exemptions are often forgotten in proposed state legislation or regulation. Finally, despite ACS CAN's suggestion, cancer survivors and those no longer in active treatment are not protected under the CDC guideline and, as a result, often find themselves unable to access pain medication even though many still need it.

ACS CAN acknowledges the need for policy to curb opioid abuse and supports efforts to do so, but it must be done in a way that strikes a balance between curbing abuse and preserving patient access.

disparities continue to be documented in pain treatment showing restricted access in medically underserved and socioeconomically disadvantaged populations.

To keep patient pain under control, integrative pain care, which includes non-drug therapies along with medications, is encouraged. While not the only tool, opioid medications are recognized as a mainstay of treatment for moderate to severe cancer pain and can be a beneficial treatment for managing serious, persistent pain in carefully selected patients. These medications provide much-needed pain relief to patients, but their properties also make them subject to misuse and abuse. Death from overdoses of opioids, which includes prescription as well as illicit drugs, has become a major public health issue.

Pressure has mounted for policymakers at both the federal and state levels to address opioid misuse and curtail the use of these medications. While inappropriate and illegal use of opioids must be reduced, it is important to simultaneously preserve the

Cancer Pain Control:
Advancing Balanced State Policy

rights of patients who are suffering from pain. Unfortunately, policies that are targeted at reducing opioid use are sometimes developed and applied without distinguishing between legitimate and illegitimate uses, making it difficult for cancer patients and survivors to access needed pain medications, and sometimes subjecting them to stigmatization. In March of 2016, federal officials released a final opioid prescribing guideline that was based on weak evidence and failed to balance efforts to reduce inappropriate use with the needs of patients in legitimate pain. While well-intended, this guideline will likely impede access to pain relief for cancer survivors struggling with pain that limits their quality of life. In the current environment, it is more important than ever to create and promote balanced public policies that will make medications available to patients who need them, while also keeping opioids away from those who are likely to misuse them.

The Solution

State policies play a significant role in balancing patient access to pain relief by controlling misuse and adverse events associated

with pain medication. States should enact measures, such as state prescription drug monitoring programs that examine whether pain management is encouraged or discouraged, that do not interfere with normal medical practice by adding special requirements on prescriptions of opioid pain medicines. Many recently-enacted state policies have focused solely on preventing illicit drug abuse and have, therefore, shifted the policy balance such that legitimate patient access to pain relief is jeopardized.

To ensure ongoing balance in pain policies, the American Cancer Society Cancer Action Network (ACS CAN) recommends developing pain policies based on scientific evidence that recognize the need to preserve access to treatment for patients in legitimate pain. When evaluating pain policies, states should consider task forces, commissions and advisory councils comprised of patients and specialists. Stakeholders should work together to remove the stigma attached to pain management, striking a balance between access to pain medications for use as intended and efforts to reduce abuse. Education about the way policies govern pain management is key for both practitioners and the public. While good policies are necessary, written policies by themselves can be ineffective when practitioners are unaware of them or are confused by conflicting messages.

ACS CAN continues to work with federal, state and local lawmakers to ensure pain policies strike a balance that reduces inappropriate use of pain medications without impeding access to necessary relief for individuals fighting pain from cancer and other causes.

Success Story

As mentioned in the call-out box on page 41, one of ACS CAN's major concerns was that the CDC's voluntary recommendations would be formalized by state legislatures and regulatory agencies and given the force of law. Missouri is one state where such legislation was proposed in the 2017 session, which did not include the caveat that the guideline should not apply to cancer patients.

The Missouri proposal also included very harsh penalties for any doctor, including those treating cancer patients, who did not adhere to the CDC voluntary guideline. Fortunately, ACS CAN staff and volunteers in Missouri, including cancer patients and survivors, along with scores of doctors and nurses, rallied to make sure this proposal did not become law, thus eliminating what would have been needless suffering and hardship for cancer patients and survivors in Missouri.

But Missouri has one more major hurdle to overcome. They remain the only state that does not have a statewide Prescription Drug Monitoring Program (PDMP) in place. Legislation to remedy that failed in 2017. Hopefully, next year, Missouri will once again serve as a success story when they enact a PDMP in their state.

Access to Colorectal Cancer Screening

The Challenge

Colorectal cancer is the third most common cancer in men and women and the second leading cause of cancer death among men and women combined in the United States. This year alone, an estimated 50,260 colorectal cancer deaths are expected to occur – despite it being one of the most preventable cancers.[1] Screening helps to detect the disease early when treatment is most likely to be successful and when, in some cases, the disease can be prevented by the detection and removal of precancerous polyps. Yet, only approximately 62.6 percent[2] of Americans age 50 and older are up-to-date with U.S. Preventive Services Task Force (USPSTF) colorectal cancer screening recommendations. In total, it is estimated that more than 135,400 people will be diagnosed with colorectal cancer this year.[3] Individuals less likely to get screened are those who are younger than 65, are racial/ethnic minorities, have lower education levels, lack health insurance and are recent immigrants.[4]

The Solution

80% by 2018: A National Effort to Increase Colorectal Cancer Screening

EIGHTYBY2018
To join this effort visit www.nccrt.org

The National Colorectal Cancer Roundtable (NCCRT), the American Cancer Society (ACS), and the American Cancer Society Cancer Action Network (ACS CAN) spearheaded an initiative to substantially reduce colorectal cancer as a major health problem by working toward the shared goal of 80 percent of adults age 50 and older being regularly screened for colorectal cancer by 2018. Over 200,000 lives could be saved if we achieve the 80 percent goal.[4] More than 1,000 state, local and national organizations have joined the effort. While many states have above average screening rates, with Massachusetts and Rhode Island leading the way, not one state has achieved an 80 percent screening rate. On the other hand, some states, specifically Alaska, Oklahoma and Wyoming, have screening rates well below the national average of 63 percent and have a long way to go to reach 80 percent.[6]

According to a 2015 report, to reach this shared goal of 80 percent by 2018, an additional 23 million adults need to be screened beyond the current rate.[7] ACS CAN is asking state policymakers to help make colorectal cancer screening a priority by working across all sectors to increase screening rates in their states. Specifically, state policymakers can:

- Appropriate funds to establish or invest in the state's colorectal cancer screening and control program. Programs should raise public awareness about colorectal cancer screening and improve access to screening, including patient navigation and treatment services. Programs should use evidence-based patient and provider interventions to promote screening and reduce barriers to eligible adults.
- Support policies that require insurers to cover follow-up colonoscopies after a positive stool test and guarantee that patients do not face out-of-pocket costs for polyp removal, anesthesia, pre-screening consultations or laboratory services, related to the screening colonoscopy.
- Support evidence-based educational efforts to improve uptake of preventive services, particularly in disparate populations.
- Reach out to ACS CAN representatives in your state to find out how to get involved.

Through collaborative efforts with state policymakers, health care providers, health systems, community members and business leaders, we can reach this challenging, yet achievable, goal.

Success Story

Arkansas continues to stand out as a leader in the effort to raise awareness and increase access to colorectal cancer screening services. In 2016, Governor Asa Hutchinson signed the 80% by 2018 pledge and during the Spring 2017 legislative session, Representative Fred Allen sponsored legislation that would reauthorize and broaden access to colorectal cancer screening, patient navigation and treatment services, including individuals at high risk for the disease. The bill cited numerous studies from the American Cancer Society, including *Cancer Facts & Figures*[8] and the 2015 study *Where Can Colorectal Cancer Screening Interventions Have the Most Impact?*[9] (including 15 Arkansas counties with the highest colorectal cancer mortality rates in the country) to highlight the toll that colorectal cancer has taken and continues to take on the people of Arkansans. The bill moved through the legislature with bipartisan support, passing both the House and Senate overwhelmingly. Less than 30 days after the bill was introduced, it was signed by Governor Hutchinson. The reauthorization of the *Colorectal Cancer Prevention, Early Detection and Treatment Act* will provide thousands of Arkansans access to colorectal cancer prevention and early detection services and it will also provide those individuals diagnosed with a pathway to cancer treatment services.

Did you know?

The CDC's Colorectal Cancer Control Program (CRCCP) provides 22 state health departments, one American Indian tribe and six universities with funding to support the use of evidence-based interventions to improve screening quality and to increase access to screening services for low-income, uninsured and underinsured state residents.[10,11] The CRCCP also provides Delaware, Michigan, Minnesota, Nevada, New York and Washington funding for direct colorectal cancer screening services to eligible individuals. In 2016, five states appropriated funds to support their CRCCP funded programs and three states appropriated funds to support the state's non-CDC funded colorectal cancer control efforts. The non-CDC funded programs cover a broad range of services including, but not limited to: education and awareness, evidence-based patient and provider interventions, screening, diagnostic testing, patient navigation and treatment services.

ACS CAN encourages all states to appropriate funds to establish or invest in state colorectal cancer screening and control programs and appropriate state funds to sustain these programs.

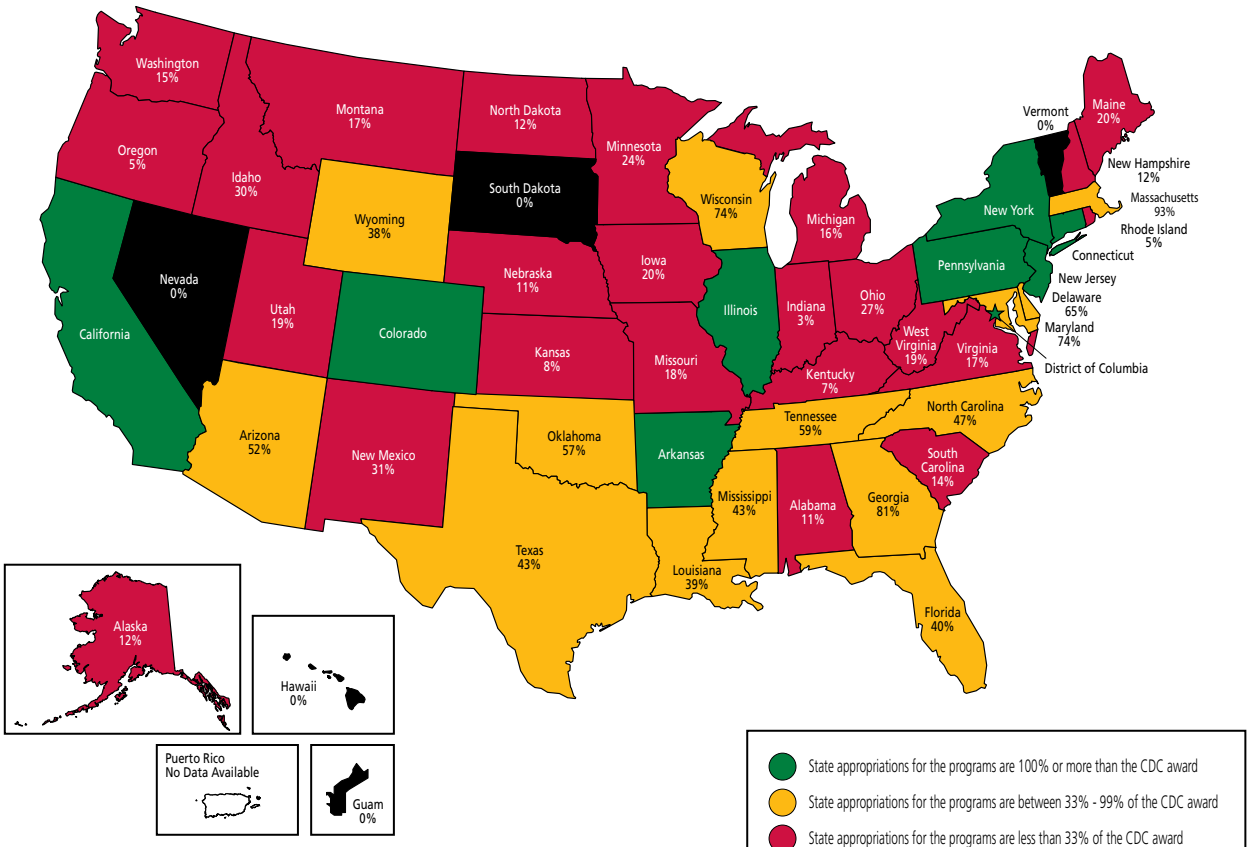
Funding for Breast and Cervical Cancer Screening Programs

The Challenge

Women who lack access to health care coverage have lower breast and cervical cancer screening rates, are more likely to be diagnosed with late stage cancers and have lower rates of cancer survival.[1,2,3,4,5] Only 30.7 percent of uninsured women (age 40 and older) have received a mammogram in the past two years, compared to 67.6 percent of insured women.[6] Likewise, only 61 percent of uninsured women (21 to 65 years of age) have received a Pap test in the past three years, compared to 85 percent of insured women.[7] Providing women access to cancer screening and early detection services can be a matter of life or death for all women in the United States, but it is even more critical for low-income and uninsured women who are at greater risk of being diagnosed at a later stage.

Every state, the District of Columbia, five U.S. territories, and 11 American Indian/Alaskan Native tribal organizations provide

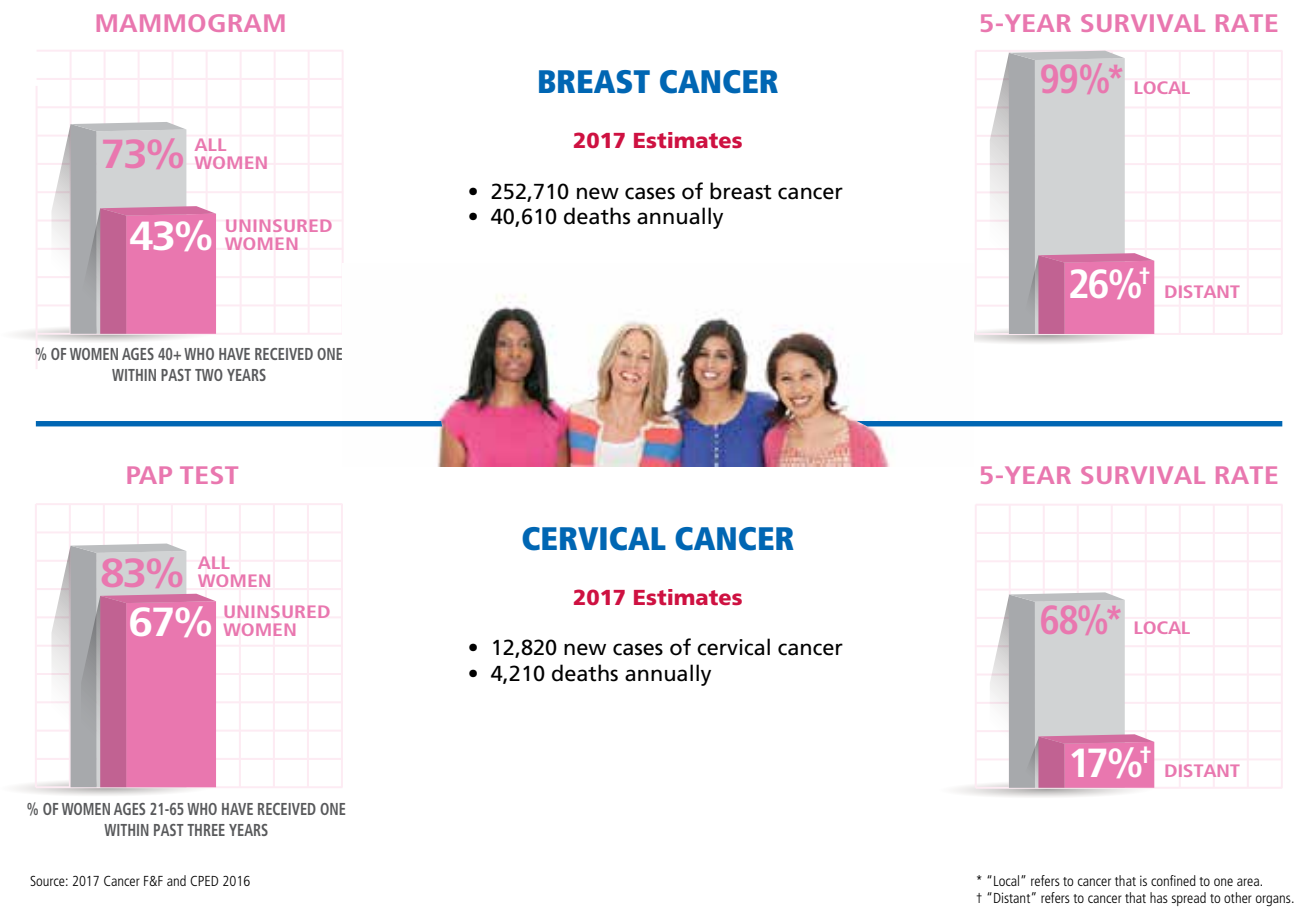
State Appropriations for Breast and Cervical Cancer Screening Programs - Fiscal Year 2016-2017



How Do You Measure Up?

Source: 2015-2016 data from the Centers for Disease Control and Prevention and unpublished data collected from ACS CAN and ACS Divisions, including input from NBCCEDP directors.

Breast and Cervical Cancer Facts and Figures



low-income, uninsured and underinsured women access to breast and cervical cancer screening and early detection services through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP).

Established by Congress in 1990 and administered by the Centers for Disease Control and Prevention (CDC), the NBCCEDP provides funding to states, tribes and territories to implement breast and cervical cancer screening services to eligible women and to implement key evidence-based strategies to reduce structural barriers to screening. The services provided by the NBCCEDP include:

- Direct screening, diagnostic testing and follow-up services;
- Patient navigation and case management;
- Educational information;
- Quality assurance, data management and program evaluation; and
- A pathway to treatment services if diagnosed through the program (for more information on the Breast and Cervical Cancer Treatment Program, see page 39).

Funding for Breast and Cervical Cancer Screening Programs

Due to inadequate federal and state funding, only one in ten eligible women are served by the NBCCEDP.

The Solution

One of the most important factors for ensuring that women have access to breast and cervical cancer screening and early detection services is adequate funding of state Breast and Cervical Cancer Early Detection Programs (BCCEDP). Increased state investment above federal funding in this critical safety net program will ensure that no woman is denied access to these lifesaving cancer control services.

The American Cancer Society Cancer Action Network (ACS CAN) advocates for states to appropriate $1 for every $3 in federal funds to ensure that no woman eligible for the program is denied access to cancer screening and early detection services. Twenty-nine states are falling short of this goal, four of which (Hawaii, Nevada, South Dakota and Vermont) are not appropriating any funds for the state's breast and cervical screening program.

State BCCEDP's have diagnosed thousands of breast and cervical cancers and saved countless lives by providing women timely access to screening and early detection services. Increasing funding for each state's BCCEDP will expand the reach of the federal program and ensure women have access to these lifesaving cancer screening, diagnostic and treatment services.

Without adequate funding at both the state and federal level, the NBCCEDP will continue to leave millions of underserved women exposed to cancer diagnoses at later stages, where survival is less likely and costs of treatment are highest.

Success Story

As Illinois' budget crisis deepens, protecting funding for the Illinois Breast and Cervical Cancer Program (IBCCP) continues to be a top priority for ACS CAN. The lack of a budget resolution has threatened the future of this lifesaving program and the women it serves. Over the past few years, ACS CAN has led a multi-year advocacy effort to preserve IBCCP funding centered on the "Red Bra" campaign, which resulted in more than 6,000 postcards being sent to the governor in 2016, and thousands of emails, phone calls and in-person meetings with members of the legislature.

In an effort to humanize the impact that the budget stalemate is having on women served by the program, this year's campaign focused on the stories of women who received screening and/or diagnostic services through the program and subsequent treatment through the state's Medicaid program. Powerful and moving stories from four IBCCP clients from across the state were recorded and these courageous women became the faces of the campaign.

Leading up to ACS CAN's Day at the Capitol, which focused on IBCCP funding, these stories were unveiled through a robust grassroots and social media campaign. The videos and images of the four breast cancer survivors were linked to action alerts, included on the state's webpage and social media sites, and featured on several billboards in Springfield and across the state. During in-person meetings, legislators were shown the videos as ACS CAN staff and volunteers discussed the value and importance of adequate funding for the IBCCP.

Under extraordinarily difficult circumstances, ACS CAN took a unique approach to its ongoing education and advocacy for the IBCCP funding. The budget stalemate continues and we have not yet achieved the legislative funding "win." However, we have raised public awareness, activated more volunteers and illuminated survivor stories. Through these efforts, Illinois policy makers have a clearer understanding of how their actions and decisions can save lives – these are advocacy successes!

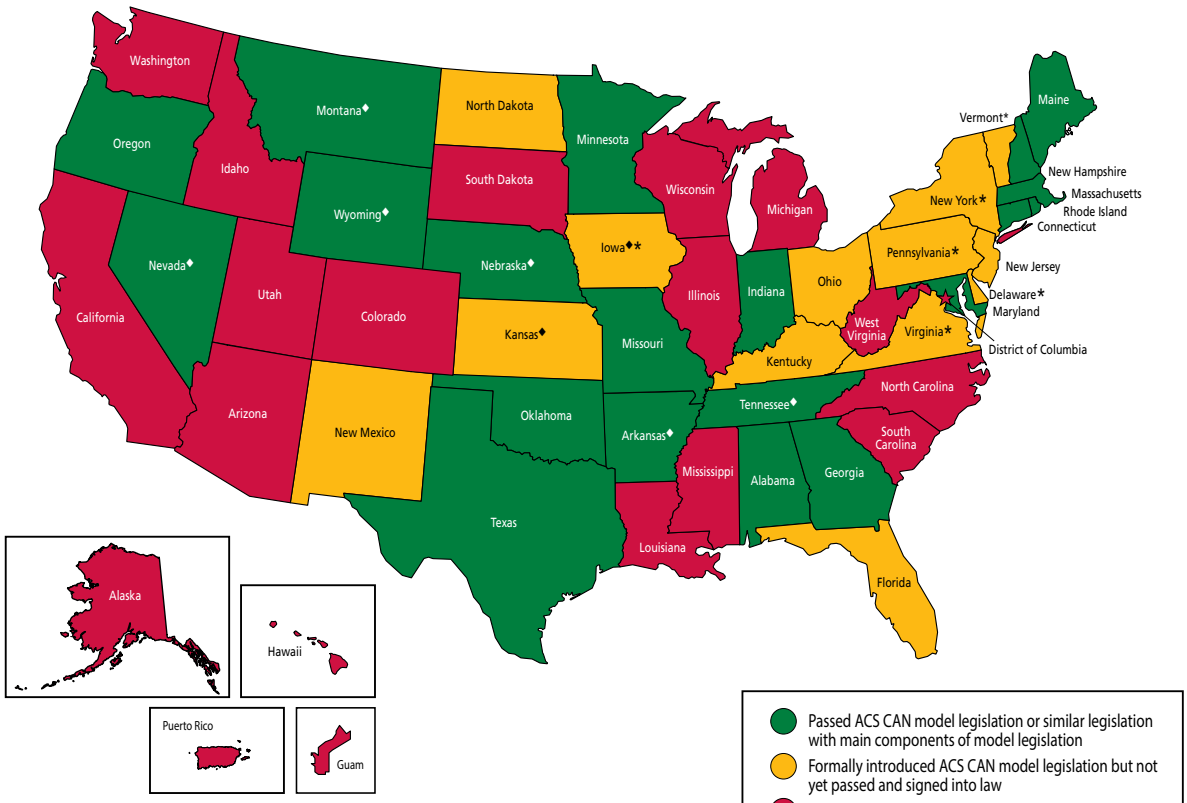
An Organized and Strategic Approach to Cancer Screening and Prevention

The NBCCEDP provides screening for breast and cervical cancer to low-income, uninsured, and underinsured women. In addition, the program is expanding its emphasis to increase breast and cervical cancer screening on a population-level within health system clinics and in communities with a high percent of disadvantaged populations and cancer burden. State BCCEDPs will be focusing on the establishment of diverse and strategic partnerships; implementation of evidence-based cancer screening intervention strategies such as clinical preventive services including patient and provider reminder systems; provider assessment and feedback; and removing structural barriers to screening, early detection and diagnostic testing services.

The National Breast & Cervical Cancer Early Detection Program (NBCCEDP)

Palliative Care

Establishing a Palliative Statewide Expert Advisory Council



How Do You Measure Up?

Source: ACS CAN
As of July 1, 2017
*DE, IA, NY, PA, VA, VT have not passed the model legislation but have statewide programs in place that closely align with the main tenets of the model legislation
♦ Legislative or regulatory changes made in 2017

The Challenge

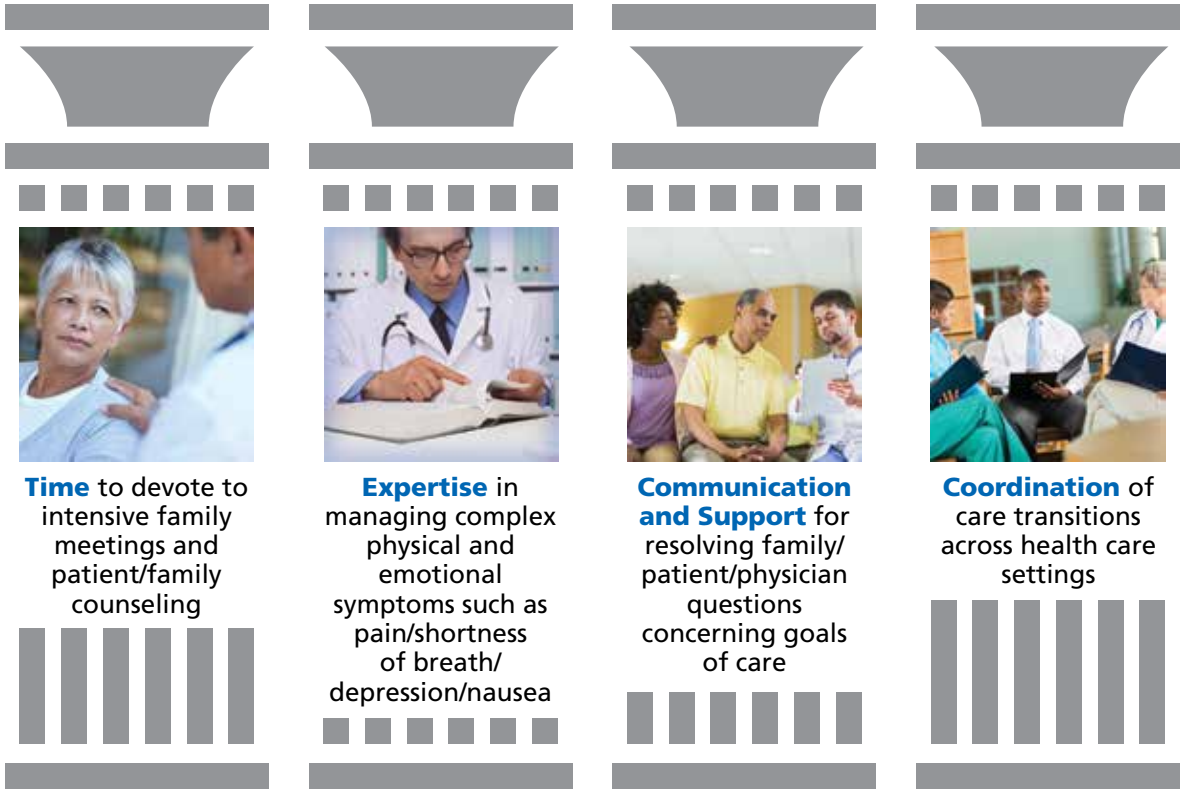
Advances in cancer research continue to provide new and more effective treatments for cancer, but therapies do not meet all the needs of cancer patients. Focusing exclusively on treating a patient's disease can result in a failure to address the full spectrum of issues that arise from a cancer diagnosis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

The Solution

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

Palliative care helps patients complete treatments, including rehabilitation to address impairments, and improves quality of life for patients, survivors and caregivers. Studies show cancer patients receiving palliative care during chemotherapy are more likely to complete their cycle of treatment, stay in clinical trials and report a higher quality of life than similar patients who do not receive palliative care.[1] Research demonstrates that palliative care improves symptom distress, quality of life, patient and family well-being and, in some settings (e.g., advanced lung cancer), survival. Palliative care also reduces unnecessary use of hospitals, diagnostic and treatment interventions, and nonbeneficial intensive care.[2] Recent research also shows palliative care increases satisfaction in caregivers of patients with cancer.[3]

Pillars of Palliative Care



Palliative Care

To benefit from palliative care, patients and families must be aware of these services, and be able to access them 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.

The American Cancer Society Cancer Action Network (ACS CAN) has created model state legislation that establishes a Palliative Care Advisory Council comprised of state experts to build out robust palliative care programs. The model legislation empowers the state health department to provide palliative care information through their website and through other channels for medical professionals, patients, families, caregivers and the public. It also improves access to palliative care services by encouraging routine screening of patients for palliative care needs. Furthermore, it boosts clinical skills for health professionals, students of medicine, nursing and other professionals, including improving workforce training in pain assessment, management, responsible prescribing and use of prescription monitoring programs. ACS CAN urges lawmakers to adopt this, or similar legislation, in their states. This legislation has consistently received bipartisan support and in just four years, ACS CAN model language or similar bills have been passed in 20 states.

Did You Know?

When palliative care is used to proactively address many of the side effects of serious illness, patients are more satisfied and overall patient care costs actually go down. A 2016 study showed that giving cancer patients a palliative care consultation within two days of hospital admission reduced costs 22-32 percent.[4] Other studies have confirmed these cost savings, including one looking at Medicaid patients in New York state hospitals, which found an average savings of $6,900 per patient when palliative care was provided. The study concluded that if the assumed 2-6 percent of Medicaid patients in need of palliative care received it, the New York Medicaid program could save between $84 million and $252 million per year.[5,6]

Success Story

Setting the ground work for a successful 2017 palliative care legislative campaign in Nebraska began during the Fall of 2016. In November, ACS CAN hosted a palliative care policy forum, which brought partners, advocates, and lawmakers together to raise awareness regarding the importance of improving quality of life for cancer patients through palliative care.

One of the forum's panelists was Amy Geschwender, a cancer survivor who was able to utilize palliative care during her cancer treatment. After hearing her speak at the event, everyone knew that Amy's story needed to be part of the legislative campaign as she was the perfect person to relay the always-important patient perspective of palliative care.

One of the forum's attendees was Senator Mark Kolterman, who brought a very personal interest to the issue. His wife is a cancer patient and he was just finding out about the benefits of palliative care not only for his wife, but also for his family. Shortly after the forum, the senator agreed to sponsor ACS CAN's Quality of Life model legislation. His support was critical because he is well-liked and respected by his peers, emerging as a leader on health care issues within the legislative body.

Through the bill's hearing and floor debate, both Amy's and Sen. Kolterman's passion for palliative care and its importance for patients undergoing cancer treatment resonated with lawmakers and, thanks to these two individuals, support for the bill was overwhelming. The bill was signed into law by Governor Pete Ricketts on May 4, bringing the total to 20 states that have now passed ACS CAN's model legislation.

State Appropriations for Cancer Control, Research and Surveillance

15th Edition

The Challenge

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

The federal government is by far the largest funder of cancer research and that is why the American Cancer Society Cancer Action Network (ACS CAN) advocates tirelessly at the federal level to increase funding for the National Institutes of Health and the National Cancer Institute. The American Cancer Society is the nation's largest non-profit entity funding cancer research.

State lawmakers also play a critical role in supporting cancer control, research and surveillance. States fund cancer registries, allowing providers and medical facilities to report cancer statistics into a central database for the Centers for Disease Control and Prevention (CDC) to produce reports on new cases of cancer, as well as incidence and mortality. These registries help public health professionals better understand different types of cancer and how to more successfully prevent and treat the disease. States also provide funding for comprehensive cancer control programs that develop statewide cancer plans aimed at reducing the number of individuals who are diagnosed with or die from this disease.

The Solution

Cancer registries and cancer control programs are typically housed in state health departments with CDC providing most of the funding. However, ACS CAN urges state legislatures to increase their investments in these evidence-based programs to maximize the impact they can have. ACS CAN also encourages states to go a step further and invest funds directly into cancer research programs. The following are examples of states rising to the challenge.

Texas

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

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

CPRIT's current funding is nearly $300 million for fiscal year (FY) 2017.

Florida

In 1999, the legislature created the Florida Biomedical Research Program, now known as the James and Esther King Biomedical Research Program, to award peer-reviewed competitive grants to researchers studying tobacco-related diseases. In 2006, the Bankhead-Coley Cancer Research Program was established, employing the same methodology to fund the best science in all cancers. The legislation was written to sunset in 2011, threatening the existence of both programs, but thankfully the legislature recognized their importance. Currently each program is funded at $10 million.

State Appropriations for Cancer Control, Research and Surveillance

California

The California Breast Cancer Research Program (CBCRP) is the largest state-funded breast cancer research effort in the nation, administered by the Research Grants Program Office within the University of California's Office of the President. CBCRP is funded through a tobacco tax, voluntary tax contributions on personal California income tax forms and individual donations. CBCRP funds California investigators to solve questions about basic breast cancer biology, causes and prevention of breast cancer, innovative treatments and ways to protect a patient's quality of life following a breast cancer diagnosis. The program involves advocates and scientists in every aspect of CBCRP decision-making, including program planning and grant application review. Since 1994, more than $257 million in research funds has been awarded to 133 institutions across California. Fiscal Year 2016 funding for this important research program is $5,507,000. California also has a robust Tobacco-Related Disease Research Program (TRDRP) that is funded through a tobacco tax (Proposition 99) and individual contributions. The program supports critical new priorities that represent gaps in funding by other agencies or areas where other agencies are reluctant or unable to provide support. Since TRDRP's inception in 1989, more than 1,600 research grants on tobacco-related studies have been funded, totaling more than $484 million in funding. TRDRP revenue is used to make grants for California scientists and community researchers to find better ways to prevent and reduce tobacco use and its related diseases; 327 grants totaling $85,210,943 have been awarded in the cancer field. The FY 2017 funding level for TRDRP is $10,478,149.

Missed Opportunity

New Jersey

Since 1983, the New Jersey State Commission on Cancer Research (NJCCR) has funded promising cancer research in New Jersey. Throughout its 30-year history, it has awarded over $40 million to more than 800 peer-reviewed cancer research grants and student fellowships. NJCCR is the only statewide institution that provides peer-reviewed scientific cancer research grants to all eligible institutions in New Jersey, and this merit-based system has a strong track record of funding the best new scientists who engage in ground-breaking basic research. After the legislature included $2 million in the FY 2017 budget bill, it was line-item vetoed to $1 million by Governor Christie. This was the first year that ACS CAN advocated for including $2 million. While the effort to reach $2 million was ultimately unsuccessful, it laid the groundwork with lawmakers and administration officials for an ongoing, identical request in the FY 2018 budget.

References

How Do You Measure Up?

1 American Cancer Society. (2017). Cancer Facts & Figures 2017. Atlanta, GA: American Cancer Society
2 Ibid
3 Ibid
4 American Cancer Society. (2003). How Do You Measure Up? A Progress Report on State Legislative Activity to Reduce Cancer Incidence and Mortality. Atlanta, GA: American Cancer Society
5 Centers for Disease Control and Prevention. Current Cigarette Smoking Among Adults—United States, 2005–2015. Morbidity and Mortality Weekly Report 2016;65(44):1205–11.
6 Robert Wood Johnson Foundation, Campaign for Tobacco-Free Kids, American Cancer Society Cancer Action Network, American Heart Association, American Lung Association, and Americans for Nonsmokers' Rights. Broken Promises to Our Children: A State-by-State Look at the 1998 State Tobacco Settlement 18 Years Later. December 2016. Available at http://www.tobaccofreekids.org/microsites/statereport2017/. Accessed June 8, 2017.
7 Campaign for Tobacco-Free Kids. Toll of Tobacco in the United States. http://www.tobaccofreekids.org/facts_issues/toll_us. Accessed June 8, 2017.
8 American Cancer Society. (2017). Cancer Facts & Figures 2017. Atlanta, GA: American Cancer Society
9 E. (2008) Association of Insurance with Cancer Care Utilization and Outcomes. CA: A Cancer Journal for Clinicians. 2008; 58(1).

Tackling Tobacco Use

1 U.S. Department of Health and Human Services (HHS). (2014). The Health Consequences of Smoking–50 Years of Progress: A Report of the Surgeon General. Atlanta, GA: HHS, Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health (OSH). Printed with corrections, January 2014.
2 Centers for Disease Control and Prevention. Tobacco Use Among Middle and High School Students—United States, 2011–2015. *MMWR* 2016;65(14):361–7.
3 Centers for Disease Control and Prevention. Current Cigarette Smoking Among Adults—United States, 2005–2015. *MMWR* 201;65(44):1205–11.
4 Xu X., Alexander R.L., Simpson S.A., et al. (2014). A Cost-Effectiveness Analysis of the First Federally Funded Antismoking Campaign. *American Journal of Preventive Medicine* 2015;48(3):318–25.
5 McAfee T, Davis KC, Shafer P, Patel D, Alexander RL, Bunnell, R. Increasing the Dose of Television Advertising in a National Antismoking Media Campaign: Results from a Randomised Field Trial. *Tob Control* 2015 Dec 16.doi: 10.1136/tobaccocontrol-2015-052517.
6 Centers for Disease Control and Prevention. Tobacco Use Among Middle and High School Students—United States, 2011–2015. Morbidity and Mortality Weekly Report, 2016;65(14):361–7 [accessed 2016 Apr 14].
7 Centers for Disease Control and Prevention. Current Cigarette Smoking Among Adults—United States, 2005–2015. Morbidity and Mortality Weekly Report 2016;65(44):1205–11 [accessed 2016 Dec 13]
8 Centers for Disease Control and Prevention. Vital Signs: Current Cigarette Smoking Among Adults Aged 18 Years with Mental Illness—United States, 2009–2011. Morbidity and Mortality Weekly Report 2013;62(05):81–7 [accessed 2016 Dec 13]
9 Institute of Medicine. Combating Tobacco Use in Military and Veteran Populations. June 2009.

Tobacco Excise Taxes

1 Campaign for Tobacco-Free Kids. Toll of Tobacco in the United States. http://www.tobaccofreekids.org/facts_issues/toll_us. Accessed April 10, 2017.
2 Ibid.
3 Campaign for Tobacco-Free Kids. Cigarette Tax Increases By State Per Year 2000-2017. November 10, 2016. Available at https://www.tobaccofreekids.org/research/factsheets/pdf/0275.pdf. Accessed March 15, 2017.
4 Ibid.

Smoke-Free Laws

1 U.S. Department of Health and Human Services (HHS). *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General*. 2006. Atlanta, GA: HHS, Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health (OSH).
2 HHS. *How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease – A Report of the Surgeon General*. 2010. Atlanta, GA: HHS, CDC, National Center for Chronic Disease Prevention and Health Promotion, OSH.
3 HHS. *The Health Consequences of Smoking–50 Years of Progress: A Report of the Surgeon Genera*l. Atlanta, GA: HHS, CDC, National Center for Chronic Disease Prevention and Health Promotion, OSH. Printed with corrections, January 2014.
4 HHS, 2010.
5 Max W., Sung H-Y, and Shi Y. (2012). Deaths from Secondhand Smoke Exposure in the United States: Economic Implications. American Journal of Public Health. 2012; 102: 2173-2180.
6 HHS, 2014.
7 American Nonsmokers' Rights Foundation. Overview List – How Many Smokefree Laws? January 2, 2017. Available at http://www.no-smoke.org/goingsmokefree.php?id=519.. Accessed March 27, 2017.
8 Ibid.
9 ACS CAN. Smoke-free. 2017. https://www.acscan.org/what-we-do/smoke-free.
10 Institute of Medicine. *Ending the Tobacco Problem: A Blueprint for the Nation*. Washington, D.C.: National Academies Press, 2007.
11 Eriksen M. and Chaloupka F. The Economic Impact of Clean Indoor Air Laws. *CA: A Cancer Journal for Clinicians* 2007; 57(6): 367-378.
12 HHS, 2014.
13 HHS 2006.
14 HHS 2006.
15 U.S. Department of Health and Human Services. The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2006 [accessed 2014 Apr 25].

Tobacco Control Program Funding

1 U.S. Department of Health and Human Services. E-Cigarette Use Among Youth and Young Adults. A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2016.
2 U.S. Department of Health and Human Services. *The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.
3 Robert Wood Johnson Foundation, Campaign for Tobacco-Free Kids, American Cancer Society Cancer Action Network, American Heart Association, American Lung Association, and Americans for Nonsmokers' Rights. *Broken Promises to Our Children: A State-by-State Look at the 1998 State Tobacco Settlement 18 Years Later*. December 2016. Available at http://www.tobaccofreekids.org/microsites/statereport2017/. Accessed March 27, 2017.

References

4 Ibid.
5 Ibid.
6 CDC. *Best Practices for Comprehensive Tobacco Control Programs*, 2014. Atlanta, GA: HHS, CDC, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.
7 Pierce J. et al. Forty Years of Faster Decline in Cigarette Smoking in California Explains Current Lower Lung Cancer Rates. *Cancer Epidemiology, Biomarkers and Prevention*, September 2010.
8 North Dakota Department of Health, "Youth Risk Behavior Survey Results-Detailed Summary Tables," 2015, https://www.nd.gov/dpi/uploads/1298/2015NDHighSchoolSummaryTables.pdf
9 Florida Department of Health. Florida Youth Tobacco Survey. Available at http://www.floridahealth.gov/statistics-and-data/survey-data/fl-youth-tobaccosurvey/index.html. Accessed March 28, 2017.

Tobacco Cessation Services In Medicaid

1 Centers for Disease Control and Prevention. Quitting Smoking Among Adults—United States, 2000–2015. Morbidity and Mortality Weekly Report 2017;65(52):1457-64 [accessed 2017 Jan 24].
2 Jamal A, Homa DM, O'Connor E, et al. Current Cigarette Smoking Among Adults – United States, 2005-2014. *MMWR* 2015; 64(44): 1233-1240.
3 Ku L, Bruen BK, Steinmetz E, and Bysshe T. Medicaid Tobacco Cessation: Big Gaps Remain In Efforts To Get Smokers To Quit. *Health Affairs*, 35, no.1 (2016):62-70.

Healthy Eating and Active Living Environments

1 American Cancer Society. *Cancer Facts & Figures 2016*. Atlanta: American Cancer Society, 2016.
2 Lauby-Secretan B, Scoccianti C, Loomis D, et al. Body Fatness and Cancer – Viewpoint of the IARC Working Group. N Engl J Med 2016; 375: 8.
3 Centers for Disease Control and Prevention. Obesity and Overweight. September 2015. Available at http://www.cdc.gov/nchs/fastats/obesity-overweight.htm. Accessed February 22, 2016.
4 Fryar CD, Carroll MD, Ogden CL. Prevalence of Overweight and Obesity Among Children and Adolescents: United States, 1963–1965 Through 2011–2012. September 2014. Available at http://www.cdc.gov/nchs/data/hestat/obesity_child_11_12/obesity_child_11_12.pdf. Accessed February 22, 2016.
5 Kushi L.H., Doyle C., McCullough M., et al. (2012). American Cancer Society Guidelines on Nutrition and Physical Activity for Cancer Prevention: Reducing the Risk of Cancer With Healthy Food Choices and Physical Activity. *CA: Cancer A Journal for Clinicians*. 2012; 62:30-67..
6 Ibid.
7 Finkelstein E.A., Trogdon J.G., Cohen J.W., Dietz W. (2009). Annual Medical Spending Attributable to Obesity: Payer- and Service-Specific Estimates. Health Affairs. 28(5): w822-w831.

Indoor Tanning

1 American Cancer Society. (2017). Cancer Facts & Figures 2017. Atlanta, GA: American Cancer Society.
2 American Cancer Society. (2017). Cancer Facts & Figures 2017. Atlanta, GA: American Cancer Society.
3 American Cancer Society. (2017). Cancer Facts & Figures 2017. Atlanta, GA: American Cancer Society.
4 Ghissassi, et al. (2009). A Review of Human Carcinogens – Part D: Radiation. The Lancet Oncology. 2009: 10.
5 U.S. House of Representatives Committee on Energy and Commerce Minority Staff. (2012, February). False and Misleading Information Provided to Teens by the Indoor Tanning Industry – Investigative Report.
6 United States of America Federal Trade Commission. (2010, May 13). In the Matter of Indoor Tanning Association, a corporation - Docket Number C-4290 Decision and Order. Available at ftc.gov/os/caselist/0823159/100519tanningdo.pdf.
7 U.S. House of Representatives Committee on Energy and Commerce Minority Staff. (2012, February). False and Misleading Information Provided to Teens by the Indoor Tanning Industry – Investigative Report.
8 Centers for Disease Control and Prevention (CDC). (2014). Youth Risk Behavior Surveillance-United States, 2015. MMWR. 2016; 65(6).
9 The 59% increased risk is cited here: Boniol B., Autier P., Boyle P., Gandini S. (2012). Corrections: Cutaneous melanoma attributable to sunbed use: systematic review and meta-analysis. British Medical Journal. 2012; 345:e8503. Published December 2012; which is a correction of the original article cited here: Boniol B., Autier P., Boyle P., Gandini S. (2012). Cutaneous melanoma attributable to sunbed use: systematic review and meta-analysis. British Medical Journal. 2012; 345:e4757. Correction published December 2012; 345:e8503.
10 Wehner, et al. (2012, October). Indoor tanning and non-melanoma skin cancer: systematic review and meta-analysis. British Medical Journal.
11 Cokkinides V., Weinstock M., Lazovich D., Ward E., Thun M. (2009). Indoor tanning use among adolescents in the U.S., 1998-2004. Cancer. 2009; 115: 190-198.
12 Guy GP, Berkowitz Z, Jones SE, Watson M, Richardson LC. Prevalence of indoor tanning and association with sunburn among youth in the United States. JAMA *Dermatol*. 2017; doi: 10.1001/jamadermatol.2016.6273. [Epub ahead of print].
13 Cokkinides V., Weinstock M., Lazovich D., Ward E., Thun M. Indoor tanning use among adolescents in the U.S., 1998-2004. *Cancer*. 2009; 115: 190-198.
14 American Cancer Society. Cancer Prevention and Early Detection Facts and Figures 2015. Atlanta: American Cancer Society; 2015.
15 Lazovich D, Vogel RI, Berwick M, Weinstock MA, Anderson KE, Warshaw EM. Indoor tanning and risk of melanoma: a case-control study in a highly exposed population. *Cancer Epidemiol Biomarkers Prev*. 2010;19: 1557-1568.
16 NAACCR Fast Stats: An interactive tool for quick access to key NAACCR cancer statistics. North American Association of Central Cancer Registries. http://www.naaccr.org/. (Accessed on 5-5-2016).
17 Guy, et al. (2014, February). State Indoor Tanning Laws and Adolescent IndoorTanning. American Journal of Public Health. Online.
18 Mayer JA, Woodruff SI, Slymen DJ, et al. Adolescents' use of indoor tanning: a large-scale evaluation of psychosocial, environmental, and policy-level correlates. *Am J Public Health*. 2011; 101(5):930-8.
19 Watson M, Holman DM, Fox KA, et al. Preventing skin cancer through reduction of indoor tanning: current evidence. *Am J Prev Med*. 2013;44: 682-689.
20 Sinclair C, Makin JK. Implications of lessons learned from tobacco control for tanning bed reform. *Pre Chronic Dis*. 2013; 10:120186. doi: http://dx.doi.org/10.5888/pcd10.120186.
21 Watson M, Holman DM, Fox KA, et al. Preventing skin cancer through reduction of indoor tanning: current evidence. *Am J Prev Med*. 2013;44: 682-689.
22 Forster JL, Lazovich D, Hickle A, Sorensen G, Demierre MF. Compliance with restrictions on sale of indoor tanning sessions to youth in Minnesota and Massachusetts. J Am Acad Dermatol. Dec 2006;55(6):962-967.
23 Mayer, et al. (2011). "Adolescent's Use of Indoor-Tanning: A Large-Scale Evaluation of Psychosocial, Environmental, and Policy-Level Correlates." American Journal of Public Health, May 2011; 101:5.
24 Guy, et al. (2014, February). State Indoor Tanning Laws and Adolescent IndoorTanning. American Journal of Public Health. Online.
25 Pichon LC, Mayer JA, Hoerster KD, et al. Youth access to artificial UV radiation exposure: practices of 3647 US indoor tanning facilities. *Arch Dermatol*. 2009;145: 997-1002.
26 Guy GP, Zhang Y, Ekwueme DU, Rim SH, Watson M. The potential impact of reducing indoor tanning on melanoma prevention and treatment costs in the United States: An economic analysis. *J Am Acad Dermatol*. 2016; 1-8.

27 Minnesota Department of Health. Teens, indoor tanning and melanoma. Published December 1, 2016. Accessed on December 2016. http://www.health.state.mn.us/divs/chs/mss/MDHIndoorTanningFactSheetw_ref.pdf.

Access to Care

1 American Cancer Society Cancer Action Network, ACS CAN Examination of Cancer Drug Coverage and Transparency in the Health Insurance Marketplace, Washington, DC: American Cancer Society Cancer Action Network; February 2017, available at www.acscan.org/drugstudy.
2 http://www.capitol.state.tx.us/tlodocs/84R/billtext/pdf/HB01624F.pdf#navpanes=0
3 ACS CAN. (2014, June 2014). Cancer Care and the Adequacy of Provider Networks Under the ACA Marketplace Plans. Available at acscan.org/content/wp-content/uploads/2014/07/ACS-CAN-Cancer-providers-and-QHP-Networks.pdf.
4 American Cancer Society. Cancer Facts & Figures 2017. Atlanta: American Cancer Society, 2017.
5 Medicaid.gov. Total Medicaid Enrollees - VIII Group Break Out Report. Updated December 2016. Accessed March 2017. https://www.medicaid.gov/medicaid/program-information/downloads/cms-64-enrollment-report-jan-mar-2016.pdf.
6 The Henry J. Kaiser Family Foundation. Distribution of the nonelderly with Medicaid by family work status: 2015. Accessed April 2017. http://kff.org/medicaid/state-indicator/distribution-by-employment-status-4/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
7 Medicaid.gov. Total Medicaid Enrollees - VIII Group Break Out Report. Updated December 2016. Accessed March 2017. https://www.medicaid.gov/medicaid/program-information/downloads/cms-64-enrollment-report-jan-mar-2016.pdf.
8 See Letter from Thomas E. Price, Secretary of Health & Human Services, and Seema Verma, CMS Admin., to Dear Governor (undated 2017).
9 Analysis provided to ACS CAN by Avalere Health. *Funding for Medicaid patients with cancer under BCRA Discussion Draft.* Analysis performed June 2017.
10 NPCR: U.S. Cancer Statistics Working Group. *United States Cancer Statistics: 1999–2013 Incidence and Mortality Web-based Report*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; 2016. Available at: www.cdc.gov/uscs and NAACCR dataset: SEER*Stat Database: NAACCR Incidence Data - CiNA Analytic File, 1995-2013, for Expanded Races, Standard File, ACS - Routine Inquiries (which includes data from CDC's National Program of Cancer Registries (NPCR), CCCR's Provincial and Territorial Registries, and the NCI's Surveillance, Epidemiology and End Results (SEER) Registries), North American Association of Central Cancer Registries, submitted December 2015. Estimates by the American Cancer Society on January 3, 2017.
11 Ward E, Halpern M, Schrag N, , et al. "Association of Insurance with Cancer Care Utilization and Outcomes." *Cancer J. for Clinicians*. 2008; 58(1): 9-31.
12 Adams E, Chien LN, Florence CS, et al. "The Breast and Cervical Cancer Prevention and Treatment Act in Georgia: effects on time to Medicaid enrollment." *Cancer*. March 15, 2009; 115(6):1300-9.
13 Miller JW, Hanson V, Johson GD, Roaylty JE, Richardson LC. From cancer screening to treatment: Service delivery and referral in the National Breast and Cervical Cancer Early Detection Program. *Cancer*. 2014; 120(16): 2549-56.

Cancer Pain Control: Advancing Balanced State Policy

1 Institute of Medicine, Relieving Pain in America: a blueprint for transforming prevention, care, education, and research (National Academy of Sciences 2011).

Access to Colorectal Cancer Screening

1 American Cancer Society. "Cancer Facts and Figures 2017". Atlanta: American Cancer Society; 2017.
2 American Cancer Society. "Cancer Prevention and Early Detection Cancer Facts and Figures 2017-18". Atlanta: American Cancer Society; 2017.
3 American Cancer Society. "Cancer Facts and Figures 2017". Atlanta: American Cancer Society; 2017.
4 American Cancer Society. "Cancer Prevention and Early Detection Cancer Facts and Figures 2017-18". Atlanta: American Cancer Society; 2017.
5 Meester RG, Doubeni CA, Zauber AG, et al. Public health impact of achieving 80% colorectal cancer screening rates in the United States by 2018. *Cancer*. 2015; 121(13):2281-85. doi: 10.1002/cncr.29336.
6 American Cancer Society. Colorectal Cancer Facts & Figures 2017-2019. Atlanta: American Cancer Society; 2017.
7 Fedawa SA, Ma J, Sauer AG, Siegel RL, Smith RA, Wender RC, et al. How many individuals will need to be screened to increase colorectal cancer screening prevalence to 80% by 2018? *Cancer*. 2015; 121(23):4258-65. doi: 10.1002/cncr.29659.
8 https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2017/cancer-facts-and-figures-2017.pdf 2017
9 http://cebp.aacrjournals.org/content/early/2015/06/30/1055-9965.EPI-15-0082
10 Centers for Disease Control and Prevention. Colorectal cancer control program: About the program. Updated August 17, 2016. Accessed March 2017. https://www.cdc.gov/cancer/crccp/about.htm.
11 "Centers for Disease Control and Prevention, Personal communication, {date of personal communication}."

Funding for Breast and Cervical Cancer Screening Programs

1 Han X, Zhu S, Tian Y, Kohler BA, Jemal A, Ward E. Insurance status and cancer stage at diagnosis prior to the Affordable Care Act in the United States. *Journal of Registry Management*. 2016: 43(3): 143-51.
2 Halpern MT, Bian J, Ward EM, Schrag NM, Chen AY. Insurance status and stage of cancer at diagnosis among women with breast cancer. Cancer. 2007.
3 American Cancer Society. Cancer Facts and Figures 2017. Atlanta: American Cancer Society; 2016.
4 Hsaia J, Kemper E, Keife C, Zapka J, Sofaer S, Pettinger M, et al. The importance of health insurance as a determinant of cancer screening: evidence from the Women's Health Initiative. *Prev Med*. 2000; 31(3):261-70.
5 American Cancer Society. Cancer Prevention and Early Detection Facts & Figures 2015-2016. 2016 Update. Atlanta: American Cancer Society; 2016.
6 American Cancer Society. "Cancer Prevention and Early Detection Cancer Facts and Figures 2017-18". Atlanta: American Cancer Society; 2017.

Palliative Care

1 Temel J.S., Greer J.A., Muzikansky A., et al., Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer. (2010, August 19). New England Journal of Medicine. 363:733-742.
2 Source: Meier DE, Brawley OW, Palliative Care and Quality of Life, Journal of Clinical Oncology 2011,29: 2750-2752.
3 McDonald, J, et. al. Impact of early palliative care on caregivers of patients with advanced cancer: cluster randomised trial. (2017 January). Annals of Oncology. 28 (1): 163-168.
4 May, P. et. al., Palliative Care Teams' Cost-Saving Effect Is Larger For Cancer Patients With Higher Numbers Of Comorbidities. (2016 January). Health Affairs. 35:44-53
5 McCarthy I.M., Robinson C., Huq S., Philastre M., Fine R.L. (2015, February). Cost savings from palliative care teams and guidance for a financially viable palliative care program. Health Services Research. 2015 Feb; 50(1):217-36, Epub 2014 Jul 15.
6 Morrison R.S., Dietrich J., Ladwig S., Quill T., Sacco J., Tangeman J., Meier D.E. (2011, March). Palliative care consultation teams cut hospital costs for Medicaid beneficiaries. Health Affairs (Millwood). 2011 Mar; 30(3):454-63.

measure@cancer.org
www.acscan.org