HOW DO YOU MEASURE UP?

July 2010

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

Cancer Action Network℠
American Cancer Society®

Mission Statement

American Cancer Society Cancer Action Network

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

Our Eighth Edition

This eighth 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.

If you want to learn more about ACS CAN's programs and/or inquire about a topic not covered in this report, please contact the ACS CAN state and local campaigns team at (202) 661-5722 or call our toll-free number, 1-888-NOW-I-CAN, 24-hours a day, seven days a week. You can also visit us online at www.acscan.org.

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ACS CAN conducts federal advocacy campaigns nationwide and leads state and local advocacy campaigns in the 12 states of the American Cancer Society's Great West Division. In the remaining 38 states, state and local advocacy campaigns are directed by Society Division staff. The Society's National Home Office grants funds in support of ACS CAN and Division advocacy efforts.

How Do You Measure Up?

In the United States, there is no reason why a woman should miss her annual mammogram due to lack of insurance; why a family should be forced to declare bankruptcy due to a cancer diagnosis; 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 does not have access to lifesaving treatments. We all have the ability to fight back against the disease by working with policy-makers to enact laws and policies that eliminate barriers for the proper diagnosis, treatment, and care of cancer patients, regardless of ethnicity, race or socioeconomic status.

With the knowledge we have today, we could prevent 60 percent of cancer deaths in the United States, which translates into approximately 340,000 lives saved each year.[1] If everyone in America were to stop smoking, get screened for cancer, eat a healthy diet and exercise regularly, we could make incredible inroads in the fight against cancer.

Scientific research has yielded numerous tools for preventing and treating life-threatening diseases, such as cancer, resulting in a nearly 14 percent decrease in U.S. death rates from all cancers combined from 1991 to 2004.[2] Despite this progress, far too many Americans are unable to access screening tests, information about leading an active lifestyle and/or counseling and cessation tools to facilitate healthy behaviors, such as quitting tobacco use.

In an effort to prevent cancer and save more lives, the American Cancer Society Cancer Action Network℠ (ACS CAN) and the American Cancer Society (the Society) work closely together to expand access to evidence-based lifesaving treatments and services, and to enact and enforce strong public health policies that have been proven to reduce the toll of cancer.

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

The Affordable Care Act

More than 46 million people in America are uninsured. Another 25 million are underinsured – they have insurance, but their coverage is inadequate. Insured or not, millions of people don't have access to cancer prevention, early detection, and evidence-based treatment and care options that give them a fighting chance against this disease.

For decades, our nation's health care system has failed to meet the needs of people with cancer, many of whom are denied coverage, offered inadequate policies that do not cover pre-existing conditions, or charged far more than they can afford for the care they need. Cancer patients have waited too long for the broken health care system to be repaired – but that's about to change. In March 2010, President Obama signed health care reform legislation into law that includes several provisions that will meaningfully improve the health care system for cancer patients and their families.

The Patient Protection and Affordable Care Act (Affordable Care Act) meets ACS CAN's priorities for meaningful reform in the following ways:

- Increases the emphasis on disease prevention, such as by eliminating out-of-pocket costs for lifesaving cancer screenings
- Guarantees access to quality, affordable health care, regardless of whether a person has a pre-existing health condition
- Emphasizes a patient's quality of life, such as by ensuring access to treatment for pain

Passage of the Affordable Care Act is only the beginning of the Society and ACS CAN's efforts to ensure that all Americans have access to quality health care. Many provisions in the new law will not take effect until 2014 and many provisions need to be strengthened. ACS CAN and the Society will continue to work at the federal, state and local levels to ensure that the new law provides an improved health care structure that is as strong as possible for people with cancer and their families.

The Fight Continues

Implementation of the Affordable Care Act will change the landscape of state-level public health policy. It is critical that states continue to proactively enact laws that improve access to quality, affordable care for cancer patients and their loved ones.

Throughout the past year, state legislatures across the country made great advances in the fight against cancer through the enactment of laws and policies focused on disease prevention. Since the last publication of this report (July 2009), 11 states and the District of Columbia have passed tobacco tax increases, bringing to 47 the total number of states with tobacco tax increases since 2002. Three states implemented comprehensive smoke-free laws protecting workers and patrons from the hazards of secondhand smoke, bringing to 35 the number of states, in addition to the District of Columbia and Puerto Rico, that now require 100 percent smoke-free workplaces and/or restaurants and/or bars. Additionally, many 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 legislatures fought hard to preserve coverage for lifesaving cancer screenings and treatments, and to stave off attempts to cut state funds that support these programs, such as the National Breast and Cervical Cancer Early Detection Program. Medicaid coverage for cancer treatments also came under attack with many state legislatures voting to protect programs that help ensure quality cancer care for those who desperately need it.

Still, too many Americans are needlessly losing their battle against cancer or facing economic ruin because

they cannot gain access to or afford the lifesaving care they need. For example, recent studies have shown that 45 percent of adults living in poverty are uninsured, fewer than one-quarter of smokers receive adequate tobacco cessation services, and only half of those recommended to be screened are actually screened for colorectal cancer.

Despite tremendous progress over the past decade, the data in this report shows that there is still much public policy work to be done to achieve our mission of eliminating suffering and death from cancer. More than 1.5 million people in the United States will be diagnosed with cancer in 2010 and more than 569,000 people will die from the disease this year alone.[3] ACS CAN, in partnership with the Society, is dedicated to ensuring that lawmakers enact state health reforms that help prevent cancer and save lives. Will you help us fight back against cancer?

How does your state measure up?

The Uninsured

The Challenge

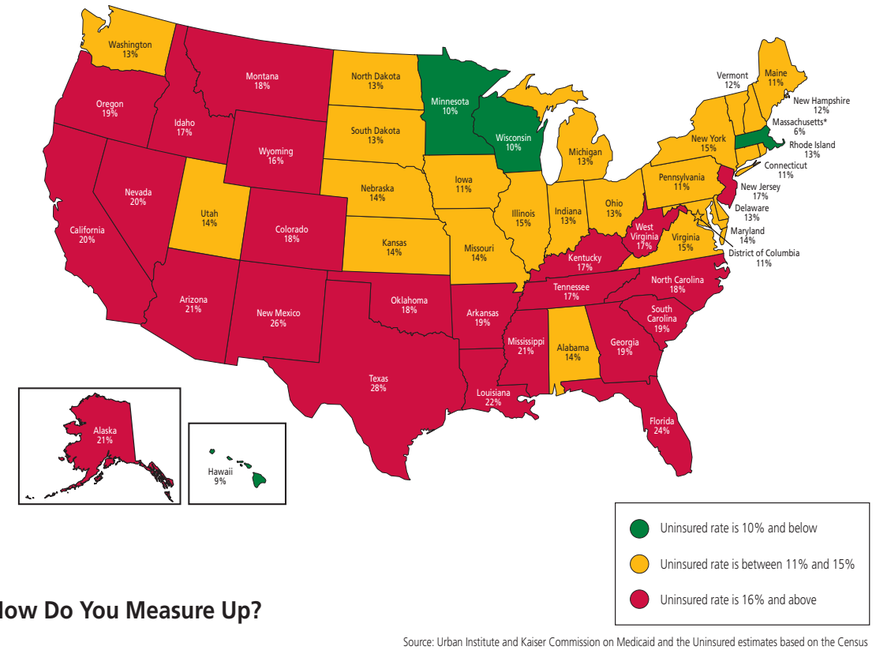
More than 46 million Americans are currently uninsured.[1] In today's tough economy, as many as 14,000 people are losing their health insurance every day. In fact, for every one percentage point rise in the national unemployment rate, 2.4 million people lose their employer-sponsored health coverage.[2]

Historically, cancer patients and survivors have faced many challenges in an effort to find adequate, affordable health care. According to a recent ACS CAN poll, two-thirds of cancer patients under age 65 who tried to find insurance outside their employer couldn't find an affordable plan. And nearly one-third of people under age 65 who have been diagnosed with cancer have been uninsured at some point since their diagnosis. For cancer patients, research shows that being uninsured can worsen the chance of survival.

Numerous studies have shown that patients without insurance may not receive adequate preventive screenings and treatments, resulting in poorer outcomes across a range of cancers. Those who are poor and uninsured are less likely to receive cancer prevention services, are 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]

The Uninsured

Proportion of State Population under Age 65 Who Were Uninsured, 2007-2008



How Do You Measure Up?

Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2007 and 2008 Current Population Survey (CPS: Annual Social and Economic Supplements).

*According to a report from the Urban Institute updated March 2009, less than 3 percent of residents under 65 were uninsured when the 2008 Massachusetts Health Insurance Survey (HIS) was conducted.

In addition, some populations are more vulnerable than others. Minorities are much more likely to be uninsured than Caucasians – 30.7 percent of Hispanics, 19.1 percent of African-Americans and 17.6 percent of Asian-Americans are uninsured, compared to 10.8 percent of Caucasians.[6]

The Facts

- Uninsured patients are significantly more likely than patients with private insurance to be diagnosed with advanced-stage cancer of the breast, colon, urinary bladder, prostate, uterus, thyroid, kidney and lung, as well as late-stage melanoma and non-Hodgkin lymphoma.[7]
- Uninsured adults under age 65 are at least 50 percent less likely to have had a mammogram or colorectal cancer screening test, compared to privately insured adults.[8]
- Uninsured women diagnosed with breast cancer are 2.5 times more likely to have a late-stage diagnosis than women enrolled in private health insurance.[9]
- Privately insured patients diagnosed with stage II colorectal cancer are more likely to survive five years than uninsured patients diagnosed with stage I colorectal cancer.[10]
- The American Cancer Society's National Cancer Information Center has received more than 30,000 calls since 2006 from cancer patients and survivors with problems accessing insurance.

The Solution

The reforms in the Affordable Care Act represent a profound structural change at the federal level in how private insurance will operate and how consumers and patients will utilize the health insurance system. Once implemented, the new law will mean that having a serious disease will no longer be a threat to affordable, quality coverage. However, much of the work of implementation will fall on the states in the coming years.

In the meantime, state policy-makers must continue addressing the number of uninsured in their states – whether it be through broad reforms or incremental changes. Currently, 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 following 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)
- Pursuing extensive statewide reforms, including private insurance and public programs designed to significantly decrease the number of uninsured residents

Since each state faces unique challenges in addressing the problem of the uninsured, ACS CAN and the Society are eager to work with state policy-makers in developing and implementing plans that will expand meaningful health coverage plans to more of their citizens. ACS CAN and the Society are also prepared to help work with state lawmakers to implement the reforms outlined in the Affordable Care Act in a way that ultimately benefits cancer patients and survivors.

Affordability of the Individual Market

The Challenge

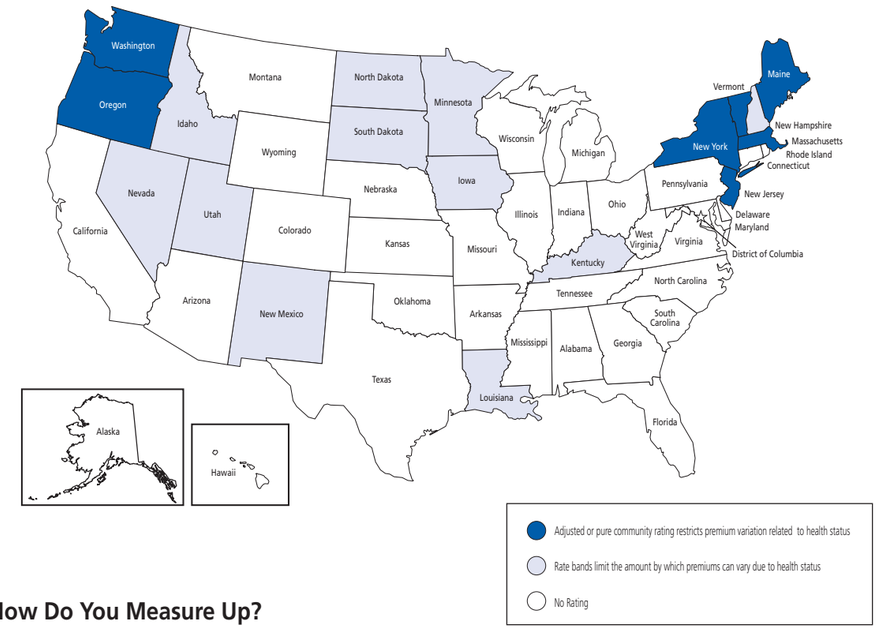
With the rising number of unemployed and the shrinking pool of employer-based insurance, more Americans may be forced to buy their health insurance in the individual market. For the most part, these individuals do not have access to employer-based health coverage because their employer does not offer health insurance, they are self-employed or work part-time, or they are currently unable to work. In these situations, health insurance in the individual market may be the only option for coverage. However, for cancer patients who must have timely medical care to combat a deadly disease, the availability and cost barriers that exist in most states' individual insurance market often leave them with no viable option for obtaining quality health care.

Cancer patients and survivors face enormous challenges finding adequate insurance in the individual market. Insurers use pre-existing conditions, such as cancer, as a reason to deny or limit coverage, and as a result, a person with cancer who is laid off, or whose employer is forced to drop coverage, is virtually uninsurable. Cost is also a concern. According to a recent ACS CAN poll, nearly half of cancer patients without insurance use up all or most of their savings while undergoing treatment. Even with insurance, one in five people see their savings dwindle as a result of a cancer diagnosis.

States have the authority to regulate how much insurers charge for health insurance in the individual market and decide which determining factors insurers may use in setting insurance premium rates. States can implement community rating regulations to limit the extent to which premiums in the individual market can vary based on factors such as age, family status and geography. Most importantly, community rating eliminates premium rating based on health status. However, some states use rate bands, which limit premium variation on some factors, while still allowing insurers to vary premiums based on health status or risk.

Private Insurance Market

State Individual Market Premium Rate Restrictions, 2010



How Do You Measure Up?

Source: Data collection and analysis by researchers at the Health Policy Institute, Georgetown University. Data compiled through review of state laws and regulations and interviews with state health insurance regulatory staff. Special Data Request, January 2010 for the Henry J. Kaiser Family Foundation.

Note: Not applicable to HIPAA-eligible individuals.

The Facts

- More than 17 million people under age 65 purchase their health insurance in the individual market.[1]
- Nearly nine in 10 people who looked into obtaining coverage through the individual market never bought a plan, citing difficulties finding affordable coverage or being denied coverage.[2]
- In recent polling of families affected by cancer, more than two-thirds of those under 65 who tried to find an affordable health insurance plan on their own were unable to do so.[3]
- In 32 states and the District of Columbia, there are no limits on how much insurers can vary premiums based on health status.[4]
- An additional 11 states have limits on premiums, yet still allow variation in premiums based on health status.[5]

The Solution

Many of the barriers that prevent cancer patients and survivors from obtaining health coverage in the individual market will be eliminated by the Affordable Care Act. As early as this year, critical reforms will abolish arbitrary annual limits on benefits and do away with lifetime limits altogether. By 2014, insurance companies will no longer be able to discriminate based on health status and pre-existing conditions, a practice that has long been detrimental to cancer patients.

These reforms will also ease the cost burden on cancer patients and their families looking for coverage in the individual market. In 2014, the law grants premium subsidies and limits out-of-pocket expenses for individuals and families earning up to 400 percent of the federal poverty level. In addition, the law will limit insurance premium ratings to a 3-to-1 ratio based only on age, geographic area and family size.

Unfortunately, cancer patients and their families who currently seek coverage in the private market need available and affordable health insurance now. In advance of the reforms that will be implemented in 2014, it is essential that states establish rules to help those who need health care to obtain it at affordable rates. State policy-makers are trying many ways to expand access for their residents in the individual market. The following strategies are currently being implemented:

- Require issuance of all health plans to all people and require adjusted community rating of premiums – that is, without regard to health status or pre-existing medical conditions.
- Provide sufficient subsidies for lower-income individuals to pay for premiums.
- Ensure a basic level of benefits for all, including access to vital preventive services and adequate coverage that would protect people if they develop a serious medical condition.

ACS CAN and the Society are available to work with state policy-makers to help expand meaningful health insurance coverage in the individual market for their residents.

Insurance Market Definitions

Individual Market – An individual can purchase health insurance if he or she does not receive coverage from an employer. Individual market health plans are regulated by the state.

Insurance Premium – The cost of participating in the health insurance plan, not including any required deductibles or co-payments. Sometimes the individual bears the entire cost. Sometimes this cost is shared between the individual, the employer or the government.

Community Rating – A method for setting health insurance premiums for covered individuals where the premium is the same for everyone within a specified geographic area. The premium is not adjusted for the individual's medical history or likelihood of using medical services. Some states use "adjusted community rating," which generally means that there is some adjustment in premiums for age.

Rate Bands – The amount by which health insurance premiums for a specific class may vary. For example, the most expensive premium may be limited to 1.5 times the cheapest premium in the individual market. The definition of "classes" or "blocks of business" for premium rating purposes varies considerably among the states.

Determining Factors – These include health status, prior health claims, age, gender, particular types of business or industry, geographical location, group size, family composition, duration of insurance, lifestyle or participation in risky activities.

Medicaid and Coverage for Low-Income Populations

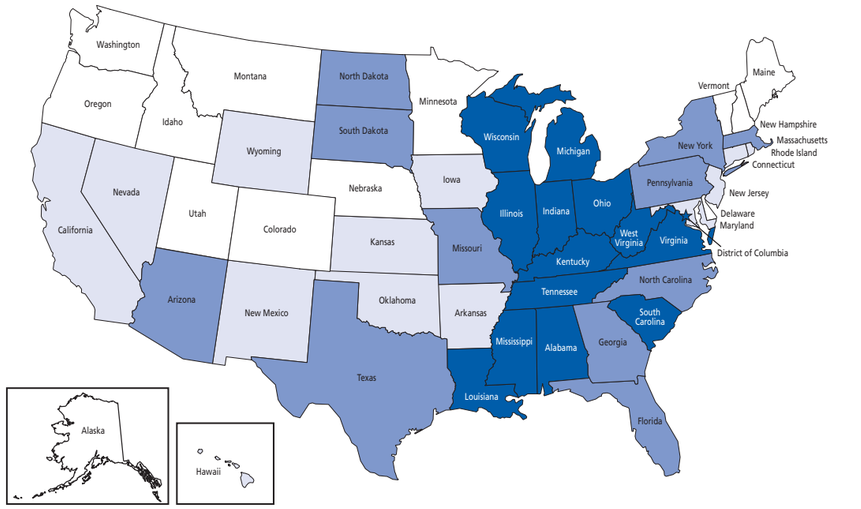
The Challenge

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. Federal and state governments jointly finance and administer the program, but there is great variation in Medicaid eligibility and coverage by state. Many people believe that Medicaid covers all Americans living in poverty, but that is not the case. In fact, the program does not cover nearly half of those currently living under the poverty line.

States are eligible to receive federal matching funds for their Medicaid program, but to qualify they must cover certain populations. Complex rules limit eligibility to people who fall into defined categories, such as pregnant women, children, the disabled, some parents and women with breast and cervical cancer. Consequently, many low-income adults with cancer are left without coverage. Additionally, adequate private insurance is not a realistic option for this population because the costs far exceed their means.

States do have the option of expanding Medicaid to people in higher-income brackets, as well as to cover additional populations, such as the medically needy, adults with no dependent children and women diagnosed with cancer through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP).

Medicaid Enrollment of Adults Living in Poverty, 2007-2008



Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2007 and 2008 Current Population Survey (CPS: Annual Social and Economic Supplements; Persons in poverty are defined as those in "health insurance units" with incomes less than 100 percent of the Federal Poverty Level (FPL).

How Do You Measure Up?

During economic downturns, Medicaid becomes even more important as people lose jobs. Unfortunately, the Medicaid program is often one of the first areas where state lawmakers consider budget cuts. State legislatures often achieve these cuts by reducing the availability, affordability, adequacy and administrative simplicity of the program. ACS CAN and the Society support protection and expansion of the Medicaid program because it provides access to quality, affordable care, which is critical in saving lives from cancer.

The Facts

- As of January 2010, low-income adults without dependent children could not qualify for Medicaid in 43 states.
- Overall, only 28 percent of adults living in poverty are covered by Medicaid. Meanwhile, 45 percent of adults living in poverty are uninsured.[1]
- State Medicaid coverage of adults living in poverty varies widely, ranging from 13 percent in Nevada to 55 percent in Maine.[2]
- Medicaid and the State Children's Health Insurance Program (SCHIP) cover approximately 25 percent of children with cancer and nine percent of adults with cancer.[3]

- In 2005, 40 percent of Medicaid enrollees received recommended colorectal cancer screening, compared to 19 percent of the uninsured. In the past two years, more than 50 percent of the women enrolled in Medicaid received a mammogram, compared to 38 percent of uninsured women.[4]

The Solution

Increasing access to care for our nation's most vulnerable populations is a critical step in the fight against cancer.

The Affordable Care Act gives all people under 133 percent of the federal poverty level (about $14,050 for a single adult) access to Medicaid. Those who do not fit into the previously eligible groups will be considered the "newly eligible." However, like many of the reforms in the new law, the expansion will not take effect until 2014.

States will continue to have the flexibility to determine the amount, duration, and scope of the Medicaid services they provide, but currently, only a handful of states cover more than 50 percent of their population living in poverty. States that have covered childless adults through Medicaid have found that these enrollees are less likely to use the emergency room for routine care and more likely to have a regular doctor. Furthermore, these states have found that the cost of such coverage is partially offset by savings to the health care safety net.

In recent years, a number of states have increased their coverage of low-income populations by:

- Increasing the income level up to which someone is eligible for certain groups, such as parents and people with disabilities
- Providing coverage for adults with no dependent children

ACS CAN and the Society believe that initiatives, such as those to cover all adults living in poverty, will help ensure that low-income Americans have improved access to prevention, detection, and treatment of cancer through the Medicaid program, allowing them to live longer and healthier lives.

Clinical Trials

The Challenge

Research conducted through clinical trials drives the development of innovations to improve cancer care and patient quality of life. Yet, consistently low enrollment of adults in clinical trials, particularly among racial and ethnic minority groups and low-income groups, delays our progress and contributes to ongoing disparities in health outcomes.

Generally, the only portion of the clinical trial that is not paid for by a trial sponsor is routine patient care costs – the costs for the care that patients would receive whether they were receiving standard care or care provided through a clinical trial. For patients who wish to participate in a clinical trial, concerns about health insurance coverage for routine care costs have been identified as a key barrier to trials enrollment. Despite increasing expansion of coverage for routine care costs in clinical trials across the United States, patients are still deterred from participating due to uncertainty under both public and private insurance plans regarding items and services that will – or will not – be covered.

The Facts

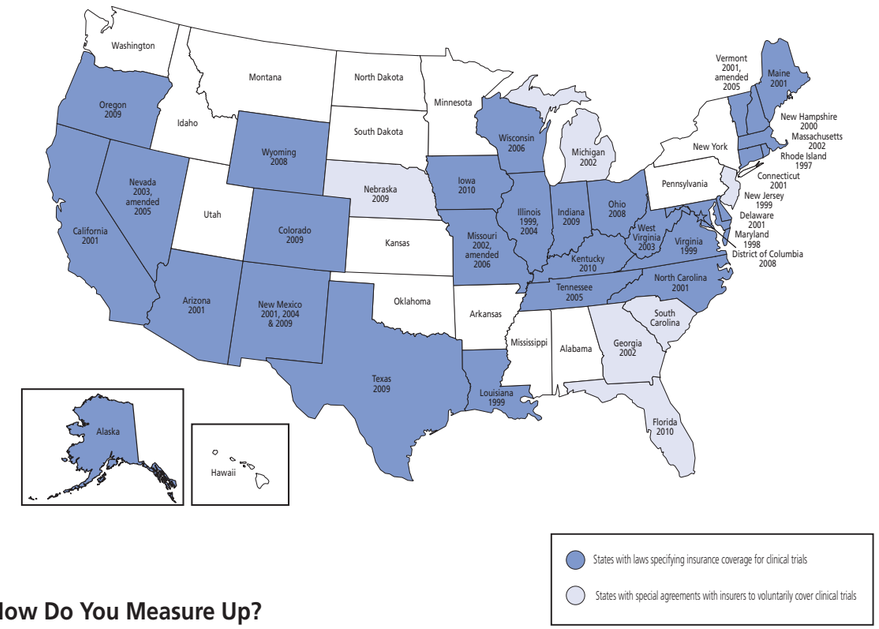
- Nearly 20 percent of adult cancer patients are eligible for participation in cancer clinical trials, but enrollment among adults consistently ranges between only 3 and 5 percent.

- Medicare covers routine patient care costs for beneficiaries enrolled in qualified clinical trials.

- Private insurers in 34 states and the District of Columbia also provide insurance coverage for patient care costs for patients enrolled in clinical trials through legislation or cooperative agreements, but the scope of coverage across the states varies considerably.

- State laws do not apply to employer-sponsored plans that self-insure and operate under the Employee Retirement Income Security Act (ERISA), leaving the vast majority of American workers outside this coverage.

State Clinical Trials Coverage



Sources: National Conference of State Legislatures (2009 update report) and www.cancer.gov/clinicaltrials/ctlaws (2010)

How Do You Measure Up?

The Solution

To boost adult patient enrollment rates and accelerate the timeline for developing new treatments, ACS CAN and the Society have consistently advocated for improved access to quality clinical trials through policies that limit the direct costs of participation for the cancer patient – including securing health insurance coverage of routine costs for patient care.

The recently enacted Affordable Care Act requires all commercial health insurance plans offering group or individual insurance coverage to pay for routine patient care costs associated with participation in clinical trials. This coverage tracks Medicare's definition for routine costs to include all items and services that are typically covered for a patient who is not enrolled in a clinical trial. The effective date is not clear and will be determined through the regulatory process. Whether this coverage is effective immediately upon enactment or in 2014, ACS CAN and the Society encourage state legislators to continue advocating in states for coverage of patient care costs associated with clinical trials. Even when these federal policies go into effect, state clinical trials policies – which in some cases may provide for more comprehensive clinical trials coverage than the federal provision and also specify coverage for state-regulated health insurance plans – will be protected and remain in force under the federal law's preemption provision.

Success Story

For the past three years in Alaska, ACS CAN has been the driving force encouraging legislators to pass legislation requiring insurance companies to provide coverage of routine patient care costs while individuals are enrolled in a cancer clinical trial.

Throughout the campaign, ACS CAN partnered with local oncologists to educate legislators regarding the importance of cancer clinical trials and the barriers Alaskans were facing. This partnership gathered postcards of support for the legislation throughout the state (at Relay For Life events, clinics, oncology offices, treatment centers and other venues) with every legislative district hearing there was strong constituent support for the bill.

Senator Bettye Davis sponsored the bill. She and several other legislators effectively persuaded their colleagues to support the legislation by sharing their personal cancer experiences and relating the importance of cancer clinical trials in the overall fight against cancer.

The campaign was a huge success that culminated in Governor Sean Parnell signing the legislation in June. Thanks to the enactment of this bill, many more Alaskans will be able to participate in cancer clinical trials without fear of losing their insurance. In addition, the campaign was the launch of a public education campaign to encourage increased adult enrollment in cancer clinical trials.

Colorectal Cancer Screening Coverage

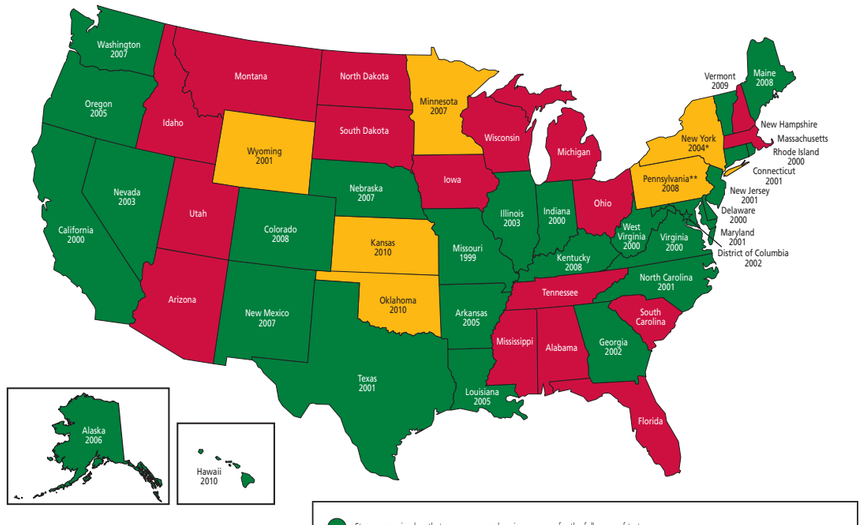
The Challenge

Colorectal cancer (otherwise known as colon cancer) is the fourth most frequently diagnosed cancer and the second most common cause of cancer death in the United States among men and women combined. Colorectal cancer is one of the few cancers that can be prevented through screening and early detection. Of the estimated 51,000 people who will die of colon cancer this year, recommended testing could have saved 80 percent of them.[1]

Colorectal cancer is easily preventable through screenings that detect and remove precancerous polyps. Furthermore, when colorectal cancer is detected and treated early, survival is greatly enhanced. When diagnosed at an early stage, the five-year survival rate is 90 percent. However, when colorectal cancer is diagnosed after spreading to other organs, the five-year survival rate is only 10 percent.[1]

Despite the lifesaving potential of colorectal cancer screening tests and the large costs associated with treating a more advanced colorectal cancer, the majority of Americans are not getting screened. Remarkably, only 39 percent of colorectal cancers are diagnosed while in the early stages. And in the 50 or older population, where colorectal cancer is most prevalent, less than half of adults in the U.S. have been screened recently.[1]

Insurance Coverage for Colorectal Cancer Screening Coverage



How Do You Measure Up?

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

The Facts

- This year, 147,000 people will be diagnosed with colorectal cancer in the United States and 51,000 will die from the disease.[2]
- Utilization of colorectal cancer screening is much lower among racial minorities and the medically underserved.
- Only 14.9 percent of those without health coverage in the United States have been screened for colorectal cancer, compared to 48.8 percent among those with insurance coverage.[3]

The Solution

The Affordable Care Act will ensure that more individuals have coverage for colorectal cancer screening. However, most of these provisions won't be implemented until 2014, and even then, more work will be required. It is critical that states continue to enact laws that increase access to colorectal cancer screening to further help reduce the number of Americans who die needlessly each year from this disease. Ensuring that all insurance policies require coverage for colorectal cancer screenings and supporting programs that provide access to colorectal cancer screenings to low-income and medically underserved populations are important steps toward reducing the total number of deaths.

Colorectal Cancer Screening Coverage

Laws that require coverage for all recommended colorectal cancer screening options help save lives. Early cancer detection is the most fundamental factor in prognosis for colorectal cancer. However, lack of insurance coverage makes people less likely to be screened for cancer, and thus, puts them at significantly greater risk for late-stage diagnosis of disease and poorer prognosis.[4]

Due to variability in access, patient choice and physician options, it is very important to cover all recommended colorectal cancer screening options as acceptable choices. Colorectal cancer screening is already underutilized in the United States. Ensuring coverage for all screening tests is an integral part of access to early detection and prevention.

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

The recently enacted Affordable Care Act only requires coverage for sigmoidoscopy, colonoscopy and guaiac-based FOBT. Therefore, it is critical that patient protection laws at the state level expand coverage to include all evidence-based tests and cover individuals who are at high risk. ACS CAN and the Society urge state legislatures to enact laws that protect and expand coverage for colorectal cancer screening.

The Society recommends that all adults over age 50 begin screening for colorectal cancer using the following methods or frequencies:

Tests that find polyps and cancer

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

Tests that mainly find cancer

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

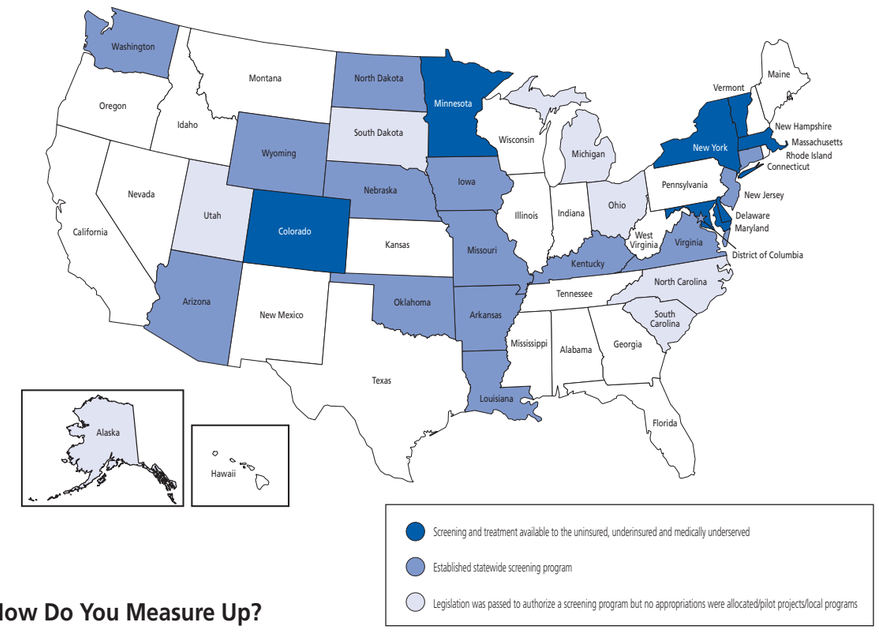
Success Story

Even in these tough economic times, with budget deficits and funding cuts to numerous programs, a few states have seen the importance of funding prevention and screening programs for the uninsured and have reflected that in their budgeting. Arkansas is one of those states.

This year, Arkansas appropriated $5 million in the 2010 state budget for a statewide colorectal cancer screening program that serves individuals who are uninsured or underinsured. Beginning July 1, approximately 80 percent of the monies will go toward actual screenings, with the remainder allocated to research and tracking of health outcomes for those individuals diagnosed with colorectal cancer through the program. The funding was due, in part, to the success of a three-year statewide pilot program that screened the same demographic as the new program.

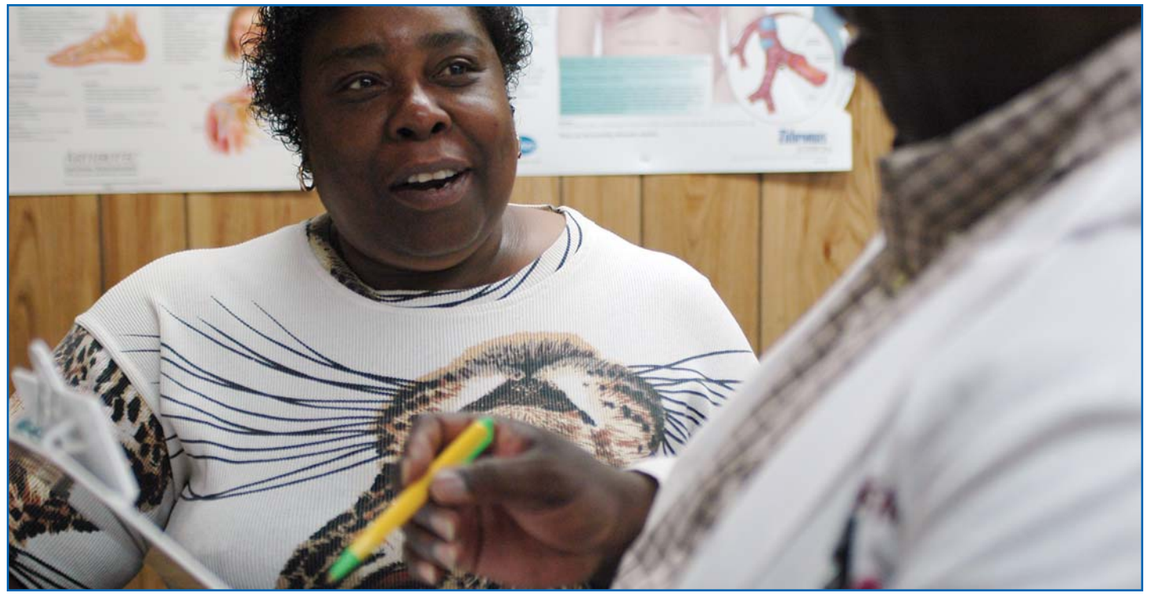
It is programs such as these that help detect cancer at the earliest, most preventable stage, when lives can be saved and future health care costs mitigated.

Colorectal Cancer Screening Programs for the Medically Underserved



*Map does not reflect CDC grants in effect in 22 states and 4 tribal organizations for colorectal cancer awareness, outreach and screening programs.

How Do You Measure Up?



Screening Programs for the Uninsured

Individuals without health insurance have lower rates of colorectal cancer screening than individuals with insurance. As a result, patients without health insurance are more likely than those with private insurance to be diagnosed with late-stage colorectal cancer and less likely to be diagnosed at the earliest, localized stage when it can be treated more effectively and less expensively. Supporting programs that ensure that neither income nor insurance status is a barrier to cancer screenings is critical. A handful of states have passed legislation to create statewide screening and treatment programs for the uninsured and underinsured and even more are beginning to support screening programs in certain populations.

ACS CAN and the Society urge state policy-makers to support programs and services that provide access to colorectal cancer screening for uninsured, underinsured and low-income populations. In addition to providing early detection screenings, these programs should also include a full range of cancer care, including treatment and follow-up for detected cancers.

Success Story

After many years of building the groundwork, Hawaii's Governor Linda Lingle signed legislation in May requiring health insurance plans to provide coverage for the full range of colorectal cancer screenings. The enactment of this law makes Hawaii the 27th state, in addition to the District of Columbia, to guarantee comprehensive colorectal cancer screening coverage.

The legislation was championed by Senator Roz Baker, an American Cancer Society volunteer, and was passed unanimously by the House, with only a single "no" vote in the Senate. Helping the cause was a state auditor's report, released prior to the vote, which found the mandate to be both good for health and cost-effective for the state. With the passage of this lifesaving legislation, Hawaii joins a long list of states who understand that regular colorectal cancer screening can not only detect cancer at an early and more treatable stage, but also can actually prevent cancer from developing by removing precancerous polyps before they develop into cancer. Thanks to this new law, many Hawaiians will not have to suffer needlessly from a cancer that is easily and effectively treated when detected early.

Funding for Breast and Cervical Cancer Screening

The Challenge

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

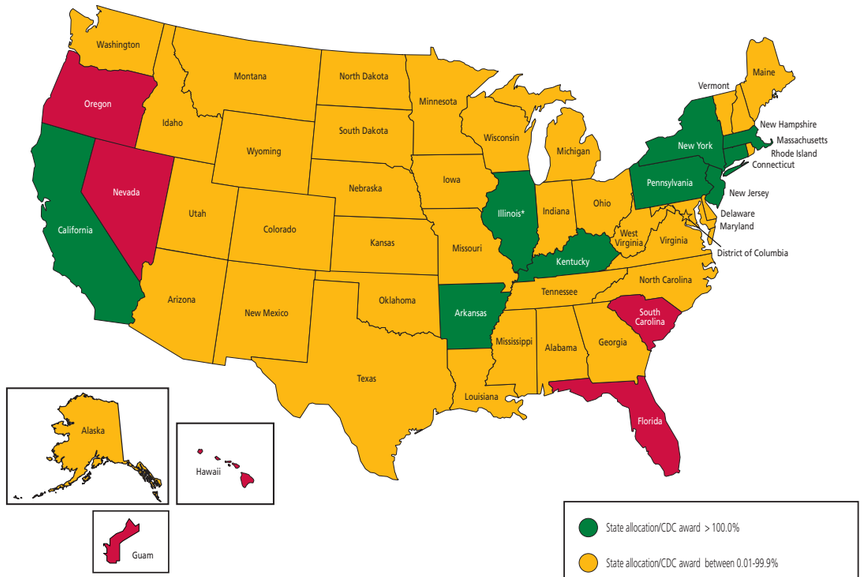
Unfortunately, the economic downturn is straining family finances and prompting some Americans to forgo preventive care and visits to the doctor. More women are now uninsured and cutting back on routine cancer screenings and examinations designed to protect their health. A recent ACS CAN survey found that 30 percent of people with a history of cancer who earn less than $30,000 annually reported not having access to affordable early detection.

The need to protect women's access to preventive health services and to provide access to breast and cervical cancer screenings is greater than ever.

The Facts

- An estimated 207,000 new cases of invasive[1] breast cancer and 12,000 new cases of cervical cancer will be diagnosed among women in the United States this year.[2]
- Studies show that the earlier breast and cervical cancer are detected and treated, the better the patient's survival rate. When breast cancer is diagnosed at the localized stage, the five-year survival rate is 98 percent; however, when it is diagnosed after spreading to distant organs, the five-year survival rate decreases to 23 percent.

State Appropriations for Breast and Cervical Cancer Screening Programs



How Do You Measure Up?

Source: 2009-2010 data from the Centers for Disease Control and Prevention and unpublished data collected from ACS CAN, Divisions, including input form NBCCEDP directors.

- A screening mammogram is the best and most cost-effective tool available to find breast cancer before symptoms appear.
- Pap tests detect precancerous 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 17 percent.
- Mammography rates continue to be low among two groups: those with low-income levels and those that 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

State policy-makers need to ensure that neither income nor insurance status is a barrier to cancer screenings. State policies and programs have a critical role in ensuring that all eligible women receive these lifesaving services.

In 2007, the NBCCEDP was reauthorized, allowing for greater flexibility in the program to enable it to reach more uninsured and other medically underserved women. The reauthorization also sets increased funding targets for the program from the previous $202 million a year to $275 million a year over the next five years. This year, ACS CAN and the Society are advocating for Congress to increase annual funding for this program to $255 million. Providing sustained funding increases for the NBCCEDP over the next few years will mean that it can provide high-quality screening services to more low-income, uninsured and underinsured women.

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

Many states, however, are slashing funding to the NBCCEDP. Decreased funding means that fewer eligible women across the United States have access to lifesaving screenings. In order to reach as many eligible women as possible, ACS CAN and the Society urge state legislatures to continue appropriating dollars for this underfunded program and continue identifying alternative funding sources.

It is also critical that patient protection laws specify that coverage for annual mammograms is guaranteed for all women over 40. The Affordable Care Act requires that all new plans and plans participating in the state exchanges cover mammograms for women over age 40; however, these provisions won't come into effect until 2014. ACS CAN and the Society urge state legislatures to maintain laws that protect access to breast cancer screenings and to expand coverage for all eligible women.

Cancer Screening for the Uninsured

In partnership with state-administered breast and cervical cancer screening programs, the Centers for Disease Control and Prevention's (CDC) 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 and serve more eligible women.

To date, the program has provided more than eight million screening exams to more than 3.6 million underserved women. As a result of the Breast and Cervical Cancer Prevention and Treatment Act of 2000, all 50 states and the District of Columbia provide the Medicaid option that treats women diagnosed with cancer under the NBCCEDP.

The CDC awards annual grants to states with breast and cervical cancer early detection programs that provide in-kind or monetary matching funds – at least $1 for every $3 in federal money. However, the limited amounts of state and federal funding currently allow for fewer than 20 percent eligible women nationwide to receive these lifesaving cancer screenings. Consequently, millions of eligible women are going without these critical early detection services.

Increased state and federal funding for the NBCCEDP 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.

Insurance Coverage and Cancer Screening

Laws that require coverage for all recommended breast cancer screening options help save lives. Early breast cancer detection is the single most important factor in achieving a good health outcome. However, lack of adequate insurance coverage makes people less likely to be screened for cancer and puts them at significantly greater risk for late-stage diagnosis of disease and poorer prognosis.[3] Research shows that mammograms can be covered for little or no additional cost to insurers, employers or employees, when compared to the cost of treatment.[4]

States that require private insurers to cover annual mammograms for women age 40 and older are considered to have comprehensive breast cancer screening policies. The science and long-term survival trends show that legislation is not adequate if it only requires private insurers to cover annual mammograms for women age 50 or older, or "if required by a physician."[5]

Success Story

In a year where state agencies experienced 7 to 8 percent cuts, Women's Health Check, Idaho's Breast and Cervical Cancer Screening program, received a significant increase in funding from $85,800 to $235,800. In addition, there was an expansion to the program that now provides younger women eligibility for lifesaving screenings and treatment.

The additional funding was made possible through Idaho's Millennium Fund, a fund endowed with Master Settlement Agreement (MSA) payments. An additional bonus to the expanded program is that each woman served will now be counseled on the dangers of tobacco use, and learn about cessation services, while receiving diagnostic services.

This effort was championed in the U.S. House by Representative McGeachin, while grassroots support through targeted contacts and emails helped make the increase possible.

Program Cuts Putting Women at Risk

Low-income women in all but a handful of states have been affected by state cuts to NBCCEDP funding. The following chart indicates how these states are placing women at risk.

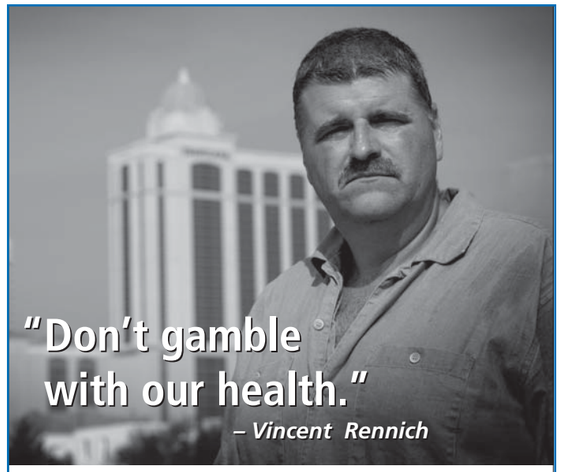
State Program	States That Have Cut Funds	Restricted Eligibilty/Stopped Screening	Implement Long Wait List	Women aged 40-49 are not eligible for the program
Alabama		X		
Alaska				
Arizona				
Arkansas				
California	X	X	X	X
Colorado				
Connecticut				
Delaware				
District of Columbia				
Florida			X	X
Georgia			X	
Hawaii	X			
Idaho				X
Illinois				
Indiana	X		X	X
Iowa	X			
Kansas	X	X	X	X
Kentucky				
Louisiana				X
Maine				
Maryland				
Massachusetts				
Michigan	X			
Minnesota	X			
Mississippi	X		X	X
Missouri				X
Montana				
Nebraska	X			
Nevada			X	X
New Hampshire			X	
New Jersey				
New Mexico	X			
New York	X	X		
North Carolina				X
North Dakota				
Ohio				X
Oklahoma			X	X
Oregon				
Pennsylvania	X		X	X
Rhode Island	X	X	X	*
South Carolina	X			**
South Dakota	X			
Tennessee				X
Texas	X	X	X	
Utah				
Vermont				
Virginia				
Washington				
West Virginia				X
Wisconsin	X			
Wyoming				X
Guam		X	X	X

* screen women 40-49 only every other year
** screens only women over 47
Note: Current annual funding includes state and federal funds for FY2010. Federal spending refers to a 12-month grant to the states by the U.S. Centers for Disease Control and Prevention (CDC) for the FY2010 period beginning April 2009.

Tobacco is responsible for more than 400,000 deaths in the United States each year, including at least 30 percent of all cancer deaths and 87 percent of all lung cancer deaths. Tobacco use is associated with increased risk of at least 15 types of cancer, as well as heart disease, stroke and hardening of blood vessels, chronic bronchitis and emphysema. Tobacco-related disease costs our nation more than $193 billion in medical care and productivity losses each year and remains the nation's most preventable cause of death.

The Annual Report to the Nation on the Status of Cancer, 1975-2005, published in 2008 as a collaborative effort of the Society, the National Cancer Institute, the Centers for Disease Control and Prevention and the North American Association of Central Cancer Registries, concluded that the regions in the United States with the least comprehensive tobacco control policies experienced higher rates of tobacco use and tobacco-related cancers. Currently, there are more than 47 million adult tobacco users in the United States. The statistics for youth are even more troubling – 20 percent of high school students are smokers. Every day, more than 3,500 children in the United States smoke their first cigarette and more than 1,000 children become addicted, daily smokers; as many as half of those children who continue to smoke throughout their lifetimes will eventually die prematurely from smoking-related diseases.

ACS CAN and the Society support a comprehensive approach to tackling tobacco use by: 1) raising the price of tobacco products through tobacco tax increases, 2) implementing comprehensive smoke-free policies, 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 overcome this country's tobacco epidemic effectively. ACS CAN and the Society work in partnership with state policy-makers across the country to ensure that tobacco use is addressed comprehensively in each community.



I never smoked cigarettes, but for 27 years working on the casino floor I was exposed to second-hand smoke – I have lung cancer.

Now folks want to exempt casinos from smoke-free laws.

Don't let this happen to more workers. Everyone deserves the right to breathe smoke-free air.

Call your legislators

and tell them to make casinos smoke-free.

Cancer Action Network℠
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Tobacco Excise Taxes

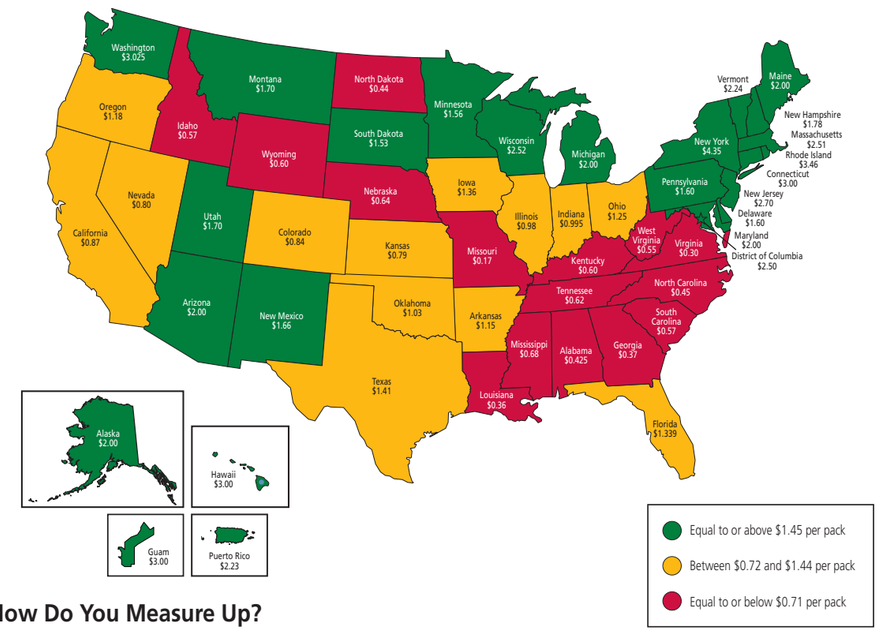
The Challenge

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

Since the last publication of this report, 11 states and the District of Columbia implemented cigarette tax increases; three of those states, Connecticut, Hawaii and Washington, joined Rhode Island with cigarette taxes of $3 or more, while New York became the first state to top $4. South Carolina, which had not passed an increase since 1977 and long held the rank of the lowest cigarette tax in the nation at seven cents, passed a 50-cent increase. These increases raised the average state cigarette tax to $1.45. However, some of the rate increases were as little as 10 to 25 cents – not nearly large enough to provide significant changes in smoking rates or state revenues. Only three states – California, Missouri and North Dakota – have not raised tobacco taxes within the past 10 years.

In addition to raising cigarette taxes, states continue to battle for significant taxes on smokeless tobacco and other tobacco products. Taxes based on the percentage of the price of cigarettes provide more health and economic benefits than weight-based taxes because they grow with inflation and ensure that low-weight products are consistently taxed at a significant enough rate to effect change. While weight-based smokeless tobacco tax measures were defeated in some states during legislative sessions this year, unfortunately, several other states moved toward this less effective structure.

State Cigarette Tax Rates



As of 7/7/10

How Do You Measure Up?

The Facts

- The health and reduced productivity costs attributed to smoking are $10.28 per pack of cigarettes.[1]
- State tobacco excise tax rates vary, ranging from a high of $4.35 in New York to $0.17 in Missouri. New York City has the highest combined city and state cigarette tax in the country, with a total tax of $4.85 per pack.
- For every 10 percent increase in the price of a pack of cigarettes, youth smoking rates drop by 7 percent and overall cigarette consumption declines by 4 percent.[2]
- A recent national poll found that 67 percent of voters support a $1 tobacco tax increase. The poll also found that voters far prefer higher tobacco taxes to other options, such as other tax increases or budget cuts, for addressing state budget deficits.[3]

The Solution

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

ACS CAN and the Society challenge states to raise cigarette tax rates by at least 10 percent of the price of a pack of cigarettes – the minimum percentage required to establish a health benefit from the increase. States with the lowest cigarette tax rates should aim for taxes that result in at least a 30 percent increase in the price of a pack of cigarettes. In addition, smokeless tobacco and other tobacco products should be taxed at a rate comparable to cigarettes to keep the intended benefit of reducing youth initiation and preventing current smokers from switching to other tobacco products, which are also highly addictive and cause cancer, instead of quitting altogether. Finally, ACS CAN and the Society encourage states to earmark tobacco tax revenues for tobacco use prevention and cessation programs.

State Tax Rates as of July 2010*

State	Rate Per Pack (Dollars)
New York	$4.35
Rhode Island	$3.46
Washington	$3.025
Connecticut	$3.00
Guam	$3.00
Hawaii	$3.00
New Jersey	$2.70
Wisconsin	$2.52
Massachusetts	$2.51
District of Columbia	$2.50
Vermont	$2.24
Puerto Rico	$2.23
Maryland	$2.00
Alaska	$2.00
Arizona	$2.00
Maine	$2.00
Michigan	$2.00
New Hampshire	$1.78
Montana	$1.70
Utah	$1.70
New Mexico	$1.66
Delaware	$1.60
Pennsylvania	$1.60
Minnesota	$1.56
South Dakota	$1.53
Texas	$1.41
Iowa	$1.36
Florida	$1.339
Ohio	$1.25
Oregon	$1.18
Arkansas	$1.15
Oklahoma	$1.03
Indiana	$0.995
Illinois	$0.98
California	$0.87
Colorado	$0.84
Nevada	$0.80
Kansas	$0.79
Mississippi	$0.68
Nebraska	$0.64
Tennessee	$0.62
Kentucky	$0.60
Wyoming	$0.60
Idaho	$0.57
South Carolina	$0.57
West Virginia	$0.55
North Carolina	$0.45
North Dakota	$0.44
Alabama	$0.425
Georgia	$0.37
Louisiana	$0.36
Virginia	$0.30
Missouri	$0.17

*Known at time of publication

Success Story

South Carolina had long held the ranking of the lowest state cigarette tax in the country. However, the state shed that title this session when the legislature overrode the governor's veto and approved the first cigarette tax since 1977. The seven-cent tax increased to 57 cents per pack when it went into effect July 1. In addition to South Carolina, Hawaii, New Mexico, New York, Utah, Washington and Guam also increased their cigarette taxes.

The victory in South Carolina is a testament to the decade-long persistence of public health advocates who successfully made the case that raising tobacco taxes is a proven method to protect public health by reducing smoking and preventing youth from starting the habit. Strong grassroots and lobbying efforts, along with committed coalition partners, persuaded legislators that the tax would improve the health of South Carolinians while raising much-needed revenue for the state.

The new revenue generated by the 50-cent tax increase is directed to important programs that further ACS CAN and the Society's shared mission. Of the new revenue, $5 million will be allocated each year to fund tobacco-related cancer research and an additional $5 million annually will be directed to the Smoking Prevention and Cessation Trust Fund. The remaining funds, an estimated $125 million per year, will be allocated to the South Carolina Medicaid Reserve Fund.

South Carolina represents the latest in a series of improvements in tobacco control policies across the Southern tobacco-growing states. However, despite recent wins, the region's cigarette taxes remain among the lowest in the nation. South Carolina has set an example for other states in the region looking for ways to improve the health of their citizens and the strength of their economies. Tobacco taxes are one of the most effective ways to reduce smoking sharply, thereby reducing health spending and lowering the cancer burden in a state. It's a win for states in every way.

Measuring Progress

In the coming year, ACS CAN will be adding a new way to measure a state's progress in preventing cancer through reducing tobacco use. In addition to rating the states on a green, yellow and red scale based on the state's tobacco tax rate, the new rating will also take into account the timeframe in which the state most recently raised its cigarette tax, with the benchmark being within one to five years, as well as the size of the increase. Research shows that the best way to curb tobacco use is through regular, significant increases in the price of cigarettes – this improved measure will help us evaluate progress in saving lives and cutting health care costs beyond simple tax changes. As a new guideline, ACS CAN recommends the following:

- Large price increases (at least 30 percent) in states with low cigarette prices
- Significant and regular increases in states with moderate prices
- Regular increases of at least 10 percent in states with higher prices

ACS CAN and the Society will be working with lawmakers on ways they can strive to meet these important goals.

The Challenge

The 2006 U.S. Surgeon General's Report, The Health Consequences of Involuntary Exposure to Tobacco Smoke, confirmed there is no level of exposure to secondhand smoke that does not pose a health risk.[1]

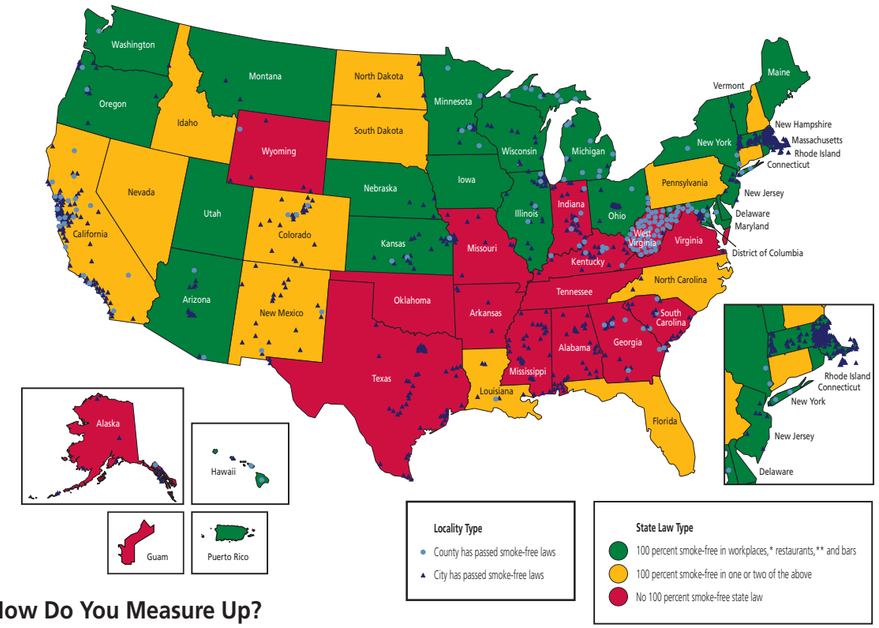
Each year in the United States, secondhand smoke causes close to 49,000 deaths from heart disease and cancer in otherwise healthy nonsmokers. In addition to these deaths, secondhand smoke can cause or exacerbate a wide range of other adverse health issues, including respiratory infections and asthma. Secondhand smoke is a serious health hazard, containing more than 60 known or probable carcinogens and more than 4,000 chemicals, including formaldehyde, arsenic, cyanide, and carbon monoxide.

As of July 2010, 35 states, the District of Columbia, Puerto Rico and 876 municipalities require 100 percent smoke-free workplaces and/or restaurants and/or bars. Combined, this represents nearly 79 percent of the U.S. population.[2] As impressive as this percentage is, 15 states still have no 100 percent statewide smoke-free laws in place for workplaces, restaurants or bars.

Even with all of these legislative advances, specific segments of the population, such as hospitality and casino workers, continue to be denied their right to breathe smoke-free air. Low-income individuals are

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

In effect as of July 5, 2010



How Do You Measure Up?

Source: American Nonsmokers' Rights Foundation U.S. Tobacco Control Laws Database, 7/5/10.
*Includes both public and private non-hospitality workplaces, including, but not limited to, offices, factories, and warehouses.
**Includes any attached bar in the restaurant.
The following state law has been enacted but is not yet in effect: South Dakota enacted a 100 percent smoke-free restaurant, bar, and gaming facilities law that was scheduled to go into effect on July 1, 2009, but has been suspended by a referendum placing the law on the ballot in November 2010, and will not go into effect unless approved by the voters.

especially vulnerable. While the levels of serum cotinine, which is a measure of secondhand smoke exposure, decreased for all populations from 1988-1994 to 1999-2004, the decline was smaller for low-income individuals.[3]

The Facts[4]

- Tobacco costs the United States approximately $193 billion annually in direct medical costs and lost productivity.[5]
- 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. For example, after Colorado's smoke-free law went into effect in 2006, calls to the state's tobacco cessation quitline increased by 1,400 percent in the month after implementation and by almost 600 percent after two months.[6]
- Smoke-free laws reduce health care spending and improve employee productivity.

The Solution

Secondhand smoke affects the entire population in every aspect of life. The Institute of Medicine and the President's Cancer Panel have recommend that comprehensive smoke-free laws cover all workplaces, including restaurants, bars, hospital and health care facilities, gaming facilities and correctional facilities. Implementing comprehensive smoke-free policies will have immediate health benefits for all citizens, especially those most at risk, such as children, as well as casino, restaurant and bar workers.

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 and the Society challenge state and local officials to pass comprehensive smoke-free laws in all workplaces, restaurants, bars and gaming facilities, in order to protect the health of our citizens. The organizations also work to overturn and prevent preemption laws that restrict a lower level of government from enacting stronger smoke-free laws than what exist at a higher government level in a state. Everyone has the right to breathe smoke-free air.

Success Story

In his State of the State address on January 11, 2010, Kansas Governor Mark Parkinson challenged the legislature to pass comprehensive smoke-free legislation. Just three months later, on March 12, 2010, Governor Parkinson signed into law House Bill 2221, the Kansas Indoor Clean Air Act.

The new law requires virtually all indoor workplaces and other public areas to be smoke-free starting July 1, 2010. While there are a few narrow exemptions (including certain private clubs, a limited number of hotel and motel rooms and casino gaming floors), it is a very strong law that will save lives by providing a smoke-free indoor environment to the vast majority of Kansas workers and consumers.

Passage of this public health victory was spurred on by the strong support of Senator David Wysong (R—Leawood), the Society's smoke-free champion in the Senate, Governor Parkinson, and a bi-partisan coalition in the House of Representatives that included Representatives Charlie Roth (R—Salina), Don Hill (R—Emporia), Jill Quigley (R—Lenexa), Cindy Neighbor (D—Shawnee), Lisa Benlon (D—Overland Park) and Mike Slattery (D—Mission). However, final passage of the Act would not have been possible without the phenomenal grassroots efforts of the Society and other coalition partners, who made sure that lawmakers heard loud and clear from more than 70 percent of Kansans, who support a strong, statewide, smoke-free law.

Although the smoke-free legislation has already been enacted, opponents continue attempts to weaken its scope substantially by adding broad exemptions. Society and ACS CAN advocates have successfully fought off these attempts and will continue to do so to ensure that everyone in Kansas has the right to breathe smoke-free air.

The "Red to Green" Campaign

In December 2009, ACS CAN launched its nationwide "Red to Green" initiative to build a smoke-free nation. The initiative is named to reflect the colors of the ACS CAN smoke-free ratings map – with red indicating states with no 100 percent smoke-free workplaces, restaurants or bars law, and green indicating states protected by 100 percent smoke-free laws in all of the above. "Red to Green" is a coordinated effort led by ACS CAN across the "red" states to enact smoke-free laws strategically, beginning at the local level and eventually statewide. The campaign takes a fresh approach to ACS CAN's already successful fight to enact comprehensive smoke-free laws in every state, with the goal of making all 50 states smoke-free by 2015.

Tough battles lie ahead in the fight to enact the next wave of statewide smoke-free laws, but the additional support of the "Red to Green" initiative will provide advocates with the knowledge and resources needed to move forward.

Tobacco Cessation Services

The Challenge

Evidence-based strategies to prevent smoking and get people to quit are well known and have been proven highly effective. States with comprehensive tobacco control programs that include cessation services experience faster declines in cigarette sales, smoking prevalence and lung cancer incidence and mortality, than states that do not invest in these programs.

Cessation is ranked as a leading cost-saving preventive service and should be a top priority for states looking for ways to curb health care costs. In most states, there is much room for improvement in providing tobacco cessation services that will save lives and reduce health care costs. Significant barriers, from co-pays and deductibles to administrative red tape, make it more difficult to reach the many smokers who want to quit.

Currently, very few states require insurance companies to offer adequate cessation benefits in their plans and only five states provide comprehensive cessation services to their employees. In addition, only 19 states cover both cessation drugs and counseling services for all Medicaid recipients and just six of these states cover all the therapies recommended by the U.S. Public Health Service. In more than half the states, co-pays are required for every cessation-related prescription filled or every cessation counseling visit. And in 25 states, Medicaid programs limit the length of the treatment programs offered. Eighteen states restrict the number of quit attempts covered in a year. Evidence shows that administrative barriers such as these, from co-pays to pre-authorization requirements, can deter people from using preventive services, such as cessation treatment.

The Facts

- Evidence-based treatments for smoking cessation are safe and can double or triple successful quit attempts.[1]
- Including cessation services as a covered health benefit increases quit rates by 30 percent.[2]
- Providing both medication and professional counseling in cessation treatments increases quit rates by 40 percent.[3]

With the enactment of the Affordable Care Act in March, there was progress in cessation coverage. Although details of the benefits are not yet defined, the new law requires all states to provide cessation benefits to pregnant women beginning October 1, 2010.

- Smokers and other tobacco users need access to a range of treatments and combinations to find the most effective cessation tools that work for them.
- Quitlines can increase quit success more than 50 percent, compared to using no cessation intervention.[4]

The Solution

Enhancing the availability of tobacco cessation treatment by requiring better insurance coverage, strong community-based interventions, and adequate funding for cessation programs, will curb tobacco-related death and disease, especially among low-income populations that need it most.

In 2009, Massachusetts released the impressive results of its pilot program, which provided cessation benefits to every smoker in the state's Medicaid program. In the two-year program, smokers were offered a choice of any FDA-approved cessation therapy, in addition to counseling. Barriers were reduced to remove pre-authorization requirements, allow multiple quit attempts per year, and require only minimal co-pays. MassHealth heavily promoted the availability of these services, drawing more than 75,000 smokers, or 40 percent of the Medicaid smoking population, to try the benefit.[5] The results were dramatic – smoking rates for those enrolled in Medicaid dropped by 26 percent and 33,000 smokers quit during the pilot.[6]

The Massachusetts example clearly shows that state Medicaid programs, private plans and other public state health plans, can increase quit rates and reduce overall tobacco use by improving access to tobacco cessation services and removing barriers to quitting. The CDC, the U.S. Public Health Service and the Institute of

Medicine all recommend that government-funded health insurance programs provide evidence-based smoking cessation programs.

ACS CAN and the Society advocate for public policies, legislation and private sector initiatives to make effective, affordable coverage for comprehensive, evidence-based tobacco cessation services available to those who need them.

Success Story

In July 2006, the commonwealth of Massachusetts enacted a smoking cessation benefit through MassHealth, the state's Medicaid program, to help its members quit smoking. The program was designed to provide access to all FDA-approved medications and behavioral counseling, with co-pays for these services set at no more than $3.

For the decade prior to the pilot, the smoking rate for the state's Medicaid recipients had remained steady at more than 38 percent. Within the first year of the benefit's implementation, the smoking rate fell by 10 percent, and at the end of two and a half years, smoking prevalence for this group fell by 26 percent. This reduction is primarily attributed to driving smokers to seek treatment through an effective, targeted public awareness campaign, which promoted the benefits through radio ads, transit ads and extensive community outreach. At the height of the campaign, 75 percent of MassHealth members were aware that the benefit was available. In total, 75,000 MassHealth members (40 percent of total MassHealth members) used the cessation benefit during its first two and a half years to try to quit smoking. At the conclusion of the two-year pilot, the program was made permanent.

In addition to the drop in smoking rates, there were also significant, short-term health impacts for program participants: heart attack hospitalizations declined by 38 percent after the first year; emergency room visits for asthma-related symptoms fell by 17 percent after the first year; and claims for adverse maternal birth complications decreased by 17 percent.

As evidenced by the Massachusetts pilot, legislators' investment in offering comprehensive Medicaid smoking cessation benefits led to both short- and long-term success of the program.

State Comprehensive Cessation Benefit Coverage

Medicaid Beneficiaries	State Employees
Indiana	Illinois
Massachusetts	Maine
Minnesota	Nevada
Nevada	New Mexico
Oregon	North Dakota
Pennsylvania	

Source: American Lung Association, *Helping Smokers Quit: State Cessation Coverage 2009*

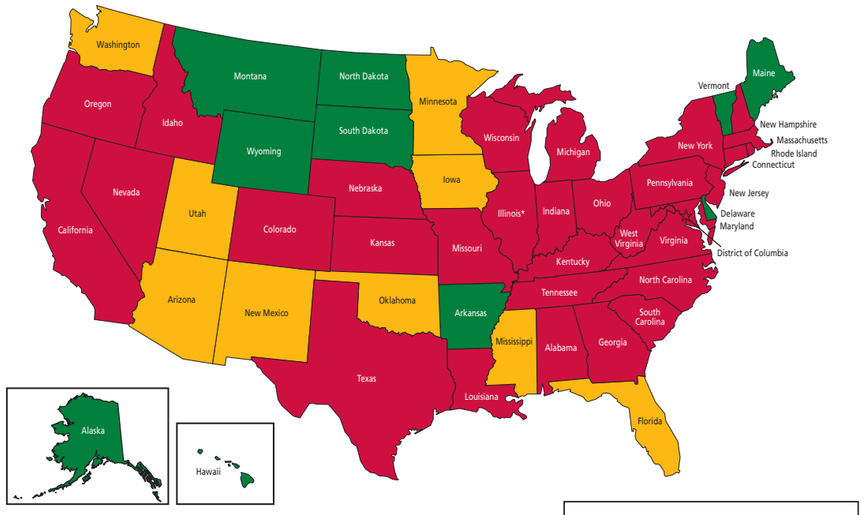
Tobacco Prevention Program Funding

The Challenge

Comprehensive, adequately funded tobacco control programs reduce tobacco use and tobacco-related disease and, thereby, reduce tobacco-related health care costs. The level of funding and the length of time states invest in these prevention and cessation programs directly influence the health and economic benefits of tobacco control. Currently, states spend only a small percentage of the revenues from tobacco taxes and Master Settlement Agreement (MSA) payments on tobacco control.

In fiscal year 2009, states collected approximately $25.1 billion in tobacco-related revenues from tobacco taxes and MSA payments.[1] At the same time, given the current economic climate, many states are facing deep cuts in tobacco control funding or diversion of MSA dollars away from tobacco control programs. This reduction of funds threatens the growing momentum of state tobacco control programs that promote the health of residents, reduce tobacco use and provide essential services to help people quit.

FY2010 Funding for Tobacco Prevention



How Do You Measure Up?

Current annual funding includes state and federal funds for FY2010. Federal spending refers to a 12-month grant to the states by the U.S. Centers for Disease Control and Prevention (CDC) for the FY2010 period beginning April 2009.

The Facts

- In fiscal year 2010, states will spend $567.5 million on tobacco control funding – a 12 percent decrease in funding from the previous year.[2]
- Health care costs to the states from tobacco-related disease total more than $95 billion each year.[3]
- The Centers for Disease Control and Prevention (CDC) recommends that states spend $3.7 billion or more on tobacco control programs. The recommended spending levels were updated in October 2007.
- Only nine states are funding at even half of the CDC's recommended spending levels.[4] In 2010, North Dakota became the first state to fully fund its tobacco control program at the new CDC prevention spending targets.
- If each state maintained target funding levels for five years, there would be an estimated five million fewer smokers in the United States.[5]

Missed Opportunity

Over the past 10 years, states have received $229.3 billion in tobacco-generated revenue – $87.2 billion from the tobacco settlement and $142.1 billion from tobacco taxes. But states have spent only 3.1 percent, or $7.02 billion, of this money on tobacco prevention and cessation programs.[6]

The Solution

The CDC's *Best Practices for Comprehensive Tobacco Control Programs* continues to be an effective guideline for state investment in tobacco control.[7] In 2007, the Institute of Medicine recommended states fund tobacco control activities at levels from $15 to $20 per capita. The best practices include five components:

- Health communication interventions – messaging and counter-marketing strategies to promote tobacco control
- Cessation interventions – tobacco use screening, telephone counseling quitlines and policies to increase cessation rates
- State and community interventions – local and statewide policies and programs for tobacco control
- Surveillance and evaluation – monitoring tobacco-related measures and health outcomes to assess program success
- Administration and management – financial, organizational, and staffing capacity to implement and carry out effective tobacco control programs

Call to Action

ACS CAN and the Society challenge states to combat tobacco-related illness and death by funding comprehensive tobacco control programs at the CDC-recommended level or above; implementing strategies to continue that funding over time; and applying the specific components delineated in the CDC's best practices guideline.

State Prevention Spending

State	Tobacco Prevention Spending (FY10)	CDC Recommended Spending	Tobacco Prevention Spending % of CDC Recommended
North Dakota	$9.4 million	$9.3 million	100.6%
Alaska	$8.6 million	$10.7 million	80.0%
Delaware	$10.8 million	$13.9 million	77.5%
Montana	$9.4 million	$13.9 million	67.3%
Wyoming	$5.8 million	$9.0 million	64.9%
Maine	$11.8 million	$18.5 million	63.6%
Hawaii	$8.8 million	$15.2 million	58.1%
Vermont	$5.9 million	$10.4 million	57.1%
Arkansas	$19.8 million	$36.4 million	54.4%
South Dakota	$6.0 million	$11.3 million	52.7%
Oklahoma	$21.1 million	$45.0 million	47.0%
New Mexico	$10.6 million	$23.4 million	45.5%
Minnesota	$21.5 million	$58.4 million	36.8%
Utah	$8.3 million	$23.6 million	35.3%
Arizona	$23.4 million	$68.1 million	34.3%
Florida	$67.7 million	$210.9 million	32.1%
Iowa	$11.1 million	$36.7 million	30.3%
Mississippi	$11.7 million	$39.2 million	29.8%
Washington	$17.2 million	$67.3 million	25.5%
West Virginia	$6.9 million	$27.8 million	24.7%
Colorado	$12.4 million	$54.4 million	22.8%
New York	$57.0 million	$254.3 million	22.4%
Nebraska	$4.2 million	$21.5 million	19.7%
North Carolina	$20.0 million	$106.8 million	18.7%
Oregon	$7.7 million	$43.0 million	17.9%
California	$79.0 million	$441.9 million	17.9%
Louisiana	$8.9 million	$53.5 million	16.6%
Connecticut	$7.2 million	$43.9 million	16.4%
Indiana	$11.8 million	$78.8 million	15.0%
Idaho	$2.3 million	$16.9 million	13.8%
District of Columbia	$1.4 million	$10.5 million	13.1%
Virginia	$13.4 million	$103.2 million	13.0%
Wisconsin	$8.1 million	$64.3 million	12.6%
Pennsylvania	$19.0 million	$155.5 million	12.2%
Rhode Island	$1.9 million	$15.2 million	12.2%
Nevada	$3.8 million	$32.5 million	11.6%
Maryland	$6.7 million	$63.3 million	10.6%
New Jersey	$8.9 million	$119.8 million	7.4%
Kansas	$2.3 million	$32.1 million	7.0%
Kentucky	$3.9 million	$57.2 million	6.9%
Massachusetts	$6.1 million	$90.0 million	6.7%
Illinois	$9.7 million	$157.0 million	6.2%
New Hampshire	$1.0 million	$19.2 million	5.4%
South Carolina	$3.2 million	$62.2 million	5.2%
Ohio	$7.4 million	$145.0 million	5.1%
Texas	$13.3 million	$266.3 million	5.0%
Alabama	$2.1 million	$56.7 million	3.7%
Michigan	$4.3 million	$121.2 million	3.5%
Missouri	$2.4 million	$73.2 million	3.2%
Georgia	$3.2 million	$116.5 million	2.7%
Tennessee	$1.5 million	$71.7 million	2.1%
Total	*$629.5 million*	*$3.7 billion*	*17.0%*

Note: Current annual funding includes state and federal funds for FY2010. Federal spending refers to a 12-month grant to the states by the U.S. Centers for Disease Control and Prevention (CDC) for the FY2010 period beginning April 2009.

The Challenge

Skin cancer is the most prevalent type of cancer in the United States, with melanoma being one of the most commonly diagnosed cancers among young adults. Ultraviolet (UV) radiation exposure from the sun is a known cause of skin cancer, and excessive UV exposure, particularly during childhood and adolescence, is an important predictor of future health consequences. The link between UV exposure from indoor tanning devices and melanoma is consistent with what we already know about the association between UV exposure from the sun and skin cancer. Because of this, the International Agency for Cancer Research reclassified indoor tanning devices as having the highest level of cancer risk in the summer of 2009.[1]

There has been a drastic increase in rates of melanoma in young, Caucasian women over the past few decades that is widely thought to be a consequence of increased use of indoor tanning devices and exposure to solar UV radiation. Compounding this risk is the popularity of indoor tanning among young adults– especially girls. There is also a general misconception among teens and adults that a so-called "base tan," obtained by using indoor tanning devices, will have a protective effect from excessive sun exposure.

The Facts

- Melanoma is the most deadly of skin cancers – accounting for more than two-thirds of skin cancer deaths in 2009.[2]
- People who use tanning beds before the age of 35 increase their risk for melanoma by 75 percent.[3]
- Since 1998, teens reporting use of tanning beds has increased from 1 percent to 27 percent.
- In 2004, almost one in five 16- to 18-year old girls reported using indoor tanning devices.[4]
- Among kids who reported using indoor tanning devices, more than half (57.5 percent) reported burns from use.[5]

The Solution

On March 25, 2010, the Food and Drug Administration's (FDA) Medical Devices Advisory Committee held a meeting to discuss the risks of indoor tanning devices and to make recommendations to the FDA regarding the regulation of these devices. In the first step toward major action by the federal government to regulate indoor tanning devices, the committee agreed upon the need for age restrictions for use, better and more informative warnings to consumers, improved training for operators and closer regulation. Thirty-one states currently regulate the use of indoor tanning devices by people under the age of 18, although policies vary widely by state.

To help reduce the incidence and mortality of skin cancer in the United States, ACS CAN and the Society support state and local initiatives to prohibit people under the age of 18 from using indoor tanning devices, ensure that all consumers are properly informed of their risk prior to use, and require that all indoor tanning devices are properly regulated with effective enforcement provisions in place.

The Challenge

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. Data shows that more than 166,000 cancer deaths can be attributed to these factors each year.[1] Individuals who have diets that are high in calories, heavy on processed meats, and low in fruits and vegetables, who are not physically active, and who are overweight or obese, are at higher risk for several different types of cancers, including breast, colon, endometrium, esophagus and kidney.[2]

The majority of adults and children in the United States are not meeting the Centers for Disease Control and Prevention's (CDC) recommended levels of physical activity, are making poor dietary choices and are overweight or obese. Currently, two-thirds of adults in this country are overweight or obese – more than double the rate from just 20 years ago.[3] Even more troubling is that during the same time period, the percentage of obese adolescents more than tripled.[4] This rapid increase of overweight and obese populations over the past two decades points to environmental and social changes, rather than solely genetic or physiologic changes.

Ultimately, these risk factors place a huge financial burden on the health care system in the United States; obesity alone costs the nation more than $145 billion in direct medical costs each year.[5] Improving nutrition, increasing physical activity and reducing levels of obesity offer a critical opportunity for cancer prevention.

The Facts

- Two-thirds of adults in the United States are overweight or obese; 32.2 percent of men and 35.5 percent of women are obese.[6]
- Compared with non-Hispanic Caucasian women (33 percent), non-Hispanic African-American women (49.6 percent) and all Hispanic women (43.0 percent) had higher prevalence rates of obesity.[7]
- In 1991, no state had an adult obesity rate of more than 20 percent; currently, every state except for Colorado has a rate of more than 20 percent.[8]
- 16.9 percent of U.S. adolescents are obese; 70 percent of adolescents who are overweight will remain so into adulthood.[9]
- 14.6 percent of low-income, preschool-aged children were obese in 2008; prevalence was highest among American Indian/Alaska Native children (21.2 percent).[10]

The Solution

Earlier this year, the surgeon general released the *Vision for a Healthy and Fit Nation*.[11] The report highlights the need for a commitment across sectors to create healthy communities for all Americans. Similarly, the CDC released a report last year outlining 24 strategies with corresponding measures that communities can utilize to improve healthy eating and active living in their community to reduce obesity and its associated chronic diseases.[12] The strategies are divided into six key categories:

- Promote the availability of affordable healthy food and beverages
- Support healthy food and beverage choices
- Encourage breastfeeding
- Encourage physical activity or limit sedentary activity among children and youth
- Create safe communities that support physical activity
- Encourage communities to organize for change

At the federal level, the Department of Health and Human Services has already distributed millions of dollars through the American Recovery and Reinvestment Act to communities and health departments around the country to start planning, implementing and evaluating these strategies. In addition, the Affordable Care Act provides billions of dollars that can be used for community prevention activity. But ultimately, it is up to state and local community leaders and policy-makers to improve the health and well-being of their residents by making the changes necessary to improve nutrition, increase physical activity and reduce obesity.

Multifaceted, population-based policy approaches can significantly improve nutrition and physical activity and reduce obesity rates by removing the barriers, changing social norms and increasing awareness. ACS CAN and the Society support a range of evidence-based cancer prevention strategies, including those of the surgeon general and the CDC, to promote healthy living and reduce barriers through targeted research, education, outreach, health promotion programs and advocacy. ACS CAN and the Society stand ready to work with state policy-makers to plan, implement and evaluate these strategies to move to a healthier nation with less cancer.

Success Story

With the highest rate of adolescent obesity in the nation, the District of Columbia has been categorized by the CDC as having a childhood obesity epidemic. In 2009, the DC Department of Health found that 43 percent of students enrolled in public and public charter schools were overweight or obese. Faced with this overwhelming data on youth obesity rates, along with a multitude of studies linking childhood obesity to cancer, hypertension and diabetes, council members Mary Cheh and Vincent Gray championed the Healthy Schools Act, in an effort to improve the health outcomes of DC's youngest residents.

The Healthy Schools Act is designed to improve the health, wellness and nutrition for the 75,000 public and public charter school students in the District. Specifically, the new requirements:

- Make school meals healthier by adopting the USDA's HealthierUS School Challenge Gold Level nutrition standards
- Increase the amount of fruits, vegetables and whole grains served in the schools
- Prohibit the marketing in schools of foods and beverages that don't meet nutritional standards
- Establish a farm-to-school program to bring local produce into District schools
- Increase the amount of physical activity and health education in schools
- Promote recycling, energy efficiency, school gardens and other green initiatives
- Improve school health and wellness programs
- Establish a "Healthy Schools and Youth Commission" to regularly examine the health of the schools

The District of Columbia Healthy Schools Act was approved by the council on May 4, 2010, and will go into effect in August 2010.

Increasing the Price of Sugar-Sweetened Beverages

The consumption of sugar-sweetened beverages, such as sodas or sports drinks, plays an important role in our society's growing obesity problem. Sugar-sweetened beverages have become one of the largest single sources of calories in both adult and youth diets.

There is an emerging body of research on the potential impact on consumption of a higher sugar-sweetened beverage tax, but the research is not yet conclusive. That lack of conclusive evidence precludes ACS CAN and the Society from supporting many proposals for excise tax increases on sugar-sweetened beverages at this time.

However, given the extraordinary importance of the obesity problem, the link to cancer mortality, and the enormous role played by sugar-sweetened beverages, it is important to conduct further policy research and evaluation of community-wide efforts to reduce consumption of these beverages. To that end, ACS CAN and the Society encourage states and localities to consider sugar-sweetened beverage excise tax proposals that include all of the following:

- Clearly applies to all sugar-sweetened beverages
- Earmarks resulting revenue for public health programs
- Includes a thorough evaluation component
- Assures the tax is applied at the point of sale so consumers are faced with a higher price that has the potential to discourage consumption

Cancer Pain Control: Advancing Balanced Prescription Monitoring Programs

The Challenge

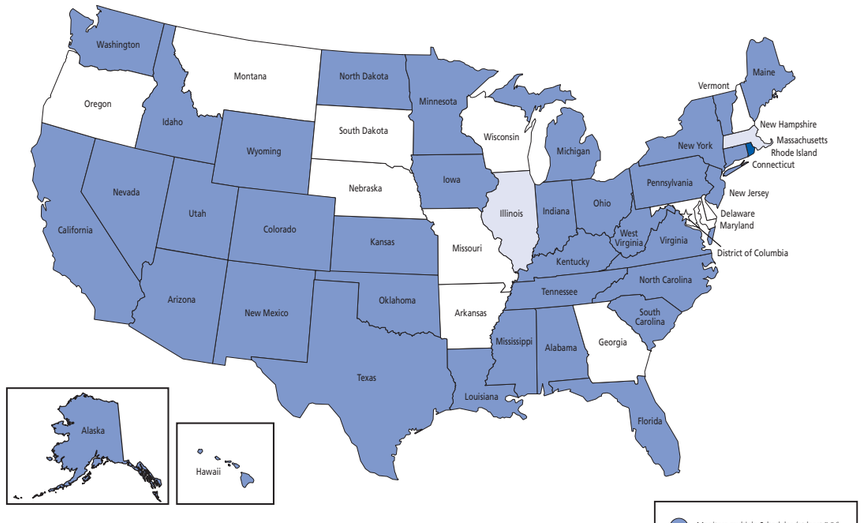
Pain remains one of the most feared and burdensome symptoms for cancer patients and survivors. Nearly all cancer pain can be relieved, yet the prevalence of pain and its inadequate treatment has remained consistently high and largely unchanged for decades. Even more troubling, significant pain treatment and access disparities in medically underserved and socio-economically disadvantaged populations continue to be documented.

Opioid analgesics, generally recognized as a mainstay of treatment for moderate to severe cancer pain, pose particular policy challenges. These controlled substances tend to trigger a dueling policy and practice debate for physicians who must balance providing pain relief and curbing abuse. Combating illegal use of prescription drugs is very important, as is ensuring that well-intentioned efforts to curb abuse do not cause harm to the patients these medicines are intended to help. The challenge is to promote balanced public policies that will make medications available to patients who need them, while keeping them from those who intend to misuse them.

The Facts

- Cancer pain can almost always be relieved, yet it is still a problem for more than 60 percent of patients in active treatment or with advanced disease, and in at least 30 percent after treatment concludes.
- Cancer-related pain can interfere with a patient's ability to adhere to recommended treatments and can devastate quality of life – affecting work, appetite, sleep and time with family and friends.
- While addiction to strong pain medications is a common concern, it is actually very rare among pain patients, with the vast majority able to take their medicine as prescribed to ease their suffering without difficulty controlling its use.

Cancer Pain Management
Prescription Monitoring Programs 2010



How Do You Measure Up?

Sources: Pain & Policy Studies Group http://www.painpolicy.wisc.edu/domestic/pmp.htm and National Alliance for Model State Drug Laws

The Role of Prescription Monitoring Programs

Prescription Monitoring Programs (PMPs) were created to monitor the prescribing of certain controlled substances, including opioid analgesics and other types of prescription medications used to control cancer-related pain in patients and survivors. Enactment of the National All Schedules Prescription Electronic Reporting Act (NASPER) in 2005, a federal grant program for states to create or improve a PMP, has triggered renewed interest in PMPs in many states.

PMPs detect illicit prescribing and dispensing and identify individuals who are obtaining prescriptions from multiple sources. A significant limitation of PMPs is that they are only able to address drug diversion that occurs from prescribing practices. PMPs do not identify other sources of drug diversion, such as theft from pharmacies or other criminal activities that occur without medicines being prescribed or dispensed. Recent studies also indicate that PMPs may influence health care professionals to limit or avoid prescribing strong pain medications for fear of being investigated by state regulators or law enforcement officials, which can lead to increased prescriptions for weaker, less effective pain medications for legitimate pain patients.

The Solution

Combating the illegal use of prescription drugs is a public health imperative, but issues of addiction and abuse should not impede effective treatment options for cancer patients who legitimately need prescription pain medications. To ensure that PMPs are balanced, programs must, at a minimum:

- Monitor multiple schedules of medications (e.g., at least Schedules II-IV)
- Be administered by the State Department of Health or Board of Pharmacy
- Create a multidisciplinary advisory council
- Require frequent evaluation of program effectiveness

ACS CAN and the Society support efforts to prevent illegal use of prescription pain medicines and challenge state legislatures to enact balanced PMPs and other policies that promote pain control and responsible pain medicine prescribing practices to relieve suffering and improve quality of patient care.

Success Story

To promote pain management and balanced pain policies in Pennsylvania, the state formed a new Pennsylvania Pain Coalition (PPC) in 2009 – a statewide coalition that includes physicians, nurses, pharmacists, psychologists, law enforcement, patients, advocacy groups and other stakeholders.

During the past year, the PPC has worked with the Pennsylvania Medical Society to enhance pain education offerings for practitioners, including encouraging distribution and use of the Federation of State Medical Board's publication, "Responsible Opioid Prescribing: A Physician's Guide," authored by leading pain medicine clinician Scott M. Fishman, MD. In addition, the PPC hosted its first "Putting a Face on Pain" summit in April 2010.

Looking ahead, PPC will be an important organizing force, working with the medical, nursing and pharmacy boards in the state, to improve pain policies and pain management practice in Pennsylvania, including efforts to enhance Pennsylvania's Prescription Monitoring Program.

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