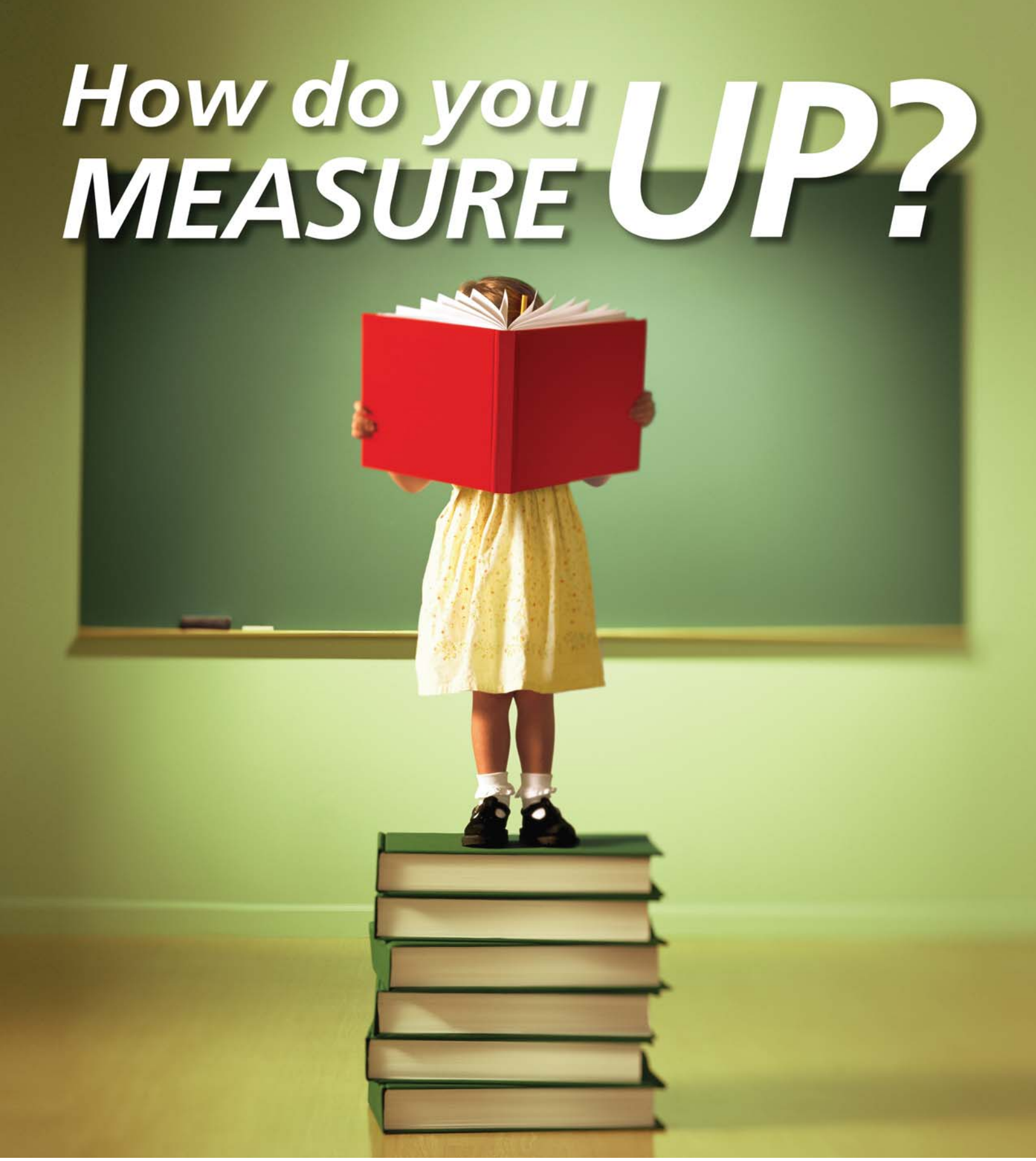
How do you MEASURE UP?



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

July 2008

Cancer Action Network℠
American Cancer Society®

Mission Statement

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

A Story of Triumph

The Delaware governor and state legislature are serious about fighting cancer and have shown this dedication by flexing their political muscle through passage, implementation, and funding of real solutions. In 2001, the governor and the General Assembly formed a task force, later called the Delaware Cancer Consortium, to look at cancer incidence and mortality and provide recommendations for reducing both. One of the Consortium's major accomplishments was the creation of the Delaware Cancer Treatment Program (DCTP), the first state-run program in the nation that pays for treatment for residents diagnosed with cancer who do not have comprehensive health insurance.

More than 30 percent of the patients served by the DCTP are minorities. Between the program's 2004 start and December 2007, more than 400 Delaware residents diagnosed with cancer received free cancer treatment. And, in 2007, the DCTP program eligibility was extended from one year to two years. To date, 15 patients have needed to extend treatment into the second year.

A testament to DCTP's success and that of other programs implemented by the Consortium is that Delaware's cancer mortality rate is declining twice as fast as the national rate. Based on preliminary data,[1] the U.S. average annual rate of decline is 0.6 percent; Delaware's average annual rate of decline is 1.2 percent.

How Do You Measure Up?

A Progress Report from the American Cancer Society Cancer Action Network℠ in collaboration with the American Cancer Society on State Legislative Activity to Reduce Cancer Incidence and Mortality

In 2008, more than 1.4 million people in the United States will be diagnosed with cancer and more than 565,000 people in America will die from the disease. Men in this country have an almost 1-in-2 lifetime risk of developing cancer, and the lifetime risk for women is 1-in-3. To help lower the risk, the American Cancer Society Cancer Action Network (ACS CAN) and the American Cancer Society (the Society) work closely together in the fight against cancer. We've made great strides in the past year, but we're not done yet.

As advocates, we have the responsibility to educate our constituents on how to prevent and fight cancer effectively, but we cannot do it without the help of state and local policymakers. Therefore, ACS CAN joins the Society in urging legislators to take advantage of this unique opportunity to fight back against cancer.

In the United States, there is no reason why a woman should miss her annual mammogram due to lack of insurance; why a child should pick up his or her first cigarette because effective tobacco control measures are not in place; or why a cancer patient should die simply because he or she cannot afford or does not have access to lifesaving treatments. We have a responsibility to fight back against barriers that prevent the proper diagnosis, treatment, and care of cancer patients, regardless of ethnicity, race, or socio-economic status.

Throughout the past year, state legislatures across the country have made great advances in the fight against cancer. From July 1, 2007 to June 30, 2008, five states increased their tobacco tax, bringing to 44 the total number of states with tobacco tax increases since 2002. Five more states implemented comprehensive smoke-free laws, protecting workers and patrons from the hazards of secondhand smoke and ensuring that more than 60 percent of the U.S. population is covered by 100 percent smoke-free workplace and/or restaurant and/or bar laws.

Meanwhile, 10 states increased their match funding for the National Breast and Cervical Cancer Early Detection Program, and a number of states created new programs to screen uninsured residents for colon cancer, while other states, where programs were already in place, increased program funding. Many more states are working on policies and programs to reduce cancer risk related to poor nutrition, lack of physical activity, and obesity.

In addition to passing these measures, many state legislators fought hard to preserve coverage for lifesaving cancer screenings and treatments and to stave off attempts to cut state funds that support these programs. Medicaid coverage for cancer screenings and treatment also came under attack, and many state legislators voted to protect programs that help ensure quality cancer care for those who desperately need it.

Still, countless Americans are needlessly losing their battle against cancer because they cannot gain access to the lifesaving care they need. ACS CAN, in partnership with the Society, is dedicated to ensuring that quality health care is available to all Americans. We believe meaningful reform must include adequate, available, affordable, and administratively simple health insurance coverage for all, regardless of health status or risk.

Will you help us fight back against cancer?

How does your state measure up?

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

This report covers the legislative priorities of ACS CAN and the Society. If you want to learn more about our programs and/or inquire about a topic not covered in this report, please contact Emily Stallman at 202-661-5722 or call our toll-free number, 1-800-NOW-I-CAN, 24 hours a day, seven days a week. You can also visit us online at www.acscan.org.

Tackling Tobacco Use

Every day, an estimated 4,000 children in the United States smoke their first cigarette, and more than 1,000 of them will become addicted, daily smokers.[1] After declining from 1997 to 2003, current youth smoking rates remained unchanged at 23 percent in 2005.[2] As many as half of those who continue to smoke will eventually die from smoking-related diseases.[3]

Tobacco use is responsible for nearly one in five deaths in the United States, including at least 30 percent of all cancer deaths and 87 percent of all lung cancer deaths.[4] Tobacco use is associated with increased risk of at least 15 types of cancer, as well as heart disease, cerebrovascular disease, chronic bronchitis and emphysema.[5] In addition, exposure to secondhand smoke causes an estimated 3,000 deaths each year from lung cancer and 35,000 deaths from heart disease in people who are not current smokers.[6] Tobacco-related disease costs our nation more than $167 billion in medical costs and productivity losses each year and remains the world's most preventable cause of death.[7]

ACS CAN supports a comprehensive approach to tackling tobacco use by: 1) increasing the price of tobacco products through tobacco tax increases, 2) implementing comprehensive smoke-free policies and repealing preemption laws, and 3) fully funding and sustaining evidence-based, statewide tobacco prevention and cessation programs. Like a three-legged stool, each component works in conjunction with the others and all three are necessary to tackle this country's tobacco epidemic effectively. ACS CAN and the Society work hand-in-hand with state legislators across the country to ensure that tobacco use is comprehensively addressed in each community.

Tobacco Excise Taxes

The Challenge

Increasing the price of tobacco products, specifically by raising tobacco taxes, is a proven method of preventing kids from starting to smoke and encouraging current smokers to quit or cut back. This results in fewer tobacco-related diseases and deaths and saves states money in future health care costs.

The vast majority of states around the country have recognized the public health and economic benefits of increasing their tobacco tax. Since 2002, 44 states have raised tobacco taxes with 23 of those states increasing the tax multiple times. During the same time period, only six states have failed to raise their tobacco taxes: California, Florida, Mississippi, Missouri, North Dakota, and South Carolina.

Currently, the average state cigarette tax is $1.14, but it still needs to be higher to be most effective. Higher increases can save more lives. Furthermore, a portion of the tax revenues should be dedicated to tobacco control and/or cancer control programs.

Tobacco

Other tobacco products, such as smokeless tobacco, are highly addictive, and cause cancer and other serious health problems. Despite their dangers, smokeless tobacco products are generally taxed at a lower rate than cigarettes in most states.

ACS CAN encourages states to tax non-cigarette tobacco products at a minimum tax rate comparable to that of cigarettes and to tax these products as a percentage of price, as opposed to weight-based. Taxing as a percentage of price allows the tax rate to automatically keep pace with inflation and ensures that the most expensive, heavily marketed and most popular brands among youth are taxed at a higher rate.

The Facts

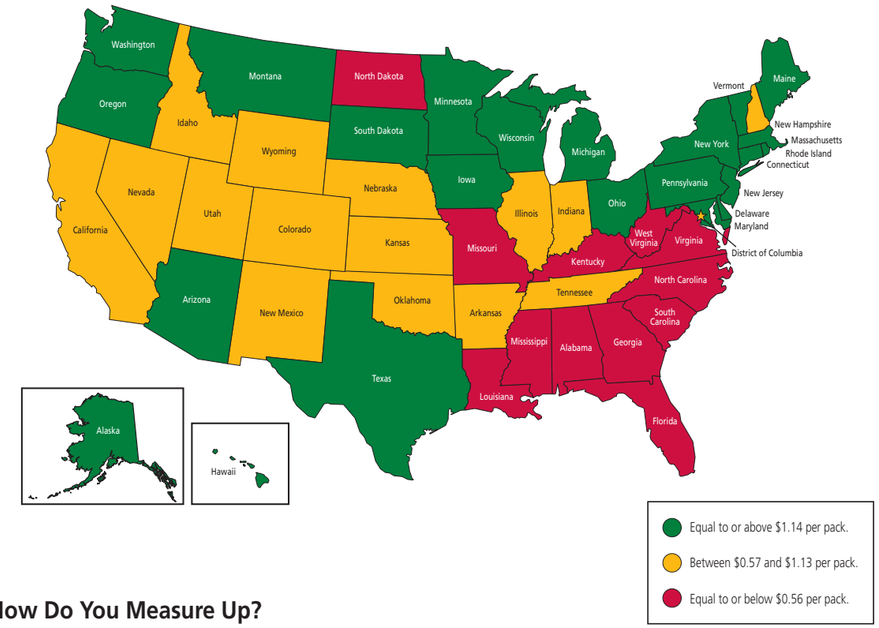
- Nearly 18 billion packs of cigarettes were sold in the United States in 2007.[1]
- The health and productivity costs attributed to smoking are $10.28 per pack of cigarettes.[2]
- The average state tax on a pack of cigarettes is $1.14.
- State tobacco excise tax rates vary, ranging from a high of $2.75 in New York to a low of seven cents in South Carolina. New York City has the highest cigarette tax in the country, with a state tax of $2.75 and a city tax of $1.50 for a combined tax rate of $4.25 per pack.

The Solution

States benefit greatly from increasing their tobacco tax, which results in improved citizen health and lower health care costs for the state. For every 10 percent increase in the price of a pack of cigarettes, youth smoking declines by 7 percent and overall consumption decreases by 4 percent.[3]

The President's Cancer Panel, the Institute of Medicine, and a majority of states, recognize the public health and economic benefits of tobacco tax increases.[4] The Institute of Medicine recommends that states raise their tobacco tax to a rate at least as high as that of the top 10 states and that all tobacco tax rates be indexed for inflation, to keep them from eroding over time.

State Cigarette Tax Rates



How Do You Measure Up?

State	Rate Per Pack (Dollars)	Year of Last Increase
New York	$2.75	2008
New Jersey	$2.575	2006
Rhode Island	$2.46	2004
Washington	$2.025	2005
Alaska	$2.00	2007
Arizona	$2.00	2007
Connecticut	$2.00	2007
Maine	$2.00	2005
Maryland	$2.00	2008
Michigan	$2.00	2004
Vermont	$1.99	2008
Hawaii	$1.80	2007
Wisconsin	$1.77	2008
Montana	$1.70	2005
South Dakota	$1.53	2007
Massachusetts	$1.51	2002
Minnesota	$1.493	2005
Texas	$1.41	2007
Iowa	$1.36	2007
Pennsylvania	$1.35	2004
Ohio	$1.25	2005
Oregon	$1.18	2002
Delaware	$1.15	2007
New Hampshire	$1.08	2007
Oklahoma	$1.03	2005
District of Columbia	$1.00	2003
Indiana	$0.995	2007
Illinois	$0.98	2002
New Mexico	$0.91	2003
California	$0.87	1999
Colorado	$0.84	2005
Nevada	$0.80	2003
Kansas	$0.79	2003
Utah	$0.695	2002
Nebraska	$0.64	2002
Tennessee	$0.62	2007
Wyoming	$0.60	2003
Arkansas	$0.59	2003
Idaho	$0.57	2003
West Virginia	$0.55	2003
North Dakota	$0.44	1993
Alabama	$0.425	2004
Georgia	$0.37	2003
Louisiana	$0.36	2002
North Carolina	$0.35	2006
Florida	$0.339	1990
Kentucky	$0.30	2005
Virginia	$0.30	2005
Mississippi	$0.18	1985
Missouri	$0.17	1993
South Carolina	$0.07	1977
States' Average	*$1.14*	
Median	*$1.00*	

ACS CAN challenges states to raise their cigarette tax rates to at least $1.14 and to tax non-cigarette tobacco products at a rate comparable to cigarettes. Finally, to maximize the impact of the tobacco tax, states are also encouraged to earmark tobacco tax revenues for tobacco use prevention and cessation programs.

Success Story

In a hard-fought campaign, advocacy staff and volunteers in New York, working in collaboration with coalition partners, successfully persuaded the legislature to pass the single biggest state tobacco tax increase in history. The $1.25 per pack tax increase makes New York number one in nationwide rankings of state tobacco taxes, with a cumulative state tax of $2.75 per pack. In addition, New York City has a local tax of $1.50.

Despite a pledge from politicians in both parties not to raise taxes in an election year, advocates built momentum for the proposal through grassroots activism. Surveys also indicated more than 70 percent of New Yorkers supported the tax increase, and when offered the chance to dedicate some of the new tax dollars to efforts that help smokers quit, more than 80 percent agreed. Additionally, more than half the state's active smokers agreed with this allocation of funds.

The new tax will prevent approximately 250,000 children alive today from becoming smokers and will encourage 100,000 adult smokers to quit. The tax went into effect June 3, 2008, and is expected to raise $400 million annually.

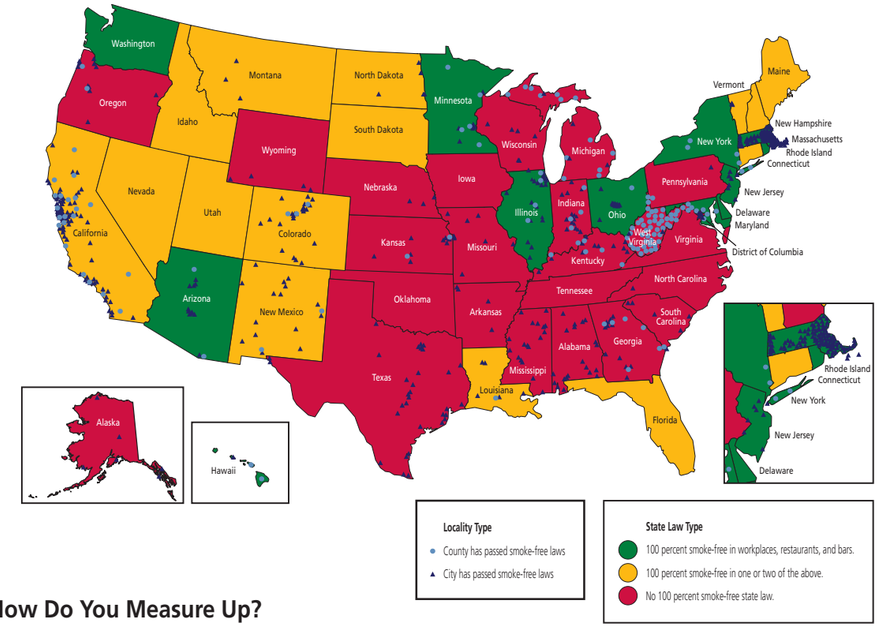
Smoke-Free Laws

The Challenge

Secondhand smoke is a serious health hazard, containing more than 60 known or probable carcinogens and more than 4,000 chemicals, including formaldehyde, arsenic, cyanide, and carbon monoxide. Each year, secondhand smoke causes between 35,000 and 40,000 deaths from heart disease and 3,000 lung cancer deaths in otherwise healthy nonsmokers. In addition, secondhand smoke can cause or exacerbate a wide range of other illnesses, including respiratory infections and asthma.

As of June 30, 2008, 28 states plus the District of Columbia and Puerto Rico require 100 percent smoke-free workplaces and/or restaurants and/or bars. Additionally, more than 2,700 municipalities have local laws in effect that restrict where smoking is permitted. Combined, this represents almost two-thirds of the U.S. population.[1] Two more states and numerous other localities have already passed smoke-free laws that will go into effect in the next year. Yet, even with all of these legislative advances, specific segments of the population, such as hospitality and casino workers, continue to fight for their right to breathe clean air.

Smoke-Free Legislation at the State, County and City Level
In effect as of June 30, 2008



How Do You Measure Up?

The following state laws have been enacted but are not yet in effect: Iowa enacted a 100 percent smoke-free workplace, restaurant and bar law, effective July 1, 2008. Montana enacted a 100 percent smoke-free bar law, effective October 1, 2009. Nebraska enacted a 100 percent smoke-free workplace, restaurant and bar law, effective June 1, 2009. Oregon enacted a 100 percent smoke-free workplace, restaurant and bar law, effective January 1, 2009. Utah enacted a 100 percent smoke-free bar law, effective January 1, 2009.

The Facts[2]

- Smoke-free laws reduce exposure to cancer-causing pollutants and the incidence of disease.
- Smoke-free laws encourage smokers to quit, increase the number of successful quit attempts, and reduce the total number of cigarettes smoked.
- Smoke-free laws save individuals, employers, and the government money in excess health care costs when smokers quit or cut back.

The Solution

The 2006 the U.S. Surgeon General's Report, *The Health Consequences of Involuntary Exposure to Tobacco Smoke*, confirmed there is no risk-free level of exposure to secondhand smoke.[3] Implementing comprehensive smoke-free policies will have immediate health benefits for restaurant and bar workers as well as for the health of all citizens. The Institute of Medicine and the President's Cancer Panel recommend that comprehensive smoke-free laws cover all workplaces, including restaurants, bars, hospital and health care facilities, and correctional facilities.[4]

Across the country, elected officials at the state and local level are recognizing the health and economic benefits of comprehensive smoke-free laws. ACS CAN challenges state and local officials to overturn existing preemption laws, to prevent future preemption laws, and to pass comprehensive smoke-free laws in order to protect the health of our citizens. Everyone deserves the right to breathe clean air.

Success Story

Advocates and staff continue to educate legislators on the harmful effects of secondhand smoke and the need for comprehensive statewide smoke-free policies. As a result, the smoke-free movement is sweeping the nation. As of July 1, 2008, approximately 65 percent of the U.S. population is protected from secondhand smoke at the state and/or local level by a 100 percent smoke-free workplace and/or restaurant and/or bar law.

Since July 1, 2007, New Hampshire, Minnesota, Illinois, and Maryland all have implemented smoke-free laws. Iowa and Nebraska passed 100 percent smoke-free workplace, restaurant, and bar laws. (Iowa's law took effect July 1, 2008; Nebraska's law will take effect June 1, 2009.) Pennsylvania also passed a 100 percent smoke-free workplace law that takes effect September 11, 2008. Finally, recognizing the importance of truly comprehensive smoke-free laws, casinos in Colorado went smoke-free this year.

In addition to these great state-level successes, local lawmakers were also busy protecting their constituents. In all, 129 local smoke-free workplace and/or restaurant and/or bar ordinances took effect this year. Voters played a big role in continuing the momentum with smoke-free ballot initiatives passing in Kansas City, Missouri (effective June 21, 2008), and in Fargo and West Fargo, North Dakota, (effective July 1, 2008).

Finally, the Nebraska Supreme Court strengthened Omaha's local smoke-free ordinance by ruling that exemptions for Keno parlors and some bars were unconstitutional; Keno parlors and all bars therefore went smoke-free on June 17, 2008. The ruling proved, once again, that the best smoke-free policies are comprehensive and protect the right of all workers to breathe smoke-free air.

Tobacco Cessation Services

American Indian and Alaska Native adults and youth have higher smoking rates than other racial and ethnic groups, putting them at greater risk of suffering from tobacco-related death and disease.

The Challenge

Tobacco cessation services rank second only to childhood immunizations as the most clinically cost-effective preventive treatment available.[1] Increasing access to these services will reduce the incidence of cancer and other chronic diseases related to tobacco use.

Tobacco users in low-income populations suffer from more smoking-related health problems and are more likely to die from smoking-related disease than any other population in the United States. Due to inadequate access to cessation medications and counseling services, these groups have virtually no access to preventive treatments.

Tobacco cessation programs are especially needed among pregnant women, low-income, and hospitalized smokers. Enhancing availability of tobacco cessation treatment and expanding insurance coverage for these services will curb smoking-related deaths and disease, especially among populations who need it most.

The Facts

- Studies show that individuals whose cessation services are covered under insurance are more likely to quit smoking.[2]
- Medicaid recipients have a smoking rate more than 50 percent greater than the rest of the U.S. population, costing Medicaid $30 billion each year for tobacco-related health care services.[3, 4]
- Only 17 states cover both cessation drugs and counseling services for all Medicaid recipients, and only Oregon covers all the therapies recommended by the U.S. Public Health Service.[5]
- Evidence shows that quitting success rates can increase by 40 percent when professional counseling and drug therapy are both covered under insurance.[6]

The Solution

According to the U.S. Public Health Service publication "Treating Tobacco Use and Dependence: A Clinical Practice Guideline," published in 2000 and updated in May 2008, all public and private sector health care plans should cover both medication and counseling on tobacco cessation services, including over-the-counter nicotine replacement therapies. The guidelines also recommend minimal copayments, deductibles, and other fees for tobacco cessation services to ensure treatment is affordable and available to low-income patients.

ACS CAN encourages state and local policymakers to expand coverage of tobacco cessation services to all government-financed health programs and private health plans, through public policy, legislative, and private sector initiatives. ACS CAN and the Society are available to work with state lawmakers to help their constituents access affordable tobacco cessation treatment that will increase quit rates and save lives.

Tobacco Prevention Program Funding

The CDC's 2007 update of "Best Practices for Comprehensive Tobacco Control Programs" lists five components of a comprehensive tobacco control program, all of which work in synergy to reduce tobacco use. The components include: 1) state and community interventions; 2) health communication interventions; 3) cessation interventions; 4) surveillance and evaluation; and 5) administration and management.

The Challenge

Adequately funded tobacco prevention programs are effective at reducing smoking rates and thereby reducing tobacco-related health care costs. Yet, states are spending a miniscule portion of their tobacco-related revenues on statewide tobacco control programs.

In the past fiscal year, states collected approximately $22 billion in new revenues from tobacco taxes and payments from the Master Settlement Agreement. Simultaneously, the tobacco companies continue to pour billions of dollars into the marketing and promotion of their products. Without adequate funding and appropriate application of that funding, prevention programs cannot compete with the tobacco companies.

The Facts

- States currently spend $717.2 million a year on tobacco control funding.[1]
- The tobacco companies spend more than $13 billion a year on marketing and advertising in the states – 18 times more than what the states spend on tobacco control programs.[2]
- The Centers for Disease Control and Prevention (CDC) recommend states spend $3.7 billion a year or more on tobacco control programs.

State	Tobacco Prevention Spending (FY08)	CDC Recommended Spending
Alabama	$0.77 million	$56.7 million
Alaska	$7.5 million	$10.7 million
Arizona	$23.5 million	$68.1 million
Arkansas	$15.6 million	$36.4 million
California	$77.4 million	$441.9 million
Colorado	$26.0 million	$54.4 million
Connecticut	$0.0	$43.9 million
Delaware	$10.7 million	$13.9 million
District of Columbia	$3.6 million	$10.5 million
Florida	$58.0 million	$210.9 million
Georgia	$2.2 million	$116.5 million
Hawaii	$10.4 million	$15.2 million
Idaho	$1.4 million	$16.9 million
Illinois	$8.5 million	$157.0 million
Indiana	$16.2 million	$78.8 million
Iowa	$12.3 million	$36.7 million
Kansas	$1.4 million	$32.1 million
Kentucky	$2.4 million	$57.2 million
Louisiana	$7.7 million	$53.5 million
Maine	$16.9 million	$18.5 million
Maryland	$18.4 million	$63.3 million
Massachusetts	$12.8 million	$90.0 million
Michigan	$3.6 million	$121.2 million
Minnesota	$22.1 million	$58.4 million
Mississippi	$8.0 million	$39.2 million
Missouri	$0.2 million	$73.2 million
Montana	$8.5 million	$13.9 million
Nebraska	$2.5 million	$21.5 million
Nevada	$2.0 million	$32.5 million
New Hampshire	$1.3 million	$19.2 million
New Jersey	$11.0 million	$119.8 million
New Mexico	$9.6 million	$23.4 million
New York	$85.5 million	$254.3 million
North Carolina	$17.1 million	$106.8 million
North Dakota	$3.1 million	$9.3 million
Ohio	$44.7 million	$145.0 million
Oklahoma	$14.2 million	$45.0 million
Oregon	$8.2 million	$43.0 million
Pennsylvania	$31.7 million	$155.5 million
Rhode Island	$0.94 million	$15.2 million
South Carolina	$2.0 million	$62.2 million
South Dakota	$5.0 million	$11.3 million
Tennessee	$10.0 million	$71.7 million
Texas	$11.8 million	$266.3 million
Utah	$7.3 million	$23.6 million
Vermont	$5.2 million	$10.4 million
Virginia	$14.5 million	$103.2 million
Washington	$27.1 million	$67.3 million
West Virginia	$5.7 million	$27.8 million
Wisconsin	$15.0 million	$64.3 million
Wyoming	$5.9 million	$9.0 million
Total	*$717.2 million*	*$3.7 billion*

The Solution

In 2007, the CDC released an update of "Best Practices for Comprehensive Tobacco Control Programs" for all 50 states and the District of Columbia.[3] According to the CDC, if each state sustained its recommended level of funding for five years and followed the implementation components described in "Best Practices," an estimated five million fewer people would smoke, resulting in hundreds of thousands of lives saved and substantial health care savings. The Institute of Medicine and the President's Cancer Panel also agree that adequate funding of comprehensive tobacco prevention programs is essential to the fight against tobacco.[4]

ACS CAN challenges states to combat tobacco-related illness and death by funding comprehensive tobacco control programs most effectively at the CDC-recommended level or above, continue that adequate funding over time, and implement the components delineated in "Best Practices."

Success Story

During the 2008 legislative session, Wisconsin Governor Jim Doyle and the state legislature showed leadership in reducing tobacco use in their state. In a tough economic climate and with bipartisan support in the legislature, the governor approved measures to reduce Wisconsin's tobacco burden with a $1 cigarette tax increase to $1.77 per pack and an additional $5 million toward tobacco control funding.

The $1 cigarette tax increase means an estimated 33,000 fewer Wisconsin kids will start smoking and 66,000 Wisconsin adults will stop. In the first two months after the tax went into effect, 20,000 Wisconsin residents called the state's Quit Line, looking to kick the habit; twice the number of calls the Quit Line handled in all of the months of 2007 combined.

Moreover, the increased funding for tobacco cessation means smokers who call the Quit Line can receive two free weeks of nicotine replacement therapies, including lozenges, gum, or nicotine patches. These therapies, combined with counseling and other Quit Line resources, substantially increase the likelihood a smoker will quit for good, improving Wisconsin's public health for years to come.

Colorectal Cancer Screening Coverage

Racial and ethnic minorities, the uninsured, and persons of lower income are less likely to report receiving timely colorectal cancer screening. Among adults age 50 and older, 53 percent of whites had an endoscopy within the past 10 years, compared to 42 percent of African Americans, 32 percent of Hispanics, 32 percent of American Indian and Alaska Natives, and 34 percent of Asians. Of uninsured adults age 50-64, 15 percent received an endoscopy within the past 10 years, compared to 42 percent of privately insured adults.

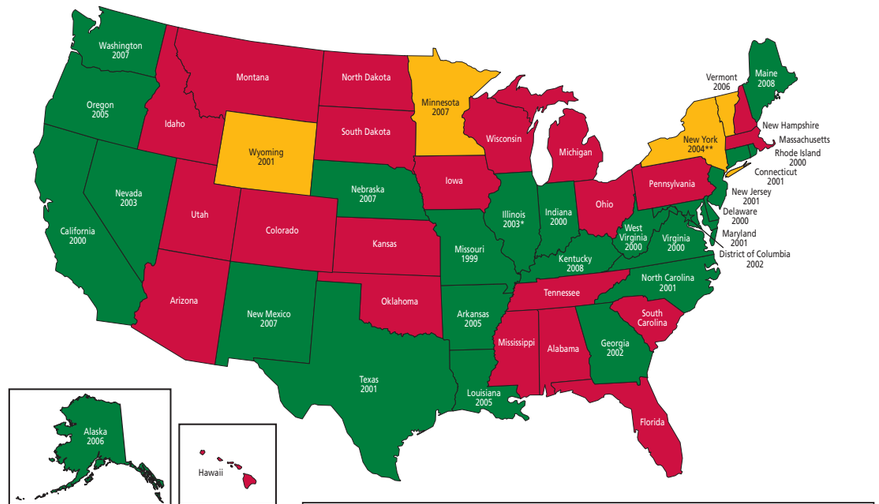
The Challenge

Colorectal cancer (otherwise known as colon cancer) is the second most frequently diagnosed cancer and the second most common cause of cancer death in the United States. Colorectal cancer is one of the few cancers that can be prevented through screening and early detection. Of the 49,960 people expected to die of colon cancer in 2008, appropriate testing could have saved more than half. Screening and early detection saves lives.

Colon cancer is easily preventable through the identification and removal of precancerous polyps that are detectable only by screenings. Additionally, when colon cancer is detected and treated early, survival rates are greatly enhanced. When diagnosed at an early stage, the five-year survival rate is 90 percent. However, when colon cancer is diagnosed after spreading to distant organs, the five-year survival rate is only 10 percent.

Despite the lifesaving potential of colon cancer screening tests and the large costs associated with treating a more advanced colon cancer, most Americans are not getting screened for the disease. Remarkably, only 39 percent of colon cancers are diagnosed while in the early stages. And in the 50 or older population, where colon cancer is most prevalent, less than half of U.S. adults have been screened recently.

Access to Care – Colorectal Cancer Screening Coverage



How Do You Measure Up?

Sources: Health Policy Tracking Service & Individual state bill tracking services
*In 2003, Illinois expanded its 1998 law to cover the full range
**The New York Health Plan Association, which serves 6 million New Yorkers, covers the full range of colorectal cancer screening tests, as a part of a voluntary collaborative with ACS.

The Facts

- This year, 148,810 people in the United States will be diagnosed with colon cancer and 49,960 will die from the disease.
- Utilization of colon cancer screening is much lower among racial minorities and the medically underserved.
- Factors that affect colon cancer screening include whether individuals have health insurance and whether health plan benefits cover colon cancer screening. Only 18.8 percent of those without health coverage in the United States have been screened for colon cancer, compared to 48.3 percent among those with insurance coverage.[1]

The Solution

Enacting laws that provide coverage for colon cancer screening is one important step that lawmakers can take to reduce the number of Americans who die needlessly each year from colon cancer. And while state legislatures continue to make steady progress in the war against colon cancer, there is still more to be done. Ensuring that all insurance policies require coverage of colon screenings is an important step toward reducing the number of Americans who die needlessly from the disease.

Earlier this year, the Society, the American College of Radiology, and the U.S. Multi-Society Task Force on Colorectal Cancer released the first joint consensus guidelines for colon cancer screening. The guidelines add two new tests to the list of recommended options: stool DNA (sDNA) and CT colonography (CTC), also known as virtual colonoscopy.

While the colon cancer screening guidelines recommend a menu of screening options, the guidelines also stress the importance of shared decision-making between the patient and his or her doctor. Each cancer diagnosis is unique, and only the doctor, in consultation with his or her patient, can know the best course of treatment to follow. However, these treatment options are only available if all of the recommended screening tests are covered.

Research shows that the full range of colon cancer screenings can be covered for little or no additional cost to insurers, employers, or employees. These screenings can prevent a person from getting colon cancer, thus preventing needless suffering and death, while reducing the amount of money spent on treatment.

ACS CAN urges state legislators to enact laws that protect coverage for colon cancer screening.

Success Story

This year, Kentucky and Maine passed legislation requiring health insurance plans to provide coverage for colon cancer screenings in accordance with Society guidelines. With the June addition of Colorado to the list of states requiring colon cancer screening coverage, more than half the nation, 25 states and the District of Columbia, now have these coverage guarantees.

Notably, in Colorado, House Bill 1410 took an interesting approach to mitigating an individual's costs associated with colonoscopies. The legislation requires that for individuals in HMOs, total out-of-pocket expenses (deductibles, co-payments, co-insurance and any other form of cost sharing) cannot exceed 10 percent for any of the screening tests. This will relieve the cost burden associated with these tests for thousands of people in Colorado.

Funding for Breast and Cervical Cancer Screening

In 2005, 68 percent of white women 40 years and older had a mammogram within the past two years, compared to 65 percent of African-American, 59 percent of Hispanic/Latina, 67 percent of American Indian/Alaska Native, and 54 percent of Asian American women. Among women aged 40-64 years old with private health insurance coverage, 76 percent had a mammogram within the past two years, compared to 42 percent of women without health insurance.

The Challenge

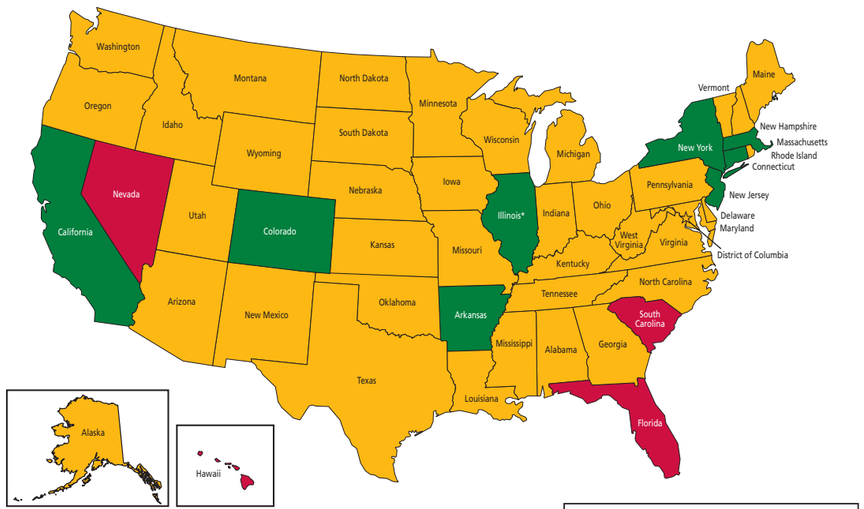
In partnership with state-administered breast and cervical cancer screening programs, the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) provides low-income, uninsured, and underinsured women access to lifesaving breast and cervical cancer screenings and follow-up services.

Increased state and federal funding will ensure that this program has adequate resources to reach more women who are eligible for NBCCEDP services.

To date, the NBCCEDP has provided more than 7.5 million screening exams to underserved women. To ensure prompt delivery of care, the Breast and Cervical Cancer Prevention and Treatment Act of 2000 gave all 50 states and the District of Columbia the option to provide Medicaid coverage to treat women diagnosed with cancer under the NBCCEDP.

In addition, the Centers for Disease Control and Prevention (CDC) awards annual grants to states with programs that provide in-kind or monetary matching funds — $1 for every $3 in federal money. However, due to limited state and federal funding, only one in five eligible women currently receive these lifesaving cancer screenings. Consequently, millions of eligible women are going without these critical early detection services.

State Appropriations for Breast and Cervical Cancer Screening Programs



How Do You Measure Up?

Source: 2007 data from the Centers for Disease Control and Prevention and unpublished data collected from NGRD, Divisions, including input form NBCCEDP directors

* Illinois expanded their program to serve all uninsured women in Illinois in the age group served

Increased state and federal funding for the program would provide millions of medically underserved women with access to screenings that catch cancer at its earliest, most treatable stages. More state and federal funds will save more lives.

The Facts

- An estimated 182,460 new cases of invasive breast cancer and 11,070 new cases of cervical cancer are expected to occur among women in the United States during 2008.
- Studies show that the earlier breast and cervical cancer are detected and treated, the better the survival rate. When breast cancer is diagnosed at the localized stage, the five-year survival rate is 98 percent. When breast cancer is diagnosed after it has spread to distant organs, the five-year survival rate decreases to 27 percent.
- Pap tests detect pre-cancerous lesions that can be treated before they become cervical cancer, resulting in a nearly 100 percent survival rate. When detected at an early stage, cervical cancer has a five-year survival rate of 92 percent. However, when cervical cancer is diagnosed at an advanced stage, survival rates plummet to 16.5 percent.
- Rates of mammography continue to be low among two groups: those with low income levels and those who lack health insurance. Consequently, women in these groups are more likely to have their breast cancers detected at an advanced stage, when treatment is less likely to be effective. Given the decreased survival rates and the cost of treating late-stage diagnosis, it is imperative that we improve early screening rates among these women.

The Solution

Lawmakers need to ensure that neither income nor insurance status is a barrier to cancer screenings. Programs have been enacted at the federal level; however, supplemental state funding is needed to ensure that all eligible women receive these lifesaving services.

At the federal level, on April 20, 2007, President George W. Bush signed the National Breast and Cervical Cancer Early Detection Program Reauthorization Act into law. The legislation allows for greater flexibility in the program so it can reach more uninsured and other medically underserved women. It also sets increased funding targets for the program from the current $202 million a year to $275 million a year over the next five years. ACS CAN and the Society are advocating for Congress to accelerate annual funding for this program to $250 million. Providing sustained funding increases for the program over the next few years will mean that it can provide high-quality screening services to more low-income, uninsured, and underinsured women.

More funds are needed, however, which makes state legislative action critical. The number of eligible women aged 40 to 64 who were eligible to receive a program-funded mammogram during 2002–2003 varied by state from 2 percent to 79 percent, with an average of 13 percent nationally.[1, 2]

Several states have appropriated state dollars above the required match to expand their screening program capacities and thus serve more women. Recognizing their fiscal constraints, a few states have leveraged funding from other public and private sources to expand the program's reach.

In order to reach as many eligible women as possible, states should continue appropriating dollars for this underfunded program and continue to identify alternative funding sources.

Success Story

In September 2007, Illinois Governor Rod Blagojevich used his executive rule-making authority to expand the Illinois Breast and Cervical Cancer Program (IBCCP). Prior to the expansion, uninsured women qualified for the program only if their income was less than 250 percent of the federal poverty level — about $52,000 per year for a family of four.

The program expansion means at least 260,000 more women are now eligible for screening and treatment through the IBCCP. IBCCP qualifies all uninsured women between the ages of 40 and 64 for mammograms and breast exams and provides pelvic exams and Pap tests to uninsured women between 35 and 64, free of charge. In addition, younger, symptomatic women who meet certain guidelines are considered for the program on a case-by-case basis. With the expansion, the program will cost Illinois about $50 million annually.

The expansion of the IBCCP program will help save lives by detecting cancers in women who, due to cost, would not regularly receive these life-saving screenings. Now, all women in Illinois — within the highest-risk age brackets — have the ability to receive essential screenings without concern for how they will be covered, and women who receive a breast or cervical cancer diagnosis will be eligible to receive treatment benefits through the state's Medicaid system.

Through the dramatic expansion of the state program, the state of Illinois has demonstrated what can be accomplished when NBCCEDP's full potential is realized. This is a victory for the efforts of ACS CAN and the Society to ensure that all individuals have fair and equal access to quality cancer care.

Poor nutrition, lack of physical activity, and excess weight are contributing factors in roughly one-third of all cancer deaths in the United States. Currently, nearly 18 percent of children in the United States are overweight or obese — a threefold increase from just 30 years ago. Additionally, approximately one-third of U.S. adults are obese, and 5 percent are extremely obese.

Obesity has reached epidemic proportions and costs our nation $117 billion in direct medical costs. In the long run, obesity puts individuals at an increased risk for many chronic diseases, including cancer, heart disease, stroke, diabetes, and osteoporosis.

For the majority of Americans who do not use tobacco, weight control, dietary choices, and physical activity are the most modifiable determinants of cancer risk. In 2006, the Society published updated Nutrition and Physical Activity Guidelines to educate health care professionals and the general public about the correlation between nutrition, physical activity, and cancer risk. To reduce the incidence of cancer, the guidelines recommend that individuals maintain a healthy weight, adopt a physically active lifestyle, and eat a healthy diet.

The guidelines also recommend community action steps to reduce cancer risk. Fostering the development of a healthy society requires a combination of approaches, such as education and awareness campaigns, as well as program and policy initiatives. Programmatic and policy approaches have the most potential to influence large segments of the population, and ACS CAN urges state legislators and local communities to lead these efforts.

Successful solutions include protecting and strengthening physical education and nutrition programs in schools, providing nutritional information in restaurants, and promoting healthy workplace environments. In the coming year, the Society and ACS CAN will continue to review the science on the impact of physical activity and nutrition on cancer and will educate states about legislative steps they can take to protect their communities.

Cancer Pain Management: Policy and Practice

The Challenge

Pain is one of the most feared and burdensome symptoms for cancer patients. Fortunately, nearly all cancer-related pain can be relieved.

When pain is controlled, health outcomes improve and patients and their loved ones report significantly improved quality of life. Yet the statistics describing the burden of cancer pain have remained largely unchanged for 40 years.[1] These difficulties are even greater in medically underserved populations.

A variety of barriers contribute to this disconnect between what is possible in pain control and what is actually achieved:

- People often do not fully understand the importance of pain control and, for a variety of reasons, may be reluctant to raise pain as a problem when they see their doctor or nurse.
- Medical and nursing school training on pain is very limited, so many health care professionals lack knowledge of medical standards, current research, and clinical guidelines for appropriate pain assessment and treatment.
- People's misperceptions about addiction, dependence, and tolerance contribute to patient and family fears about using pain medications, physicians' reluctance to prescribe them, and pharmacists' reluctance to dispense them.
- Many health care professionals do not understand the state policies that regulate prescribing practices. They have expressed concern that prescribing certain pain medicines may subject them to investigation, disciplinary action, or criminal prosecution.

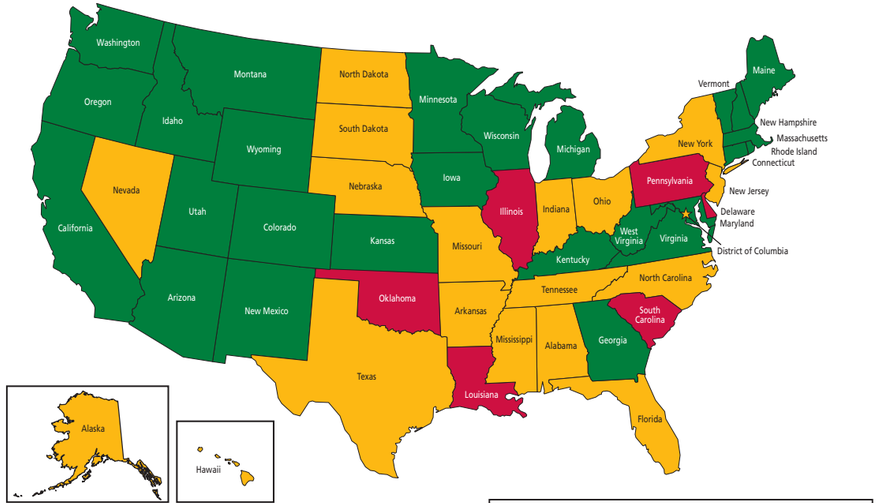
The Solution

Pain control is an essential part of care throughout the cancer experience and often continuing as needed into survivorship and at the end of life. Patients need to understand the importance of talking openly about pain with their loved ones and their health care providers. At the same time, health care professionals must be trained to assess pain and properly use the many treatments that are safe and effective to relieve pain.

State policies regulating professional practice, prescribing, and patient care vary widely and play a significant role in pain management. While several states have adopted helpful policies that promote adequate pain treatment, many others have provisions that interfere with medical decision making and deter adequate pain control.

ACS CAN has made great strides toward meeting the Society's Nationwide Pain Control Objective of achieving more balanced policies in every state, as measured by the continuing trend of state grade improvements reported in the 2008 Progress Report Card from the Pain and Policy Studies Group (PPSG) at the University of Wisconsin.[2] But more still needs to be done. ACS CAN challenges state legislators to enact more balanced

Cancer Pain Management: 2008 State Policies and Practice



How Do You Measure Up?

*Source: Data from University of Wisconsin's Pain & Policy Studies Group, Achieving Balance in State Pain Policy: A Progress Report Card (2008). http://www.painpolicy.wisc.edu/Achieving_Balanceindex.html

State Pain Policy and Practice Improvement Criteria:

- Existence of state pain commission, task force or advisory council
- Nurse Practitioner authority to prescribe all controlled substances for pain
- Medical, nursing, and/or pharmacy professional licensing boards have adopted policies on pain management
- Pain management provisions included in state comprehensive cancer control plan
- Pain policy grade improvement achieved between 2000 and 2008

  Source: Pain & Policy Studies Group. *Achieving Balance in State Pain Policy: A Progress Report Card (Fourth edition).* University of Wisconsin Paul P. Carbone Comprehensive Cancer Center. Madison, Wisconsin, 2008.
- Medical Board partnered with Federation of State Medical Boards to distribute to state licensees *Responsible Opioid Prescribing – A Physician's Guide (2007)*

policies on pain management practices to ensure that prescription pain medications are available to patients who need them, while also keeping such medications from individuals who intend to misuse them. In addition to passing more balanced policies, it is also essential that policymakers ensure the implementation of these policies by educating regulatory boards and practitioners who license health care professionals (medical, nursing, and pharmacy).

Success Story

For years, Georgia's PPSG Report Card grade was a D+, the lowest in the nation and no statewide pain initiative existed. To rectify the situation, ACS CAN and the Society brought together stakeholders at a pain forum in 2007 to plan activities geared toward improving the state's pain policies and advancing their practice. In attendance were state experts in pain management, members of the health care community, legislators, the state Attorney General's office and other concerned parties.

The result was the formation of a strong coalition comprised of both new and existing partnerships. This coalition experienced immediate success. The state medical board adopted updated pain management guidelines in January, and in April, the Georgia Pain Initiative Steering Committee was formed and Society staff and volunteers, physicians, pharmacists, nurses, law enforcement, and policymakers were invited to join.

As a result, more than 100 multidisciplinary stakeholders from across the state have indicated a desire to be active participants in Georgia's new State Pain Initiative. One of the Steering Committee's first projects will be working with the state medical board to distribute the Federation of State Medical Board's new Responsible Opioid Prescribing Physician's Guide to all state licensees.

As of June 30, Georgia's PPSG grade now stands at a B. What a difference a year and dedicated effort can truly make.

Medicaid and Cancer Treatment

The Challenge

Recent American Cancer Society research suggests that Medicaid enrollees with cancer are more likely than patients with private insurance or Medicare to be diagnosed with later stage disease and are less likely to survive five years after diagnosis. However, this doesn't mean that Medicaid is an ineffective program — a number of factors explain this result.

First, some people who are classified as having Medicaid insurance are actually uninsured when they are diagnosed with cancer and are then retroactively enrolled in the program. Oftentimes, it is the initial uninsured status that leads to later stage discovery of cancer, which lowers survival rates.

Second, some Medicaid enrollees are more likely than other populations to encounter additional barriers to care. For example, recipients are less likely to have additional funds to meet non-medical needs related to receiving care, such as adequate transportation.

Third, Medicaid beneficiaries are more likely to have low health literacy, which could lead to lower use of preventive services and poorer compliance with treatments.

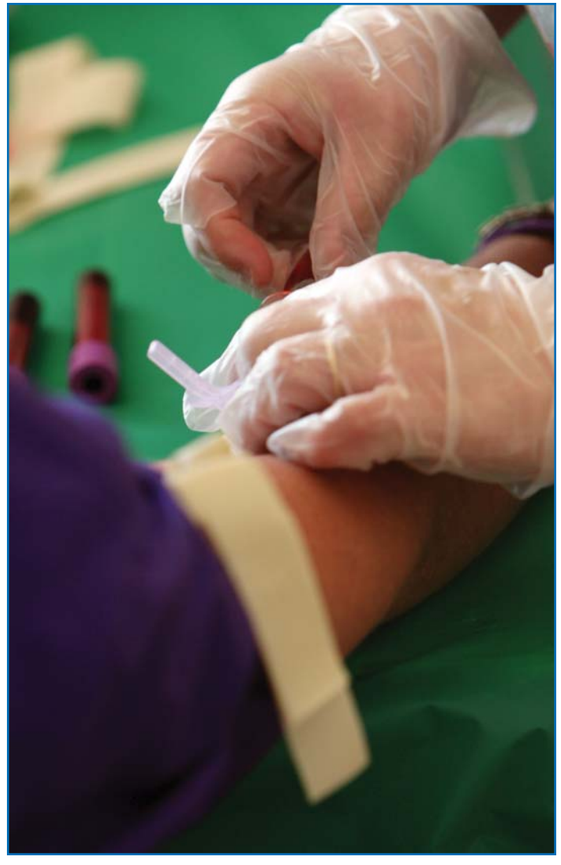
Finally, high rates of co-morbidities may also contribute to the lower survival rates among Medicaid cancer patients.

Medicaid policies regarding eligibility and enrollment vary considerably among states. They are also often complex, which can lead to delays in treatment, gaps in care, and, sometimes, worse outcomes. Additionally, many patients have difficulty finding physicians currently accepting new Medicaid patients.

As states face increased economic pressures, many may consider making significant changes to the design and operation of their Medicaid program, possibly to the detriment of cancer patients who rely on this program for access to lifesaving cancer screenings and treatment.

The Facts

- Without Medicaid, more than 55 million of the nation's most vulnerable individuals would be uninsured, lowering their chances of early detection and timely treatment, as well as potentially higher death rates.[1]



- Approximately 25 percent of children with cancer and 9 percent of adults with cancer are covered by Medicaid or the State Children's Health Insurance Program (SCHIP).[1]

- Medicaid increases access to cancer screenings. In 2005, 40 percent of Medicaid enrollees received recommended colorectal cancer screening, compared to 19 percent of the uninsured. More than half of the women enrolled in Medicaid received a mammogram in the past two years, compared to 38 percent of uninsured women (Ward et al.2008).

Medicaid

The Solution

Medicaid is a public health insurance program that provides free or low-cost health and long-term care coverage to certain categories of low-income Americans who otherwise would not have health insurance. States have an opportunity to improve the health and well-being of some of our nation's most vulnerable citizens through the Medicaid program.

ACS CAN strongly discourages state legislatures from cutting essential Medicaid funds and urges states to evaluate all proposed changes to the program based on the Society's principle for health insurance coverage (the 4As: Availability, Affordability, Adequacy, and Administrative simplicity). While not all Medicaid reform proposals will address all of these areas, the issues identified can serve as a starting point for evaluation for any proposed changes to the program.

Defining Meaningful Medicaid Coverage

Based on the 4As, the Society has defined key issues as they relate to Medicaid reform proposals.

Available Medicaid Coverage

Covers optional categorical groups, including the medically needy and childless adults; increases income limits above minimum thresholds; does not have a cap on enrollment; and allows spend-down/buy-in programs.

Affordable Medicaid Coverage

Does not charge premiums and limits total cost-sharing to minimal percent of family income. By definition, Medicaid enrollees are low-income, and studies indicate that even nominal cost-sharing can cause low-income populations to forego or delay screenings or treatment.

Adequate Medicaid Coverage

Does not replace traditional coverage with more restrictive "benchmark" plans; does not tier benefits based on health status or health behaviors; has an open formulary and exceptions for medically necessary drugs.

Administrative Simplicity

Program advertises widely; it uses providers and community organizations to enroll beneficiaries; forms and plan materials are simple and easy to read; materials are available in languages other than English.

Success Story

In April 2006, in an effort to improve Massachusetts' uninsured problem, especially among working-age adults, state policymakers enacted comprehensive health care reform with the goal of providing coverage for nearly everyone in the Commonwealth. To ensure this access, the legislation stipulated that coverage be delivered through Medicaid expansion, insurance market reforms, and subsidized private insurance coverage (CommCare), and required actions for both employers and individuals.

According to a recent Urban Institute study, the percentage of uninsured adults age 18 - 64 in Massachusetts dropped by almost half — from 13 percent to 7 percent — within a year of the reform's implementation; 93 percent of adults, excluding the elderly, are now insured. The uninsured rate of adults with incomes below 300 percent of the poverty level (CommCare's target population), dropped to approximately 13 percent, compared to 24 percent the previous year. The greatest gains were seen among adults with income less than 100 percent of the poverty level, who are eligible for fully subsidized coverage under CommCare. This group's uninsured rate dropped to 10 percent in the fall of 2007, an almost two-thirds decline from the previous year. Additionally, low-income adults are now more likely to have a regular place to go when they are sick or need advice about health, an important indicator for continuity of care. They are also 6 percent more likely to seek out preventive care by visiting a doctor for a physical exam or check-up, according to the study.

While intending to get more people insured, the Massachusetts health care reform effort has also expanded access to care. Significant access gains have been made in the overall population, particularly among low-income adults. Additionally, out-of-pocket expenses have gone down across the board in the past year. One reason for these astonishing results is that CommCare received a waiver allowing it to redirect some Medicaid funds into its program.

Access to Care — The Uninsured

Racial and ethnic minorities and persons of lower income are more likely to report being uninsured. In 2006, 20.5 percent of African Americans were without health insurance coverage, compared to 10.8 percent of Caucasians. Of households earning less than $25,000, 24.9 percent were uninsured in 2006, compared to 8.9 percent of households earning $75,000 or more.

The Challenge

Almost 47 million Americans are uninsured.[1] In 2004, the Institute of Medicine estimated that 18,000 deaths each year are attributed to a lack of health insurance. Since then, the number of uninsured Americans has grown; a recent study estimated that 22,000 people died in 2006 as a result of being uninsured.[2]

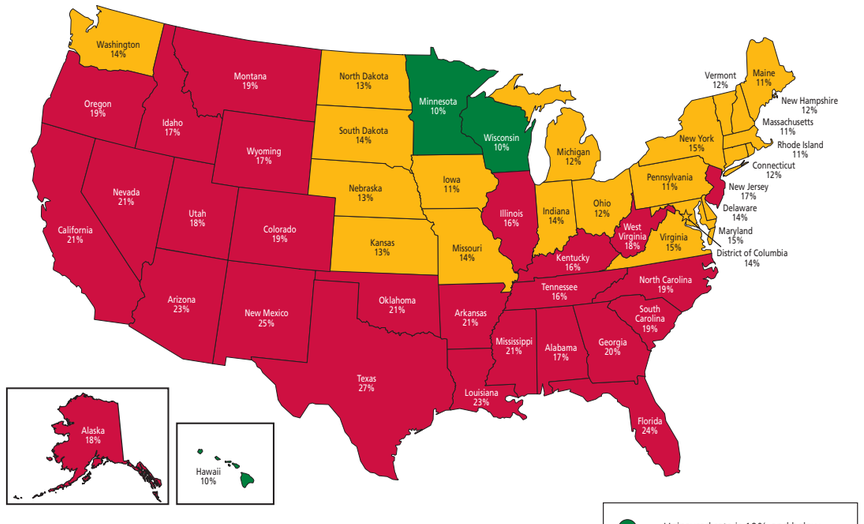
Numerous studies have shown that cancer patients without insurance may not receive adequate preventive screenings and treatments, resulting in poorer outcomes. Those who are poor and uninsured are less likely to receive cancer prevention services, more likely to be treated for cancer at late stages of the disease, more likely to receive substandard care and services, and more likely to die from cancer.[3, 4, 5]

In addition, minorities are much more likely to be uninsured than Caucasians — 34 percent of Hispanics, 21 percent of African Americans, and 16 percent of Asian Americans are uninsured, compared to 11 percent of Caucasians.[6]

The Facts

- One in 10 cancer patients under age 65 does not have health insurance.[7]
- Uninsured adults under age 65 are at least 50 percent less likely than insured adults in the same age group to have received preventive care, such as Pap smears, mammograms, and prostate exams.[8]
- Uninsured patients are significantly more likely than patients with private insurance to present with advanced stage cancer.[9]

The Uninsured
Proportion of State Population under Age 65 Who Were Uninsured, 2005-2006



Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2006 and 2007 Current Population Survey (CPS: Annual Social and Economic Supplements).
* Note: This map is not directly comparable to the 2007 map due to differences in the thresholds used to define colors.
*As of July 1, 2007, Massachusetts' law to cover the state's uninsured population went into effect. The law includes an individual mandate and provides government subsidies to ensure affordability of coverage, in addition to other components.

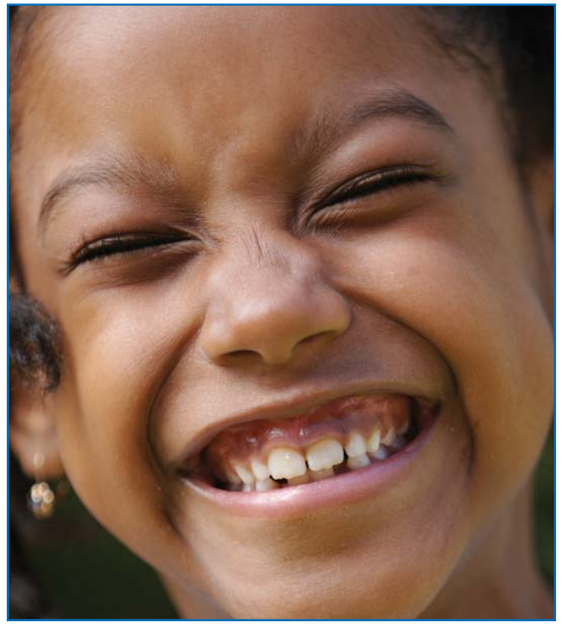
How Do You Measure Up?

- Uninsured women diagnosed with breast cancer are 2.4 - 2.5 times more likely than women enrolled in private health insurance to have a late-stage diagnosis.[10]
- Privately insured patients diagnosed with Stage II colorectal cancer are more likely to survive five years than uninsured patients diagnosed with Stage I cancer.[11]

The Solution

State policymakers are addressing the problem of the uninsured through a variety of tactics — some with broad and sweeping plans, others with more incremental solutions. States are pursuing a number of strategies to ensure that uninsured cancer patients and those at risk for cancer have access to lifesaving screenings, treatments, and care, such as:

- Providing immediate medical coverage for the uninsured upon a diagnosis of cancer.
- Creating Patient Navigator Programs to assist uninsured healthy individuals and cancer patients in accessing screening, medical information, and treatment.
- Expanding public coverage for the low-income uninsured by building on Medicaid and the State Children's Health Insurance Program (SCHIP).
- Establishing or improving state high-risk pools to cover those who are unable to obtain private health insurance.
- Developing extensive statewide reforms, including private insurance and public programs designed to significantly decrease the number of uninsured.



Since each state faces different challenges in addressing the uninsured problem, ACS CAN and the Society are available to help state policymakers create meaningful coverage plans for their constituents.

Success Story

Faced with an increasing number of uninsured residents, Utah Governor Jon Huntsman challenged the legislature last summer to come up with a two-year legislative plan to provide adequate, affordable, and accessible health care coverage for everyone in the state. The legislature accepted the governor's challenge and passed 16 major pieces of health care reform legislation in the 2008 session alone.

Of particular significance was Utah House Bill 133, aptly titled "Health System Reform." This bill established a legislative Health System Reform Task Force to lay the groundwork for developing a master plan for health care reform. The legislation also set goals for health system reform, including the development of insurance coverage plans that include cancer screenings following Society guidelines. Finally, it set the major goal of developing a comprehensive system for electronic exchange of clinical health information.

ACS CAN and the Society have been invited to participate in these discussions since cancer prevention, detection, and treatment options will play a major role in any health care reform proposal. The Society plans to advocate for the best options available to cancer patients as plans, programs, and products are developed and implemented.

Access to Care — High-Risk Health Insurance Pools

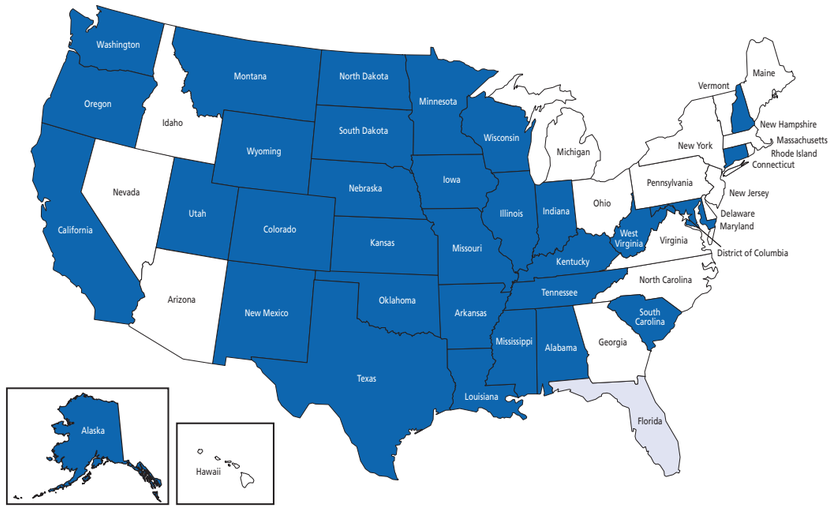
Thirty-three states have established high-risk pools as a health insurance safety net for residents who do not have access to employer-sponsored health insurance and cannot purchase health insurance in the non-group market due to health status.

The Society's Health Insurance Assistance Service (HIAS) offers cancer patients in 34 states and the District of Columbia a free resource that connects them with insurance specialists who work to address their needs. Between July 2006 and March 2008 HIAS received 2,696 calls from cancer patients and survivors living in states with high-risk pools[1] who were either uninsured or about to lose their health insurance. Due to significant barriers to enrollment, only 57 of these callers were able to enroll in high-risk pools.

The biggest barrier for cancer patients who need to enroll in high-risk pools is pre-existing condition restrictions. In most states the health condition that makes the person medically eligible for the high-risk pool is subject to a pre-existing condition exclusion period, a significant barrier to access.

For people who have been diagnosed, these exclusions eliminate all coverage for cancer-related treatment for the duration of the exclusion period — usually three to 12 months. For a cancer patient in need of treatment, the pre-existing condition waiting period can mean a deterioration of health, which will likely result in subsequently higher medical costs, as well as a lower quality of life.

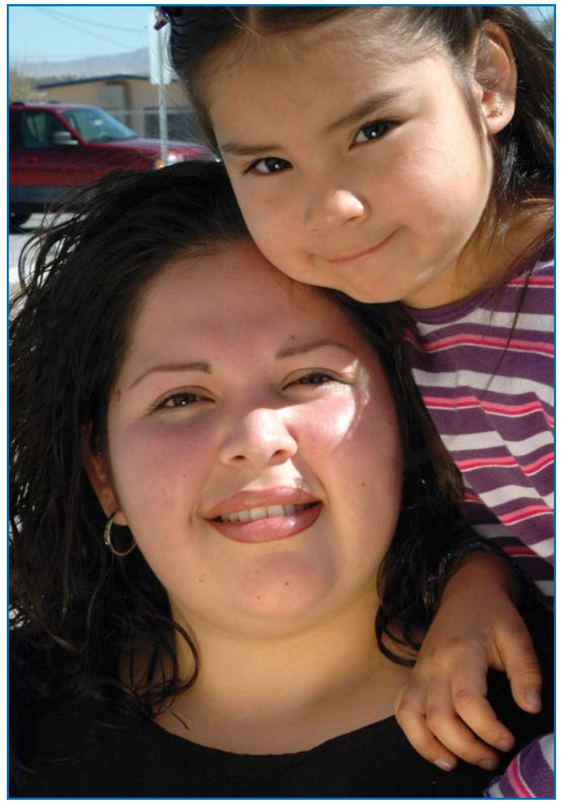
State High-Risk Pools
States with High Risk Insurance Pools, 2008



Source: National Association of State Comprehensive Health Insurance Plans, 2008

* In 2007, the North Carolina General Assembly passed Session Law 2007-0532 which created the North Carolina Health Insurance Risk Pool (NCHIRP). NCHIRP is scheduled to begin offering coverage on 1 January 2009.

How Do You Measure Up?



The second barrier for HIAS callers is affordability. High-risk pool premiums are set at above-market rates — usually 125 to 200 percent of the premiums found in the individual health insurance market — and are adjusted for age.

For cancer, which is more likely to occur in the older population, age is a barrier to affordability. During HIAS calls, the Society is hearing stories where cancer patients enrolled in high-risk pools are spending as much as two-thirds of their income on premiums alone, not to mention what they pay for the plan's deductibles and co-pays. Furthermore, few state high-risk pools offer subsidies to lower-income enrollees, and many plans offered in the high-risk pools have high deductibles or significant co-insurance.

Information from HIAS suggests that high-risk pools are not serving as an effective safety net for cancer patients in need of health insurance. While marketed as the alternative to conventional health insurance for those at high risk, the reality is that the pools have established significant barriers that prevent those in need from gaining access to timely and affordable care. For cancer patients, who often must have timely medical care to combat their deadly disease, the availability and cost barriers that exist in virtually all state high-risk pools mean that this safety net has failed, often leaving them with no viable option for obtaining quality health care.

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