2019 • 17TH EDITION

HOW DO YOU MEASURE UP?

Cancer Action Network℠
American Cancer Society®

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

OUR 17TH EDITION

The 17th edition of *How Do You Measure Up?* illustrates how your state stands on issues that play a critical role in reducing cancer incidence and death. Every day, legislators at the state and local levels are making decisions that affect cancer patients and their families. It's critical that state and local lawmakers consider how their work on issues such as access to health insurance coverage for lifesaving cancer screenings and treatment, access to cancer drugs, investments in research, tobacco control and prevention policies, and funding for prevention and screening programs impacts the cancer community. Changes in laws can affect millions of people, exponentially expanding and enhancing the efforts of American Cancer Society Cancer Action Network to eliminate cancer as a major health problem.

TABLE OF CONTENTS

OUR 17TH EDITION

A LETTER FROM OUR PRESIDENT

Cancer touches every community—and from communities to state capitols, in research laboratories, and around kitchen tables across this country, Americans are fighting back.

The American Cancer Society Cancer Action Network (ACS CAN) is proud to lead the fight. Through advocacy and public education, we aim to make cancer a top priority for public officials at every level of government. We mobilize our powerful grassroots network of cancer advocacy volunteers to ensure lawmakers are aware of cancer issues that matter to their constituents. Using our expert lobbying, policy, grassroots and communications capacity, we work to enact evidence-based public policies that help prevent and save more lives from cancer. ACS CAN is a strictly nonpartisan organization—the only side we are on is the side of cancer patients and survivors.

Passing statewide policies that help prevent and treat cancer is critical to building healthy communities. ACS CAN's advocates are dedicated to reducing cancer's deadly toll by working with state lawmakers to implement the proven evidence-based policy solutions laid out in this year's *How Do You Measure Up? A Progress Report on State Legislative Activity to Reduce Cancer Incidence and Mortality*. The 17th edition of *How Do You Measure Up?* grades states on eight important cancer-fighting policies. These policies—developed through close coordination with the American Cancer Society's research and cancer control leadership—have the potential to not only save lives, but save millions and perhaps billions of dollars in states through health care cost reductions and increased worker productivity.

After 11 years at ACS CAN, and as the organization's new president, I take great pride in the victories won by our nationwide cancer-fighting staff and volunteers, whose voices and advocacy have delivered legislative and regulatory solutions that

will reduce the cancer burden on our states and communities. We are making remarkable strides in cancer treatment and prevention spurned by investments in cancer research. As we gain an increasing understanding of the causes of cancer, we have worked with all states to implement proven prevention strategies like comprehensive statewide smoke-free laws and restrictions on indoor tanning devices by kids under the age of 18. And we have fought to ensure more Americans are equipped with the health care coverage they need to survive a cancer diagnosis through increased access to Medicaid.

But despite this progress, much work remains to ensure that everyone has the equitable opportunity to live healthy, full, cancer-free lives. Unfortunately, lawmakers in numerous states have voted to remove protections that cancer patients and survivors count on to maintain access to comprehensive, affordable insurance coverage and erected barriers to access that endanger families fighting cancer—even though having access to adequate health care is the number one predictor of whether someone survives a cancer diagnosis. Despite evidence showing the lives and state healthcare dollars that can be saved through properly funded cancer prevention, many states continue to fall short in providing funding for important programs that could protect their residents from cancer's deadly toll.

This year's report also calls special attention to a dangerous trend: good faith efforts to raise the tobacco age of sale to 21 are being coopted by Big Tobacco and industry allies, who are successfully inserting loopholes and exemptions into these bills to hamper their effectiveness and protect the industry's bottom line. At the same time, tobacco product use among kids is skyrocketing as a result of the youth e-cigarette epidemic, with 1.3 million middle and high schoolers becoming new tobacco product users just last year.

While we must be clear-eyed about the challenges we face, my work with ACS CAN volunteers across the country—who give every spare moment to fight to protect their families and their communities from this disease—gives me hope that we will build a world without cancer. However, to achieve this lofty goal, we must work together. Ending cancer will require a comprehensive public policy agenda and the courage and commitment from public officials and everyday Americans to make that agenda a reality. By implementing the solutions set forth in this report, lawmakers can stand and fight back against this disease by taking proven steps to help prevent cancer, help those who have been diagnosed access the care they need and empower survivors to live healthy lives.

ACS CAN stands ready to work with everyone who shares our vision to win the fight against cancer. Join us. Changing the future of cancer depends on it.

Lisa Lacasse, President
American Cancer Society Cancer Action Network

ENSURING ALL AMERICANS HAVE ACCESS TO AFFORDABLE, QUALITY HEALTH CARE

ACCESS TO CARE INTRODUCTION

Access to health care is a significant determinant in whether an individual diagnosed with cancer will survive. Uninsured individuals are more likely to be diagnosed with cancer at a later stage and more likely to die from the disease.[1] The American Cancer Society Cancer Action Network (ACS CAN) believes everyone should have access to affordable, quality health insurance.

Fortunately, in recent years there has been an increase in the number of Americans who have health insurance coverage.[2] Since the health care law was fully implemented in 2014, more Americans have gained access to comprehensive health coverage that includes key consumer protections critically important to cancer patients. These protections include: prohibiting insurance companies from denying coverage or charging more due to a consumer's pre-existing conditions, restrictions against insurers imposing arbitrary caps on coverage, and a requirement that all insurance offered to individuals cover a broad set of benefits called essential health benefits.

Yet challenges remain. Many cancer patients have difficulty finding specialists who participate in their insurance plan's network, affording their prescription medications, and understanding their out-of-pocket expense liability. Recent regulatory and legislative approaches on both the federal and state levels have had the potential to weaken current patient protections, segment the insurance market, allow for more insurance plans with inadequate coverage, and reduce access to health care for cancer patients and survivors.

NEW REPORT

Inadequate Coverage – An ACS CAN Examination of Short-Term Health Plans

Federal law has expanded access to short-term, limited-duration health plans, which are exempt from many of the patient protections relied upon by individuals with cancer and survivors. In response, ACS CAN released a report that sought to explore whether short-term, limited-duration plans would be sold to cancer patients and, if so, what kind of coverage a cancer patient could expect. We studied short-term plans in six states: Florida, Illinois, Maine, Pennsylvania, Texas and Wisconsin.

- Examination of brochures for each issuer revealed that each one expressly stated that the plan excluded coverage for pre-existing conditions.
- To illustrate what an enrollee in one of these plans might pay should they face a cancer diagnosis, the report includes a calculation of the out-of-pocket costs for a hypothetical 57-year-old woman diagnosed with breast cancer. The report found the hypothetical patient's out-of-pocket costs would be more than $40,000 in the 12-month plan analyzed, $63,000 in the six-month plan and $111,000 in the three-month plan.
- In all cases, the individual incurred significantly higher out-of-pocket costs under her short-term plan than had she purchased a plan on the marketplace, which provides more robust coverage of services and imposes a yearly cap on in-network cost sharing of $7,900.
- Because the expiration of short-term coverage is not considered a qualifying event, the individual would be ineligible to enroll in comprehensive coverage until the next Affordable Care Act open enrollment period.

Source: https://www.fightcancer.org/policy-resources/inadequate-coverage-acs-can-examination-short-term-health-plans

FEDERAL ACTIVITIES

In 2018, the administration finalized a rule that would expand access to short-term, limited-duration (STLD) policies.[3] The rule allows STLD products to be sold for a coverage period of up to 12 months and be renewed for three years. ACS CAN urged the administration to withdraw the rule due to concern that these policies are exempt from many of the key patient protections that ensure individuals with cancer and survivors have access to the quality health care needed to treat their disease.

Additionally, the current administration has repeatedly reduced enrollment education and outreach funding,[4] which limits efforts to inform consumers about open enrollment and plan options. Concerns remain about enrollment trends in future years and the abilities of non-governmental groups to continue outreach and enrollment efforts.

The federal government has also weakened coverage standards by allowing states to select Essential Health Benefit (EHB) benchmarks that are less comprehensive. ACS CAN is concerned that this could result in a "race to the bottom," with some states reducing benefits and services.

STATE ACTIVITIES

Faced with uncertainty from the federal government, some states have implemented policies that seek to either strengthen or weaken the individual health insurance market.

ENSURING ALL AMERICANS HAVE ACCESS TO AFFORDABLE, QUALITY HEALTH CARE

SUCCESS STORY

Missouri

Short-term limited-duration (STLD) health plans were originally intended to provide individuals with insurance for a brief period of time until comprehensive coverage became available to them. These plans have historically been limited to a few months and did not qualify as minimum essential coverage.

This year, Missouri lawmakers proposed legislation to expand access to STLD plans and allow them to avoid some of the coverage requirements and patient protections that exist in current Missouri law. ACS CAN had serious concerns about this effort and urged state lawmakers to reject the bill because of the impact it could have on Missourians who purchased a STLD plan and were then diagnosed with cancer. A 2019 report released by ACS CAN found STLD plans to be inadequate, confusing and expensive for enrollees diagnosed with serious illnesses.

Though the legislation passed in one chamber, lawmakers heard our concerns and did not bring the bill up for debate in the state Senate. ACS CAN applauds Missouri lawmakers for working in the best interest of Missourians with cancer and urges them to continue to reject legislation that exempts STLD plans from the state's patient protection laws.

Short-Term Limited-Duration Plans

As federal regulations try to expand access to short-term, limited-duration (STLD) policies, some states are trying to prohibit or minimize their expansion. For example, New York state law permits the sale of short-term limited-duration policies, but requires these plans abide by the consumer protections required for Affordable Care Act (ACA)-compliant plans.[5] Other states are considering legislation that would limit STLD policies to a coverage period of less than three months without the option for renewal. ACS CAN supports these efforts.

State Individual Mandates

The federal individual health insurance mandate penalty ended January 1, 2019. In response, a few states have begun considering state-level individual mandates requiring state residents to maintain health insurance. Such policies would help to provide stability to a state's individual health insurance market, potentially keep premiums lower, and improve access to care. Massachusetts has had an individual insurance mandate since before the implementation of the ACA and never rescinded it.[6] New Jersey has also enacted legislation to impose an individual mandate.[7]

Non-Comprehensive Coverage

Following administrative actions encouraging creation of association health plans (AHPs)—plans wherein small businesses join together to purchase health coverage—some states are considering legislation that exempts AHPs from state regulation. These plans are already exempt from the important patient protections provided under the ACA. ACS CAN is concerned these plans will be able to discriminate against people based on their health status and will siphon off younger, healthier people, leaving older and sicker people in the state's individual market, which would increase premiums.

Utilization Management

Cancer patients often need to choose a health plan based, in part, on the plan's prescription drug coverage. Utilization management programs are health insurer practices used to control spending. These practices may include: prior authorization or approval of a drug by the patient's health insurer before a prescription can be filled; and step therapy, which requires patients to try and fail on an insurer-chosen prescription drug before gaining access to the drug that was prescribed by their doctor but may be more expensive. ACS CAN is concerned that if used inappropriately, utilization management may delay care or impede access to prescription drugs for cancer patients. Several states are considering legislation to ensure that utilization management practices are timely, efficient, clearly described for both patients and doctors, and allow for appeals and exceptions when appropriate.

MISSED OPPORTUNITY

Kansas

In 2019, the Kansas legislature proposed a bill to allow the Kansas Farm Bureau to sell health benefit plans that are exempt from state regulation. ACS CAN and its partners expressed serious concerns that these plans would be able to discriminate against people based on their health status, as well as be completely exempt from critical patient protections provided under the federal health care law. These plans may also attract younger, healthier individuals, leaving older and sicker individuals in the state's individual market and increasing premiums. Lack of affordable, comprehensive insurance may have dire consequences as individuals without health insurance are more likely to be diagnosed with cancer at a later stage and more likely to die from the disease.

ACS CAN and its partners strongly opposed the Kansas Farm Bureau legislation. Kansans across the state made phone calls and sent emails to ask their legislators to defeat the proposal and strongly urged Gov. Kelly to veto the legislation if passed. Despite these deep concerns, the legislation was enacted, marking a significant missed opportunity to defend the protections that are critical to cancer patients and those who may be diagnosed with cancer in the future.

ENSURING ALL AMERICANS HAVE ACCESS TO AFFORDABLE, QUALITY HEALTH CARE

NEW SURVEY

Utilization Management Delays Cancer Care; Leads to More Stress and Contributes to Worse Outcomes

A new nationwide survey of cancer patients, caregivers and doctors details the negative effects insurance utilization management policies in private insurance have on patient care. Patients and caregivers reported that utilization management requirements like step therapy and prior authorization delayed their care, increased their stress and frustration, contributed to worse outcomes and cost them more out of pocket.

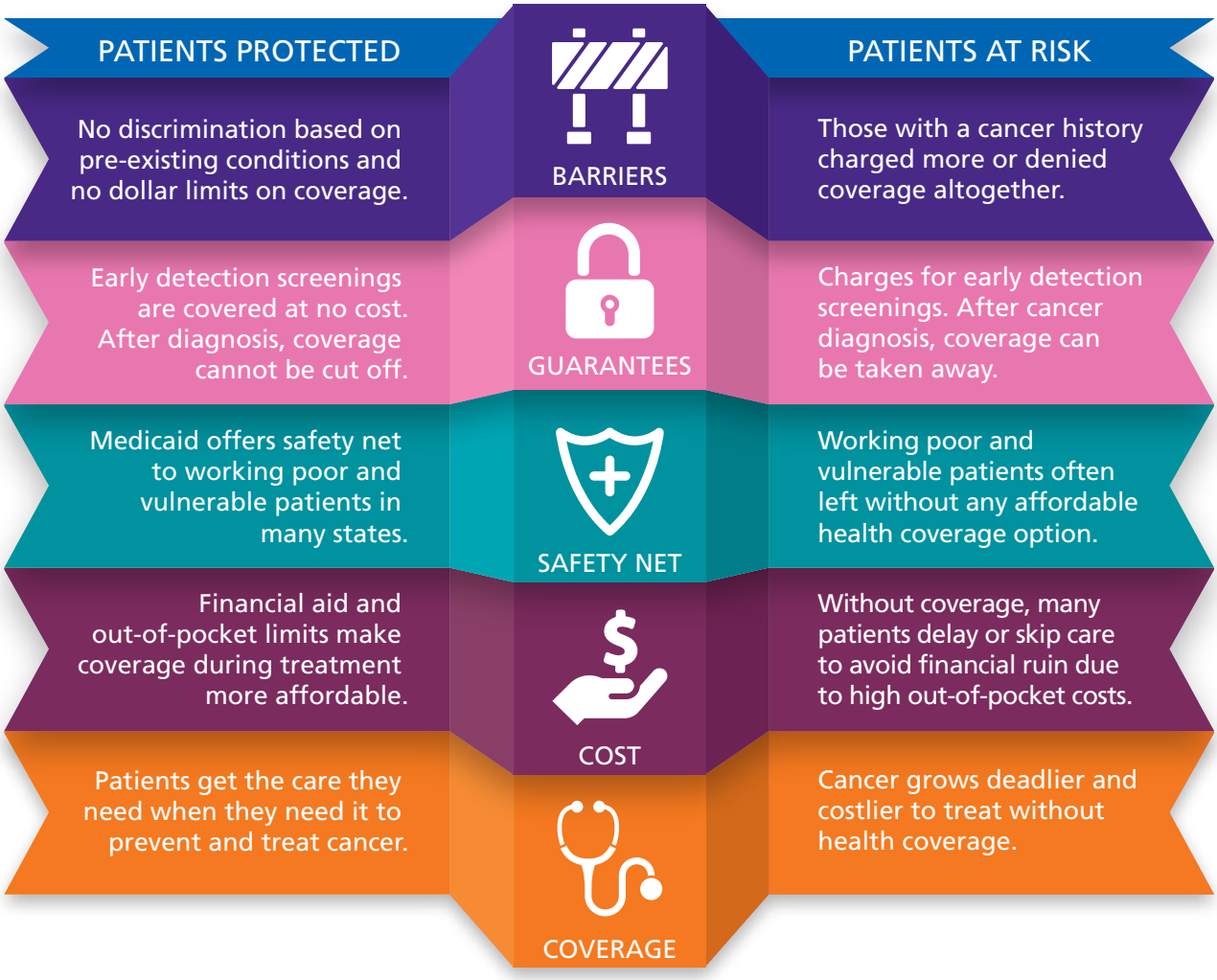
- One in three (34%) cancer patients and more than half (56%) of doctors reported having to wait for an insurance plan to approve a cancer treatment, test, or prescription drug because of utilization management policies, resulting in delayed patient care.
- The most common policies doctors encountered were prior authorization (96%), mandatory generic substitution (90%), quantity limits on prescription drugs dispensed (89%) and having to use a lower-cost drug first, often known as "fail first" or "step therapy" (88%).
- Those with private health insurance coverage reported much higher levels of delays in their or their loved one's cancer care compared to those on Medicare (38% of those with private health coverage compared to 14% of those with Medicare).

Source: Public Opinion Strategies national survey January 2019

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, denies patients access to lifesaving treatment or makes health coverage unaffordable.

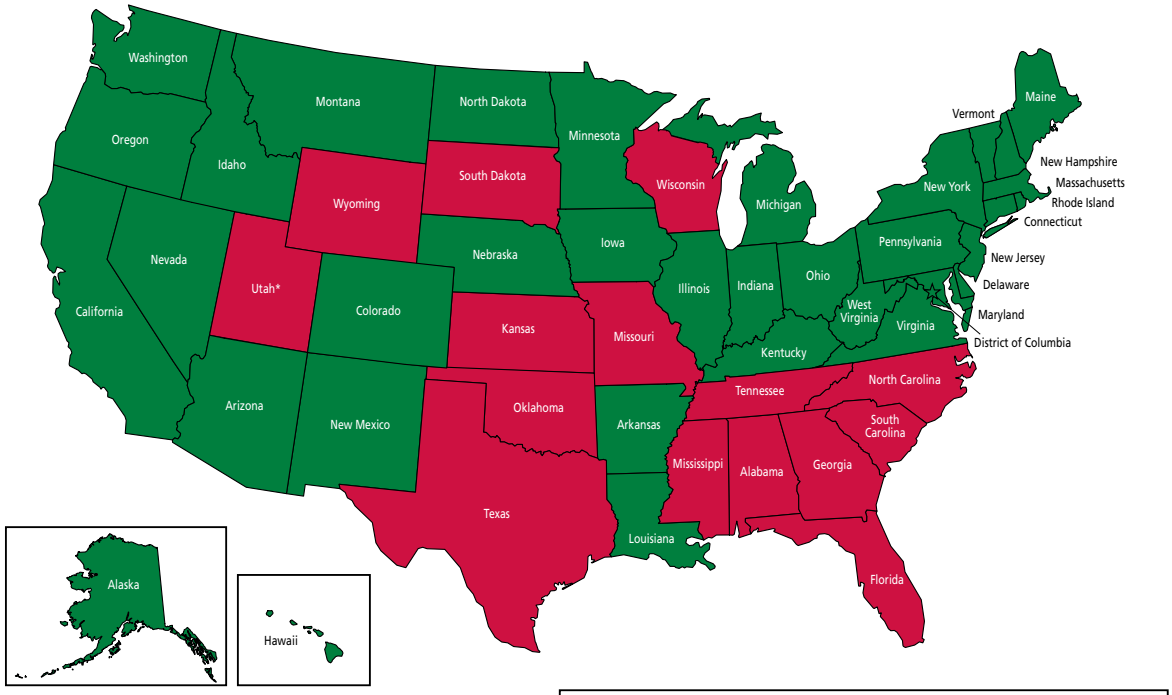
That's why the American Cancer Society Cancer Action Network is urging Congress to keep patient protections in the health care law, while ensuring coverage is affordable. Any changes to the law should provide equal or better health insurance coverage of cancer prevention and treatment.



INCREASED ACCESS TO MEDICAID

EXTENDING COVERAGE AND IMPROVING OUTCOMES

State Decisions on Increasing Medicaid Eligibility Up to 138% of the Federal Poverty Level (FPL)



How Do You Measure Up?

*In November 2018, Utah voters passed ballot initiative to expand Medicaid up to 138% FPL, however in February 2019, the governor signed a bill that would only expand eligibility to 100% FPL
U.S. Territories received additional ACA funding for their Medicaid programs, however expansion of eligibility was not a requirement to receive funds.
As of June 2019.

THE CHALLENGE

For the 1.7 million Americans who will hear the words "you have cancer" in 2019,[1] having comprehensive, adequate and affordable health insurance coverage is key to successfully detecting and treating their disease. Medicaid provides health insurance coverage to low-income children, adults, seniors and people with disabilities—many of whom face greater risk of being diagnosed with a late-stage cancer and are more likely to face challenges surviving the disease.[2] The coverage provided by state Medicaid programs helps to reduce disparities in early detection of some cancers[3] by offering millions of low-income Americans access to primary care and timely and appropriate cancer prevention services, as well as accessible and affordable treatment and survivorship care.

An estimated 2.3 million individuals (children and adults under age 65) with a history of cancer rely on the health care coverage provided by their state Medicaid program. Nearly one-third of all children diagnosed with cancer are enrolled in Medicaid at the point of diagnosis. The health care coverage provided through the program is proven to

improve health outcomes and reduce the burden of cancer.[4,5,6] State Medicaid programs also provide low-income women screened and diagnosed with breast or cervical cancer through state Breast and Cervical Cancer Early Detection Programs (BCCEDP) a pathway to comprehensive health care and cancer treatment services.[7]

Since 2014, 35 states and the District of Columbia have provided low-income uninsured individuals access to life-changing and lifesaving health insurance coverage by expanding eligibility for their Medicaid programs. An additional 2.5 million low-income parents and adults could gain health care coverage if the remaining 15 states expanded eligibility up to 138% of the federal poverty level.[8]

Unfortunately, a number of states have adopted or are pursuing policy changes to Medicaid that could roll back the progress that has been made in reducing the number of uninsured Americans and increasing access to care. Many of these proposals will limit or restrict access to coverage and care for low-income state residents, including cancer patients and survivors. States are changing these policies through legislative and regulatory action, principally 1115 Research and Demonstration Waivers (or 1115 waivers). These waivers allow states to seek greater flexibility in administering the Medicaid program from the Centers for Medicare and Medicaid Services (CMS).

The American Cancer Society Cancer Action Network (ACS CAN) actively reviews and provides public comments on 1115 waivers at the state and federal level. The most important consideration in our evaluation of these proposals is the potential impact that these demonstration waivers could have on cancer patients, survivors and all of those at risk of developing the disease.

THE SOLUTION

To improve health outcomes and reduce cancer disparities, states must improve access to health coverage for low-income individuals and families through Medicaid. ACS CAN encourages state policymakers to broaden eligibility for the Medicaid program to low-income adults earning less than $17,236 a year for an individual and $35,535 for a family of four, as permitted under the federal health law. We urge state policymakers to advance and support policies that protect and improve low-income Americans' access to health care, which has been proven to improve health outcomes and reduce the burden of cancer.[9,10,11] We also ask states to invest in evidence-based quality improvement programs that emphasize primary and preventive care through integrated care coordination, disease management and patient navigation programs.

Maintaining access to comprehensive and affordable health care coverage through state Medicaid programs is a matter of life and death for millions of low-income cancer patients and survivors. Ensuring that low-income individuals and families have access to comprehensive, affordable health care coverage is one of the most critical ways lawmakers can successfully reduce cancer incidence and mortality in their state.

DID YOU KNOW?

Between 2007 and 2015, more than 670,000 adult cancer patients diagnosed with blood, breast, cervical, colorectal, lung, pancreatic or prostate cancer were enrolled in Medicaid at the time of diagnosis.[12]

EXTENDING COVERAGE AND IMPROVING OUTCOMES

ADMINISTRATIVE (WORK) REPORTING REQUIREMENTS

In January 2018, CMS approved the first 1115 waiver conditioning Medicaid eligibility on compliance with work requirements in the state of Kentucky. These new administrative reporting policies would require individuals enrolled in Medicaid to prove they are working, actively trying to get a job, in school or volunteering in order to qualify for or maintain eligibility in the Medicaid program.

ACS CAN opposes such policies because cancer patients, survivors and those who will be diagnosed with the disease, as well as those with other complex and chronic health conditions, could be seriously disadvantaged and find themselves ineligible for any affordable health care coverage options.

If work reporting requirements were implemented in all 50 States and the District of Columbia, it is estimated that 1.4 million to 4 million adults enrolled in Medicaid could lose their health care coverage.[13] This could include cancer patients and survivors that rely on Medicaid for their care. Losing access to health care coverage could make it difficult or impossible for an individual to have their cancer diagnosed at an earlier, more treatable stage. It could make it difficult or impossible for cancer patients and survivors to continue treatment or pay for their medication. Losing access to one's cancer care team could be a matter of life or death for a cancer patient or survivor and the financial toll of losing coverage would be devastating for individuals and their families.

While states have included several categories of exemption from these requirements, the complexity and frequency of the administrative reporting requirements could lead to countless individuals, including cancer patients and survivors, losing their Medicaid coverage.[14] In fall of 2018, 18,000 low-income Arkansans were disenrolled from the Medicaid program, many of whom should have been exempt from the requirement, while others were simply unable to successfully navigate the state's reporting system and lost their Medicaid coverage as a result.

As of July 2019, a total of eight states (Arizona, Arkansas, Indiana, Kentucky, Michigan, New Hampshire, Utah and Wisconsin), have received CMS approval to implement similar work and administrative reporting requirements. An additional seven states are awaiting a decision from CMS on their work requirement waivers.[15]

Note: Work requirements, as well as other enrollment and eligibility restrictions, are currently being litigated in the federal courts. Three lawsuits have been filed in federal court to block the Kentucky, Arkansas and New Hampshire waivers on the grounds that they violate the Administrative Procedure Act (APA) and violate the section 1115 waiver requirements. The lawsuits identify work requirements as one of the violations of the APA. As a result of the lawsuit, implementation of the Kentucky waiver is on hold and Arkansas cannot enforce its waiver at this time.

An estimated 2.3 million individuals (children and adults under age 65) with a history of cancer rely on the health care coverage provided by their state Medicaid program.

Medicaid Benefits and Services Necessary for 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 • Lung cancer screening	• Biopsy • Histological assessment • Pathology reporting • Tumor stage documented • Palliation	• Chemotherapy • Hormone therapy • Pain management • Psychosocial care • Radiation • Surgery • Palliation	• Surveillance • Psychosocial care • Management of long-term effects • Palliation	• Hospice care • Palliation

EXTENDING COVERAGE AND IMPROVING OUTCOMES

MISSED OPPORTUNITY

Utah

In 2018, three states—Utah, Idaho and Nebraska—considered increasing access to Medicaid through ballot initiatives. On election day, a majority of voters in all three states supported expansion of eligibility for the states' Medicaid programs, which would provide hundreds of thousands of low-income adults access to health insurance coverage. In Utah, more than half a million voters cast ballots in support of Proposition 3, which increased access to Medicaid for people up to 138% of the federal poverty level (FPL) and implemented a .15% sales tax increase to cover the resulting costs. ACS CAN strongly supported the ballot initiative and contributed to the successful campaign through a variety of grassroots and media advocacy activities.

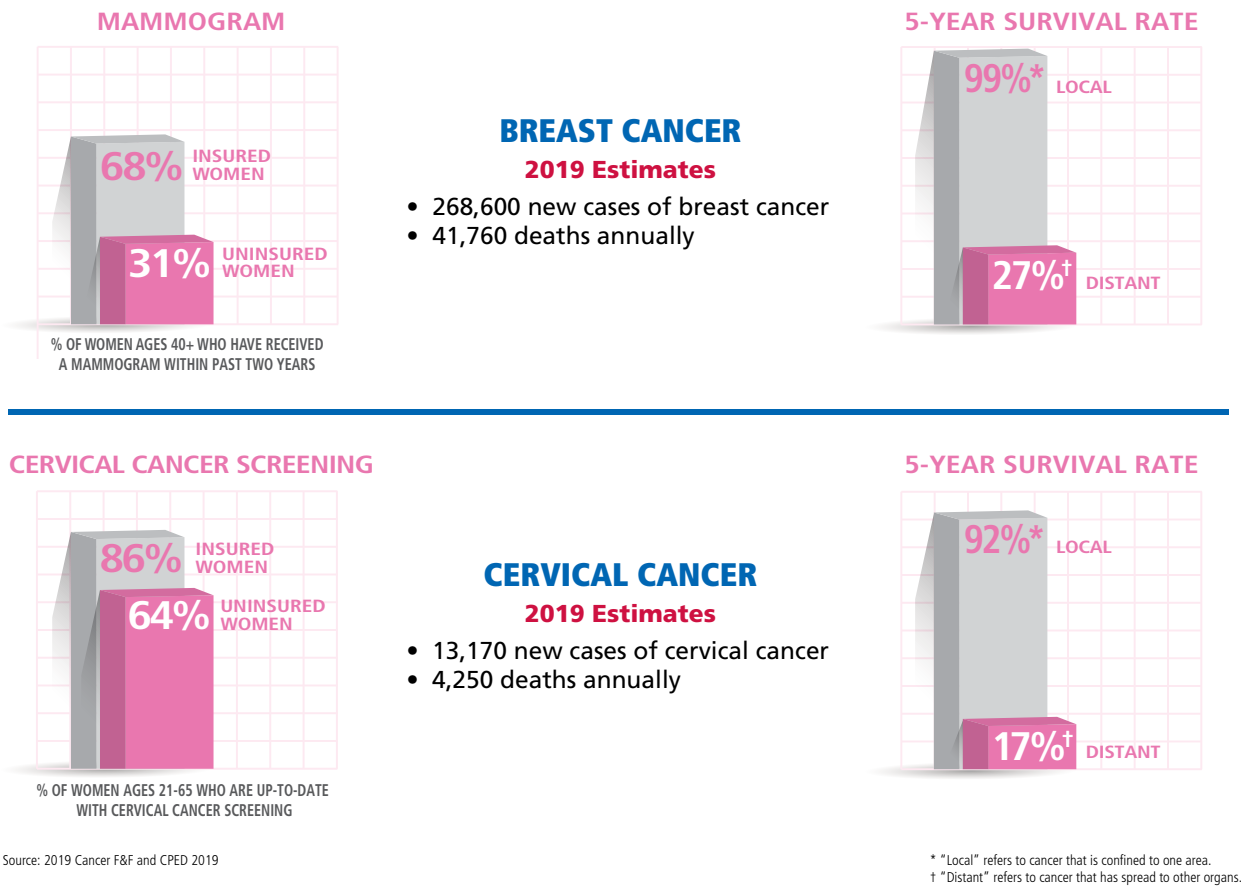
Shortly after the Utah legislature convened for its 2019 legislative session, efforts were immediately undertaken to reverse Proposition 3. The majority in the House and Senate led the effort to disregard the will of Utah voters by passing legislation that would only partially expand the state's Medicaid program up to 100% FPL (an annual income of $12,490 for an adult); limit or cap the number of individuals who could enroll in the program; impose new administrative (work) requirements; and cap or limit the amount that the state would spend to provide health care to individuals enrolled in the program.

In a matter of weeks, the legislature passed the bill and Gov. Gary Herbert signed it into law, reversing Proposition 3. Less than a month later, the federal Centers for Medicare and Medicaid Services (CMS) approved the state's 1115 waiver, approving the enrollment cap, work requirements and partial expansion. The spending cap and level of federal matching funds that Utah can receive will be considered later this year and ACS CAN will vigorously oppose these proposals.

Not only does this law undermine the will of Utah voters, but it will also result in low-income Utahns being denied access to affordable health insurance coverage, putting them at a disadvantage in the fight against cancer and costing the state millions of dollars in uncompensated care and lost federal revenue.

DETECT AND PROTECT

Breast and Cervical Cancer Facts and Figures



Source: 2019 Cancer F&F and CPED 2019

* "Local" refers to cancer that is confined to one area.
† "Distant" refers to cancer that has spread to other organs.

THE CHALLENGE

In 2019, it is estimated that nearly 282,000 women will be diagnosed with breast or cervical cancer[1]—many of whom will be low-income uninsured or underinsured individuals. Countless numbers of these newly diagnosed women will lack access to comprehensive, affordable health care coverage that would allow them to receive timely and appropriate cancer screening and diagnostic services. Timely and appropriate access to care could mean the difference between detecting cancer at an earlier, more treatable stage or detecting it at a later stage, when treatment costs are higher and outcomes may be worse.[2] Uninsured women have lower cancer screening rates—only 31% of uninsured women (age 40 and older) have received a mammogram in the past two years, compared to 68% of insured women.[3] Likewise, only 64% of uninsured women (21 to 65 years of age) are up-to-date with their cervical cancer screening, compared to 86% of insured women.[4]

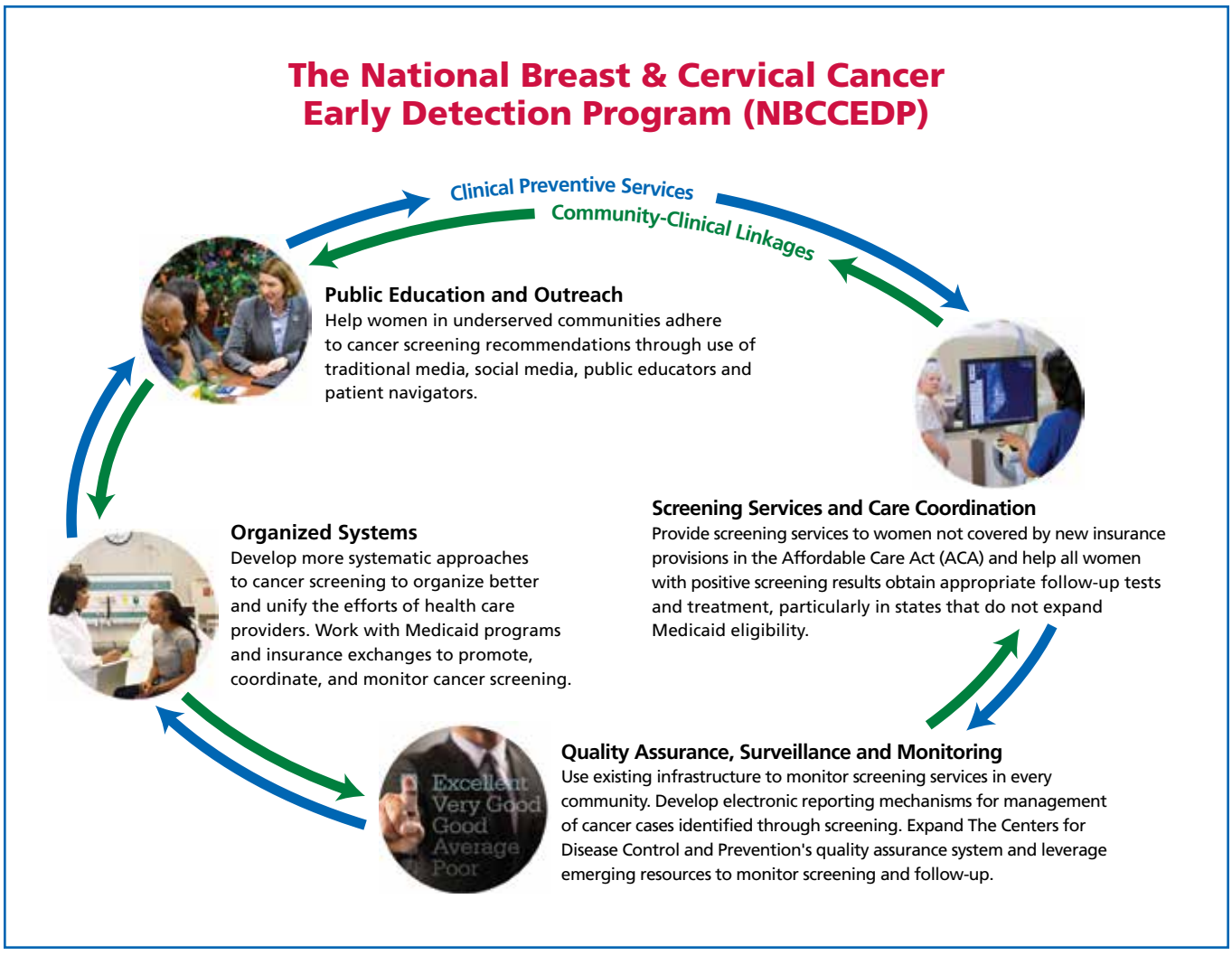
Low-income, uninsured and underinsured women are provided access to breast and cervical cancer screening and early detection services through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). In

DETECT AND PROTECT

1990, Congress authorized the Centers for Disease Control and Prevention (CDC) to administer the NBCCEDP and to provide states funding to deliver direct screening, prevention and early detection services to eligible women. All 50 states, the District of Columbia, six U.S. territories and 13 American Indian/Alaskan Native tribes or tribal organizations receive NBCCEDP funding.

Since 1991, the NBCCEDP has served more than 5.5 million women, diagnosing more than 67,000 breast cancers and over 4,600 cervical cancers. While many women gained access to affordable, comprehensive health care coverage under the federal health care law, millions of women continue to meet the eligibility requirements for NBCCEDP. Unfortunately, due to inadequate federal and state supplemental funding, only one in 10 eligible women are served by the program.

Women screened and diagnosed with breast or cervical cancer through the NBCCEDP are provided a pathway to comprehensive health care and cancer treatment services through their state Medicaid program. In 2000, Congress passed the Breast and Cervical Cancer Treatment Act (BCCT), which provides states with federal funding to help cover the cost for comprehensive health care and cancer treatment services through Medicaid for low-income women diagnosed with cancer through the NBCCEDP.



DID YOU KNOW?

Twenty states are exceeding ACS CAN's goal of appropriating $1 in state funds 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: Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Georgia, Illinois, Louisiana, Maryland, Massachusetts, New Jersey, New Mexico, New York, North Carolina, Oregon, Pennsylvania, Tennessee, Texas and Wisconsin.

Every year, thousands of low-income, uninsured and underinsured women access lifesaving health and cancer treatment care because of this BCCT eligibility option.

Recently, some states have considered proposals aimed at eliminating or limiting eligibility for Medicaid, including women eligible for the program through the BCCT option. Other states have considered proposals to reduce or eliminate funding for the NBCCEDP based on the incorrect assumption that women have gained access to comprehensive and affordable health care coverage under the federal health care law and therefore these programs are no longer needed.

Millions of women in the United States remain uninsured without adequate, affordable and comprehensive health care coverage.[5] The lifesaving cancer screening, early detection and treatment services provided through the NBCCEDP and the Medicaid BCCT option are often the only services available to help women detect and treat their breast or cervical cancer. State efforts aimed at limiting or eliminating eligibility for these programs are short-sighted and could adversely impact the health outcomes and chances for survivorship for countless women across the country.

THE SOLUTION

State Funding for Screening and Early Detection

State investment in the NBCCEDP is one of the most important factors for ensuring all eligible low-income, uninsured and underinsured women have access to the screening and early detection services provided by the program. 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.

Increasing funding for each state's NBCCEDP 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 of the NBCCEDP at both the state and federal level, millions of underserved women could be exposed to cancer diagnoses at later stages, when survival is less likely and costs of treatment are highest.

MISSED OPPORTUNITY

Hawaii, Kentucky, South Dakota, Vermont

Four states—Hawaii, Kentucky, South Dakota and Vermont—invest zero state funds in their breast and cervical cancer early detection program, potentially leaving some eligible women without access to these lifesaving screening services. Inadequate state funding may cause some underserved women to be diagnosed with cancer at later stages when survival is less likely.

DETECT AND PROTECT

Maintain Eligibility for Treatment Coverage Through Medicaid

We urge states to maintain eligibility for Medicaid and preserve access to quality, affordable, accessible and comprehensive health care coverage. Preservation of the BCCT eligibility option is a matter of life and survivorship for thousands of low-income breast and cervical cancer patients in all 50 states and the District of Columbia. The treatment services provided by a 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, typically resulting in better patient outcomes.[6] It is imperative that state lawmakers protect eligibility and maintain adequate funding for the BCCT eligibility option. ACS CAN strongly opposes any attempts to limit or eliminate eligibility or reduce funding for this lifesaving cancer treatment option.

SUCCESS STORY

Wyoming

This year, Wyoming legislators proposed a reduction in funding for the state's Breast and Cervical Cancer Treatment (BCCT) option in the state's Medicaid program. Women across Wyoming diagnosed with cancer depend on the BCCT as the only affordable, comprehensive coverage option available to them and any reduction in funding threatens their ability to access the care they need to treat their cancer as quickly and effectively as possible.

ACS CAN moved quickly to defeat this measure by activating its grassroots network, including many breast cancer survivors, in opposition to this proposal. The Wyoming team created a social media call-to-action, sharing news of the proposed cuts via Facebook, immediately mobilizing volunteers to ask their legislators to vote against the measure. Our cancer-fighting advocates sprang into action, utilizing social media, phone calls and emails to spread word of the impending cuts and urge their legislators to vote against the funding reduction. This grassroots campaign created a ripple effect, inspiring individuals across the state to take action and stand up for cancer patients and those most at risk of the disease.

In the end, Wyoming lawmakers listened to the concerns of their constituents and protected funding for the BCCT program, ensuring eligible women across the state have access to the lifesaving treatment they need when diagnosed with breast or cervical cancer.

SCREENING EARLY SAVES LIVES

THE CHALLENGE

Colorectal cancer is the third most common cancer in both 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 51,000 colorectal cancer deaths are expected to occur[1]—despite it being one of the most preventable cancers.

Screening helps to detect the disease early when treatment is more likely to be successful; the disease can often be prevented altogether by the detection and removal of precancerous polyps. Yet only approximately 63% of Americans age 50 and older are up-to-date with their colorectal cancer screening.[2,3] This means that more than one in three adults age 50 and older are not getting screened as recommended. Americans cite numerous barriers to colorectal cancer screening including no usual source of care, inadequate insurance coverage, logistical factors (e.g. transportation or scheduling), lack of a family history or symptoms, feelings of embarrassment or fear and no recommendation from a health professional.[4]

In total, it is estimated that over 145,000 people will be diagnosed with colorectal cancer this year.[5] Individuals less likely to get screened are those who are younger than 65, are racial or ethnic minorities, have lower education levels or lack health insurance.[6]

THE SOLUTION

80% in Every Community

In 2014, the National Colorectal Cancer Roundtable (NCCRT), the Center for Disease Control (CDC) and the American Cancer Society (ACS), joined by the American Cancer Society Cancer Action Network (ACS CAN) spearheaded an initiative to

REMOVING BARRIERS TO COLORECTAL CANCER SCREENING

On the federal level, ACS CAN worked with Congressional sponsors to reintroduce the Removing Barriers to Colorectal Cancer Screening Act (H.R. 1570, S. 668) in March 2019. The legislation would eliminate cost sharing for seniors on Medicare who are hit with a surprise bill during a routine screening colonoscopy when a polyp is discovered and removed during the procedure.

Currently, Medicare covers the full cost of routine screening colonoscopies. However, if a polyp is found and removed during a screening colonoscopy, patients wake up to a pricey cost-sharing payment of up to $350. Learning about the possibility of an unexpected expense can deter people from getting screened for colorectal cancer.

As of July 2019, the legislation has 274 cosponsors in the House of Representatives and 50 cosponsors in the Senate.

SCREENING EARLY SAVES LIVES

NEW AMERICAN CANCER SOCIETY COLORECTAL CANCER SCREENING GUIDELINES

In May 2018, the American Cancer Society updated its guidelines for colorectal cancer screening, lowering the recommended age for average-risk adults from 50 to 45.[9] The guideline places a greater value on patient preference and choice for screening test options, including high-sensitivity stool-based tests or structural exams (e.g., colonoscopy), to help increase adherence to screening.

The guideline was last updated in 2008. Since then, new data has emerged about the changing risk of colorectal cancer in younger adults. This includes recent analyses published by ACS showing a 51% increase in colorectal cancer among those under age 55 since 1994.[10] Adults born around 1990 have twice the risk of colon cancer and four times the risk of rectal cancer compared with adults born around 1950.[11]

The American Cancer Society and ACS CAN are working with partners to support implementation of this guideline. Many states have already passed legislation that requires insurers follow ACS guidelines for colorectal cancer screening. ACS CAN has alerted all Insurance Commissioners in these states of the change in screening age. We are currently working with our field staff and state legislators to update colorectal cancer screening guidelines in their state so more Americans will have access to the recommended screening beginning at age 45.

substantially reduce colorectal cancer as a major health problem by working toward the shared goal of 80% of adults age 50 and older being regularly screened for colorectal cancer by 2018.

Since the initiative's launch, we have seen rising screening rates nationally, with more than 3.3 million additional U.S. adults being screened between 2014 and 2016.[7] By December 2018, more than 1,700 organizations, including state and local government officials, committed to reducing colorectal cancer as a major public health opportunity. As of 2018, more than 300 organizations and sites achieved 80% or higher screening rates.

Our shared efforts are working. Community health clinics, health plans, employers, counties and others are achieving 80% screening rates and higher, but we know not everyone is benefitting equally. There are still too many communities with lower colorectal cancer screening rates—rural communities, certain racial and ethnic communities, and low income communities.

In 2019, 80% by 2018 transitioned to a new campaign, 80% in Every Community (nccrt.org/80-in-every-community/), that continues the progress and commitment from 80% by 2018, and reemphasizes our dedication to partnership, collective action and the pooling of resources to reach 80% colorectal cancer screening rates nationally. The 80% in Every Community campaign aims to continue working to bring down barriers to screening, because everyone deserves to live a life free from colorectal cancer.

ACS CAN supports the effort to build on the incredible work and infrastructure that has been created to increase colorectal cancer screening and save lives from this disease. ACS CAN continues to urge state policymakers to help address known barriers to screening rates in their states by making colorectal cancer a priority and working across all sectors to increase screening rates.

Specifically, state policymakers can:

- Appropriate funds to establish or invest in state colorectal cancer screening and control programs. Increased state investment would broaden the reach of the CDC's Colorectal Cancer Control Program (CRCCP), a program that currently supports 23 states, six universities and one American Indian tribe, by focusing on increasing screening rates among target populations through evidence-based health systems interventions.[8] Programs should use evidence-based patient and provider interventions to raise public awareness, promote screening and reduce barriers for 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 polices that require insurers to begin screening adults starting at age 45, as recommended by the American Cancer Society.
- Support evidence-based educational efforts to improve uptake of preventive services, particularly in disparate populations.

DID YOU KNOW?

ACS CAN and coalition partners have worked across the country to pass Colorectal Cancer Awareness Month proclamations and resolutions in state legislatures. In March of 2019, ACS CAN helped to introduce and pass these resolutions in 14 states; Alabama, Arkansas, California, Delaware, Florida, Illinois, Kentucky, Mississippi, North Dakota, Pennsylvania, Rhode Island, South Carolina, Texas and Wisconsin.

SUCCESS STORY

Maine

Maine Gov. Janet Mills signed LD 555, "An Act to Reduce Colorectal Cancer Incidence and Mortality by Updating Screening Coverage," in May. This new law requires private health insurance plans cover all recommended colon cancer screening tests in accordance with ACS' recently updated guidelines, which recommend screening begin at age 45 for people at average risk of colorectal cancer (instead of age 50).

Legislators were moved to action by the story of Will Bourque, whose mother was diagnosed with stage IV colon cancer in 2012 at the age of 45 and passed away less than three years later. During his moving testimony to state lawmakers, Will highlighted the bill's potential benefits to Maine families, saying it "will ensure that more people will get screened at an earlier age. This is the right thing to do. It will also save costs, as screenings are far less expensive than the hundreds of thousands of dollars that were spent for my mom's treatments." Will's wish was to see LD 555 passed before Mother's Day 2019. He received his wish when it was signed into law on May 9th, three days before Mothers' Day.

ACCESS TO COLORECTAL CANCER SCREENING

SCREENING EARLY SAVES LIVES

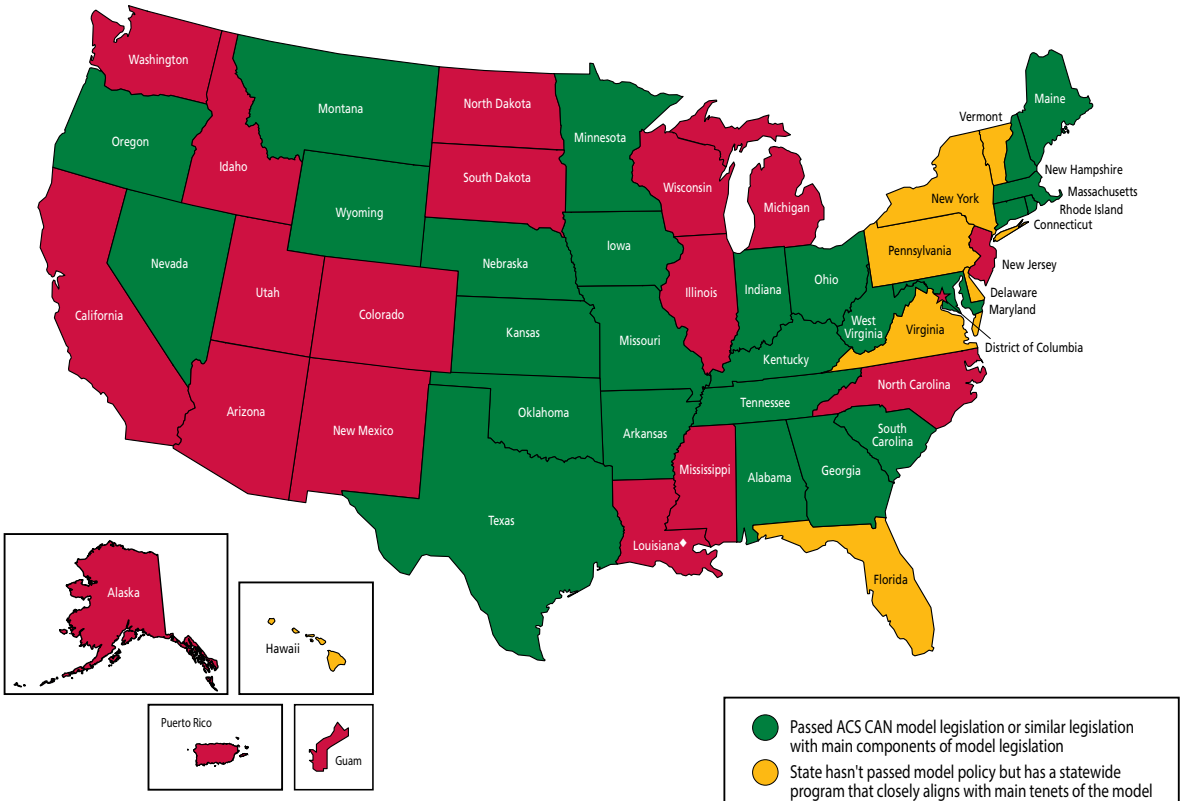
MISSED OPPORTUNITY

Indiana

The ACS CAN Indiana team worked hard to secure $300,000 in funding for colorectal cancer screening programs in the state budget. However, due to various factors, the final budget failed to include the adequate funding for screening programs for a cancer that will kill 1,110 Hoosiers this year alone. Indiana's colorectal screening rate is only 65%—well below the 80% goal—yet the state legislature has provided no funding for low-income Hoosiers to receive reduced-cost or free lifesaving screenings for colorectal cancer. If Indiana's state lawmakers want to fight cancer in their state, it is crucial they invest in colorectal cancer screening programs that will reach the most at risk and underserved populations in the state.

IMPROVING QUALITY OF LIFE FOR CANCER PATIENTS

Establishing a Palliative Statewide Expert Advisory Council



How Do You Measure Up?

♦ Legislative or regulatory change made in 2019: Louisiana law will go into effect on August 1, 2019.
Source: ACS CAN
As of July 1, 2019.

THE CHALLENGE

Advances in cancer research continue to provide new and more effective treatments for cancer, but curative 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, including emotional distress and physical symptoms such as pain, fatigue and nausea. Fatigue, for example, is one of the leading reasons cancer patients skip follow-up medical appointments. Patients often do not know to ask for, or have trouble asking for, the type of care available that focuses on issues like fatigue that may impact a patient's quality of life and treatment.

THE SOLUTION

Palliative care is specialized medical care that provides the best possible quality of life for a patient and their family by offering relief from the symptoms, pain and stress of a serious illness. It provides a coordinated, team-based

IMPROVING QUALITY OF LIFE FOR CANCER PATIENTS

approach among medical professionals to help meet a patient's needs during and after treatment. 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.

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.

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 its 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, the model legislation helps facilitate continuing education for health professionals, students of medicine, nursing and other professionals by improving workforce training in pain assessment, management, responsible prescribing and use of prescription monitoring programs. ACS CAN urges lawmakers to adopt this legislation, or similar policies, 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 more than half of the states across the country.

THE BENEFITS OF PALLIATIVE CARE

Improves Patients' Quality of Life

- 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.[1]
- Palliative care also increases satisfaction in caregivers of patients with cancer.[2]

Reduces Unnecessary Medical Care

- Palliative care reduces unnecessary use of hospitals, diagnostic and treatment interventions, and nonbeneficial intensive care.[3]
- One recent study of patients with palliative care consultations in the ICU found a demonstrated trend that these consultations reduce length of hospital stays without impacting mortality.[4]

Provides Cost Savings

- A 2016 study showed that giving cancer patients a palliative care consultation within two days of hospital admission reduced costs 22-32%.[5]
- One study of Medicaid patients in New York hospitals found an average savings of $6,900 per patient when palliative care was provided. The study concluded that if the assumed 2-6% 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.[6]
- A study of an inpatient palliative care program at Johns Hopkins Medicine found the program saved the institution $452 per transfer.[7]

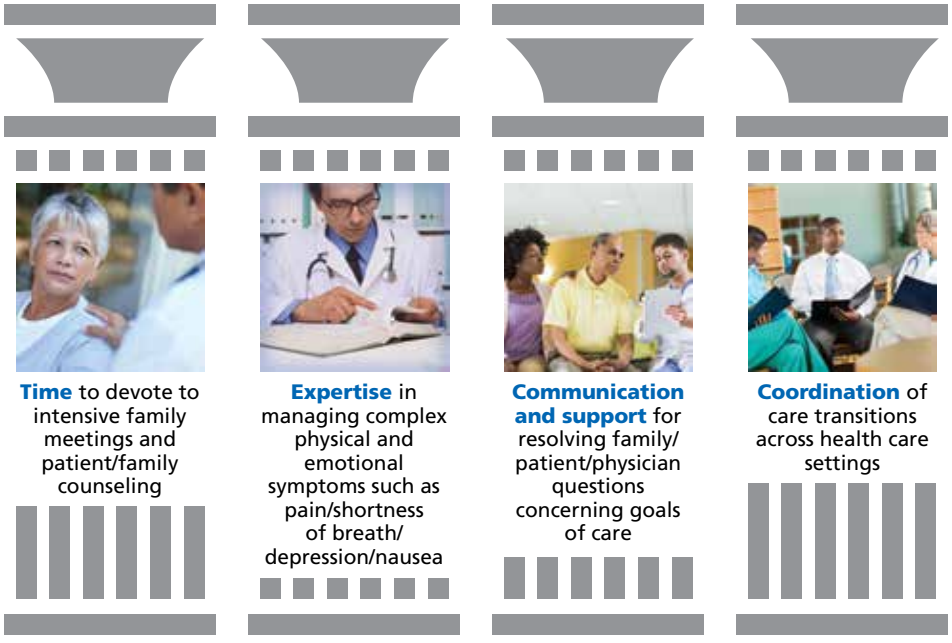
SUCCESS STORY

Kentucky

On March 27, 2019, Kentucky Gov. Matt Bevin signed a bill to expand awareness and utilization of palliative care throughout the state into law. With its passage, Kentucky became the 25th state to establish a Palliative Care Interdisciplinary Advisory Council as well as a Professional Information and Education Program in accordance with ACS CAN's model legislation.

Hospice and palliative care providers nationwide have long worked to increase public awareness and understanding of their services and misconceptions about these types of care have been a significant barrier to greater utilization. The Centers to Advance Palliative Care (CAPC) estimates that 70% of people in the United States are "not at all knowledgeable" about palliative care. Increasing public awareness can lead more patients to pursue palliative care; CAPC research shows that 92% of people who have a good understanding of palliative care say they would seek out this type of care for themselves or a family member.

Pillars of Palliative Care



PALLIATIVE CARE

IMPROVING QUALITY OF LIFE FOR CANCER PATIENTS

VOLUNTEER STORY

ACS CAN Wisconsin State Lead Ambassador Kay Lock learned firsthand about the need for access to palliative care when her son Ian was diagnosed with osteosarcoma, a rare bone cancer, when he was only 16 years old. Despite this earth-shaking diagnosis, Kay felt lucky: the hospital treating Ian specialized in palliative care and got to work immediately, not only treating Ian's cancer, but the side effects of both his disease and treatment.

"Ian's oncologists, nurses and surgeons focused on removing the tumor, cancer treatment protocol, his nausea and infection control," Kay said. "His pain team monitored his comfort level and pain caused by the surgeries and the side effects of chemotherapy, including painful sores that formed throughout his entire digestive system. Our fear, anxiety, stress and wellness were managed by social workers, psychologists, nutritionists and home care professionals."

This past April, Kay participated in ACS CAN's Day at the Capital in Madison, urging lawmakers to pass palliative care legislation to create an advisory committee that would help shape the future of palliative care for every Wisconsinite. She wants all patients faced with diagnoses as scary as Ian's to have the same wonderful level of care that her family experienced.

Ian's story dispels the misconception that palliative care means hospice or end-of-life care. Ian's cancer is in remission, and this fall he will begin a PhD program in Molecular Cancer Biology at Duke University. His mission is to become a cancer researcher and help patients like himself.

Kay Lock, Fond Du Lac, WI

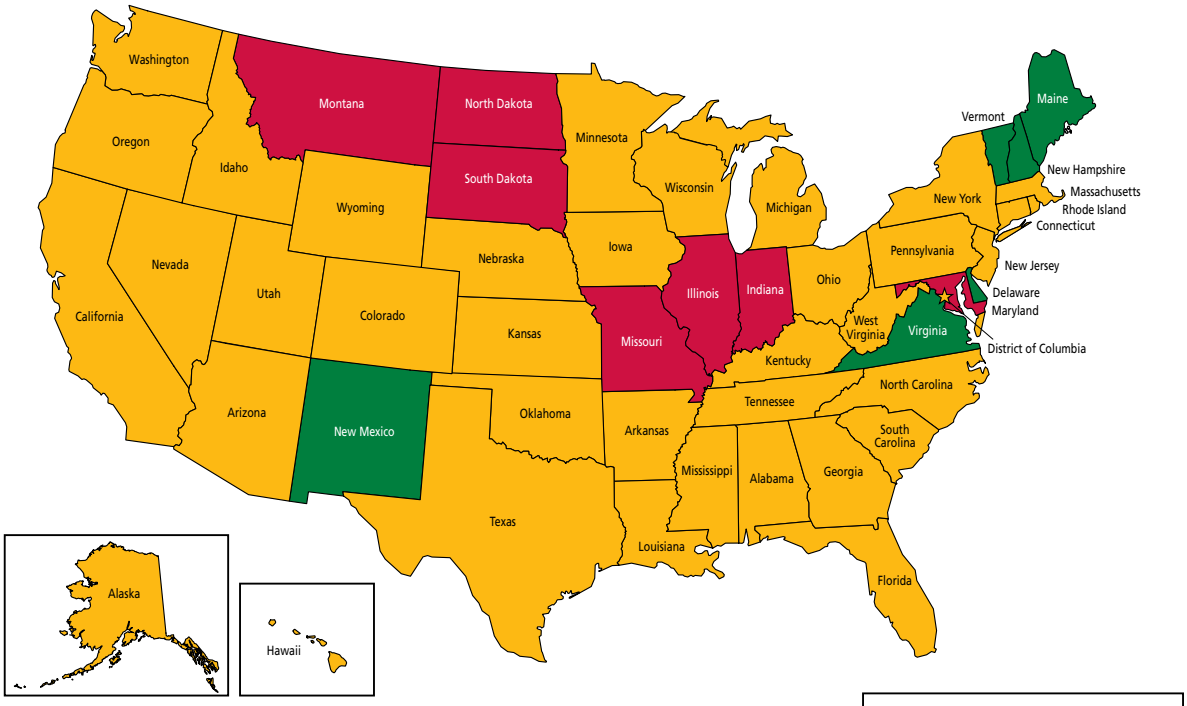
NEW FEDERAL OPIOID LEGISLATION

In the fall of 2018, Congress passed the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act—comprehensive legislation to combat the opioid epidemic. This federal law contains many new policies and funds to address the full continuum of the epidemic: preventing addiction, treating addiction and addressing problems with illicit and illegal drugs. Provisions particularly relevant to state policymakers include:

- Additional funding for prescription drug monitoring programs to improve their capabilities, including interoperability.
- Development of guidance on how payers, including state governments, can cover more opioid alternatives for pain management and incentivize their use.
- Providing resources and in some cases additional authority to state and local agencies to address problems with illicit opioids, synthetic drugs and foreign shipment of illegal drugs.
- New requirements for Medicaid programs to implement safety edits (checks at the pharmacy) for certain opioid prescriptions, with exemptions for cancer and palliative care patients.

STRIVING FOR BALANCE

2019 Pain Policy in the States



How Do You Measure Up?

Source: Sonderegger Research Center at the University of Wisconsin School of Pharmacy. For more information on this report card, please visit: www.fightcancer.org/painreportcard

THE CHALLENGE

Pain is one of the most feared symptoms for cancer patients and survivors. Nearly 60% of patients in active treatment and 30% of patients who have completed treatment experience pain. Pain can be caused by cancer when tumors interfere with normal body function; pain can also be caused by cancer treatments. Research has concluded that about one-quarter of women who have had breast cancer surgery have significant and persistent breast pain six months after the procedure. If left untreated, chronic pain can have long-term negative effects, including prolonged recovery and a weakened immune system. It can also affect a patient's quality of life, including their ability to sleep, eat, work and carry on every aspect of their daily life.

But given proper attention, most pain can be treated and relieved. Integrative pain care that includes non-drug therapies along with medications is effective in keeping cancer patient pain under control.

Unfortunately, despite the fact that millions of cancer patients and survivors experience chronic pain, it remains

STRIVING FOR BALANCE

a highly stigmatized issue. Significant disparities exist in pain treatment, with medically underserved and socioeconomically disadvantaged populations experiencing disproportionately restricted access. And many evidence-based non-drug therapies, like physical therapy or cognitive behavioral therapy, often come with high cost sharing for patients or are not reimbursed by insurers. 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 for patients in active cancer treatment as well as cancer survivors—but some legislative and regulatory proposals intended to curb the opioid addiction crisis could interfere with cancer patients' access to these medications.

THE SOLUTION

As a nation, we must take steps to identify balanced solutions that address the opioid epidemic, while not creating unintended barriers to access needed opioid medications for cancer patients, cancer survivors and others with serious chronic illness. ACS CAN strives to be the voice of the cancer patient in this nationwide debate, emphasizing the need for a balanced approach to curbing opioid misuse and abuse while maintaining access to pain relief for patients. As such, ACS CAN supports balanced policies such as:

- Ensuring that any prescribing or coverage limits for opioids do not stop cancer patients, cancer survivors, and patients in need of palliative care from receiving their clinically-appropriate treatments.
- Creating and maintaining prescription drug monitoring programs that allow doctors and pharmacies to work together to curb misuse and abuse, while also helping to ensure care coordination.
- Funding federal research to develop new, evidence-based pharmacological and non-pharmacological pain treatments, increasing provider education on pain management.
- Ensuring that public and private insurance programs cover the range of evidence-based pain treatments in a way that is accessible and affordable for patients,
- Creating effective drug take-back programs that provide cancer patients and others with a safe way to dispose of unused medication.

DID YOU KNOW?

According to recent research conducted by ACS CAN in tandem with the Patient Quality of Life Coalition and Public Opinion Strategies:

- Forty-eight percent of cancer patients and survivors have been told by doctors that their pain treatment options were limited by laws, guidelines or insurance coverage.
- Twenty-seven percent of cancer patients and survivors have been unable to get their prescription pain medication because a pharmacist would not fill it, even though they had the medication in stock.
- Both physicians and patients support policies to address the opioid epidemic— but they also agree that extreme policies that compromise access to care for patients should be rejected.[1]

A STATE INVESTMENT

CANCER PREVENTION AND RESEARCH APPROPRIATIONS

THE CHALLENGE

We have made significant improvements in the way we diagnose and treat cancer over the past two decades. Through scientific discovery, we have also learned how to reduce our cancer risk more effectively or prevent it altogether.

As the nation's largest nonprofit entity funding cancer research, the American Cancer Society is a proud leader in the fight to end suffering and death from cancer. Our work is far from done, and sustained government investment in cancer control, research and surveillance is critical to ensuring the next breakthroughs reach those who need them.

If federal and state lawmakers do not continue to invest heavily in research and discovery, we risk squandering our momentum. Research needs steady funding—without it, potential cures will languish in labs across America and the important breakthroughs we're so close to making will never come to fruition.

THE SOLUTION

The federal government is by far the largest funder of cancer research and 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.

But state lawmakers also play a critical role in supporting cancer control, research and surveillance. That's why ACS CAN is urging state legislatures to increase their investments in these evidence-based programs to maximize their lifesaving impact. ACS CAN is also encouraging states to go

a step further and invest funds directly into cancer research programs. This section highlights examples of states rising to this important challenge.

HEALTH EQUITY RESEARCH

Massachusetts

In 2018, Massachusetts Gov. Charlie Baker signed into law a decade-long effort toward improving health equity in the Commonwealth. The Massachusetts 2019 state budget includes a policy provision seeking to reduce racial and ethnic health disparities across the state. This accomplishment is the culmination of an over 10-year campaign and partnership by ACS CAN and members of the Disparities Action Network (DAN) coalition.

Not all communities are benefitting equally from notable advancements in cancer prevention, screening and treatment. Cancer incidence and mortality rates are disproportionately higher in racial and ethnic minority populations, a result of various factors including limited access to health insurance and social inequity. The consequences of such disparities are that diseases like cancer are more often diagnosed at later stages when options for treatment, as well as odds for survival, may be decreased.

The initiative passed by the Massachusetts legislature takes an essential step toward improving health outcomes for all individuals with cancer and other serious diseases. The law creates a permanent Office of Health Equity within the Executive Office of Health and Human Services. The office will eliminate health disparities through coordinating interagency initiatives, evaluating interventions and identifying and replicating successful practices across the state.

Massachusetts has long worked to address the state's health disparities gap. In 2004, the Massachusetts legislature created the "Commission to End Racial and Ethnic Health Disparities," charged with examining the racial, ethnic and linguistic disparities in health and providing an action plan for the state to address these disparities. In 2007, the Commission released its final report containing recommendations including the creation of an Office of Health Equity. Years of perseverance by public health advocates have led to this significant win for residents of the Commonwealth, including cancer patients, survivors and those at risk of developing the disease. As of result of these state efforts, Massachusetts has an insured rate of 97.5%.

CANCER RESEARCH FUNDING

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 state income tax forms and individual donations. CBCRP funding empowers California researchers 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 $280 million in research funds has been awarded to 133 institutions across California.

Florida

In 1999, the Florida 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. Total funding for Florida's biomedical research

CANCER PREVENTION AND RESEARCH APPROPRIATIONS

programs is currently at $23 million, with $3 million carved out specifically for pediatric cancer research. ACS CAN has made advocating for these programs a priority.

New Jersey

In 2018, Gov. John Murphy signed the legislature's budget which included a $2 million appropriation for the New Jersey Commission on Cancer Research, a $1 million increase from previous years. This $2 million appropriation was included in Governor Murphy's proposed budget this year and ACS CAN is advocating for its preservation in the final FY2020 budget. The New Jersey Commission on Cancer Research (NJCCR) promotes significant and original research in New Jersey into the causes, prevention, treatment and palliation of cancer and serves as a resource to providers and consumers of cancer services.

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% of CPRIT's funding is used for the delivery of cancer prevention programs and services. CPRIT's prevention programs reach Texans in every county and CPRIT's grantees have provided 5.2 million screenings and prevention services, detected over 3,500 incidences of cancer and enrolled 13,000 patients in clinical trials.

CPRIT, which brings breakthrough cancer treatments to the Lone Star State, needed to be reauthorized this year. A unanimous Senate vote reaffirmed the importance of CPRIT and in November 2019, Texas voters will again have the opportunity to voice their support for an agency dedicated to

VOLUNTEER STORY

One of the many ways in which the Cancer Prevention and Research Institute of Texas (CPRIT) benefits Texans is by bringing clinical research trials to the state. Cathleen McBurney of Lakeway, Texas, is a seven-time survivor of an extremely rare head and neck cancer. In 2013, as a result of a CPRIT-funded study, doctors were able to provide Kathleen with a more precise treatment that helped to eradicate a plum-sized tumor from her head.

In July 2018, Cathleen was diagnosed with a metastasis of her original cancer, adenoid cystic carcinoma, for the fifth time. Her tumor was inoperable, but she connected with MD Anderson physician and CPRIT grant recipient Dr. Jack Phan, who studies Stereotactic Based Radiation Therapy (SBRT) as a first line treatment for some head and neck cancers. Cathleen completed this re-irradiation trial in October 2018, which stabilized the cancer in her jaw.

During the 2019 legislative session, Cathleen told the Texas Legislature that CPRIT has helped save her life and reiterated how devastating the loss of CPRIT would be to cancer patients. She has since been diagnosed with metastasis to both her lungs and liver. There are currently no systemic treatments for her cancer, but with sustained funding and robust funding for cancer research, we can increase the odds of finding lifesaving therapies for Cathleen and others living with ineffective treatment for their cancer diagnosis.

Cathleen McBurney, Lakeway, TX

finding cures and therapies for cancer. ACS CAN was a leader in the establishment of CPRIT and led the effort this year to successfully advocate for the agency's reauthorization.

- Eighty-nine percent of Texas voters agree it is important for the state to remain a national leader in cancer research and prevention.
- Seventy-eight percent of voters believe it's important to continue CPRIT's lifesaving work.
- The fight against cancer is far from over, and the work of CPRIT is more critical than ever. Just this year, in Texas, more than 41,000 people will die of cancer and there will be an estimated 124,000 new cancer diagnoses.

TOBACCO RESEARCH FUNDING

California

California also has a robust Tobacco-Related Disease Research Program (TRDRP) that is funded through tobacco taxes (Propositions 99 and 56) 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. 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. The FY 2019 funding level for TRDRP is $58,581,000. Prior to the passage of Proposition 56, funding for TRDRP was at $10,478,000.

TOBACCO 21: PROMISING POLICY OR A WOLF IN SHEEP'S CLOTHING?

The tobacco industry has spent billions of dollars hiring lobbyists and buying influence in statehouses across the country in order to protect their profits from effective tobacco control policies.

After decades of influence spending, the tobacco industry has gained a detailed understanding of how state and local legislatures work and built a powerful network of lobbyists and lawmakers to help advance their agenda.

Big Tobacco is one of the most shrewd, capable and wealthy special interests in America. And as the industry recently surveyed the modern landscape of tobacco control and the public's rising concerns about youth use of their products, they appear to have identified a new opportunity to advance their interests, a promising and popular policy that was ripe for cooption: Tobacco 21.

TOBACCO 21

In March of 2015, the Institute of Medicine (IOM) released a report, Public Health Implications of Raising the Minimum Age of Legal Access to Tobacco Products, that used two models to predict the impact of raising the national minimum age of sale for tobacco products to 21. The two models estimated that raising the national minimum legal sales age would reduce initiation, tobacco-related morbidity and mortality across the lifespan, and ultimately save lives. Specifically, the report predicted that smoking prevalence would decline by 12% if the national minimum age of sale was raised to 21. One of the models also predicted that such a policy would result in approximately 223,000 fewer premature deaths, 50,000 fewer deaths from lung cancer, and 4.2 million fewer years of life lost for those individuals born between 2000 and 2019.

This report—and the dramatic 36% spike in youth tobacco product use over the last year driven by the popular e-cigarette Juul—has inspired a flurry of local ordinances and state bills to increase the minimum legal sales age for tobacco products to 21. While the American Cancer Society Cancer Action Network (ACS CAN) generally supports this promising policy, not all tobacco 21 bills are designed to achieve good public health outcomes and it's important to closely evaluate each proposal.

ACS CAN's Guide to Effective Tobacco 21 Policies

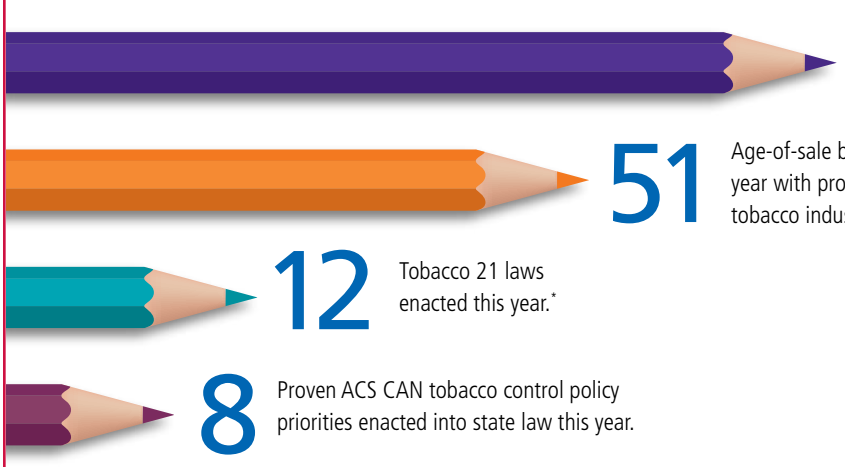
Strong tobacco 21 laws DO:

- Cover all tobacco products, including electronic cigarettes.
- Implement measures that enable active enforcement, such as retailer licensing and penalties, including license suspension and revocation.

Strong tobacco 21 laws DO NOT:

- Create new categories of products, which exempt certain products from other tobacco control laws.
- Penalize youths.
- Preempt other jurisdictions from passing strong tobacco control laws.

BY THE NUMBERS: Tobacco 21's Popularity Comes at the Expense of Other Important Tobacco Control Policies



88 State bills introduced in 2019 and tracked by ACS CAN to raise the age of sale for tobacco products.

51 Age-of-sale bills introduced this year with provisions that advance tobacco industry interests.

12 Tobacco 21 laws enacted this year.*

8 Proven ACS CAN tobacco control policy priorities enacted into state law this year.

- **ONE** Statewide cigarette tax increase by $1 per pack or more (Illinois).
- **ONE** Smoke-free law loophole closed (New Mexico).
- **FIVE** Smoke-free laws strengthened to include e-cigarettes (Colorado, Florida, Minnesota, New Mexico and South Dakota).
- **ONE** Significant increase in state tobacco control program funding (Maine). For FY 20, Maine will spend more than 50% of CDC's recommended spending.

*Tobacco 21 legislation was passed in New Hampshire and New York but both bills are still awaiting action by the state's respective governors.

In fact, tobacco companies and their allies have been using minimum legal sales age legislation to their advantage by advocating for measures that will fail to address youth tobacco use while protecting their profits and allowing them to appear genuinely concerned about tobacco's deadly impact on young people. Just this year ACS CAN has seen industry-backed bills that block communities from passing stronger public health laws, weaken restrictions on retailers selling to youths, create carve outs for certain products and exempt specific populations that are frequently targeted by industry marketing.

But for Big Tobacco, weak tobacco 21 policies are more than just a vehicle to advance their legislative agenda; working to pass ineffective laws allows the industry to appear concerned about public health while giving lawmakers whose constituents are demanding action to address youth tobacco product use a chance to act.

Tobacco companies have gone to great lengths to publicize their support for tobacco 21 laws, taking out newspaper and online ads touting their support for raising the legal age of sale for tobacco products and deploying corporate leadership to help introduce a tobacco 21 bill before state lawmakers.

TOBACCO 21: PROMISING POLICY OR A WOLF IN SHEEP'S CLOTHING?

DELAY AND DISTRACT: A DECADES-OLD STRATEGY

In a 1996 internal strategy memo, Phillip Morris—now known as Altria—laid out a plan to defeat the "anti-tobacco" movement through a variety of measures, including advancing "legislation to address youth smoking" in order to "enhance our credibility." By building a like-minded coalition and working with retailers to "reduce youth access to tobacco," Phillip Morris hoped to "publicize the effectiveness of our approach versus bans on tobacco advertising and marketing practices."

Big Tobacco's convenient advocacy for tobacco 21 is simply the newest attempt to delay and distract from efforts to pass comprehensive, meaningful tobacco control laws that would cut into their profits and effectively reduce tobacco use among youths.

IN THEIR OWN WORDS: THE TOBACCO INDUSTRY ON PREEMPTION

Industry leaders have recognized that state laws which preempt local anti-tobacco ordinances are the most effective means to counter local challenges.

– Kurt Malmgren,
R.J. Reynolds Tobacco Company internal document, 1992

Our top priority in fighting the proliferation of smoking bans and restrictions can be summed up in two words: 'accommodation' and 'preemption.'

– Ellen Merlo,
Philip Morris internal document, 1994

While we're not married to any particular form of pre-emption language, we're dead serious about achieving pre-emption in all 50 states.

– Tina Walls,
Philip Morris internal document, 1994

The companies that manufacture cigarettes—which will kill 5.6 million Americans currently under the age of 18—have not suddenly become concerned about the devastating public health impact of their products; rather, their support for tobacco 21 is simply the newest page out of their decades-old playbook. The industry is doing everything they can to distract from their record of profiting off death and disease. Their supposed newfound interest in protecting our kids is a manipulative and dangerous attempt to paint over their role in hooking young people to their deadly products through targeted marketing and flavored products.

Lawmakers are understandably eager to pass tobacco 21 legislation and act on an issue that matters deeply to their constituents and communities. But passing ineffective tobacco control laws is dangerous for public health—whether it's a tobacco tax or a smoke-free law, legislatures can take years, even decades, to correct and strengthen weak tobacco control laws they've put on the books before.

We can't count on Big Tobacco's lobbyists to pass laws that will protect our kids from a lifetime of addiction. And we can't afford to wait any longer to act. In just the past year, youth e-cigarette use has skyrocketed, and approximately 4.9 million middle and high schoolers across our country have used tobacco products. ACS CAN urges lawmakers to pass legislation that will best protect youths now and not benefit the tobacco industry for years to come.

While tobacco 21 laws have an important role to play in preventing youth tobacco product use, these laws alone will not solve this growing problem. To successfully protect our kids from a lifetime of addiction and reduce tobacco's deadly toll on our communities, strong tobacco 21 laws must be paired with effective policy interventions including increasing the price of tobacco products through regular and significant cigarette and other tobacco product taxes, implementing comprehensive smoke-free and tobacco-free laws and policies for all public places and fully funding tobacco prevention and cessation programs.

TOBACCO 21: PROMISING POLICY OR A WOLF IN SHEEP'S CLOTHING?

PREEMPTION

Preemption—when states revoke local authority, restricting local lawmakers' ability to pass innovative, proactive policies that are stronger than the state's law—is a top priority of Big Tobacco, and is the most dangerous policy that has been successfully attached to tobacco 21 laws in 2019.

It is vital that local governments retain the power to pass laws that impact their community's health, happiness and prosperity. Many important public health policies are often first developed and passed at the local level, long before state legislatures take action.

While citizens benefit from local control, special interests benefit from preemption. Preempting local control allows the tobacco industry to protect their profits by preventing the passage of tobacco control policies that would keep people from starting to use their deadly products and help others to quit.

Big Tobacco again lobbied heavily in favor of preemption this year, reflecting a sustained and significant investment in this policy strategy. The industry and its allies have advanced legislation to establish or maintain preemption over local governments' ability to regulate tobacco products, modify legal age of sale or institute smoke-free policies in 26 different states in 2019 alone.

Allowing local governments to introduce and pass public health policies that best fit their communities is critical to advancing best practices across the country. Passing public health policies at the local level creates an opportunity for community debate, education and engagement that is unparalleled at the state or federal level. This process

SUCCESS STORY

Arizona

In Arizona, the tobacco industry attempted to use a bill to raise the tobacco sales age to 21 as a vehicle to pass language that would have preempted local jurisdictions from regulating tobacco. The bill sponsor made it very clear that the bill language was drafted and supported by the tobacco industry and preemption was a primary goal. The bill's supporters were so invested in upending tobacco control in Arizona that the initial draft that passed out of the House Health and Human Services Committee would have overturned a 20 year-old law preventing the possession and use of tobacco on school campuses.

While that provision was later amended out of the bill, the measure preventing cities, towns and counties from licensing tobacco retailers and passing other proven tobacco control measures remained. Ultimately, the concerns of ACS CAN and other advocates for public health and local control were heard and the bill was never given a full vote by the Arizona House of Representatives.

fosters a broader, deeper understanding of the goals and importance of these public health approaches among local communities and can result in more sustainable, effective policies across issue areas.

As a local, state and federal advocate, ACS CAN supports each level of government's ability to implement policies to protect the public's health. In order to reduce suffering and death from cancer effectively, we must preserve the right of local governments to pass public health policies that are stronger than state and federal laws.

CONCLUSION

Restricting youth and young adult access to tobacco products can be a critical component to a comprehensive strategy to reduce initiation and lifelong addiction. But the devil is in the details—lawmakers must ensure the tobacco 21 laws they pass are designed to best prevent youth use of tobacco products and are not being deployed as a stalking horse to advance industry interests and preempt local officials' ability to pass laws that protect their community's public health.

STOPPING CANCER BEFORE IT STARTS

PREVENTION INTRODUCTION

A recent study by the American Cancer Society found that at least 42% of newly diagnosed cancers in the U.S. are potentially avoidable—including 19% caused by smoking and 18% caused by a combination of excess body weight, physical inactivity, excess alcohol consumption and poor nutrition.[1] Many of the more than 5 million skin cancer cases that are diagnosed annually could be prevented by protecting skin from excessive sun exposure and avoiding indoor tanning devices.[2]

A person's zip code should not dictate whether they are adequately protected from cancer risks. Everyone in America deserves to be covered by evidence-based cancer prevention policies that protect all from harm from secondhand smoke, prevent all kids from starting to use tobacco products and tanning beds, and provide access to healthy, affordable foods and walkable, safe communities.

TOBACCO

Tobacco use places a staggering burden on our country. According to a U.S. Surgeon General report, more than 20 million premature deaths over the past half century can be attributed to cigarette use in America.[3]

Despite the proven health risks, 14% of U.S. adults—approximately 34.3 million people—and 8.1% of high school students—approximately 1.18 million people—still smoke cigarettes.[4,5]

TOBACCO USE

Flavors in a tobacco product are one way the tobacco industry lures new, young users to a lifetime of addiction. Four in five teens and nearly three in four of young adults who were current tobacco users in 2014 reported that the first tobacco product they ever used was flavored. Youths who smoke cigarettes are more likely to smoke menthol and two-thirds of youth e-cigarette users use a flavored product.

Among high school students who reported currently using tobacco products in 2018:

- 20.8% use e-cigarettes (3,050,000 students).
- 8.1% use cigarettes (1,180,000 students).
- 7.6% use cigars, cigarillos or little cigars (1,100,000 students).
- 5.9% use smokeless tobacco (870,000 students).
- 4.1% use hookahs (590,000 students).
- 1.1% use pipe tobacco (160,000 students).[6]

Among adults who reported currently using tobacco products in 2017:

- 14% of adults used cigarettes (34.3 million adults).
- 3.8% used cigars, cigarillos or filtered little cigars (9.3 million adults).
- 2.8%used electronic cigarettes (e-cigarettes) (6.9 million adults).
- 2.1% used smokeless tobacco (5.1 million adults).
- 1.0% used regular pipes, water pipes or hookahs (2.6 million adults).[7]

Current use of any tobacco product was higher among certain adult populations including:

- Males.
- People less than 65 years old.
- Non-Hispanic American Indian/Alaska natives (AI/AN), whites, blacks and persons of multiple races.
- Persons living in the South or Midwest.
- Persons with a General Educational Development (GED) certificate.
- Persons with annual household income of less than $35,000.
- Persons who were single, never married or not living with a partner or divorced, separated or widowed.
- Persons who were uninsured or insured through Medicaid or other public insurance.
- Persons with a disability.
- Persons who identified as lesbian, gay or bisexual.
- Persons with serious psychological distress.

STOPPING CANCER BEFORE IT STARTS

The problem with tobacco dependence goes beyond just cigarettes, and it affects certain populations more than others. From 2017 to 2018, e-cigarette use spiked by an astonishing 78% among high school students and 48% among middle school students, leading to a 36% spike in overall tobacco use among youths.

As of 2018, 4.9 million kids in our middle and high schools are current tobacco product users, and 41.7% of those current youth users reported using more than one kind of tobacco product. In 2017, 19.3% of U.S. adults used any tobacco product, and 19% of those current users reported using more than one kind of tobacco product. Proven, population-level interventions that focus on the wide range of tobacco product use are important to reducing tobacco-related disease and death in the U.S.[8]

There are three proven ways to reduce tobacco use and secondhand smoke exposure. 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:

- Increasing the price of tobacco products through regular and significant tobacco tax increases of at least $1 per pack of cigarettes with an equivalent rate on other tobacco products.
- Implementing comprehensive smoke-free policies.
- Adequately funding evidence-based tobacco prevention and cessation programs.

In addition to these three proven tobacco control policy interventions, the American Cancer Society Cancer Action Network (ACS CAN) pursues other evidence-based policies that will prevent and reduce tobacco use including raising the age of sale for tobacco products to 21 with strong retailer compliance and active enforcement, restricting the sale of flavored tobacco products and limiting the quantity and location of tobacco retailers. 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 people who use tobacco in quitting permanently.[9,10]

HEALTHY EATING AND ACTIVE LIVING ENVIRONMENTS

Eighteen percent of all cancers are tied to poor nutrition, physical inactivity, excess weight and excess alcohol consumption.[12] There are policy interventions that can provide increased access to affordable healthy foods and increased physical activity opportunities.[13] It will take multi-faceted policy approaches across populations, systems and environments to enhance nutrition and physical activity and reduce obesity rates by removing barriers, changing social norms and increasing awareness. Reducing the risk of cancer can only occur when all levels of government collaborate with public, private and community sector partners to decrease obesity rates, improve nutrition and increase physical activity.

INDOOR TANNING

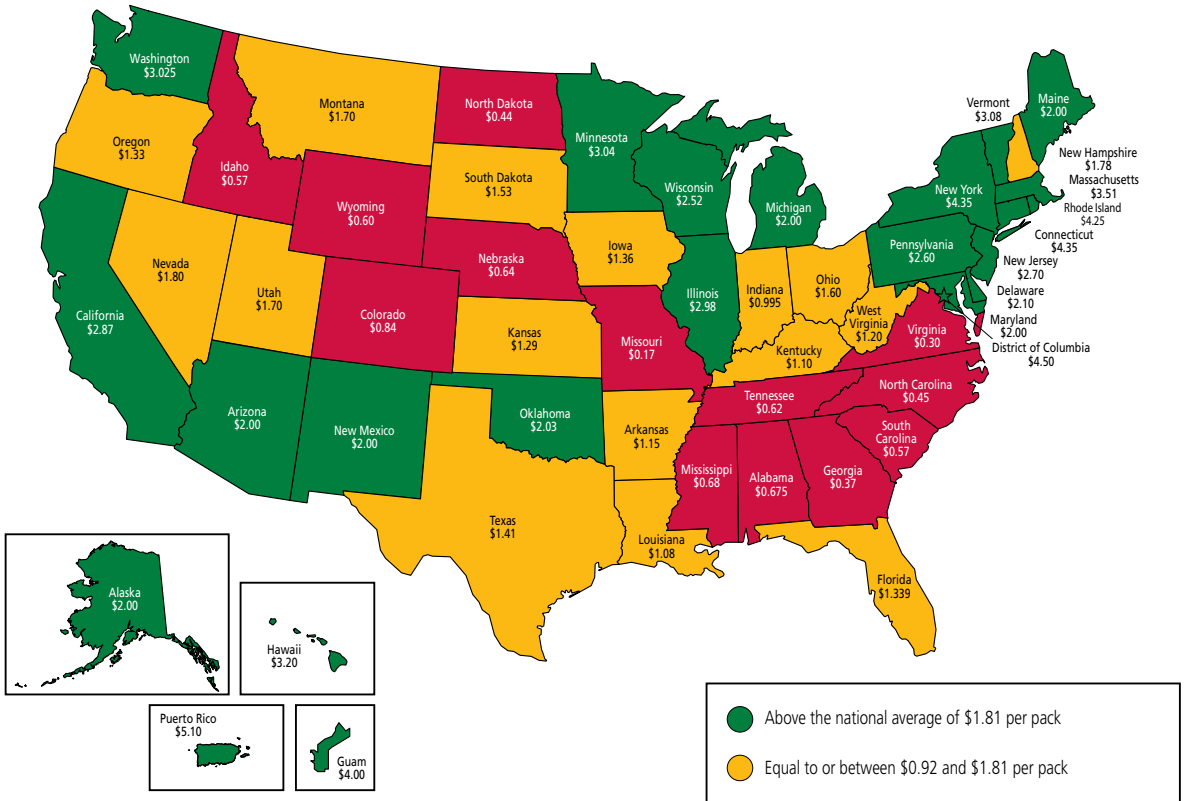
Exposure to ultraviolet (UV) radiation, through sunlight or the use of indoor tanning devices, is a risk factor for skin cancer. Fortunately, proven strategies exist to reduce this exposure. States can pass laws to prohibit minors under the age of 18 from using indoor tanning devices. Laws like these have been shown to reduce teen tanning[14,15,16,17] and can help reduce the risk of skin cancer for our young people.

DID YOU KNOW?

Tobacco use costs $170 billion annually in public and private health care expenditures in the United States.[11]

RAISING THE PRICE, ENDING ADDICTION

2019 State Cigarette Excise Tax Rates



How Do You Measure Up?

Tobacco taxes for Puerto Rico and Guam are not included in the national average.
Rates in effect as of July 1, 2019.

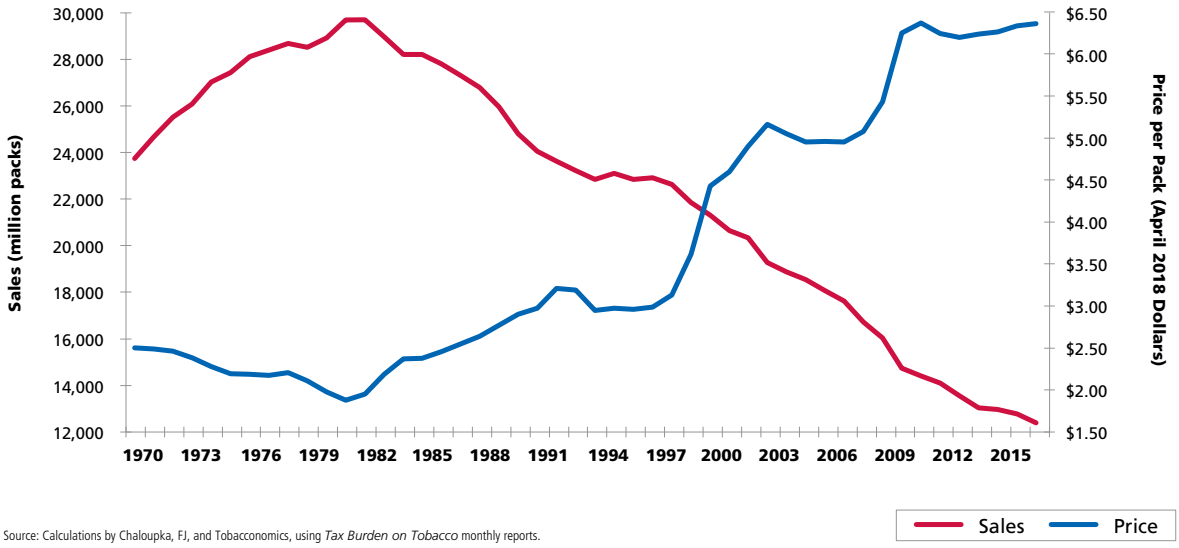
THE CHALLENGE

The personal and economic toll of tobacco on our communities is high. This deadly product costs the U.S. economy billions of dollars in health care costs and lost worker productivity annually; tobacco use drives around $170 billion in public and private health care spending 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] Yet the average retail price of a pack of cigarettes in the U.S. remains only $6.36.[3]

Research shows increasing taxes regularly and significantly on cigarettes, cigars, smokeless tobacco and all other tobacco products 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.

RAISING THE PRICE, ENDING ADDICTION

Cigarette Prices and Cigarette Sales, United States, 1970-2017



Source: Calculations by Chaloupka, FJ, and Tobacconomics, using *Tax Burden on Tobacco* monthly reports.

As of July 1, 2019, the average state cigarette excise tax was $1.81 per pack, but state cigarette excise tax rates vary widely, from a low of 17 cents per pack in Missouri to a high of $5.10 in Puerto Rico, $4.50 per pack in Washington, D.C. and $4.35 in New York and Connecticut. Since 2000, all but two states—Missouri and North Dakota—have raised their cigarette taxes in more than 140 separate instances.[4]

However, progress increasing cigarette and other tobacco products' tax rates has stalled. Since August 2014, only California, Guam, Illinois, Nevada, Northern Mariana Islands, Oklahoma, Pennsylvania, Puerto Rico and Washington, D.C., have increased their tax on cigarettes by $1 or more per pack. Lower-priced products make it easy and affordable for young people to start and continue to use tobacco products, make it harder for addicted individuals 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—often times going as far as proposing small tax increases that they know are too insignificant to have any effect on tobacco sales, consumption or incidence of tobacco-related diseases.

THE SOLUTION

The American Cancer Society Cancer Action Network (ACS CAN) recommends regularly increasing cigarette taxes by

SUCCESS STORY

Illinois

This year, Gov. J.B. Pritzker proposed a 32 cent per pack cigarette tax increase in Illinois as part of his budget. While this proposal was well intentioned, a small tobacco tax increase like this is simply not enough to have a significant public health impact.

ACS CAN Illinois staff and volunteers worked alongside partner health groups as well as key legislative champions to educate lawmakers and the public about why a tax increase of $1 or more was needed for the physical and fiscal health of the state.

ACS CAN's annual Day at the Capitol proved to be a turning point in the legislative session, with volunteers traveling in from across the state to urge their lawmakers to support a $1 per pack cigarette tax increase to save lives and state dollars. Ultimately, the vast majority of the Illinois Legislature supported this significant cigarette tax increase. Our organization is thankful for our lawmakers' work, especially Senate President John Cullerton and Gov. Prtizker.

The $1 per pack cigarette tax increase will prevent approximately 28,700 kids in Illinois from becoming adults who smoke.

RAISING THE PRICE, ENDING ADDICTION

a minimum of $1 per pack to have a meaningful public health impact. States should also regularly increase the tax on other tobacco products 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.

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

A WIN-WIN-WIN FOR STATES

Regular cigarette tax increases of $1 per pack or more—and parallel increases in the tax 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 product 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 who supports increasing the price of tobacco.

VOLUNTEER STORY

ACS CAN volunteer Brandon Hughes played a pivotal role in the successful campaign to increase the cigarette tax in the District of Columbia. Like many advocates, Brandon's motivation was personal: each of his grandparents and their siblings smoked, an addiction which would kill all but one of them. His parents, one of whom struggled to quit smoking for 30 years before succeeding, often told him how inescapable tobacco use was growing up.

Brandon met with lawmakers and testified before the District City Council to support the $2.00 per pack cigarette tax increase, which passed in the District's 2019 budget and is projected to lower youth smoking by over 20%, help 5,300 adults who currently smoke quit and save 2,000 lives. Brandon helped ACS CAN give the next generation the chance his parents and relatives never had—to grow up in a tobacco-free world.

Brandon Hughes, Washington, D.C.

EVERYONE HAS THE RIGHT TO BREATHE SMOKE-FREE AIR

THE CHALLENGE

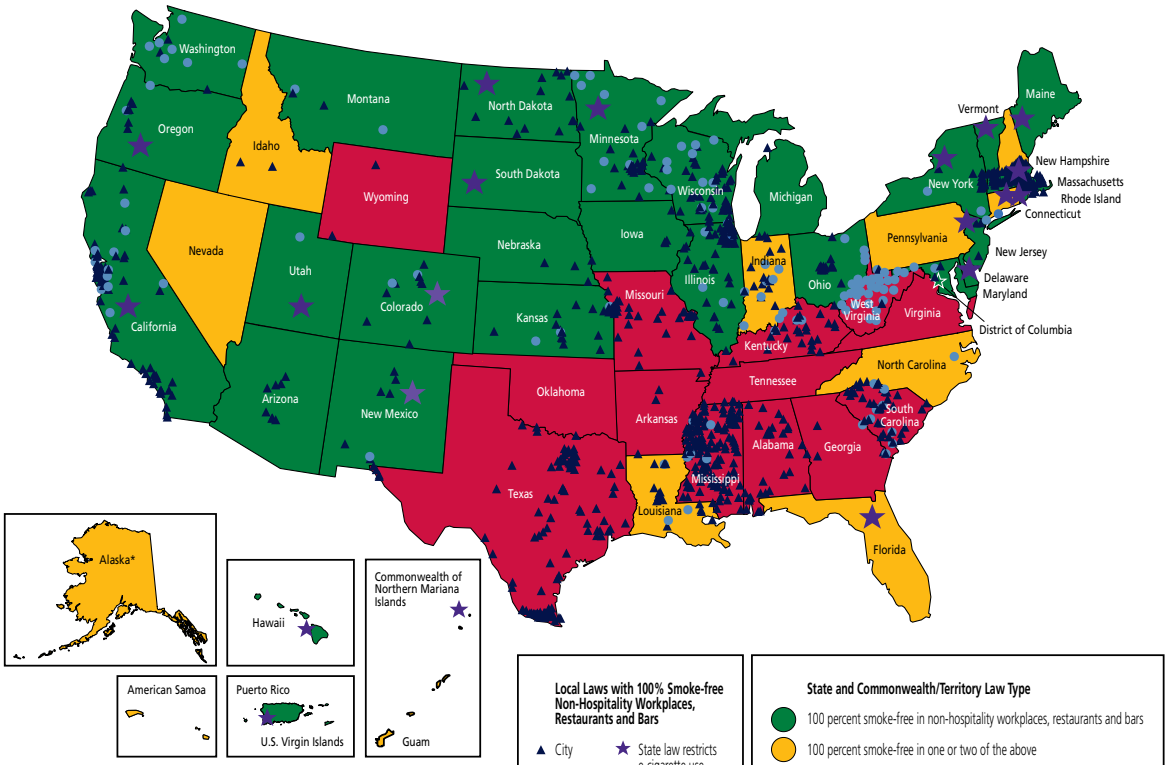
According to the U.S. Surgeon General[1,2] there is no safe level of exposure to secondhand smoke, which contains approximately 70 known or probable carcinogens[3] and more than 7,000 other toxic chemicals, including formaldehyde, arsenic, cyanide and carbon monoxide.[4]

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 health issues, including cardiovascular disease, stroke, respiratory infections and asthma.

As of July 1, 2019, 27 states, Puerto Rico, the U.S. Virgin Islands, the District of Columbia and more than 1,050 municipalities across the country have laws in effect that require 100% smoke-free workplaces, including restaurants and bars.[7]

Eighteen 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 61% of the U.S. population

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), 07/01/19 and American Cancer Society Cancer Action Network.
In effect as of July 1, 2019.

VOLUNTEER STORY

ACS CAN Georgia ACT! Lead, Lewis McTush, is playing a major role in making Atlanta the next smoke-free city. Lewis is a lifelong blues musician and advocate for the music he loves—but while Lewis' time in the blues music scene has provided some of the greatest experiences of his life, it has also caused hardship and heartbreak, as he has watched some of his closest friends become ill and die as a result of secondhand smoke exposure.

Many musicians play in smoke-filled venues across the Deep South and Midwest. After many years playing music in these dangerous conditions, Lewis decided to use his voice to protect his fellow musicians' health. Lewis joined ACS CAN as a volunteer leader representing the Stone Mountain area of Georgia. Lewis has rallied members of the music community and coordinated their testimony to elected officials in Atlanta about the importance of protecting musicians from secondhand smoke.

After working for years with ownership and management of the legendary blues establishment Blind Willies in the historic Virginia Highlands neighborhood in Atlanta, Lewis convinced them to voluntarily go smoke-free in order to protect musicians, customers and restaurant workers alike. When Atlanta goes smoke-free, it will be due in large part to the continued advocacy of Lewis and others like him who have stood up for the health of their communities.

Lewis McTush, Stone Mountain, GA

EVERYONE HAS THE RIGHT TO BREATHE SMOKE-FREE AIR

lives in a place with a comprehensive smoke-free law covering workplaces, including restaurants and bars.[8]

The American Cancer Society Cancer Action Network (ACS CAN) advocates for everyone's right to breathe smoke-free air so that no one is forced to choose between their health and a paycheck. But 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 SOLUTION

The only way to reduce exposure to secondhand smoke is to make all public places, including all workplaces, restaurants, bars and gaming facilities, 100% 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] Smoke-free laws also have been proven to reduce the incidence of coronary events among people under the age of 65.[10]

ACS CAN urges state and local officials to pass and protect comprehensive smoke-free laws in all workplaces, including restaurants, bars and gaming facilities, to protect the health of all employees and patrons. These laws should include electronic cigarettes, cigars and hookah as well. Lawmakers are encouraged to reject legislation that weakens smoke-free laws or preempts local governments from passing smoke-free laws.

DID YOU KNOW?

Smoke-free laws are good for business.

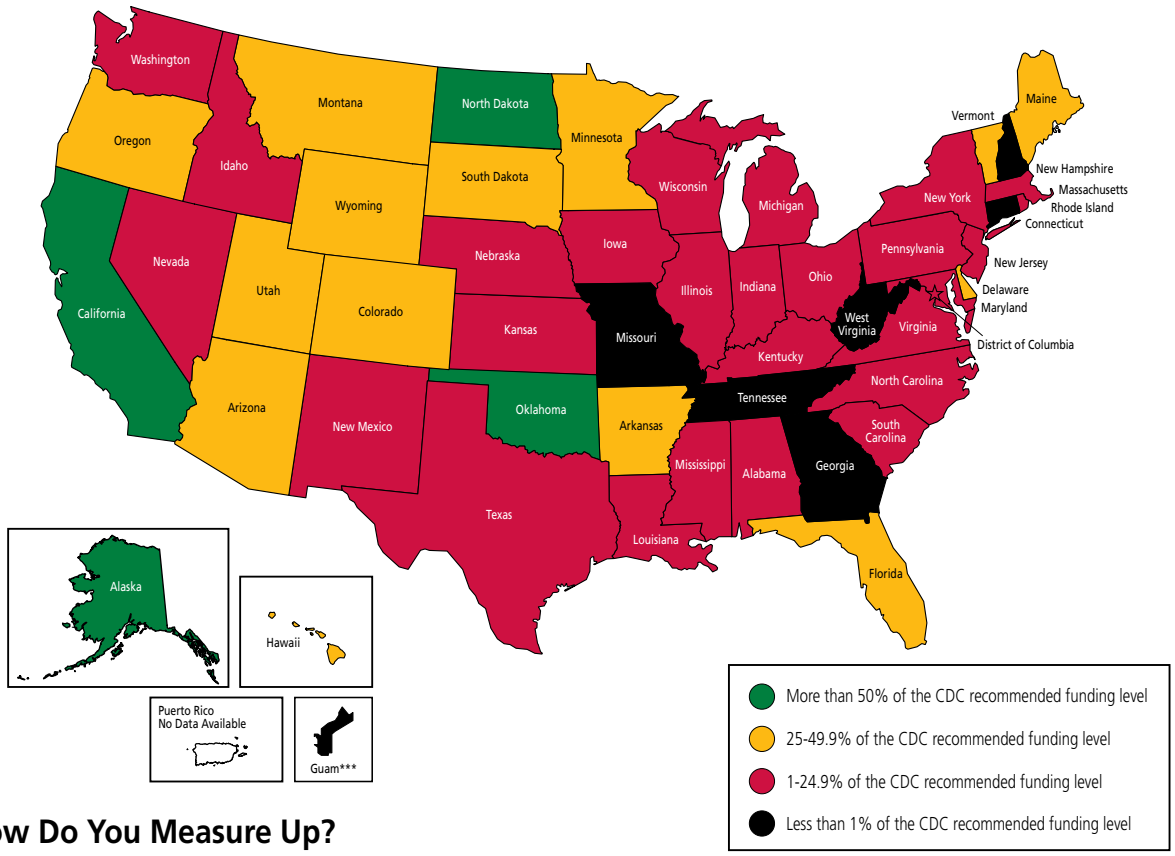
- The 2014 Surgeon General's report estimated the economic value of lost wages, fringe benefits and services associated with premature death due to secondhand smoke exposure to be $5.7 billion per year nationwide. This estimate excludes the losses due to disease and far underestimates the total economic impact of secondhand smoke.[11]

- Research strongly indicates that smoke-free laws are good for businesses, for workers and for customers. Research published in leading scientific journals has shown consistently and conclusively that smoke-free laws have no adverse effects on the hospitality industry and actually benefit businesses.[12,13,14]

TOBACCO CONTROL PROGRAM FUNDING

SUPPORTING AMERICANS IN THEIR ATTEMPTS TO QUIT AND KEEPING KIDS FROM STARTING

Fiscal Year 2019 State Funding for Tobacco Control



How Do You Measure Up?

*Source for Tobacco Prevention Funding, unless otherwise noted: Robert Wood Johnson Foundation, Truth Initiative, 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 20 Years Later. December 2018. Available at https://www.tobaccofreekids.org/what-we-do/us/statereport

**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.

***Data for Guam provided by local ACS CAN staff.

THE CHALLENGE

One of the most effective ways to reduce death and disease from tobacco use is to prevent addiction in the first place. Ninety-five percent of adults who smoke tried their first cigarette before the age of 21.[1] In 2018, a major spike in e-cigarette use and the stalling of previous declines in cigarette use led to an alarming 36% increase in overall tobacco use among youths. Many young people who use tobacco do not identify the type they use as a tobacco product or do not identify the tobacco product as harmful.[2] It's imperative that steps are taken to ensure programs are in place to protect the next generation from a lifetime of addiction.

The 2014 U.S. Surgeon General's report on tobacco concluded that comprehensive statewide and community tobacco prevention and cessation programs reduce tobacco use by keeping young people from becoming addicted and helping individuals who use tobacco to quit.[4] The report called for states to fully fund these programs at levels recommended by the Centers for Disease

SUPPORTING AMERICANS IN THEIR ATTEMPTS TO QUIT AND KEEPING KIDS FROM STARTING

The impressive results of the CDC's Tips From Former Smokers campaign builds on a proven multi-pronged approach to combat tobacco use that includes federal regulation of tobacco products, increased tobacco taxes, comprehensive smoke-free public spaces and workplaces and sustained investment in prevention and cessation.

Control and Prevention (CDC) as part of a comprehensive strategy to accelerate progress in eliminating death and disease caused by tobacco use. Unfortunately, not a single state currently funds tobacco prevention programs at the CDC-recommended level. Only two states—California and Alaska—fund their programs above 70% of the CDC-recommended level.

And in a disturbing trend, state legislatures across the country are actually gutting tobacco prevention and cessation program funding. Eighteen states experienced a decline in tobacco control funding in fiscal year 2019[3] and Connecticut, Tennessee and West Virginia allocated no state funding for tobacco prevention and cessation programs.

Although states are estimated to collect $27.3 billion in tobacco taxes and Master Settlement Agreement (MSA) payments in fiscal year 2019, they are slated to spend only 2.4% of that revenue on programs to reduce tobacco use.[5,6] It would

only take 12% of existing annual state tobacco tax and settlement revenue to fund all state programs at CDC-recommended levels.

THE SOLUTION

Comprehensive, adequately-funded tobacco prevention and cessation programs reduce tobacco use and related diseases, resulting in lower health care costs. To help states implement effective tobacco prevention and cessation programs, the CDC laid out its evidence-based recommendations for state investments in tobacco control in its Best Practices for Comprehensive Tobacco Control Programs.[7] The goals of a comprehensive tobacco prevention and cessation programs are to:

1. Prevent initiation of tobacco use among youths and young adults.
2. Promote tobacco cessation among both adults and youths.
3. Eliminate exposure to secondhand smoke.
4. Identify and eliminate tobacco-related disparities among population groups.

The American Cancer Society Cancer Action Network (ACS CAN) challenges states to combat tobacco-related illness and death by 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 resulting funds to state tobacco prevention and cessation programs.

State Tobacco Control Funding – FY 2019

State	State Tobacco Prevention Funding Allocations (FY19)[8]	CDC Recommended Spending[9]	Tobacco Prevention Spending % of CDC Recommended
Alaska	$9.1 million	$10.2 million	89.4%
California	$250.4 million	$347.9 million	72.0%
North Dakota	$5.8 million	$9.8 million	59.5%
Oklahoma	$21.3 million	$42.3 million	50.3%
Delaware	$6.3 million	$13.0 million	48.4%
Vermont	$3.8 million	$8.4 million	45.2%
Colorado	$23.6 million	$52.9 million	44.6%
South Dakota	$4.5 million	$11.7 million	38.5%
Florida	$70.4 million	$194.2 million	36.3%
Utah	$7.0 million	$19.3 million	36.3%
Wyoming	$3.0 million	$8.5 million	35.8%
Montana	$5.0 million	$14.6 million	34.0%
Hawaii	$4.5 million	$13.7 million	32.9%
Arkansas	$12.0 million	$36.7 million	32.7%
Minnesota	$17.3 million	$52.9 million	32.7%
Maine	$4.8 million	$15.9 million	30.4%
Arizona	$17.3 million	$64.4 million	26.9%
Oregon	$10.0 million	$39.3 million	25.6%
New Mexico	$5.7 million	$22.8 million	24.9%
Idaho	$3.6 million	$15.6 million	23.3%
Mississippi	$8.4 million	$36.5 million	23.1%
Maryland	$10.5 million	$48.0 million	21.8%
New York	$39.8 million	$203.0 million	19.6%
District of Columbia	$1.9 million	$10.7 million	17.8%
Iowa	$4.0 million	$30.1 million	13.4%
Nebraska	$2.6 million	$20.8 million	12.4%
Virginia	$10.8 million	$91.6 million	11.8%
Pennsylvania	$15.5 million	$140.0 million	11.1%
Indiana	$7.5 million	$73.5 million	10.2%
Ohio	$13.0 million	$132.0 million	9.8%
South Carolina	$5.0 million	$51.0 million	9.8%
Wisconsin	$5.3 million	$57.5 million	9.2%
Louisiana	$5.4 million	$59.6 million	9.0%
New Jersey	$7.2 million	$103.3 million	7.0%
Illinois	$9.1 million	$136.7 million	6.7%
Kentucky	$3.8 million	$56.4 million	6.7%
Massachusetts	$4.2 million	$66.9 million	6.3%
Alabama	$2.1 million	$55.9 million	3.7%
Nevada	$1.0 million	$30.0 million	3.2%
Rhode Island	$390,926	$12.8 million	3.1%
Kansas	$847,041	$27.9 million	3.0%
North Carolina	$2.8 million	$99.3 million	2.8%
Washington	$1.5 million	$63.6 million	2.4%
Texas	$4.2 million	$264.1 million	1.6%
Michigan	$1.6 million	$110.6 million	1.5%
New Hampshire	$140,000	$16.5 million	0.8%
Georgia	$750,000	$106.0 million	0.7%
Missouri	$48,500	$72.9 million	0.1%
Connecticut	$0	$32.0 million	0.0%
Tennessee	$0	$75.6 million	0.0%
West Virginia	$0	$27.4 million	0.0%
Guam[10]	$0	N/A	N/A

TOBACCO CONTROL PROGRAM FUNDING

SUPPORTING AMERICANS IN THEIR ATTEMPTS TO QUIT AND KEEPING KIDS FROM STARTING

DID YOU KNOW?

The more that states spend on comprehensive tobacco control programs, the greater the reductions in tobacco use. The longer states invest in such programs, the greater and quicker the impact and the more cost savings experienced. Cost savings result from tobacco control program investments in the form of reductions in smoking-caused pregnancy and birth complications, smoking-triggered asthma and respiratory illness, including those caused by secondhand smoke and other smoking-caused diseases such as stroke, heart disease and cancer.[11]

- California's tobacco control program reduced health care costs by $134 billion from 1989 to 2008, by spending only $2.4 billion on the program during the same time period.[12]
- Massachusetts estimates an annual health care cost savings of $85 million from its tobacco control investments, averaging a savings of $2 for every $1 spent.[13]
- A 2011 study found that Washington state saved more than $5.00 in tobacco-related hospitalization costs for every $1.00 spent during the first 10 years of its program.[14]

Despite the 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.

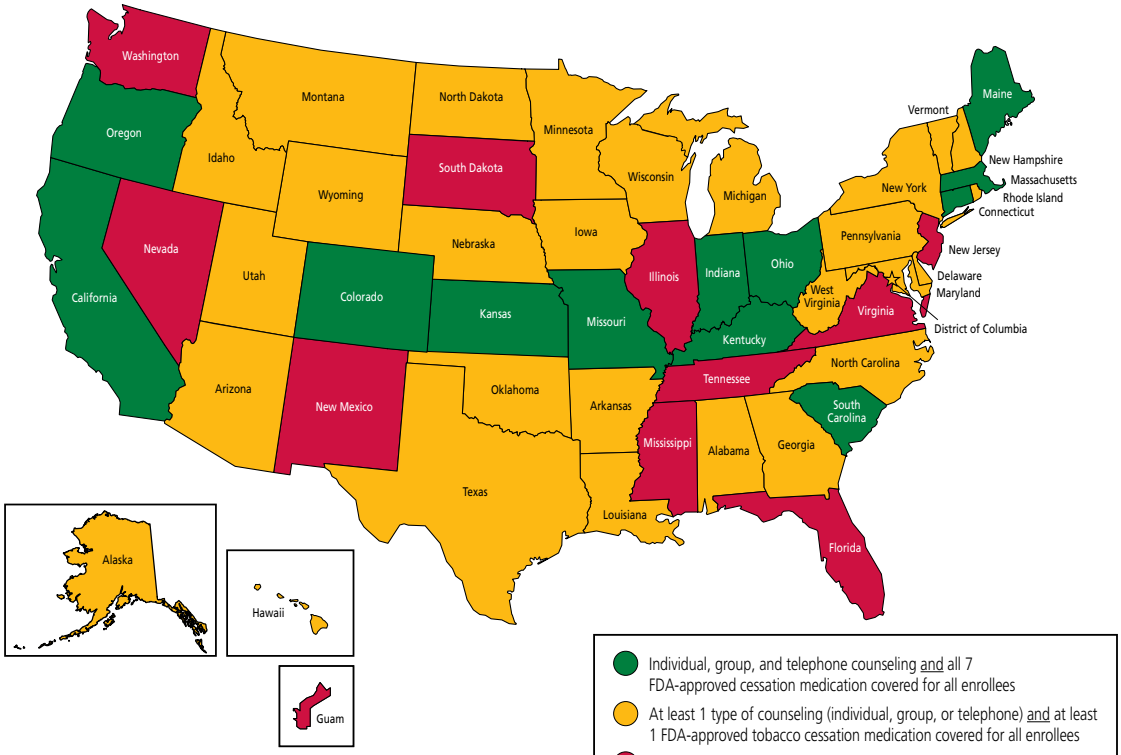
CLOSING THE GAPS IN COVERAGE

THE CHALLENGE

There are proven strategies to prevent children and adults from using tobacco products and to help current tobacco users to quit—but quitting isn't easy. In 2015, nearly seven out of 10 American adults who smoked reported that they wanted to quit completely.[1] For many people it takes multiple attempts to successfully quit smoking, and access to proven treatments and resources is critical to their success.

Individuals who rely on Medicaid for their health care have higher smoking rates (24.5%) than the overall adult smoking population (14%) and more than double that of individuals with private insurance (10.5%).[2] Yet despite this high smoking rate among Medicaid enrollees, only a third of people on Medicaid who smoked used cessation medication or counseling.[3] All tobacco users, including those enrolled in Medicaid, need access to a range of treatments to determine which cessation tools work best 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).

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.
As of July 1, 2019.

CLOSING THE GAPS IN COVERAGE

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 12 states—California, Colorado, Connecticut, Indiana, Kansas, Kentucky, Ohio, Oregon, Maine, Massachusetts, Missouri and South Carolina—provide comprehensive tobacco cessation coverage in Medicaid that includes individual, group and telephone counseling, including reimbursement through the state quitline, and all seven FDA-approved tobacco cessation medications.

Even when state Medicaid programs cover cessation services, there are often copays or limits on treatment duration that can hinder a patient's access to the medications and counseling they need to quit. Tobacco users who have access to more cessation medication and counseling options are more likely to be able to take advantage of these proven cessation services.

THE SOLUTION

Federal law requires Medicaid expansion plans, marketplace plans on state or federal health insurance exchanges, and non-grandfathered private plans, including employer-offered plans, to cover—without cost sharing—tobacco use screening and cessation services. The traditional Medicaid program is required to cover comprehensive tobacco cessation benefits for pregnant women at no cost to the patient; and is only required to cover tobacco cessation drugs, not counseling, for all other enrollees while sometimes applying cost sharing. Thus, coverage and cost to the patient varies by state. States are incentivized to cover the comprehensive benefit for all enrollees through a 1% increase in their federal matching rate, if the state covers all services rated A or B by the United States Preventive Services Task Force (USPSTF).

Given the great need for cessation services in the Medicaid population, the American Cancer Society Cancer Action Network (ACS CAN) advocates that Medicaid programs 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.

Ensuring that all tobacco users in any health plans, especially those enrolled in Medicaid, have coverage for tobacco cessation services is critical to reducing tobacco use, saving lives and ultimately reducing health care spending. In addition to covering 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.

DID YOU KNOW?

- Smoking-related disease costs Medicaid $40 billion dollars a year (15% of total Medicaid expenditures).[4]
- During a period of two years, when Massachusetts covered pharmacotherapy, counseling and outreach, it spent about $183 per participant, and saved an estimated $571 per participant in annual hospital costs. For every $1 spent, it received $3.12 in medical savings for cardiovascular conditions alone. For every $1 spent, it received an average $2.12 return on investment.[5]

Comprehensive Cessation Benefits Should Include Coverage for:

- Individual counseling
- Group counseling
- Phone counseling
- Nicotine Replacement Therapy (NRT) gum
- NRT patch
- NRT lozenge
- NRT inhaler
- NRT nasal spray
- Bupropion
- Varenicline

A Comprehensive Cessation Benefit Does Not Include these Barriers to Accessing Services:

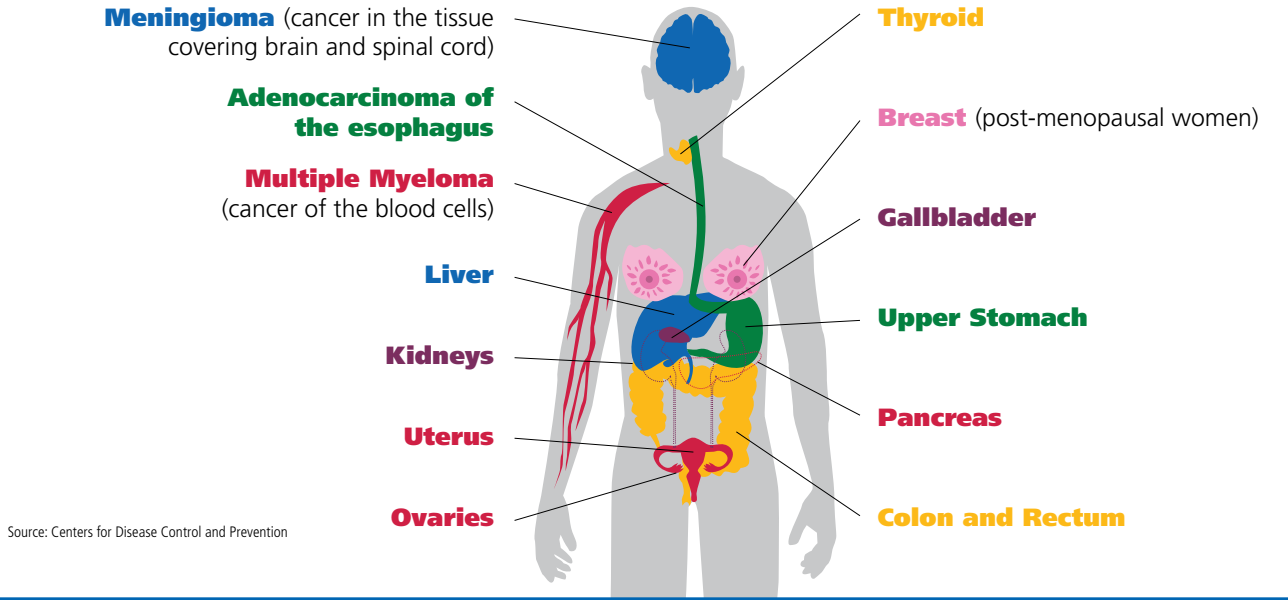
- Co-payments
- Prior authorization requirements
- Limits on treatment duration
- Yearly or lifetime dollar limits
- "Stepped Care" therapy
- Counseling required for medications

WHY SHOULD MEDICAID REIMBURSE QUITLINE PHONE COUNSELING?

Phone counseling, often facilitated through a service known as Quitline, is typically free for patients to use. State quitlines are just as effective as individual or group counseling and may be more convenient. Currently, some states do not provide Medicaid coverage for quitlines, depending on state tobacco cessation programs for funding. Unfortunately, state tobacco control funds are limited and vulnerable to budget cuts. Medicaid reimbursement of quitlines for phone counseling increases the capacity of the quitline and provides an added layer of sustainability. Medicaid enrollees make up 39% of state quitlines users; therefore, it makes sense that Medicaid should provide reimbursement to the quitline for providing the service to enrollees.[6] Including state quitline coverage under Medicaid adds a layer of financial protection and provides more resources so that the quitline can expand to accommodate new users. This allows the state tobacco control dollars to provide free telephone counseling as a last resort for those are not covered by another source. Medicaid can contract with existing state quitlines and either reimburse the quitline per user, like other services are reimbursed, or through an administrative match, where Medicaid pays a set amount to the quitline. It is financially beneficial for state budgets to have Medicaid reimburse quitlines because states receive a federal match for paying Medicaid expenses.

MAKING THE HEALTHY CHOICE THE EASY CHOICE

13 Cancers Are Associated with Overweight and Obesity



Source: Centers for Disease Control and Prevention

THE CHALLENGE

For the majority of Americans who do not use tobacco, the greatest behavioral risk factors for cancer are diet, levels of physical activity, amount of alcohol consumption and weight.[1] About 20% of all cancers are caused by poor diet, physical inactivity, excess weight and excess alcohol consumption.[2] In fact, excess weight increases the risk for 13 cancers.[3] Cancer's toll from excess weight also varies by state; cancers due to excess body weight were highest in Texas for men (6.0%) and in Hawaii for women (11.4%).[4] Even more troubling, a new study found that younger adults are at higher risk for developing six obesity-linked cancers than older adults.

While rates of excess weight and obesity have begun to level off over the past decade, currently 39.8% of adults and 18.5% of young people ages 2 - 19 are obese; an additional 31.8% of adults and 16.6% of young people are overweight.[5] These high rates of childhood obesity and excess weight are particularly troubling because children who are overweight or obese are much more likely to remain so as adults.

Sugary drinks are part of the problem—they are the leading source of added sugar and one of the leading sources of calories in Americans' diets.[6] About 50% of the population consume sugary drinks on any given day, with about 10% of young people consuming three or more on a given day.[7,8] Research has shown that both children and adults who consume greater amounts of sugary beverages gain more weight,[9,10] increasing their risk for obesity-related cancers.

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; and limit consumption of alcoholic beverages.[11]

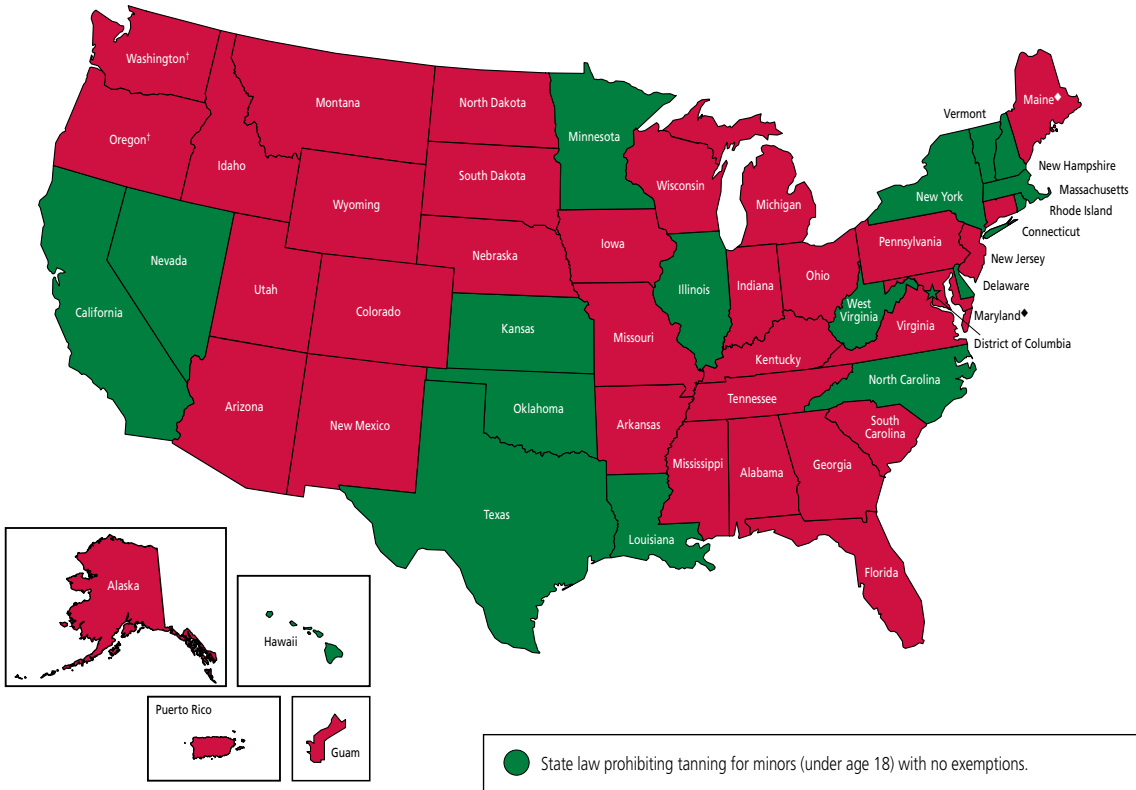
The guidelines also recommend that public, private and community organizations work collaboratively at all levels of government to implement policy and environmental changes that increase access to affordable, healthy foods, decrease access to foods with low nutritional value and provide safe, accessible places for physical activity.[12] 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.

The American Cancer Society Cancer Action Network (ACS CAN) supports improving access to healthy food and drink options through the following:

- Funding for creating healthy corner store initiatives to help existing corner stores offer healthier food options to their customers.
- Funding for healthy food financing initiatives to help food establishments open, expand and improve in neighborhoods that need food and jobs the most.
- Expanding Supplemental Nutrition Assistance Program (SNAP) incentives so more people can immediately afford fresh fruits and vegetables.
- Restricting the sale of sugary drinks at public parks, beaches and in schools, including at school events.
- Requiring healthy eating options on kids' menus in restaurants, including ensuring that menu items targeting youth do not include sugary drinks.
- Strengthening current nutrition standards for all foods and beverages sold, served or marketed in schools, before, during and after regular school hours.
- Improving current nutrition standards for all foods and beverages sold, served, or marketed in government buildings and other public service venues to increase access to healthy options.

PROTECTING YOUNG PEOPLE FROM INCREASED CANCER RISK

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 change made in 2019: MD law will go into effect on Oct.1, 2019 and ME law will go into effect 90 days after the Legislature adjourns.

THE CHALLENGE

Skin cancer is the most commonly diagnosed cancer in the U.S. Rates have continued to rise over the past 30 years,[1] though evidence suggests young non-Hispanic white women may be experiencing a recent decline of melanoma, the deadliest type of skin cancer.[2] In 2019, an estimated 104,300 invasive skin cancers will be diagnosed in the U.S., and 96,400 of these cases will be melanoma. During the same period, over 95,800 cases of non-invasive melanomas and millions of cases of basal and squamous cell skin cancers will also be diagnosed.[3] It is estimated that 11,600 men and women will die of skin cancer this year in the U.S. and over 7,200 of those deaths will be from melanoma.[4]

The greatest avoidable known risk factor for skin cancer is the use of indoor tanning devices. Yet misconceptions

about indoor tanning persist in large part because of misleading advertising and inaccurate health claims put forth by the tanning industry.[5,6] Young people are especially susceptible to the tanning industry's misleading and dangerous marketing tactics which are aimed directly at this impressionable group through back-to-school, prom and homecoming specials.[7] Significant progress has been made in recent years—the tanning device usage rate among high schoolers has dropped from over 15% in 2009 to 5.6% in 2017.[8] Unfortunately, tanning bed usage remains high among high school aged girls.

The most recent data indicates that one in 13 high school girls have used a tanning device and the numbers increase to one in eight by their senior year.[9] The use of indoor tanning devices by young people is a serious concern because studies show using an indoor tanning device before the age of 35 increases the risk of melanoma by 59%, squamous cell carcinoma by 67% and basal cell carcinoma by 29%.[10,11] Risk for melanoma increases with the number of total hours, sessions and years that indoor tanning devices are used.[12,13,14] Melanoma is currently the second most common cancer among females aged 15 to 29 and the third most common cancer among females aged 25 to 29.[15]

VOLUNTEER STORY

At the age of 12, ACS CAN volunteer Macken'z Smith was diagnosed with skin cancer and subsequently had a large portion of skin removed from her back. "That was the first time I had ever really heard the "C" word, and it was the scariest moment of my life," Macken'z said. Since that first diagnosis, she has had many other screenings and several biopsies done on other possible cancerous spots.

Macken'z's grandparents and father have also been diagnosed with skin cancer, and her father developed a rare form called Merkel Cell Carcinoma. After watching generations of her family fight skin cancer and receiving her own diagnosis, Macken'z became highly aware of how crucial proper skin care is at every age.

Along with being an ACS CAN volunteer, Macken'z competes in local and state beauty pageants and uses her platform to spread awareness of skin cancer prevention. She has made it one of her missions to educate children and adults about the steps needed to save their skin and understand the consequences that may come later if that protection is overlooked.

"Just one sunburn can double your risk of developing skin cancer," Macken'z said. "Take a second and think about how many hours in a day we spend in the sun. The simple fact is that skin cancer is preventable, and you can ensure your own healthy future by taking proper precautions for sun safety." In 2018, Macken'z was crowned Miss University of Southern Mississippi, and presented her campaign for skin cancer prevention when she competed in the Miss Mississippi pageant this summer.

Macken'z Smith, Philadelphia, MS

PROTECTING YOUNG PEOPLE FROM INCREASED CANCER RISK

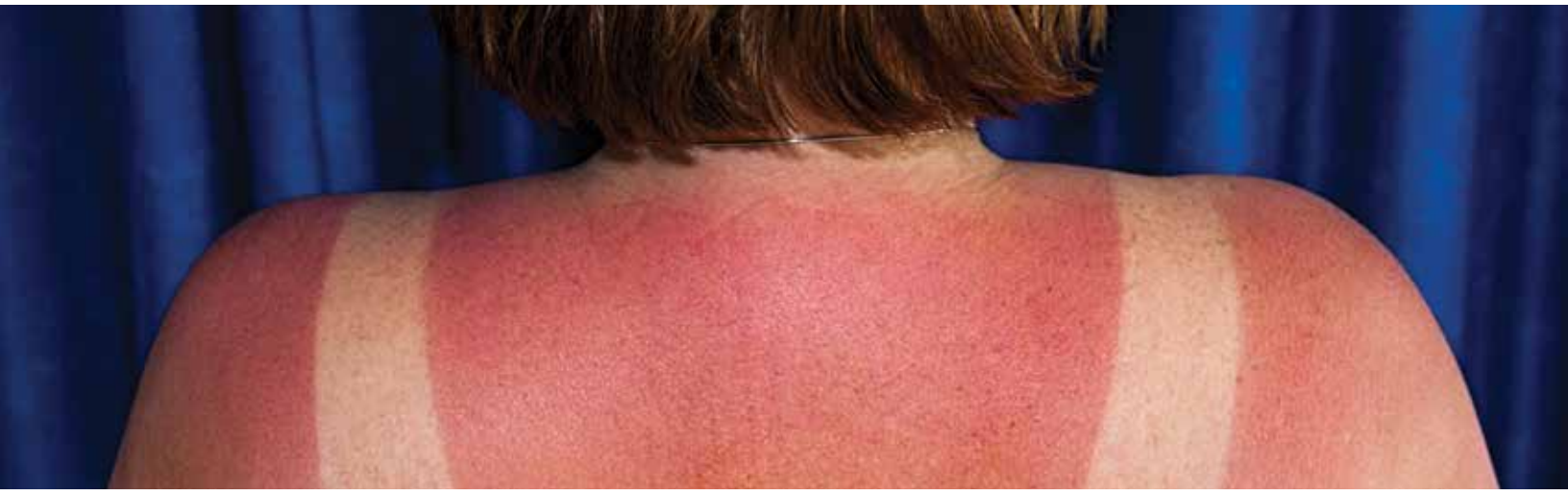
SUCCESS STORY

Maryland and Maine

In the Spring of 2019, Maryland and Maine joined 17 other states and the District of Columbia by passing the American Cancer Society Cancer Action Network legislation prohibiting the use of indoor tanning devices by youth under the age of 18.

In response to the legislation being signed into law by Gov. Larry Hogan in Maryland, Jocelyn Collins, the state's Government Relations Director said, "We know that kids and tanning devices don't mix. One of the most avoidable risk factors for skin cancer is exposure to ultraviolet radiation through the use of indoor tanning devices, and this bill brings Maryland one step closer to reducing suffering and death from skin cancer by limiting young people's access to these devices."

A nine-year, ACS CAN-led campaign concluded on June 13th when Maine Gov. Janet Mills signed their tanning bill into law, protecting kids under 18 from using these harmful devices.



THE SOLUTION

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.[16,17,18,19] Therefore, to protect young people from the damaging effects of artificial ultraviolet radiation, the American Cancer Society Cancer Action Network (ACS CAN) supports laws that prohibit access to tanning devices for individuals under 18, without exceptions. With usage rates increasing as teens get older, it is critical to protect all people under the age of 18, not just younger teens. In addition, state and local governments need to ensure that enforcement measures and oversight mechanisms are in place to guarantee that young people are not gaining access to these harmful devices.

REFERENCES

Access to Care: Ensuring All Americans Have Access to Affordable, Quality Health Insurance

1 Ward E. Association of Insurance with Cancer Care Utilization and Outcomes. *CA: A Cancer Journal for Clinicians.* 2008; 58(1).
2 Kaiser Family Foundation. Key Facts About the Uninsured Population. December 7, 2018. https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/
3 Department of Health and Human Services, Department of the Treasury, and Department of Labor. Short-Term, Limited-Duration Insurance. Final Rule. 83 Fed. Reg. 38212 (Aug. 3, 2018).
4 Keith, Katie. "CMS Announces Even Deeper Navigator Cuts." Health Affairs Blog. July 12, 2018. https://www.healthaffairs.org/do/10.1377/hblog20180712.527570/full/.
5 New York Department of Financial Services. Insurance Circular Letter No. 7. 2018. https://www.dfs.ny.gov/insurance/circltr/2018/cl2018_07.htm
6 2006 Massachusetts House Bill 4479. Acts (2006) Chapter 58. https://malegislature.gov/Laws/SessionLaws/Acts/2006/Chapter58
7 2018 New Jersey Assembly Bill 3380. https://www.njleg.state.nj.us/2018/Bills/PL18/31_.PDF

Increased Access to Medicaid: Extending Coverage and Improving Outcomes

1 American Cancer Society. *Cancer Facts & Figures 2019.* Atlanta: American Cancer Society; 2019.
2 Ibid.
3 Jemal A, Lin CC, Davidoff AJ, Han X. Changes in insurance coverage and stage at diagnosis among nonelderly patients with cancer after the Affordable Care Act. *J Clin Oncol.* 2017; 35(35):3906-15.
4 Soni A, Simon K, Cawley J, Sabik L. Effect of Medicaid Expansion of 2014 on overall and early-stage cancer diagnoses. *Am J Public Health.* 2018; 108(2): 216-18.
5 Mazurenko O, Balio C, Agarwal R, Carroll A, & Menachemi N. The Effects Of Medicaid Expansion Under The ACA: A Systematic Review. *Health affairs (Project Hope)*, 37(6), 944–950. doi:10.1377/hlthaff.2017.1491.
6 Jemal A, Lin CC, Davidoff AJ, Han X. Changes in insurance coverage and stage at diagnosis among non-elderly patients with cancer after the Affordable Care Act. *J Clin Oncol.* 2017; 35:2906-15.
7 Centers For Disease Control and Prevention. National Breast and Cervical Cancer Early Detection Program (NBCCEDP). https://www.cdc.gov/cancer/nbccedp/about.htm. Accessed March 2019.
8 Garfield R, Orgera K, Damico A. The coverage gap: Uninsured poor adults in states that do not expand Medicaid. Kaiser Henry J Kaiser Family Foundation. Published March 1, 2019. Accessed March 2019. https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/.
9 Aparna Soni, Kosali Simon, John Cawley, Lindsay Sabik, "Effect of Medicaid Expansions of 2014 on Overall and Early-Stage Cancer Diagnoses", *American Journal of Public Health* 108, no. 2 (February 1, 2018): pp. 216-218.
10 Dehkordy, SF, Hall, K, West, B, et al.. "Medicaid Expansion Improves Breast Cancer Screening for Low Income Women." November 30, 2015. <https://www2.rsna.org/timssnet/Media/pressreleases/14_pr_target.cfm?id=1849>
11 Ungar, Laura. "More KY Medicaid Patients Get Preventative Care." Courier Journal. August 7, 2015. Web <http://www.courier-journal.com/story/life/wellness/2015/08/05/preventive-care-rises-among-kentucky-medicaid-patients/31190973/>
12 ACS CAN analysis performed by Avalere (2019)
13 Garfield R, Rudowitz R, Musumeci M. Implications of a Medicaid work requirement: National estimates of potential coverage losses. Henry J Kaiser Family Foundation. Published June 27, 2018. Accessed March 2019. https://www.kff.org/medicaid/issue-brief/implications-of-a-medicaid-work-requirement-national-estimates-of-potential-coverage-losses/ .Ku
14 Arkansas Department of Human Services. Arkansas Works Program: December 2018 Report. Accessed January 2019. https://humanservices.arkansas.gov/images/uploads/011519_AWReport.pdf.
15 Alabama, Mississippi, Ohio, Oklahoma, South Dakota, Tennessee, Utah, Virginia

Breast and Cervical Cancer Early Detection and Treatment Programs: Detect and Protect

1 American Cancer Society. Cancer Facts & Figures 2019. Atlanta: American Cancer Society; 2019.
2 Ward E, Halpern MT, Schrag N. Association of insurance with cancer care utilization and outcomes. *CA Cancer J Clin.* 2018; 58(1):9-31.
3 American Cancer Society. Cancer Prevention & Early Detection Facts & Figures 2019-2020. Atlanta: American Cancer Society; 2019.
4 Ibid.
5 Ranji U, Rosenweig C, Gomez I, Salganicoff A. 2017 Kaiser Women's Health Survey. Kaiser Family Foundation. March 2018.
6 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.

Access to Colorectal Screening: Screening Early Saves Lives

1 American Cancer Society. Cancer Facts & Figures 2019. Atlanta: American Cancer Society; 2019.
2 American Cancer Society. Cancer Prevention & Early Detection Facts & Figures 2019-2020. Atlanta: American Cancer Society; 2019.
3 Fecal occult blood test (FOBT) or fecal immunochemical test (FIT) within the past year.; a sigmoidoscopy within the past five years; or a colonoscopy within the past 10 years.
4 American Cancer Society. *Colorectal Cancer Facts & Figures 2017-2019.* Atlanta: American Cancer Society; 2017.
5 American Cancer Society. Cancer Facts & Figures 2019. Atlanta: American Cancer Society; 2019.
6 American Cancer Society. Cancer Prevention & Early Detection Facts & Figures 2019-2020. Atlanta: American Cancer Society; 2019.
7 Joseph DA, King JB, Richards TB, Thomas CC, Richardson LC. Use of colorectal cancer screening tests by state. *Prev Chronic Dis.* 2018; 15:170535.
8 Division of Cancer Prevention and Control, Centers for Disease Control and Prevention. Colorectal cancer control program (CRCCP): About the program. Updated October 4, 2018. Accessed March 2019. https://www.cdc.gov/cancer/crccp/about.htm.
9 Wolf AMD, Fontham ETH, Church TR, et al. Colorectal cancer screening for average-risk adults: 2018 guideline update from the American Cancer Society. *CA Cancer J Clin.* 2018; 68(4):250-81.
10 Ibid.
11 Siegel RL, Fedewa SA, Anderson WF, et al. Colorectal cancer incidence patterns in the United States, 1974-2013. *JNCI J Natl Cancer Inst.* 2017; 109(8):djw322.

Palliative Care: Improving Quality of Life for Cancer Patients

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 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.
3 Meier DE, Brawley OW, Palliative Care and Quality of Life, Journal of Clinical Oncology 2011,29: 2750-2752.
4 Kyeremanteng, K. et al. (2018) The Impact of Palliative Care Consultation in the ICU on Length of Stay: A Systematic Review and Cost Evaluation, Journal of Intensive Care Medicine 2018, 33(6), pp. 346–353.
5 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-
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.
7 Isenberg SR, et al. Economic Evaluation of a Hospital-Based Palliative Care Program. Journal of Oncology Practice 2017 13:5, e408-e420.

Cancer Pain Control: Striving for Balance

1 The American Cancer Society Cancer Action Network, Patient Quality of Life Coalition, and Public Opinion Strategies. *Key Findings Summary: Opioid Access Research Project.* Available at https://www.acscan.org/sites/default/files/ACS%20CAN%20PQLC%20Opioid%20Research%20Project%20Key%20Findings%20 Summary%20Memo%20FINAL.pdf. Accessed June 26, 2018.

Prevention: Stopping Cancer Before It Starts

1 American Cancer Society. *Cancer Facts & Figures*, 2018. Atlanta, GA: American Cancer Society, 2018.
2 Ibid.
3 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.
4 Centers for Disease Control and Prevention. *Vital Signs:* Tobacco Product Use Among Middle and High School Students — United States, 2011–2018. Morbidity and Mortality Weekly Report 2019;68:157–164.
5 Centers for Disease Control and Prevention. Tobacco Product Use Among Adults – United States, 2017. *Morbidity and Mortality Weekly Report* 2018;67:1225–1232.
6 Centers for Disease Control and Prevention. *Vital Signs:* Tobacco Product Use Among Middle and High School Students — United States, 2011–2018. Morbidity and Mortality Weekly Report 2019;68:157–164.
7 Wang TW, Asman K, Gentzke AS, et al. Tobacco Product Use Among Adults — United States, 2017. MMWR Morb Mortal Wkly Rep 2018;67:1225–1232. DOI: http://dx.doi.org/10.15585/mmwr.mm6744a2

REFERENCES

8 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.
9 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.
10 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.
11 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.
12 American Cancer Society. *Cancer Facts & Figures*, 2018. Atlanta, GA: American Cancer Society, 2018.
13 Kushi L.H., Doyle C., McCullough m., et at. (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.
14 Guy GP, Berkowitz Z, Jones SE, Olsen E, Miyamoto JN, Michael SL, et al. State indoor tanning laws and adolescent indoor tanning. *Am J Public Health*. 2014; 104(4):e69-74.
15 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.
16 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.
17 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.

Tobacco Excise Taxes: Raising the Price, Ending the Addiction

1 Campaign for Tobacco-Free Kids. Toll of Tobacco in the United States. . https://www.tobaccofreekids.org/problem/toll-us . Accessed February 28, 2019.
2 Ibid.
3 Orzechowski and Walker. The Tax Burden on Tobacco. Historical Compilation, Volume 51, 2016, and adjustments for industry price promotions, price increases, cigarette tax increases, and inflation.
4 Campaign for Tobacco-Free Kids. Cigarette Tax Increases By State Per Year 2000-2018. December 11, 2018. Available at https://www.tobaccofreekids.org/assets/factsheets/0275.pdf .

Smoke-free Laws: Everyone Has the Right to Breathe Smoke-free Air

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 General.* 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? July 1, 2019. Available https://no-smoke.org/wp-content/uploads/pdf/mediaordlist.pdf. Accessed July 1, 2019.
8 Ibid.
9 ACS CAN. Smoke-free. 2017. https://www.fightcancer.org/what-we-do/smoke-free.
10 HHS, 2014.
11 HHS, 2014.
12 Scollo, M., A. Lal, Hyland, A. and S. Glantz (2003). Review of the Quality of Studies on the Economic Effects of Smoke-Free Policies on the Hospitality Industry. *Tobacco Control* 12: 13-20.
13 Scollo, M. and A. Lal (2004). Summary of Studies Assessing the Economic Impact of Smoke-free Policies in the Hospitality Industry. Melbourne: VicHealth Centre for Tobacco Control. http://www.vctc.org.au/tc-res/Hospitalitysummary.pdf.
14 Loomis, B.R.; Shafer, P.R.; van Hasselt, M., "The economic impact of smoke-free laws on restaurants and bars in 9 states," *Preventing Chronic Disease* 10: e128, August 1, 2013.

Tobacco Control Program Funding: Supporting People in Their Attempts to Quit and Keeping Kids from Starting

1 United States Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Center for Behavioral Health Statistics and Quality. National Survey on Drug Use and Health, 2014. ICPSR36361-v1. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor], 2016-03-22. http://doi.org/10.3886/ICPSR36361.v1

2 Agaku I, Odani S, Vardavas C, Neff L. Self-Identified Tobacco Use and Harm Perceptions Among US Youth. Pediatrics. 2018 Apr, 141 (4).

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 20 Years Later*. December 2018. Available at http:// https://www.tobaccofreekids.org/what-we-do/us/statereport . Accessed March 4, 2019.

4 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.

5 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 20 Years Later*. December 2018. Available at http:// :// https://www.tobaccofreekids.org/what-we-do/us/statereport . Accessed March 4, 2019.

6 Ibid.

7 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.

8 Source for Tobacco Prevention Funding, unless otherwise noted: Robert Wood Johnson Foundation, Truth Initiative, 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 20 Years Later.* December 2018. Available at https://www.tobaccofreekids.org/what-we-do/us/statereport

9 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.

10 Data for Guam provided by local ACS CAN staff.

11 Campaign for Tobacco Free Kids. Comprehensive Statewide Tobacco Prevention Programs Save Money, https://www.tobaccofreekids.org/assets/factsheets/0168.pdf .

12 Lightwood, J and Glantz SA. The Effect of the California Tobacco Control Program on Smoking Prevalence, Cigarette Consumption, and Healthcare Costs: 1989- 2008.*PLOS ONE* 8(2), February 2013.

13 Harris, J. Status Report on the Massachusetts Tobacco Control Campaign, with a Preliminary Calculation of the Impact of the Campaign on Total Health Care Spending in Massachusetts. 2000.

14 Dilley, J.A. et al. Program, Policy and Price Interventions for Tobacco Control: Quantifying the Return on Investment of a State Tobacco Control Program. American Journal of Public health, published online ahead of print December 15, 2011.

Tobacco Cessation Services in Medicaid: Closing the Gaps in Coverage

1 Stephen Babb, MPH; Ann Malarcher, PhD; Gillian Schauer, PhD; ; Kat Asman, MSPH1; Ahmed Jamal, MBBS. Quitting Smoking Among Adults — United States, 2000–2015. *MMWR Morb Mortal Wkly Rep* 2016;65: 1457-1464. https://www.cdc.gov/mmwr/volumes/65/wr/pdfs/mm6552a1.pdf accessed June 12, 2019.

2 TW, Asman K, Gentzke AS, et al. Tobacco Product Use Among Adults — United States, 2017. *MMWR Morb Mortal Wkly Rep* 2018;67:1225–1232.

3 Stephen Babb, MPH; Ann Malarcher, PhD; Gillian Schauer, PhD; ; Kat Asman, MSPH1; Ahmed Jamal, MBBS. Quitting Smoking Among Adults — United States, 2000–2015. *MMWR Morb Mortal Wkly Rep* 2016;65: 1457-1464. https://www.cdc.gov/mmwr/volumes/65/wr/pdfs/mm6552a1.pdf accessed June 12, 2019.

4 Xu X, Bishop EE, Kennedy SM, Simpson SA, Pechacek TF. Annual healthcare spending attributable to cigarette smoking: an update. *Am J Prev Med.* 2015;48(3):326–333. https://www.ncbi.nlm.nih.gov/pubmed/25498551

5 Richard P, West K, Ku L . The return on investment of a Medicaid Tobacco Cessation Program in Massachusetts. *PLoS ONE.* 2012; 7(1):e29665. doi:10.1371/ journal.pone.0029665.

6 Survey of State Quitline Efforts to Build Relationships and Cost-Sharing Strategies with State Medicaid Agencies: Current Landscapes and Critical Questions for the Work Ahead. North American Quitline Consortium; 2015. http://c.ymcdn.com/sites/www.naquitline.org/resource/resmgr/medicaid/MedicaidReport2015Survey.pdf. Accessed July 13, 2017.

Healthy Eating and Active Living: Making the Healthy Choice the Easy Choice

1 American Cancer Society. *Cancer Facts & Figures 2018*. Atlanta: American Cancer Society, 2018.

2 World Cancer Research Fund and American Institute for Cancer Research. Continuous Update Project Available from URL: http://www. wcrf.org/int/research-we-fund/continuous-update-project-cup

REFERENCES

3 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.
4 Islami, F, et al. Proportion and Number of Cancer Cases and Deaths Attributable to Potentially
5 National Center for Health Statistics. Prevalence of Overweight, Obesity, and Severe Obesity Among Adults Aged 20 and Over: United States, 1960–1962 Through 2015–2016. Health E-Stats.September 2018. Available at: https://www.cdc.gov/nchs/data/hestat/obesity_adult_15_16/obesity_adult_15_16.pdf National Center for Health Statistics. Prevalence of Overweight, Obesity, and Severe Obesity Among Children and Adolescents Aged 2–19 Years: United States, 1963–1965 Through 2015–2016. Health E-Stats.September 2018. Available at: https://www.cdc.gov/nchs/data/hestat/obesity_child_15_16/obesity_child_15_16.pdf
6 U.S. Department of Health and Human Services and U.S. Department of Agriculture. Figure 2-9: Average Intakes of Added Sugars as a Percent of Calories per Day by Age-Sex Group, in Comparison to the Dietary Guidelines Maximum Limit of Less Than 10 Percent of Calories. *Dietary Guidelines for Americans,* 2015-2010. Available at http://health.gov/dietaryguidelines/2015/guidelines/chapter-2/a-closer-look-at-current-intakes-and-recommended-shifts/. Accessed July 17, 2016.
7 Ibid.
8 Rosinger A, Herrick K, Gahche J, Park S. Sugar-sweetened beverage consumption among U.S. adults, 2011–2014. NCHS Data Brief. No 270. Hyattsville, MD: National Center for Health Statistics. 2017.
9 Mozaffarian D, Hao T, Rimm EB, Willett WC, Hu FB. Changes in diet and lifestyle and long-term weight gain in women and men. *N Engl J Med.* 2011;364:2392-404.
10 Malik VS, Pan A, Willett WC, and Hu FB. Sugar-sweetened beverages and weight gain in children and adults: a systematic review and meta-analysis. *Am J Clin Nutr.* 2013 Oct; 98(4): 1084–1102.
11 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.
12 Ibid.

Indoor Tanning: Protecting Young People from an Increased Cancer Risk

1 American Cancer Society. (2019). *Cancer Facts & Figures 2019*. Atlanta, GA: American Cancer Society.
2 Holman DM, Freeman MB, Shoemaker ML. Trends in Melanoma Incidence Among Non-Hispanic Whites in the United States, 2005 to 2014. *JAMA Dermatol*. 2018; 154(3):361-2.
3 American Cancer Society. (2019). *Cancer Facts & Figures 2019*. Atlanta, GA: American Cancer Society.
4 Ibid.
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/0823159/100519 tanningdo.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. *Skin Cancer Prevention Progress Report 2018*. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2018.
9 Centers for Disease Control and Prevention (CDC). Youth Risk Behavior Surveillance-United States, 2017. *MMWR*. 2018; 67(8).
10 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.
11 Wehner MR, Shive ML, Chren MM, Han J, Qureshi AA, Linos E. Indoor tanning and non-melanoma skin cancer: systematic review and meta-analysis. BMJ. 2012, 345:35909. doi: http://dx.doi.org/10.1136/bmj.e5909.
12 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.
13 American Cancer Society. *Cancer Prevention and Early Detection Facts and Figures 2015*. Atlanta: American Cancer Society; 2015.
14 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.
15 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 07-2018)
16 Guy GP, Berkowitz Z, Jones SE, Olsen E, Miyamoto JN, Michael SL, et al. State indoor tanning laws and adolescent indoor tanning. *Am J Public Health*. 2014; 104(4):e69-74.
17 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.
18 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.
19 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.

measure@cancer.org
www.fightcancer.org

Cancer Action Network℠
American Cancer Society®