Cancer Action Network℠
American Cancer Society®

11th Edition

HOW DO YOU **MEASURE UP**?

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

AUGUST 2013

Mission Statement

American Cancer Society Cancer Action Network (ACS CAN)

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

Our 11th Edition

The 11th edition of *How Do You Measure Up?* illustrates how states stand on issues that play a critical role in reducing cancer incidence and death. The goal of every state should be to achieve "green" in each policy area delineated in the report. By implementing the solutions set forth in this report, state legislators have a unique opportunity to take a stand and fight back against cancer. In many cases, it costs the state little or nothing to do the right thing. In most cases, these solutions will save the state millions and perhaps billions of dollars through health care cost reductions and increased worker productivity. If you want to learn more about ACS CAN's programs and/or inquire about a topic not covered in this report, please contact the ACS CAN state and local campaigns team at (202) 585-3206 or call our toll-free number, 1-888-NOW-I-CAN, 24 hours a day, seven days a week, and we can put you in contact with your state's staff. You can also visit us online at www.acscan.org.

Table of Contents

How Do You Measure Up?

Tackling Tobacco Use 4

Tobacco Excise Taxes 5

Smoke-Free Laws 8

Emerging Tobacco Products 11

Tobacco Cessation Services 13

Tobacco Control Program Funding 15

Obesity, Nutrition and Physical Activity 18

Indoor Tanning Beds 22

Cancer Care and the Affordable Care Act 24

Increasing Access to Medicaid Coverage 30

Funding for Breast and Cervical Cancer Screening 34

Colorectal Cancer Screening Coverage 38

Palliative Care 39

Cancer Pain Control 41

References 44

More CAN, Less Cancer

On September 1, 2012, American Cancer Society divisions across the country integrated their advocacy programs with ACS CAN. By aligning all federal, state and local advocacy efforts within a single, integrated nationwide structure, our advocacy work has become more efficient and effective, and we will sooner achieve our shared mission to save lives from cancer. Like the Society, ACS CAN continues to follow the science and support evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. ACS CAN also remains strictly nonpartisan. The only side ACS CAN is on is the side of cancer patients.

Thanks to progress in the fight against cancer, there are nearly 14 million cancer survivors living in the United States today. In the last two decades, there has been a 20 percent decline in cancer death rates and a 50 percent drop in smoking rates. These are huge victories that can be measured by lives saved. In fact, we are saving 400 more lives each day from cancer than we did in 1991. Despite that progress, more than half a million people still die every year from cancer in this country and 1.6 million more hear the feared words, "you have cancer."

Breakthroughs in cancer treatment are emerging every day that help to save or prolong lives. But what about the things we already know about prevention and treatment that can help avert cancer-related deaths right now? Research shows that we could prevent nearly half of all cancer deaths annually if everyone stopped smoking, got screened for cancer according to guidelines, ate a healthy diet and exercised regularly.

Finishing the fight against cancer will not happen in the research labs alone. We can make major strides in the prevention and treatment of cancer if we work to enact stronger tobacco control laws, guarantee improved access to health coverage and screenings, make palliative care and effective pain management available to people managing a cancer diagnosis, and increase education to young people about the importance of proper nutrition and physical fitness.

For the 11th year, ACS CAN has published a blueprint for state legislators on how to save more lives from cancer. Framed entirely on evidence-based policy approaches, How Do You Measure Up? provides an outline of what states can do to reduce the cancer burden and provides a snapshot of how states are progressing on critical public health measures.

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

Every day 1,500 people die from cancer and more than 4,000 people are diagnosed with the disease. The data in this report show that there is still much public policy work to be done to finish the fight. ACS CAN is dedicated to ensuring that lawmakers enact state health reforms that help prevent cancer and save lives.

New Opportunities

In recent years, the health care landscape in the states has changed dramatically. With the 2010 passage of the Affordable Care Act (ACA), states have been given great authority and flexibility on how to implement new programs and coverage options that can expand access to affordable and adequate health coverage to millions of uninsured and underinsured people. When many of the final provisions of the ACA are implemented in 2014, ACS CAN will continue to work closely with state lawmakers to ensure the strong implementation of consumer protections guaranteed under the law. States are working on implementing new insurance market rules required under the ACA, consumer-based health insurance marketplaces and policies that ensure access and affordability of prescription drugs that can improve patients' quality of life.

States are also considering whether to accept funds that the federal government has allocated to increase access to health coverage to hard-working adults and families through state Medicaid programs. Each state must decide whether to make health coverage under Medicaid available to individuals and families up to 133 percent of the federal poverty level ($30,657 for a family of four), made possible by the ACA. Under the health law, the federal government will pay 100 percent of the costs for the first three years to provide Medicaid coverage to more low-income people, and no less than 90 percent of the costs starting in 2020. Beginning next year, Medicaid will offer a defined set of essential benefits to help prevent and treat a serious disease such as cancer.

By accepting the federal funds, states will help to ensure that more people will be able to see a doctor regularly, access preventive services such as Pap tests, mammograms and smoking cessation aids, and avoid unnecessary visits to the emergency room. Access to these critical services enhances the likelihood of detecting cancer at an earlier, more curable stage that is far less expensive to treat. To date, nearly half of all states have decided to accept the funding and many more states will continue to grapple with the decision into the 2014 legislative sessions.

The tobacco control landscape is evolving as well. Public health advocates continue to fight for regular

and significant increases in state tobacco taxes, with a growing emphasis on tax parity for other tobacco products such as cigars, roll-your-own and smokeless. Some progress has been made on smoke-free laws, but there are still many opportunities to pass more comprehensive laws and close loopholes, including ventilation exemptions, and prohibiting smoking in gaming facilities and tobacco retail shops and cigar bars.

Meanwhile, within the last few years, the tobacco industry has been making significant investments in the development and marketing of new tobacco products – including snus, sticks, orbs, dissolvables, water pipes and electronic cigarettes – all of which may keep existing tobacco users hooked and entice youth to start the deadly habit. Tobacco companies are waging a war of distraction by touting these new products as "reduced harm" or "modified risk." And while not all tobacco products are equally harmful, there is no such thing as a safe tobacco product. While conversations about tobacco control may be changing, the most effective ways to reduce death and disease from tobacco use remain the same and are backed by strong scientific evidence: raising tobacco taxes, implementing smoke-free policies and fully funding tobacco control prevention and cessation programs.

Progress in the States

Since the first issue of How Do You Measure Up? was published, states have made tremendous progress toward implementing laws and policies that help fight cancer. In that time, 45 states increased their tobacco taxes more than 100 times and 24 states implemented comprehensive smoke-free laws covering bars, restaurants and workplaces. Since its establishment in 1991, the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) has served more than four million low-income and uninsured women and provided more than 10 million screening exams. During the past six years, 26 states and D.C. have passed oral chemotherapy fairness legislation, improving patient access to anti-cancer oral drugs, and five states have passed comprehensive laws to prohibit the use of indoor tanning devices by those under the age of 18.

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

legislative initiatives can benefit the public health and the economic wellbeing of the states.

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

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

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

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

How does your state measure up?

Tackling Tobacco Use

The burden of tobacco use is well known – resulting in more than 443,000 deaths and $193 billion in health care and productivity losses across the states each year. Despite the understanding of the extent of the problem and the clear evidence for what policies work to reverse it, troubling new and existing trends remain pervasive.

Increases in state cigarette taxes have stalled in the past two years, with some states even considering tax rollback proposals. Taxes on other products such as smokeless, cigars and snus remain significantly low compared to cigarettes. Some progress has been made in smoke-free laws, but there are still many opportunities to pass more comprehensive laws and close loopholes, including ventilation exceptions, and allowing smoking at gaming facilities and/or tobacco retail shops and cigar bars. At the same time, the tobacco industry continues to introduce new types and variations of tobacco products that challenge existing policies. Meanwhile, funding for state tobacco control programs remains on a troubling downward trend.

In 2013, states are making critical decisions about implementing the Affordable Care Act, including the provision that gives them the option of applying a tobacco rating surcharge to health insurance for tobacco users. ACS CAN has been working with legislators and policymakers to show that charging tobacco users more for health insurance is an unproven way of addressing tobacco use compared to the documented improvements that have been seen in public health by raising the price of tobacco products, creating smoke- and tobacco-free venues and implementing tobacco use prevention and cessation programs. Higher health insurance premiums based on tobacco use will only create barriers for individuals who need coverage the most, including low-income tobacco users who have fewer quality health care options but are more likely to have serious health problems from tobacco use (see Insurance Market Reforms Under the Cancer Care section for more information).

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

1. Raise the price of all tobacco products through regular and significant tobacco tax increases.

2. Implement comprehensive smoke- and tobacco-free policies.

3. Fully fund and sustain evidence-based, statewide tobacco prevention and cessation programs.

Like a three-legged stool, each component works in conjunction with the others, and all three are necessary to overcome this country's tobacco epidemic. ACS CAN works in partnership with state and local policymakers across the country to ensure tobacco use is addressed comprehensively in each community.

The Challenge

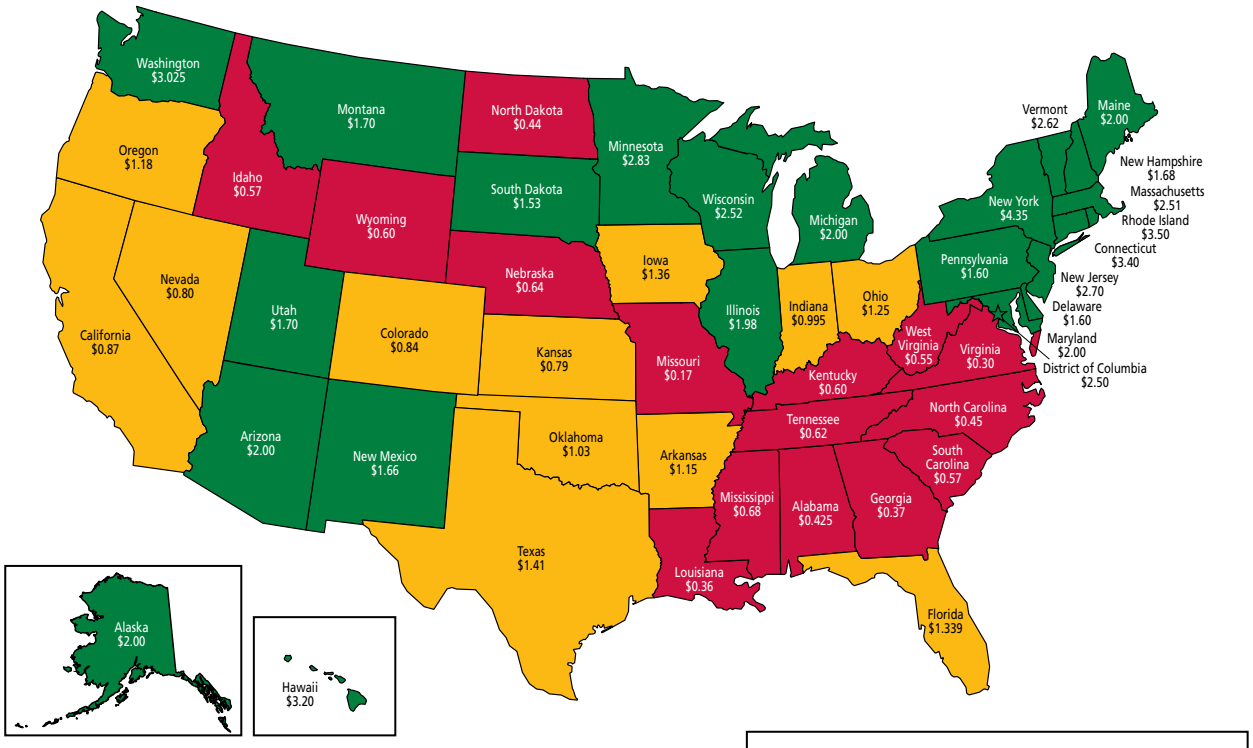
By increasing taxes on cigarettes, cigars, little cigars, smokeless tobacco and all other tobacco products (OTPs), states can save lives, reduce health care costs and generate much-needed revenue. Evidence clearly shows that raising tobacco prices through regular and significant tax rate increases encourages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

ACS CAN continues to advocate for increased excise taxes on cigarettes and OTPs and to urge legislators to reject any proposals to roll back tobacco taxes. The average state cigarette excise tax is currently $1.51[1] per pack. In the past 10 years, only three states – California, Missouri and North Dakota – have not raised their cigarette tax. In 2012, voters in California and Missouri considered tobacco tax increases of $1.00 and 73 cents per pack, respectively, and increases in their state's tax on OTPs. The tobacco industry spent millions to defeat these initiatives, with $50 million spent in California alone. Unfortunately, this means that California's cigarette tax will remain at 87 cents per pack and Missouri's at 17 cents per pack, the lowest in the nation.

The Facts

- Nationally, health costs and reduced productivity costs attributed to smoking are $10.47 per pack of cigarettes.[2]
- State cigarette excise tax rates vary widely, ranging from a high of $4.35 per pack in New York to a low of 17 cents in Missouri. New York City has the highest combined city and state cigarette tax in the country, with a total tax of $5.85 per pack.

State Cigarette Excise Tax Rates



As of 7/1/13

How Do You Measure Up?

- For every 10 percent increase in the retail price of a pack of cigarettes, youth smoking rates drop by 6.5 percent and overall cigarette consumption declines by 4 percent.[3, 4]

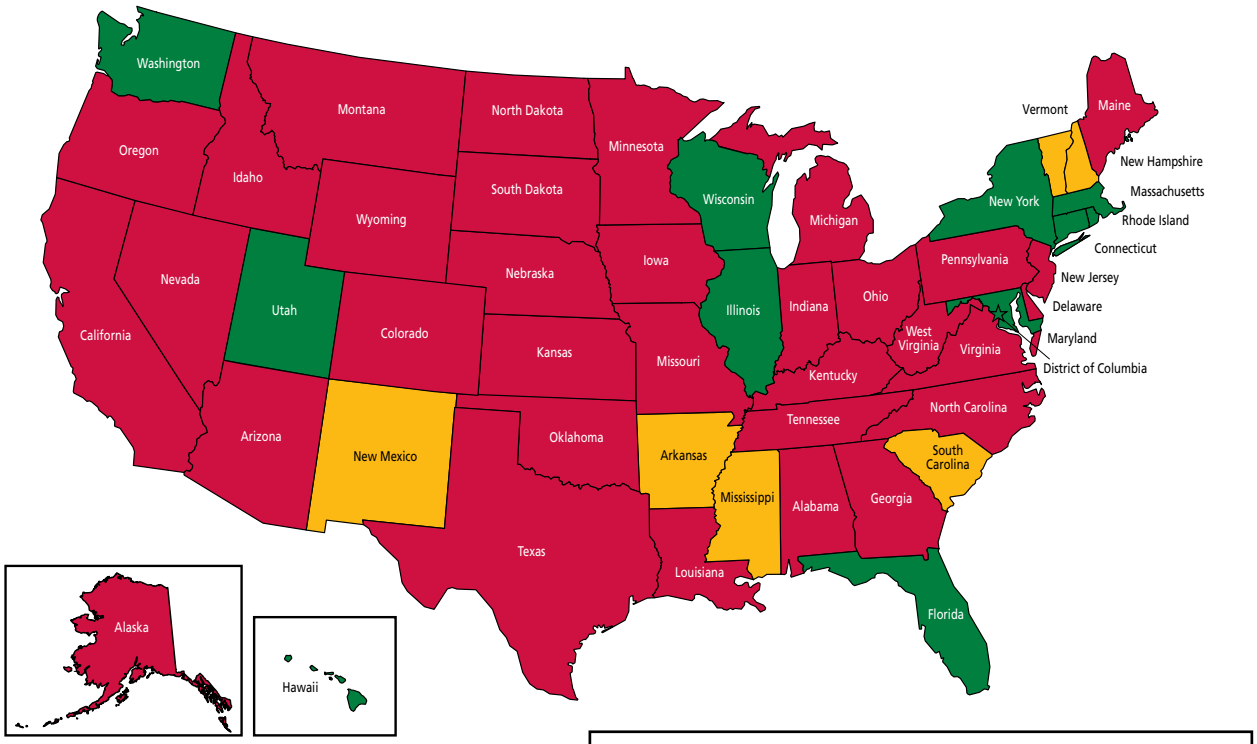
The Solution

Many state lawmakers have recognized the public health and economic benefits of tobacco tax increases, as evidenced by the fact that 15 states, the District of Columbia, Puerto Rico and Guam have cigarette taxes of $2 or more per pack. Two states – Minnesota and Massachusetts – significantly increased their cigarette and OTP taxes this year, and as of July 1, Massachusetts has passed a bill in both chambers and the governor has not signed the bill into law. Raising tobacco taxes reduces suffering and death caused by smoking; reduces health care expenditures; and is a significant, stable and predictable source of revenue in challenging fiscal times.

ACS CAN challenges states to raise cigarettes and OTP taxes regularly by a significant percentage of the retail price, which the research says is the best way to curb tobacco use.

ACS CAN has recently introduced a new way to measure a state's progress in preventing cancer by reducing tobacco use. In addition to rating the states on a green, yellow, and red scale based on their cigarette tax rate, the new rating will also take into account how recently the state raised its cigarette tax, with the benchmark being within six years or three legislative cycles. The rating also will take into account the size of the tax increase and the percentage increase in the overall price per pack within that time period. ACS CAN believes that states should aim for tax increases that

State Cigarette Tax and Price Increases
Since July 1, 2007



How Do You Measure Up?

As of 7/1/13

are at least $1.00 per pack and result in at least a 30 percent increase in the retail price of a pack of cigarettes. States should also raise taxes on OTPs to an equivalent percentage of the manufacturer's price as the tax on cigarettes. ACS CAN also encourages states to earmark tobacco tax revenues for tobacco prevention and cessation programs, along with other programs that will benefit cancer patients.

Quantifying the Public Health and Economic Benefits of State Tax Increases

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

- Reduction in adult smokers
- Reduction in future smokers
- Total adult smoker and future smoker deaths prevented
- Smoking-affected births prevented
- Lung cancer health care cost savings
- Heart attack and stroke health care cost savings
- Smoking-affected pregnancy and birth-related health care cost savings
- Medicaid program savings for the state
- Long-term health care cost savings

Success Story

Surrounded by members of the Raise it for Health Coalition, including representatives from ACS CAN, Minnesota Governor Mark Dayton signed a 2013 omnibus tax bill into law that includes a $1.60-per-pack cigarette tax increase and comparable increases in the taxes on all other tobacco products. The OTP tax provision adopts the higher of two numbers – a minimum tax equal to 95 percent of the wholesale rate or the same rate as a pack of cigarettes ($2.83 per pack). This prevents the deep discounting of popular brands, which is particularly significant because some of these brands are currently the most popular smokeless products among 12-17 year olds. This change means that nearly 50,000 kids will never become addicted to tobacco products and more than 36,000 people will quit using tobacco products, thus dramatically reducing their risk for disease and premature death. It also closes the little cigar loophole so that all cigarettes are taxed at the same rate.

Achieving Tax Parity

As states increase their taxes on cigarettes and smoking rates decline, increasing the tax on OTPs to achieve tax parity becomes particularly important. In many states, cigarettes are taxed at a much higher rate than OTPs, making the lower-priced tobacco alternatives – such as cigars, snus and newer products such as dissolvable orbs – more appealing to youth. When OTPs are taxed at a much lower rate than cigarettes, smokers may switch to another lower-priced tobacco product instead of quitting or cutting down on tobacco use altogether. Youth are particularly price sensitive, so they are most likely to be impacted by this price differential. Further compounding the issue, some OTPs, such as orbs, look like candy and use flavorings to appeal to kids.

After the federal excise taxes on cigarettes, roll-your-own tobacco and small cigars were increased in 2009, a disparity emerged between the taxes on these products and lesser-taxed pipe tobacco and small cigars. Usage of the higher taxed products decreased while consumption of the less expensive large cigars and pipe tobacco increased significantly.[5] Between 2008 and 2009, consumption of pipe tobacco increased by 142 percent and consumption of large cigars increased 73 percent.[6] Lower taxes on these OTPs in conjunction with the tobacco companies' aggressive marketing practices resulted in making these products more attractive to price-sensitive consumers, such as youth. Taxing all OTPs at a comparable rate to cigarettes would help to curb these price disparities and cut down on overall usage.

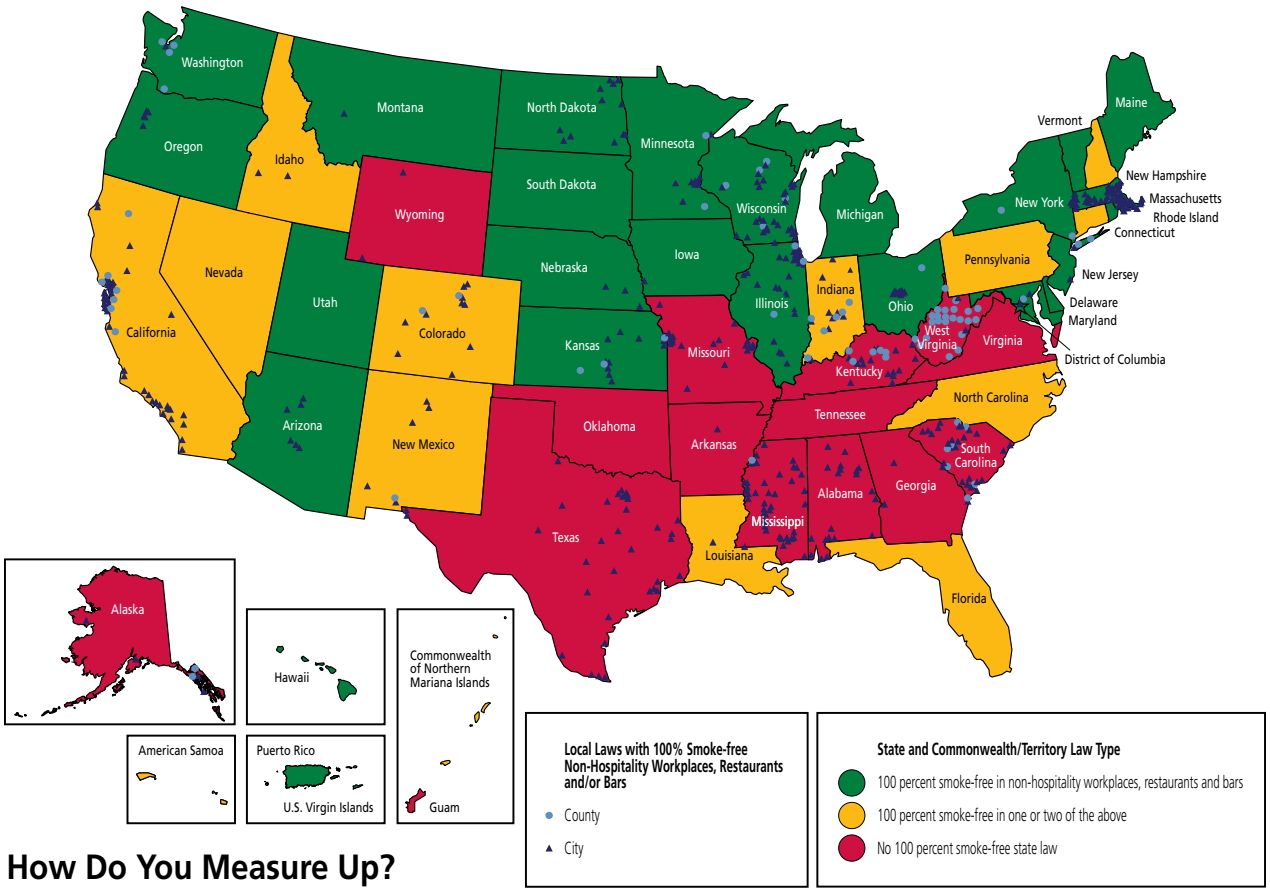
The Challenge

The 2010 Surgeon General's report, *How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking – Attributable Disease*, and the 2006 Surgeon General's report, *The Health Consequences of Involuntary Exposure to Tobacco Smoke*, confirm there is no safe level of exposure to secondhand smoke.[1, 2] Each year in the United States, secondhand smoke causes approximately 42,000 deaths among nonsmokers, including up to 7,300 lung cancer deaths.[3] Secondhand smoke also can cause or exacerbate a wide range of other adverse health issues, including respiratory infections and asthma. Secondhand smoke is a serious health hazard, containing more than 70 known or probable carcinogens and more than 7,000 substances, including formaldehyde, arsenic, cyanide and carbon monoxide.[4]

As of July 8, 2013, 24 states (along with Puerto Rico, the U.S. Virgin Islands and Washington, D.C.) and 575 municipalities have laws in effect that require 100 percent smoke-free workplaces, including restaurants and bars.[5] Combined, this represents 49 percent of the U.S. population. According to a 2011 report by the Centers for Disease Control and Prevention, all states could have comprehensive smoke-free policies by 2020, if current progress continues. However, reaching that goal will require accelerated progress in parts of the country where there are no comprehensive smoke-free laws.[6] Currently, only 12 states have a statewide 100 percent smoke-free law covering one or two of non-hospitality workplaces, restaurants and bars, and 14 states still have no statewide 100 percent smoke-free laws covering any of these three types of venues. In addition, 20 states, Puerto Rico and the U.S. Virgin Islands currently have a law in

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

In effect as of July 6, 2013



Note: American Indian and Alaska Native sovereign tribal laws are not reflected on this map.
Source: American Nonsmokers' Rights Foundation U.S. Tobacco Control Laws Database(c), 07/01/13

How Do You Measure Up?

effect requiring all state-regulated gaming facilities to be 100 percent smoke-free.

Despite major legislative advances during the past decade, certain segments of the population, such as hospitality and casino workers, continue to be denied their right to breathe smoke-free air. In addition, approximately 45 percent of individuals in multi-unit housing, such as apartments and condominiums, are exposed to some secondhand smoke in their homes from common areas or other units in the building.[7] Low-income individuals are especially vulnerable. While the levels of serum cotinine, which is a measure of secondhand smoke exposure, decreased for all populations from 1988 -1994 and from 1999 -2004, the decline was smaller among low-income individuals.[8] As of 2007-2008, the most recent date for which data are available, approximately 88 million nonsmokers ages three or older in the United States were exposed to secondhand smoke.[9]

The Facts

- Smoke-free laws reduce exposure to secondhand smoke and reduce the incidence of cancer, heart disease and other conditions caused by exposure to tobacco smoke.[10]
- Smoke-free laws encourage smokers to quit, increase the number of successful quit attempts and reduce the total number of cigarettes smoked.[11, 12]
- Smoke-free laws reduce health care spending and improve employee productivity.[13]

The Solution

The best way to reduce exposure to secondhand smoke is to make all public places 100 percent smoke-free. The Institute of Medicine and the President's Cancer Panel recommend that comprehensive smoke-free laws cover all workplaces, including restaurants, bars, hospitals and health care facilities, gaming facilities and correctional facilities.[14, 15] Implementing comprehensive smoke-free policies has immediate health benefits for all individuals, especially those most at risk, such as those with cancer, heart disease and asthma, as well as casino, restaurant and bar workers.

Across the country, elected officials at the state and local levels are recognizing the health and economic benefits of comprehensive smoke-free laws. However, despite the evidence about the positive impact of the laws on people's health, legislators in several states are considering repealing or weakening existing smoke-free laws by adding exemptions for places such as cigar bars, hookah bars and casinos. ACS CAN advocates are fighting for the health of all workers and have successfully defended strong laws in a majority of the states in which comprehensive smoke-free laws have been challenged.

ACS CAN urges state and local officials to pass or maintain comprehensive smoke-free laws in all workplaces, including restaurants, bars and gaming facilities, in order to protect the health of all employees and patrons. Policy makers are also encouraged to overturn and prevent preemption laws that restrict a lower level of government from enacting stronger smoke-free laws than exist at a higher government level in a state. ACS CAN believes that everyone has the right to breathe smoke-free air.

The Red to Green Campaign

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

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

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

Success Story

On November 6, 2012, North Dakota voters passed a statewide smoke-free law by a vote of 66 percent to 33 percent. Voters from each of North Dakota's 53 counties and all legislative districts voiced support for making North Dakota the 24th state, along with the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, to require all non-hospitality workplaces, restaurants and bars to be 100 percent smoke-free. In addition, North Dakota's smoke-free law adds provisions that require all gaming/gambling facilities to be 100 percent smoke-free and prohibits the use of electronic smoking devices where smoking is not allowed. The new statewide law went into effect December 6, 2012.

The Problem with Exemptions for E-Cigarettes

Electronic cigarettes, or e-cigarettes, are battery-operated devices that allow the user to inhale a vapor produced from cartridges filled with nicotine, flavor and other chemicals. While e-cigarette companies often market them as healthier, more convenient and more socially acceptable alternatives to traditional cigarettes, there is no scientific evidence that e-cigarettes are safe or that they can help smokers quit. E-cigarettes also are available in flavors that would attract youth. Awareness and use of e-cigarettes have grown significantly in recent years, particularly among current smokers. In 2011, 58 percent of adults surveyed were aware of e-cigarettes, an increase from about 40 percent only one year earlier. E-cigarette use among current smokers more than doubled between 2010 and 2011, from 10 to 21 percent of smokers. Among former smokers, e-cigarette use nearly tripled during that time period. Regardless of how they are marketed or used, e-cigarettes are often made to resemble traditional cigarettes, making enforcement of smoke-free laws difficult. As a result, comprehensive smoke-free laws should prohibit use of e-cigarettes in all venues where cigarette smoking is prohibited – including workplaces, restaurants and bars.

The Challenge

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

The Facts

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

The Solution

All tobacco products can cause disease and death, and should be regulated like cigarettes to keep them away from children and discourage smokers from switching among tobacco products instead of cutting down on tobacco use or quitting altogether. In recent years, major cigarette manufacturers have been advocating for lower tax rates on smokeless tobacco products, diverting tobacco prevention and cessation funds toward harm reduction research, lobbying state legislatures to pass resolutions supporting harm reduction strategies, and advocating to change warning labels on smokeless products to state they are less harmful than cigarettes. These so-called solutions are coming from the same manufacturers that violated civil racketeering laws and defrauded the American people with a decades-long conspiracy to deceive the public and target children with their deadly and addictive products. ACS CAN opposes these tobacco industry efforts to continue to deceive the public with claims their products are safe. States should also know that the Food and Drug Administration (FDA) is currently examining the potential health changes to individuals and to the population as a whole from the use of modified-risk tobacco products. It would be duplicative and wasteful to spend state dollars on such research since the FDA is the best entity, with its scientific and medical expertise and resources, to undertake and direct this research.

The most effective ways to reduce death and disease from tobacco use are backed by strong scientific evidence: raising tobacco taxes, implementing smoke-

free policies, and fully funding tobacco control prevention and cessation programs – these actions reduce consumption, prevent initiation and save lives. Specifically, ACS CAN recommends:

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

- Passing comprehensive smoke-free and tobacco-free laws and policies that do not provide exemptions for tobacco retail stores, cigar bars, hookah bars or any other retail or hospitality venue or for specific products such as electronic cigarettes. Secondhand smoke from cigars and hookah contains the same, or even greater, levels of toxic chemicals as secondhand smoke from cigarettes.[5, 6, 7, 8, 9, 10, 11] These products also are often smoked for longer periods of time than cigarettes, resulting in users of these products inhaling a much larger volume of smoke, along with its cancer-causing components.

- Ensuring that the definition of "tobacco product" in new laws is sufficiently broad to include all types of tobacco and tobacco-derived products, including dissolvable tobacco products and e-cigarettes. ACS CAN does not support exempting any type of smoked or smokeless tobacco product from smoke-free and tobacco-free laws and policies, tobacco tax increases or tobacco sales or marketing restrictions.

- Fully funding, promoting and providing access to all FDA-approved cessation treatments for all types of tobacco use.

- While the federal law giving the FDA the authority to regulate tobacco products includes a number of restrictions on the manufacturing, marketing, labeling, distribution and sale of tobacco products, it also allows states to further restrict or regulate the time, place and manner (but not the content) of tobacco product advertising or promotions. While some of the regulations in the FDA law apply only to cigarettes, including restrictions on flavored cigarettes and minimum pack-size requirements, ACS CAN supports extending these types of restrictions to all tobacco products.

SMOKING TOBACCO

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

SMOKELESS TOBACCO

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

Source: The Tobacco Atlas: Fourth Edition
Eriksen M, Mackay J, Ross H. The Tobacco Atlas Fourth Edition, Atlanta, GA: American Cancer Society; New York, NY: World Lung Foundation; 2012.

The Challenge

Public health experts have long supported proven strategies to prevent children and adults from smoking and to get smokers to quit. States with comprehensive tobacco control programs that include cessation services for a wide scope of their population experience faster declines in cigarette sales, smoking prevalence and lung cancer incidence and mortality than those states that do not invest in these programs.

Only two states – Indiana and Massachusetts – provide comprehensive cessation coverage for all Medicaid beneficiaries. Only nine states require private insurance plans to cover tobacco cessation treatments.[1] While the Affordable Care Act (ACA) requires non-grandfathered private health plans to offer cessation coverage, there are no guidelines or requirements at this time for effective and comprehensive cessation coverage. Only four states – Illinois, New Mexico, North Dakota, and Rhode Island – offer comprehensive cessation coverage for their own employees.

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

Evidence shows that administrative barriers such as copays, preauthorization requirements and administrative "red tape" can deter people from utilizing preventive services such as cessation treatment. In 26 state Medicaid programs, copays are required for every cessation-related prescription filled or every cessation counseling visit. In at least 23 states, Medicaid programs limit the number of weeks the tobacco treatment programs are covered or the number of covered quit attempts per year. In an improvement over earlier years, 25 states do cover all evidence-based nicotine replacement therapy and cessation medication for all patients, but not counseling.

The Facts

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

Affordable Care Act Cessation Provisions:

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

Source: Centers for Disease Control and Prevention

CDC's Tips Success

The CDC's Tips From Former Smokers campaign was a huge success in 2012. While all 50 states and Washington, D.C., have their own quitlines, 29 states and communities used the CDC's Tips ads at little or no cost. Calls to the 1-800-QUIT-NOW, which connects callers to their state quitlines, doubled during the campaign to more than 365,000 calls over 12 weeks. Evidence is clear that quitline calls significantly increase the rates of users who successfully quit and that quitlines are a great return on state investment in addition to saving lives. The CDC already released Tips 2 in March 2013, which is expected to encourage even more smokers to quit.

The Solution

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

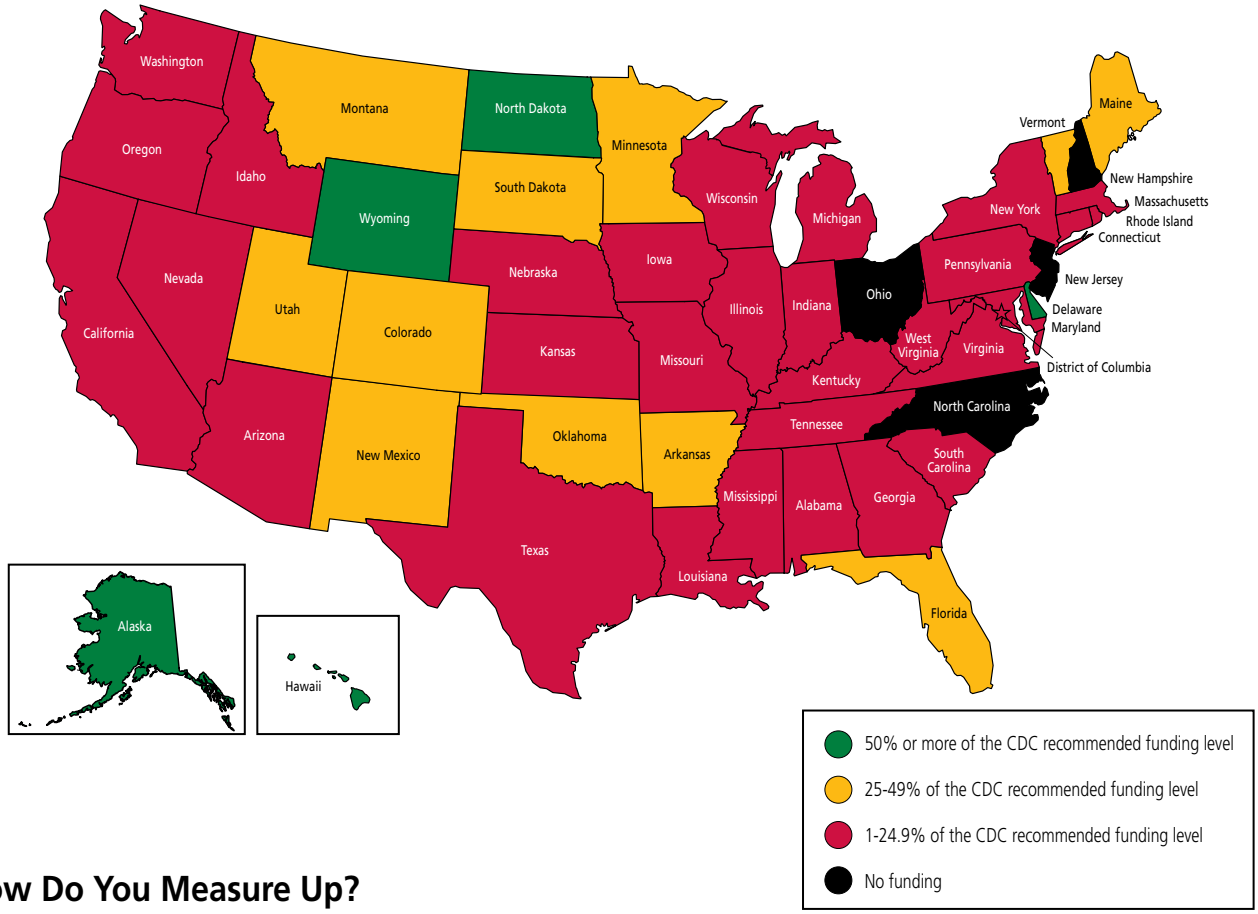
Tobacco Control Program Funding

The Challenge

The level of funding and the emphasis states place on proven prevention and cessation programs over time directly influence the health and economic benefits of their tobacco control interventions. Comprehensive, adequately funded tobacco control programs reduce tobacco use and tobacco-related disease, resulting in reduced tobacco-related health care costs. Unfortunately, states currently spend only a small percentage of the revenues from tobacco taxes and Master Settlement Agreement (MSA) payments on tobacco control programs.

In fiscal year 2013, states budgeted a total of $459.5 million for tobacco prevention and cessation programs.[1] While states will collect $25.7 billion in tobacco revenue this year, they will devote less than 2 percent of it to support prevention and cessation efforts. States' funding for tobacco prevention and cessation programs essentially remained flat between fiscal year 2012 and 2013, with the $456.7 million that states allocated for tobacco control programs in fiscal year 2012 being the lowest amount spent on tobacco control since states began receiving MSA payments in 1999. In the past five years, states have cut funding for tobacco prevention programs by 36 percent ($257.7 million). The drop in funding threatens the viability of state tobacco control programs that promote the health of residents, reduce tobacco use and provide services to help people quit.

FY 2013 State Funding for Tobacco Prevention



How Do You Measure Up?

Source: Robert Wood Johnson Foundation, Campaign for Tobacco-Free Kids, American Cancer Society Cancer Action Network, American Heart Association, and American Lung Association. *A Broken Promise to Our Children: The 1998 State Tobacco Settlement 14 Years Later.* December 2012. Available at http://www.tobaccofreekids.org/what_we_do/state_local/tobacco_settlement/
Current annual funding includes state funds for FY2013 and does not include federal funds directed to states.
*Source for AL funding level: AL Department of Health. FY13 funding level for AL not available in the Broken Promises to Our Children report.

The Facts

- Health care costs from tobacco-related disease total approximately $96 billion in the United States each year.[2]
- The $459.5 million that states budgeted for tobacco prevention and cessation programs in fiscal year 2013 is only 1.8 percent of the $25.7 billion in revenue they are collecting from the tobacco settlement and tobacco taxes.[3]
- The CDC recommends that states spend at least $3.7 billion per year on tobacco control programs. In total, states budgeted only 12.4 percent of the recommended funding in fiscal year 2012.[4]
- It would take only 15 percent of annual tobacco settlement revenue to fund all states' tobacco prevention and control programs at the CDC-recommended levels.[5]
- When federal and state funds are counted together, Alaska and North Dakota are the only two states currently funding their tobacco prevention programs above CDC-recommended levels. Only three additional states – Delaware, Wyoming and Hawaii – are funding at even half of the CDC's recommended spending levels.[6]

- State budget shortfalls have resulted in significant cuts to some previously successful state tobacco control programs in recent years. Four states – New Hampshire, New Jersey, North Carolina and Ohio – allocated no state funds for tobacco control in FY 2013.
- If each state maintained target funding levels for five years, there would be an estimated five million fewer smokers in the United States.[7]

The Solution

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

1. State and community interventions, which include supporting and implementing programs and policies to influence societal organizations, systems and networks that encourage and support individuals to make behavior choices consistent with tobacco-free norms.
2. State health communication interventions, which deliver strategic, culturally appropriate, and high-impact messages in sustained and adequately funded campaigns integrated into the overall state tobacco program effort.
3. Cessation interventions ensuring that all patients seen in the health care system are screened for tobacco use and receive brief interventions to help them quit and are offered more intensive counseling services and FDA-approved cessation medications, as well as telephone-based cessation (quitline) counseling for all tobacco users who wish to access the service.

4. Surveillance and evaluation to monitor the achievement of overall program goals and to assess the implementation and outcomes of the program and demonstrate accountability.

5. Implementation of effective tobacco prevention and control programs requires substantial funding. An adequate number of skilled staff enables programs to plan their strategic efforts, provide strong leadership, and foster collaboration between the state and local tobacco control communities.

ACS CAN challenges states to combat tobacco-related illness and death by sufficiently 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. Legislators are urged to resist sacrificing tobacco prevention and cessation programs in tough economic times as short-term budgetary fixes and to instead consider the long-term health and economic burden that such cuts will ultimately put on the state and the state's population.

Success Story

For the first time since 2008, the Iowa state legislature increased funding for tobacco prevention and cessation. ACS CAN staff and volunteers in Iowa successfully urged lawmakers to increase funding for tobacco control by 41percent for fiscal year 2014, for a total of more than $5.1 million. The legislature recognized the importance of youth programs for tobacco prevention and cessation by appropriating these new funds specifically for an annual youth summit and social media. In addition, new revenue was dedicated to promote smoking cessation and to reduce the number of tobacco users in the state by offering nicotine replacement therapy to uninsured and underinsured Iowans. While still significantly lower than the recommendations from the CDC, this funding increase signifies the tide is turning for tobacco control in Iowa.

State Tobacco Prevention Spending

State	State's FY2012 Tobacco Prevention Spending (millions)	CDC Recommended Spending (millions)	State Tobacco Prevention Spending % of CDC Recommended
Alaska	$10.9	$10.7	101.6%
North Dakota	$8.2	$9.3	88.4%
Delaware	$9.0	$13.9	64.9%
Wyoming	$5.4	$9.0	60.0%
Hawaii	$8.9	$15.2	58.8%
Arkansas	$17.8	$36.4	48.9%
Oklahoma	$19.7	$45.0	43.8%
Colorado	$22.6	$54.4	41.5%
Maine	$7.5	$18.5	40.7%
Vermont	$4.0	$10.4	38.2%
South Dakota	$4.0	$11.3	35.4%
Minnesota	$19.6	$58.4	33.6%
Montana	$4.6	$13.9	33.1%
Florida	$64.3	$210.9	30.5%
Utah	$7.0	$23.6	29.8%
New Mexico	$5.9	$23.4	25.3%
Mississippi	$9.7	$39.2	24.7%
Arizona	$15.2	$68.1	22.3%
West Virginia	$5.7	$27.8	20.5%
Oregon	$7.5	$43.0	17.5%
New York	$41.4	$254.3	16.3%
California	$62.1	$441.9	14.1%
Connecticut	$6.0	$43.9	13.7%
Louisiana	$7.2	$53.5	13.4%
Idaho	$2.2	$16.9	13.0%
Indiana	$9.3	$78.8	11.8%
Nebraska	$2.4	$21.5	11.1%
Pennsylvania	$14.2	$155.5	9.1%
Iowa	$3.2	$36.7	8.7%
Wisconsin	$5.3	$64.3	8.2%
Virginia	$8.4	$103.2	8.1%
South Carolina	$5.0	$62.2	8.0%
Illinois	$11.1	$157.0	7.1%
Maryland	$4.2	$63.3	6.6%
District of Columbia	$0.5	$10.5	4.7%
Massachusetts	$4.2	$90.0	4.6%
Kentucky	$2.1	$57.2	3.7%
Washington	$2.5	$67.3	3.7%
Kansas	$1.0	$32.1	3.1%
Rhode Island	$0.4	$15.2	2.5%
Texas	$6.5	$266.3	2.4%
Michigan	$1.8	$121.2	1.5%
Georgia	$0.8	$116.5	0.6%
Alabama	$0.3*	$56.7	0.5%*
Nevada	$0.2	$32.5	0.5%
Tennessee	$0.2	$71.7	0.3%
Missouri	$0.1	$73.2	0.1%
New Hampshire	$0.0	$19.2	0.0%
North Carolina	$0.0	$106.8	0.0%
New Jersey	$0.0	$119.8	0.0%
Ohio	$0.0	$145.0	0.0%

Note: These funding amounts include state funds only. If both state and federal funds are considered, North Dakota funds tobacco prevention above the CDC-recommended level.

Source: Robert Wood Johnson Foundation, American Cancer Society Cancer Action Network, Campaign for Tobacco-Free Kids, American Heart Association, Americans for Nonsmokers' Rights, and American Lung Association. *Broken Promises to Our Children: The 1998 State Tobacco Settlement Fourteen Years Later.* December 2012. Available at http://www.tobaccofreekids.org/what_we_do/state_local/tobacco_settlement/.

*Source for Alabama funding level: Alabama Department of Health. FY13 funding level for Alabama not available in the *Broken Promises to Our Children* report.

The Challenge

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

Approximately two in three adults and one in three youths in this country are overweight or obese – more than double the rate from just 20 years ago. Just one in five adults are meeting recommendations for at least 150 minutes of moderate physical activity or an equivalent amount of vigorous physical activity per week and muscle-strengthening activity at least twice a week,[4] and 14 percent of high school students do not get the recommended daily hour of physical activity on any day of the week.[5] Americans also consume too few fruits and vegetables and whole grains and too many refined grains, added sugars, unhealthy fats and calories overall.[6]

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

American Cancer Society Nutrition and Physical Activity Guidelines

The American Cancer Society recently released two sets of nutrition and physical activity guidelines – one focused on cancer prevention and the other focused on cancer survivorship.

The updated American Cancer Society Guidelines on Nutrition and Physical Activity for Cancer Prevention recommend that individuals achieve and maintain a healthy weight, adopt a physically active lifestyle, consume a healthy diet with an emphasis on plant sources and limit consumption of alcoholic beverages.[7] The guidelines also recommend that public, private and community organizations work collaboratively at all levels of government to implement policy and environmental changes that increase access to affordable, healthy foods in communities, worksites and schools; decrease access to and the marketing of foods of low nutritional value, particularly to youth; and provide safe, enjoyable, and accessible environments for physical activity in schools, worksites, and communities.[8] Both the individual and community recommendations in the cancer prevention guidelines are consistent with the 2010 Dietary Guidelines for Americans, developed by the U.S. Department of Agriculture and the U.S. Department of Health and Human Services.

The first-ever Nutrition and Physical Activity Guidelines for Cancer Survivors, which cover the active treatment and recovery phase, life after recovery, and advanced cancer and end of life, also stress the importance of achieving and maintaining a healthy weight, being physically active, and consuming a nutrient-rich diet as much as possible at all points during the cancer survivorship trajectory.[9] The survivorship guidelines recommend that cancer survivors follow the cancer prevention guidelines as much as possible in order to improve their quality of life and reduce their risk of cancer recurrence and death.

The Facts

- Approximately 68.8 percent of adults in the United States ages 20 and older are overweight, including 35.7 percent of adults who are obese.[10]
- Overweight and obesity rates vary among racial and ethnic groups. Among African Americans, 76.7 percent are overweight, including 49.5 percent who are obese. Among Hispanics, 78.8 percent are overweight or obese, including 39.1 percent who are obese. This is compared with 66.7 percent of non-Hispanic whites who are overweight or obese and 34.4 percent who are obese.[11]
- Currently, 31.8 percent of youth ages 2 to 19 are overweight or obese, including 16.9 percent who are obese.[12]
- Childhood obesity rates have more than tripled in the past four decades.[13] These statistics are especially concerning because childhood overweight and obesity increase the risk for overweight and obesity in adulthood.
- In addition to increasing the risk for cancer and other chronic diseases, overweight and obesity place a huge financial burden on the health care system in the United States. Obesity alone costs the nation $147 billion in direct medical costs each year.[14]

The Solution

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

While the federal government has been active in setting laws and regulations focused on making healthy food and physical activity choices easier – and environments, such as schools, healthier – there are still significant opportunities for states and local governments to pass and implement their own policies.

The federal Healthy, Hunger-Free Kids Act of 2010 reauthorized the child nutrition programs and made numerous changes to improve the foods and beverages sold and served in schools. Pursuant to the law, updated

Setting Priorities

Given the range of potential strategies for improving nutrition, increasing physical activity and reducing obesity that have been proposed by state governments, ACS CAN recently underwent a strategic planning process to guide its nutrition, physical activity and obesity advocacy work. After reviewing the existing evidence and expert recommendations, ACS CAN developed a strategic plan with several tiers of nutrition, physical activity and obesity policy priorities.

Top-tier issues include:

- Establishing strong nutrition standards for all foods and beverages sold or served in schools
- Increasing the quality and quantity of physical education in K-12 schools, supplemented by additional school-based physical activity
- Increasing funding for research and interventions focused on improving nutrition, increasing physical activity and reducing obesity, with the ultimate goal of reducing cancer risk
- Reducing the marketing of unhealthy foods and beverages, particularly to youth

ACS CAN recommends that legislators focus their efforts on changing policies in these four key areas, which are likely to have a significant impact on making healthy choices easier, particularly for youth.

national nutrition standards for school lunches took effect at the beginning of the 2012-2013 school year, and updated breakfast requirements are slated to take effect as students go back to school in the fall of 2013. Earlier this year, the USDA also released the national nutrition standards for competitive foods, or all foods sold in schools outside of meals during the school day, including a la carte and in vending machines and school stores. When these requirements for competitive foods take effect in fall 2014, all school districts across the country will have to meet minimum nutrition standards for their reimbursable meals, snack foods and beverages. However, the federal requirements are not preemptive, and states and localities still have the opportunity to fill in gaps, including strengthening the federal standards, extending them beyond the end of the official school day, closing loopholes and setting nutrition standards for school-sponsored fundraisers. Local communities also have an opportunity to set stronger school nutrition and wellness requirements by reviewing and updating their local wellness policies, which is also required by federal law. Local wellness policies must include goals for nutrition education and promotion, physical activity, nutrition standards for foods sold in schools, and other school-based wellness activities; must be developed with input from a broad group of stakeholders; and must be widely disseminated throughout the community.

State legislators can also help to increase physical activity by setting strong requirements for physical education in schools. The Physical Activity Guidelines for Americans recommend children and adolescents engage in at least one hour of physical activity daily,[20] and the Institute of Medicine recommends that children have opportunities to engage in an hour of physical activity at school each day,[21] half of which should be during the regular school day.[22] Quality physical education is the best way for youth to get a significant portion of their recommended physical activity, improve their physical fitness, and obtain the knowledge and skills they need to be physically active throughout their lifetimes.[23, 24, 25] Physical education may even increase students' academic achievement.[26, 27, 28, 29, 30] Physical education should be part of a comprehensive school physical activity program, which also provides opportunities for and encourages students to be active before, during and after school through recess, classroom physical activity breaks, walk-to-school programs, joint- or shared-use agreements that allow community use of school facilities and vice versa and after-school physical activity programs, such as competitive, intramural and club sports and activities. However, these other opportunities for physical activity before, during and after school should supplement – rather than supplant – physical education.

The Problem with Preemption

While some states and localities have advanced policies aimed at promoting healthier foods and beverages, other states have passed laws that would prevent localities within their state from doing so. For example, a law in Mississippi – the state with the highest obesity rate – prevents localities from taking action on policy relating to calorie labeling in restaurants, zoning to increase access to healthy foods and decrease access to fast-food restaurants and other unhealthy food vendors in underserved areas, and setting nutrition standards for restaurant meals that include toy giveaways, as a few examples. A similar bill became law in Ohio in 2012. It is important for localities across the country to have the opportunity to put their own innovative initiatives in place that have the potential to improve nutrition, increase physical activity, and decrease obesity in order to increase the evidence base. Just as is the case with tobacco control, local control is essential for good public health.

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

- Require students to engage in moderate to vigorous physical activity for at least 50 percent of physical education class time.
- Disallow automatic waivers or substitutions for physical education, including for students with disabilities, and prohibit students from opting out of physical education to prepare for other classes or standardized tests.

- Hire a state-level physical education coordinator to provide resources and offer support to school districts throughout the state and a district-level coordinator to provide support to physical education teachers.

- Require school districts or schools to complete comprehensive self-assessments of their physical education programs; report their findings to parents, community members and the school board; and integrate the results into the district or school's long-term strategic planning, improvement plan or wellness policy.

- Offer regular professional development opportunities to physical education teachers that are specific to the field and require physical education teachers to be highly qualified and certified.

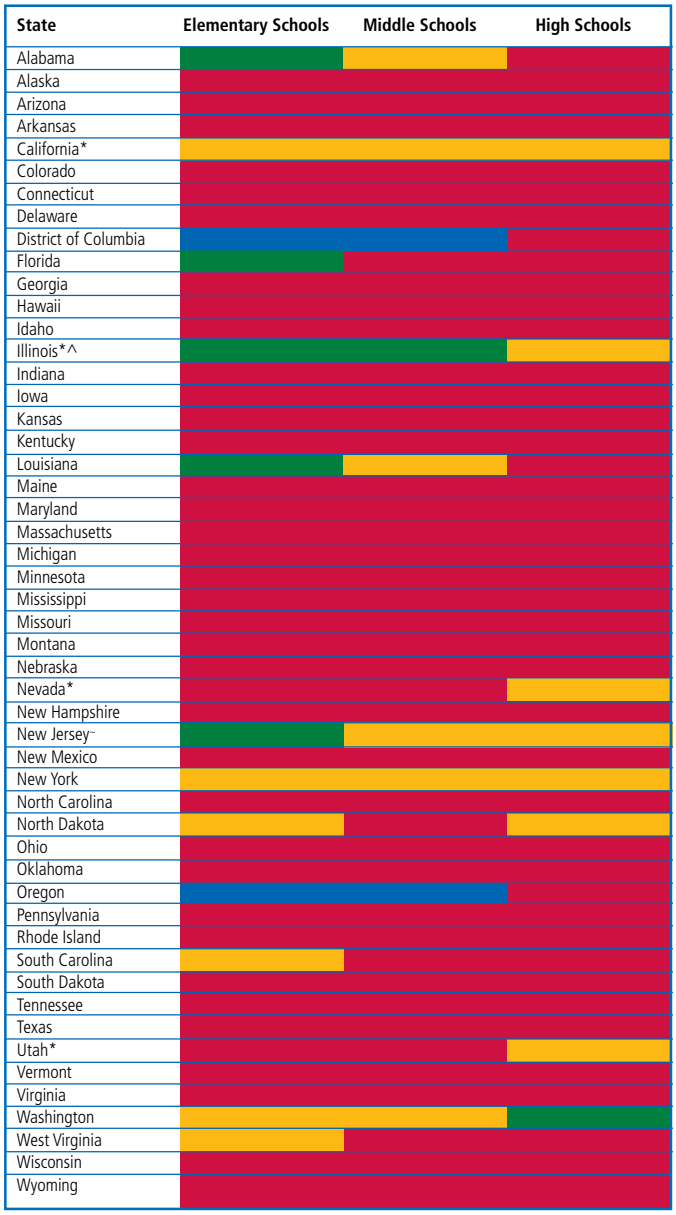
- Add valid fitness, cognitive and affective assessments in physical education based on student improvement and knowledge gain.

- Provide physical education programs with appropriate equipment and adequate facilities, and require class size consistent with other subject areas.

States should also support schools and school districts in increasing opportunities for additional school-based physical activity, as long as this does not come at the expense of physical education. Ways to increase physical activity include implementing classroom-based physical activity breaks, daily recess in elementary schools and before and after school physical activity programs. Such programs include competitive and intramural sports and activity clubs, walk-and-bike-to-school programs and joint-use agreements, in which the school allows community use of their facilities outside of school hours.

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

Physical Education Time Requirements



Key:

State requires at least 150 minutes per week of physical education at the elementary school level or at least 225 minutes per week at the middle and high school levels, for all grades

State requires at least 90 minutes per week of physical education for all grades, but less than the recommended 150 or 225 minutes per week

State requires less than 90 minutes per week of physical education or does not require physical education at all

Requirement is not yet in effect as of 7-1-13

Footnotes:

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

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

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

Sources:

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

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

Additional research by ACS CAN.

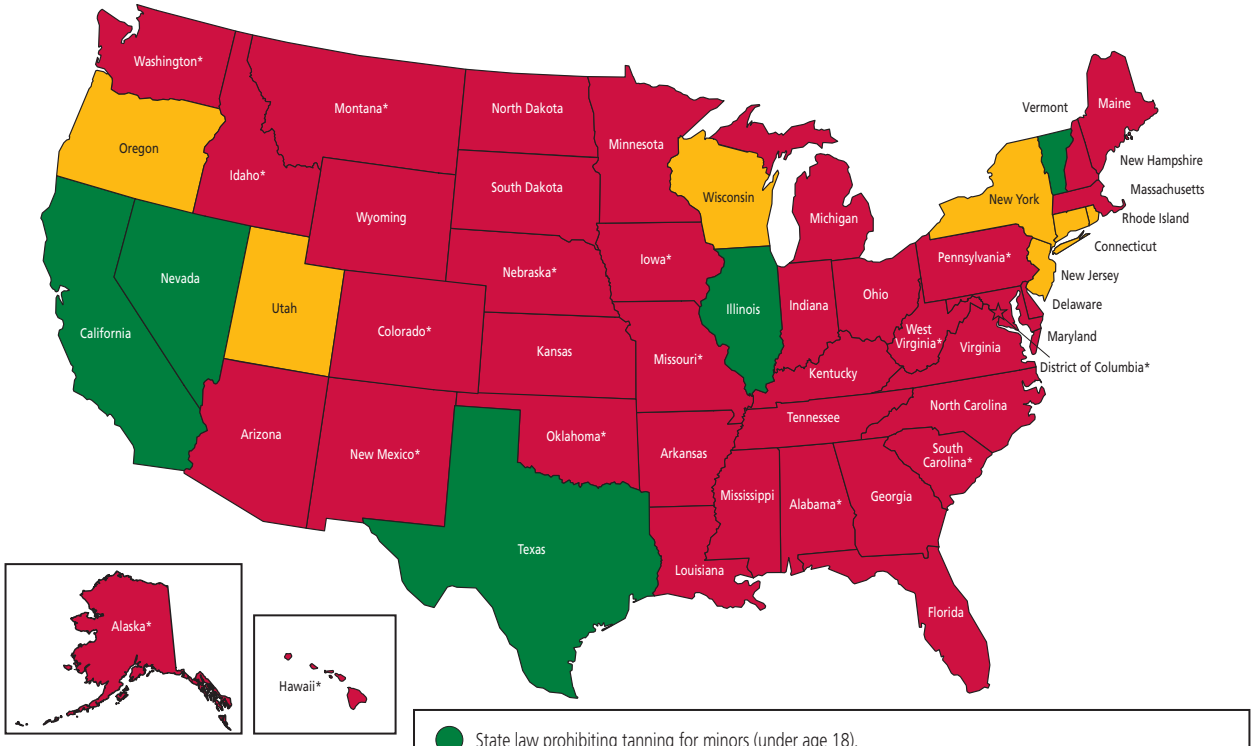
Indoor Tanning Beds

The Challenge

Skin cancer is the most prevalent type of cancer in the United States. The most deadly form of skin cancer, melanoma, has been increasing over the past 30 years,[1] and is one of the most commonly diagnosed cancers among young adults. The main cause of melanoma, and all skin cancers, is exposure to ultraviolet rays (UV) through the sun and/or tanning beds. UV exposure, particularly during childhood and adolescence, is an important predictor of future health consequences. That is why in 2009 the International Agency for Research on Cancer (IARC) elevated tanning devices to its highest cancer risk category – "carcinogenic to humans," a category that includes other harmful products such as asbestos and tobacco.

Melanoma rates have been increasing among young white women during the past few decades. The increase is widely thought to be a consequence of an elevated use of indoor tanning devices and exposure to UV radiation, especially due to the popularity of indoor tanning among teen girls. There is a general misconception among teens and young adults that a so-called base tan obtained by using indoor tanning devices will have a protective effect from excessive sun exposure when in fact, any sort of tan signifies DNA damage to the skin. Also, the tanning bed industry is not regulated as well as it should be in terms of exposure times and frequencies, education of employees, and information given to consumers. For instance, a recent survey of tanning salons showed that 71 percent of facilities would allow a teen to tan more often than the government's recommended limit of three times per week.[2]

State Tanning Bed Restrictions



State law prohibiting tanning for minors (under age 18).

State law prohibits tanning for those under 17 (NY, NJ, CT), or under 16 (WI). State law requires parental accompaniment for every visit for those under 18 (UT), allows for physician prescription under 18 (OR), or prohibits tanning for under age 18 unless a signed parental permission slip is obtained for every two visits (RI).

No state law regarding tanning (indicated with an *), state law prohibits those 14 or 15 or under, law allows for signed parental permission, or law requires parental accompaniment for every visit under 16 or younger.

Sources: Health Policy Tracking Service & Individual state bill tracking services
As of 7/17/13, the govenor has signed

How Do You Measure Up?

The Facts

- Melanoma is the most deadly of all skin cancers, with more than 9,480 deaths expected to occur in 2013.[3] An estimated 76,690 people will be diagnosed with melanoma in 2013 alone.[4]
- People who use indoor tanning booths before the age of 35 have a 59 percent increased melanoma risk, as well as a 67 percent increased risk of squamous cell carcinoma and a 29 percent increased risk of basal cell carcinoma, than individuals who never use indoor tanning devices.[5,6,7]
- Since 1988, teens reporting use of tanning beds have increased from 1 percent to 27 percent.[8]
- The 2011 National Health Interview Survey showed that more than 20 percent of girls in high school (grades 9 -12) reported using an indoor tanning device in the past year. Those in the12th grade had a much higher rate of tanning bed use at 32 percent.[9] This number decreases to just 9 percent when asking women 18 and over.[10]

The Solution

To help reduce the incidence of and mortality from skin cancer in the United States, ACS CAN supports state and local initiatives to prohibit the use of indoor tanning devices by those under the age of 18, ensure all consumers are properly informed of their risk prior to use and require all indoor tanning devices to be properly regulated with effective enforcement provisions in place. In May, the FDA announced their intentions to reclassify tanning beds from a class I device, which includes adhesive bandages and tongue depressors, to a class II device, which institutes stricter regulations to protect public health. ACS CAN believes that this is a step in the right direction, but doesn't go far enough to protect youth from the dangers of these devices.

ACS CAN is not alone in wanting to change behaviors and attitudes about tanning beds among youth. Many states across the nation have implemented laws that restrict the use of tanning beds by minors, and many are currently working to either improve their laws, which did not go far enough in protecting children, or implement laws where there were previously none. However, there is still a long way to go in protecting youth from melanoma. Laws that require parental consent, parental accompaniment, a physician's prescription, or restrict use to anyone under the age of 18, could do more to ensure that minors are protected. ACS CAN strongly encourages states to pass legislation prohibiting use of indoor tanning beds for all minors.

Success Story

Tanning bed regulation has continued to be an active issue this year for ACS CAN. In June, three states – Nevada, Texas and Illinois – became the third, fourth and fifth states in the nation to pass a comprehensive law that protects all minors from using tanning beds. In a western, conservative state like Nevada, legislation of this kind is a very difficult sell and it passed with large margins in both the state Assembly and Senate. The Silver State is a clear example of how we can pass a law like this in every state. Texas was another example of a state where it was tough-going to pass this type of legislation. Before passing this legislation, Texas's law was a prohibition for minors under 16.5. The ability for a state like Texas to pass a law like this proves that we can continue to strengthen laws that are currently in place. Illinois' law, coming off the heels of Chicago's and Springfield's local laws that prohibit minors from using tanning beds, was signed by the governor in mid-July.

Missed Opportunity

In early April, Maine passed comprehensive legislation that would have strengthened their existing law to protect all minors from the dangers of tanning bed usage. Governor LePage vetoed the bill almost immediately, and the state Senate fell five votes short of overriding his veto. We are very proud of the work that ACS CAN volunteers and staff did to pass this legislation and we will continue to work this issue in Maine until all children are protected.

Oregon passed a law this session that prohibits minors from using tanning beds unless they have a physician's prescription to use one. ACS CAN does not support this law due to the physician's prescription exemption and urges all states to pass comprehensive legislation that prohibits all minors from using tanning beds.

In 2014, many of the final provisions of the Affordable Care Act (ACA) will be implemented, creating many new health coverage options for people with cancer and their families. Millions of Americans will be able to access health coverage for the first time or will be able to afford better coverage that has previously been out of reach. While each state has implemented the law differently, it is important that decision makers support policies that connect citizens to newly available forms of health coverage, and enforce consumer protections guaranteed under the law that will help people with cancer and other chronic diseases.

Insurance Market Reforms

The Challenge

With the passage of the ACA, states have an unprecedented opportunity to reshape and improve their health coverage delivery system to fit the needs of their citizens. It is imperative that legislators and policymakers focus on the issues most critical to long-term reform that will best serve the interests of consumers and create a constructive competitive market for health services.

To implement the ACA fully, states must pass conforming legislation to align their insurance market rules with the new law and give the state insurance departments authority to enforce those rules. Areas where states may need to change their laws include age ratings, geographic ratings and guaranteed issue. States may also adopt laws that are more protective than the ACA. If states fail to make the necessary changes to their insurance markets, the Department of Health and Human Services (HHS) will enforce the ACA provisions of the law in that state.

In February, HHS issued the final regulation affecting state insurance markets, including age ratings, guaranteed issue, and tobacco ratings. States now have the direction they need to implement the ACA insurance market reforms and achieve a truly consumer-oriented, competitive market for health insurance, one that can both lower costs and improve access to quality health care.

Age Rating

Beginning in 2014, states may not vary age premiums by more than a 3:1 ratio. The rule implements the age rating through single-year age bands beginning at age 21 and ending at age 65. HHS also stipulates that the age-related rating factor can only be applied once a year, either at the time of issuance or at re-enrollment. Large increases in health insurance premiums make it very difficult for consumers to plan their household finances adequately from year to year. The use of single-year age bands helps consumers avoid sharp increases in premiums that would occur if the age bands were larger.

Despite the new age rating protections, concerns have been raised that some people, particularly younger adults, might see a dramatic increase in their health insurance premiums in 2014 as a result of the ACA. For most young Americans, the reality is quite different. Few young people have access to insurance through their jobs. As a result, insurance was simply out of reach for many young adults until the ACA: more than 19 million young people are uninsured. New options in 2014, including Medicaid, premium subsidies, catastrophic plans and guaranteed issue, will improve the lives of millions of young Americans. A recent study found that for insured individuals between 133 percent and 300 percent of the federal poverty level (FPL), there will be virtually no difference in net health care costs before and after the ACA.[1]

Guaranteed Issue

The ACA ensures that no one will be denied health insurance due to a pre-existing condition. This assurance is realized through the guaranteed issue provision, which requires insurers to accept all applicants

regardless of their claims history or health status. States may go further to ensure that consumers are not being wrongfully denied coverage by insurance companies.

Tobacco Ratings

The ACA allows insurers in the individual and small-group markets to charge tobacco users premiums up to 50 percent more than non-tobacco users. The final rule issued by HHS clarifies who may be considered a tobacco user and limits the look-back period to six months. The rule also clearly indicates that states have the authority to prohibit tobacco ratings in their markets or to adopt policies that lower the premium surcharge that can be imposed on smokers.

A health insurance surcharge (penalty) for tobacco use, which can lead to the chronic disease of tobacco addiction, is likely to produce adverse consequences. There is little evidence that financial incentives or disincentives through insurance premiums change individual behavior. In addition, while some people will be eligible to pay a reduced rate for their premiums through federal subsidies, the tobacco surcharge added on top of this reduced rate will likely cause premiums to remain unaffordable. As a result, higher health insurance premiums due to the tobacco surcharge will create an affordability barrier for individuals who need coverage the most.

In 2012, health insurance researchers Rick Curtis and Ed Neuschler analyzed the impact of a tobacco rating on California consumers. The study confirmed that allowing plans to charge smokers a higher premium will not only increase the price of health insurance, but also will likely result in greater numbers of uninsured. In California alone, between 200,000 and 400,000 people would remain uninsured due to the 50 percent surcharge making coverage unaffordable.[2] ACS CAN believes that this consequence goes directly against the purpose of the ACA – to provide access to quality, affordable health insurance to a greater population.

The Facts

The need for reform remains as important as ever:

- "Smokers with lower incomes who are eligible for premium tax credits would generally face prohibitively high health insurance premiums under the maximum 50 percent tobacco-rating factor allowed by the ACA."[3]

- Tobacco users, particularly smokers, are disproportionately members of a racial minority, are low-income, and are less educated than non-tobacco users. Native Americans have a smoking prevalence of about 33 percent, and the African American smoking prevalence is above 20 percent.[4] Thirty-four percent of the nearly poor and 31.4 percent of the middle-income population smoke in the U.S., while only 20 percent of those with higher incomes are current smokers.[5] Across all racial groups, those who are classified as nearly poor or middle income have higher smoking rates than those with higher incomes.[6]

- The vast majority of young adults ages 21 to 27 – 92 percent – who are expected to enroll in individual plans through the health insurance marketplaces have incomes below 300 percent FPL. These individuals likely would not face an increase in premium costs because they would be eligible for premium subsidies.

Next Steps for the States

As the nation moves closer to full implementation of the ACA in 2014, states must take critical steps to ensure that their insurance markets operate fairly for consumers and state insurance departments have the authority to enforce new market rules required under the law. These steps include:

- Passing conforming legislation to ensure that state laws are at least as protective as required by the ACA.

- Prohibit insurers from using tobacco as a ratings factor.

- Consider collecting data and reporting on the implementation of the 3:1 (or tighter) age rating, including changes to premiums, consumer comprehension and consumer experience in states using narrower age bands or alternative age curves.

- Subjecting geographic rating areas to a minimum population test to avoid unnecessary fluctuations in the geographic ratings factor.

- Requiring issuers to provide a consumer-friendly notification to those in the individual market on their special enrollment rights.
- Collecting data on denials of coverage to understand consumers' experience better in the marketplace.
- Requiring data collection and reporting on consumer experience and understanding of the allowed rating factors, special enrollment rights, and denials of coverage.
- Requiring all plans in the individual and small-group markets to post their summary plan descriptions (SPDs) or insurance contracts on their websites.

Implementing a Consumer-Based Health Insurance Marketplace

The Challenge

Health insurance marketplaces (also known as exchanges) will provide a one-stop shop for consumers to compare health plans, better understand benefits offered in each plan, and obtain premium subsidies to help pay for the plans they purchase. Each state's marketplace will play an integral role in achieving greater access to affordable health coverage in the individual and small-group markets. Marketplaces will be responsible for administering consumer assistance programs, ensuring that health plans are compliant with new ACA market reforms and seamless eligibility determination and enrollment coordination with state Medicaid programs. States must work to implement these policy areas fully in 2014 and closely monitor ways in which improvements can be made to increase access to coverage.

The 2014 open enrollment period is fast approaching, and state-based, partnership, and federally facilitated health insurance marketplaces must be ready to help consumers gain health coverage. HHS has supported states in their marketplace implementation process by awarding nearly $4 billion in planning, establishment and early innovator grants.[7] While the goal is for all states to work toward a state-based marketplace, HHS acknowledges that this process will move at a different pace in each state. Given this reality, HHS will continue to award establishment grants through the end of 2014 in hopes that every state will eventually run their own marketplace.[8]

The Facts

State-Based Marketplaces

As of July 1, 2013, 17 states and the District of Columbia have received conditional approval to run a state-based health insurance marketplace in 2014.[9] These states will be responsible for most aspects of their exchange marketplace, including administration of the state consumer assistance program; certification of qualified health plans (QHP) sold in the marketplace; operating a website and toll-free telephone line providing information on QHPs and allowing eligible consumers to purchase a plan; assigning ratings for plans based on quality and price; and determining eligibility for tax credits, cost sharing reductions, Medicaid coverage and exemptions from the requirement to purchase coverage.[10]

State-Based Marketplaces

California
Colorado
Connecticut
D.C.
Hawaii
Idaho
Kentucky
Maryland
Massachusetts
Minnesota
Nevada
New Mexico*
New York
Oregon
Rhode Island
Utah*
Vermont
Washington

Partnership Marketplaces

Arkansas
Delaware
Iowa
Illinois
Michigan
New Hampshire
West Virginia

*In 2014, New Mexico and Utah will operate a state-based marketplace for their small-group insurance markets and allow HHS to run the marketplaces for their individual insurance markets.

Partnership Marketplaces

In 2014, seven states will partner with HHS by opting to take on some of the primary functions of a federally facilitated marketplace (FFM).[11] Under this hybrid model, states may administer plan management functions, in-person consumer assistance functions, or both. States opting to carry out the plan management function will be responsible for certifying, recertifying and decertifying QHPs sold in the FFM. States that want to oversee the consumer assistance and outreach program will be responsible for constructing an adequate navigator and in-person assistance program that reaches all parts of the state. The partnership model allows states that are still working toward a state-based marketplace to remain as the primary point of contact for issuers and consumers.

Federally Facilitated Marketplaces

HHS will run the health benefits marketplace in the 26 states that have chosen not to implement a state-based marketplace or take on either function of the partnership model.[12] The federal agency will also carry out all marketplace functions, including stakeholder engagement, consumer assistance and outreach, eligibility determinations for insurance affordability programs, technical enrollment assistance for consumers, and plan management.

Health Benefit Marketplace Establishment Grants

The ACA authorizes funding for states to establish a marketplace through grants outlined in section 1311 of the law.[13] States setting up a state-based marketplace, building necessary components of a partnership FFM, or building integrations with a FFM are all eligible to apply for Establishment Grant funding through the end of 2014.

Establishment Grants are offered in both one-year (level one) and multi-year (level two) awards. Level-one grants are awarded to states that have taken initial steps toward setting up a marketplace under their planning grant. Level-two grants provide up to three years of funding and are intended for those states that are establishing a state-based marketplace. Establishment Grant funding is available to fund first-year operations fully of a state-based marketplace until: the end of the startup year during which coverage is provided through the marketplace; the time a state-based marketplace becomes self-sufficient; or when 1311 Establishment Grant funds have been fully exhausted, whichever occurs first.[14]

Deadlines for Marketplace Establishment Grant Applications

November 15, 2013
February 14, 2014
May 15, 2014
August 15, 2014
October 15, 2014

*Applications can be submitted at www.grants.gov, CFDA # 93.525.

Next Steps for States

- Regardless of the type of marketplace, states should implement policies that support coordination between the state Medicaid program and the health benefit marketplace.
- States should implement rules that give the state insurance departments authority to enforce ACA consumer protections for plans sold outside the marketplace in the same way they will be enforced for plans sold inside the marketplace.
- States wanting to set up a state-based marketplace should utilize grant funding for startup costs such as consumer outreach, development of IT and other communication systems, staff training and general needs related to first year of marketplace operation.
- States wanting to set up a partnership model FFM should utilize Establishment Grants to: fund the first year of activities related to consumer assistance, plan management or both; or to transition to and establish a state-based marketplace for the following year.

Navigators and Their Role in Successfully Implementing the ACA

The Challenge

The ACA establishes a new program of "navigators" within health insurance marketplaces. Navigators will play a particularly important role in assisting hard-to-reach populations, many of which currently lack health insurance, by helping consumers submit coverage eligibility applications and understand available coverage options. Unfortunately, some see the navigator program as potentially impinging on the role that has traditionally been served by insurance agents or brokers (commonly referred to as producers). The reality is that the need for assistance in the new system will far exceed the capacity of existing producers and new navigators combined.

The Facts

- Post-2014, producers will continue to provide a vital service to their traditional stakeholders. In fact, the likely expansion of enrollment in private insurance under the ACA is likely to increase the need and potential market for producers.
- Navigators will fill a significant need that is different from what is traditionally provided by producers, including knowledge of Medicaid. Navigators will also play the primary role of assisting the previously uninsured and underserved populations such as those with disabilities or language barriers that may have distinct challenges in accessing the new system.
- Navigators will not engage in the business of insurance; federal law expressly requires them to provide impartial information to consumers and prohibits navigators from being compensated by insurers. Navigators will not be paid to sell, solicit, or negotiate insurance contracts or premiums.
- The HHS program for federally facilitated and partnership marketplace navigators and assisters is being launched prior to the open enrollment period for 2014 which begins in October 2013. Entities that receive FFM navigator grants will have to pass a certification examination and will be subject to ongoing oversight by the exchange and the HHS.

Next Steps for States

ACS CAN urges all states to consider the following when making decisions related to the consumer assistance program:

- States should not establish training and licensing structures for navigators that are separate from those already under way at the FFM and would result in the unnecessary duplication of effort and inefficient use of resources.
- All states, including those that will not be operating the navigator program or the marketplace, should ensure that qualified organizations seeking to become navigators do not face unnecessary hurdles and that the program becomes a valuable and trusted resource for consumers.
- States that plan to develop and operate the marketplace's navigator program should take a broad look at the needs of state residents (particularly those who are uninsured) and establish an effective outreach and education strategy that will achieve the greatest rate of enrollment in new health coverage options.

Access to Prescription Drugs: Working to Improve Patients' Quality of Life

The Challenge

ACS CAN considers the availability and affordability of prescription drug medication an important component of its efforts to improve access to care for cancer patients. Currently, there are more than 40 FDA-approved oral cancer drugs and 900-plus cancer drugs in development. Clearly, there is enormous potential for improvements in care and quality of life for cancer patients as these drugs become approved.

Unfortunately, cancer treatment in the form of prescription drugs often comes with a much higher out-of-pocket (OOP) cost to the patient, compared to drugs administered intravenously. Many cancer medications that have become the standard of care for treating patients with

certain cancers are only available in oral form and have no IV equivalent, and this may be truer in the future as more cancer drugs are approved. Twenty-six states and the District of Columbia have addressed the issue by passing laws that require state-regulated health insurance companies to cover orally administered anticancer drugs "on a basis no less favorable than" IV-administered drugs.

The enactment of the ACA – and specifically, the essential health benefits (EHB) requirements established under the law – has significantly changed the public policy debate about access to affordable prescription drugs. Published by HHS in February, the final EHB regulation established a process of using benchmark plans for each state to define the essential benefits (including prescription drug coverage) required of health plans in the individual and small-group markets. The extent of the drug coverage may vary, depending upon the state's benchmark plan, and insurers may have the option to make changes in the benchmark plans array of drug offerings.

The Facts

- Although the ACA places limits on patient out-of-pocket (OOP) costs per year, cancer patients could still face significant costs for certain oral cancer treatments under the yearly OOP limit of up to $6,350 for an individual plan and $12,100 for a family plan.
- The EHB regulation does not prevent plans from using tiered formulary models, which typically place newer, more expensive drugs on a tier that requires a significantly higher OOP cost to the patient.
- The EHB regulation states that plans required to cover EHB must cover the greater of one drug per class[15] or at least the minimum number of drugs covered in each class under the state's benchmark plan.
- Insurers do not have to have the exact same drugs in each class as the benchmark plan, only the same number per class.
- Drugs in the same class of anti-cancer drugs are not necessarily interchangeable for treating a particular cancer. For example, if a drug used for breast cancer is not on the formulary, a patient often can't take one indicated for another cancer even though it is in the same class.
- The EHB regulation suggests that patients will have the right to request a medically appropriate drug if it is not on their plan's formulary.

Next Steps for States

ACS CAN's focus is on monitoring the implementation of the EHB in 2014 and advocating for the implementation of related provisions of the ACA to ensure cancer patients have access to all medically appropriate drugs. Moving forward, states can take the following action to ensure the EHB for prescription drugs is adequate in their QHPs:

- Enact policies to ensure that each state department of insurance has the authority to enforce EHB coverage, including prescription drug coverage, for all individual and group health plans sold inside and outside the health insurance marketplace.
- Enact policies that define a timely, consumer-friendly process when beneficiaries need to request a medically necessary drug that is not on their plan's formulary.
- Enact policies that prohibit discriminatory drug benefit designs that make certain cancer treatments (for which there is no alternative) unavailable or unaffordable (such as by placing the drug on a tier that imposes higher out-of-pocket costs).

Increasing Access to Medicaid Coverage

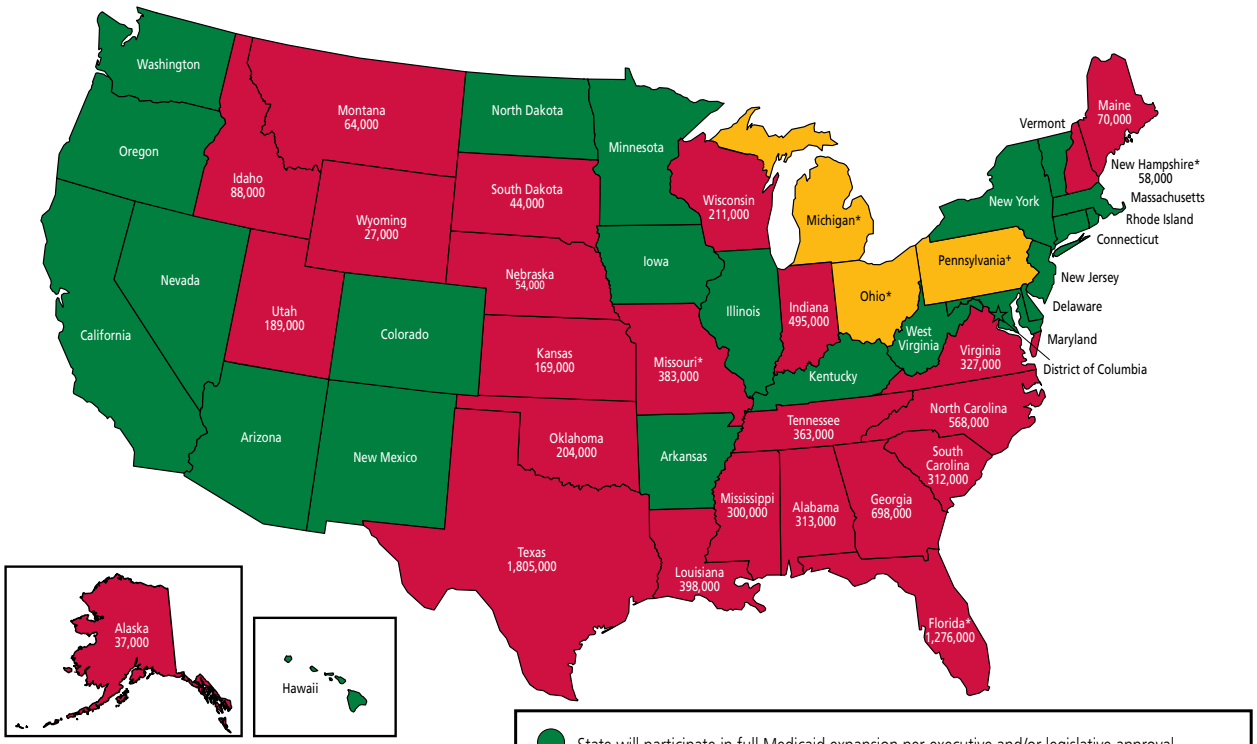
The Challenge

Medicaid is a free or low-cost public health program for certain low-income individuals that is jointly financed and administered by the federal government and the states. The federal government matches dollars spent by each state, on the condition that states cannot restrict coverage or establish waiting lists. For many low-income uninsured or underinsured individuals under the age of 65, Medicaid is the only coverage option for regular cancer care. States largely decide the breadth of Medicaid benefits, and must cover services in some broad categories. Many people believe that Medicaid covers all Americans living in poverty, but that is not the case. Currently, Medicaid serves only about half of those living under the poverty line.

Historically, health coverage through Medicaid was only available to certain "eligible" groups such as pregnant women, children, people who are disabled, some parents and women with breast or cervical cancer. The ACA gives states the option to expand health coverage to all people under 133 percent of the federal poverty level (about $15,282 for a single adult) through their Medicaid programs. Those new enrollees who do not belong to one of the previously eligible groups will be considered the "newly eligible." The ACA allows states to expand health care coverage to all low-income adults through Medicaid with an enhanced matching rate from the federal government. Under the ACA, the state receives a 100 percent match for 2014 - 2016, which will phase down to 90 percent by 2020.

State Decisions on Participation in Medicaid Expansion to 133% FPL

Beginning January 1, 2014



How Do You Measure Up?

Source: ACS CAN and Kaiser Commission on Medicaid and the Uninsured, The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis – November 2012
As of 7/1/13

Through Medicaid coverage, the newly eligible will be guaranteed access to the essential health benefits (EHBs), plus some additional benefits that are not typically provided by private insurance, but required by Medicaid. Combined, these benefits will be provided through a benchmark plan, known as an alternative benefit plan (ABP). ABPs must cover all 10 coverage categories of the EHB established in the ACA, including prescription drugs and preventive services. Although the drug coverage in the ABP is likely to be comprehensive, states still have flexibility to employ techniques intended to hold down costs that could have the potential to make access to some drugs cost prohibitive for cancer patients. As states choose their Medicaid benchmark plan, it is critical that they adopt plans that will provide adequate access to the health care needs of enrollees.

As states have considered providing health care coverage to the newly eligible population, they have sought clarification from the Centers for Medicare and Medicaid Services (CMS) regarding their implementation options. A number of states are utilizing a long-standing option to gain greater flexibility in their Medicaid program (for both the current and newly eligible populations), by requesting permission to waive certain provisions of the federal Medicaid requirements through a "waiver" request. Through these waiver requests, states are requesting permission to provide alternative delivery systems, modified benefits/services and targeted care/disease management to select populations. In response to these requests, CMS has been releasing guidance, clarifying the criteria that must be met for a waiver request to be eligible for the enhanced ACA matching rate. Such proposals would go through the 1115 Research & Demonstration waiver process and must be budget neutral, provide any wrap-around services and cost sharing required by Medicaid and end by December 16, 2016. If a state pursues an expansion proposal that does not cover all low-income adults or offer all of the required benefits and cost sharing, pending approval, it is likely that it would only be eligible to receive regular federal matching funds, not the enhanced match (100 percent through 2016 and no less than 90 percent in 2020 and thereafter).

If states choose not accept the federal funds available to cover more uninsured people through Medicaid, many hard-working adults and families below the poverty line will continue to lack access to health care coverage. They will not be eligible for federal subsidies and they may not be able to afford health coverage in the private market. The safety net for those who would otherwise be newly eligible for Medicaid is weak or nonexistent in many states.

Reductions in payments to hospitals that provide a large amount of uncompensated care will begin in October 2013 and continue through 2020, further straining the health care safety net. Furthermore, uncompensated or charity care seldom provides good prevention and screening services and is rarely able to provide for the costs of treating a potentially expensive disease like cancer.

The ACA contains a number of provisions that will improve the Medicaid program regardless of whether a state expands eligibility to the newly eligible population. These provisions include coordination with the health insurance marketplace in their state, changes to eligibility determinations, and changes to coverage options. State Medicaid programs must coordinate with their state exchange to ensure a seamless enrollment process for applicants. States may no longer use restrictive redetermination standards. All beneficiaries will remain eligible for Medicaid for at least 12 continuous months. States must convert the financial eligibility calculations to modified adjusted gross income (MAGI). Furthermore, states may no longer use asset tests in eligibility determinations for most beneficiaries. Finally,

Medicaid Benefits for the Newly Eligible – Alternative Benefit Plan

Essential health benefits

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

Other mandatory benefits

Non-emergency medical transportation
Federally qualified health center services
Early periodic screening, diagnostic, and treatment services (EPSDT) for children

all Medicaid benchmark plans, regardless of whether they are used to cover the new eligible population, must expand to include the EHBs.

ACS CAN believes that every American deserves access to adequate, affordable health coverage. For the ACA's Medicaid provisions to be successful, they must build on the solid foundation of the current Medicaid program.

ACS CAN supports states' efforts to create innovative solutions for delivering health care through their Medicaid programs. However, approaches that recommend block granting or placing per-capita spending restrictions on Medicaid are not recommended. Estimated cost savings through block grants and per-capita caps are imprecise, and federal funding would be set at a fixed amount based on projected health care costs, which would not automatically adjust for increases in health care expenses such as the current federal financing structure does. Consequently, states would have to shoulder the burden of all the program costs above the per-capita caps or block grants, which would likely result in drastic reductions in enrollee benefits and services.

The Facts

- Medicaid and the Children's Health Insurance Program (CHIP) cover approximately 25 percent of children with cancer and 9 percent of adults with cancer.
- Overall, only 28 percent of adults living in poverty are covered by Medicaid. Meanwhile, 45 percent of adults living in poverty are currently uninsured.[1]
- An estimated 17 million low-income people could gain coverage if all states chose to accept federal funds available to increase access to Medicaid coverage.[2]
- An estimated 11.5 million uninsured people with incomes below the poverty line are at risk of remaining uninsured if their states do not move forward and expand Medicaid.[3]
- Medicaid recipients are less likely to report financial problems. A 2011 study of the Oregon Medicaid expansion found that Medicaid enrollees were 40 percent less likely than their uninsured counterparts to report having to borrow money or skip payments on other bills because of medical expenses.[4]

The Solution

Ensuring access to care for hard-working, low-income adults and families is essential to the fight against cancer. The ACA offers states an opportunity to cover more such people through Medicaid, giving them the opportunity to receive recommended cancer screenings, which can prevent certain types of cancer or detect them early while the cancer can still be easily treated. A late-stage cancer diagnosis often necessitates high-cost treatment options and diminished odds of survival. ACS CAN supports improved access to the Medicaid program because it provides access to quality, affordable care, which is critical in saving lives from cancer. The Medicaid coverage expansions should:

- Cover all patients under 133 percent of the federal poverty level.
- Coordinate benefits with the EHB benchmark in the private insurance market.
- Improve Medicaid health systems. States are eligible to receive more money to develop simpler and more efficient information technology systems to modernize Medicaid enrollment.
- Ensure that enrollment and access to benefits are seamless for patients. This can be done by closely coordinating with the state exchange and certifying that any benefits and cost sharing provided through an alternative coverage proposal closely align with the EHB rules for the newly eligible.

ACS CAN believes that broadening Medicaid coverage to include all low-income adults will ensure that all Americans living in poverty who qualify for Medicaid will have routine access to cancer prevention, early detection and treatment services, which may allow them to live longer and healthier lives.

Success Story

Since the U.S. Supreme Court concluded that states are not required to increase access to Medicaid, ACS CAN has been actively encouraging states to accept the federal funds available to provide health coverage to more than 16 million Americans. ACS CAN's focused advocacy efforts have paid off in a number of states, including Arizona, Arkansas, Iowa and North Dakota. Months of

grassroots and media advocacy, public education and outreach resulted in the passage of legislation authorizing a number of states to accept the federal funds.

Arizona: Led by the efforts of Governor Jan Brewer, the Arizona legislature authorized the state to restore and extend coverage to working, low-income adults. An estimated 300,000 adults will benefit from the Medicaid Restoration Plan, many of whom will gain access to health care coverage for the first time and tens of thousands of individuals will have their coverage restored as a result of this legislative win.

Arkansas: Members of the Arkansas legislature came together to approve a plan to provide health care coverage to individuals under 133 percent FPL through premium assistance. Pending federal approval, Arkansas would be the first state to get permission to pay the premiums for the newly eligible population to receive their health care coverage from health plans operating in the state's marketplace/exchange. This innovative approach created a potential middle ground for a number of state legislators and governors considering ways to use available federal funds to cover more uninsured people through Medicaid.

Iowa: In the final hours of the legislative session, ACS CAN volunteer and staff advocacy efforts paid off with the passage of legislation authorizing the state to accept the federal funds and cover more than 150,000 currently uninsured Iowans. During the final debate, Senate President Pam Jochum recognized ACS CAN for its commitment, dedication and hard work on this issue.

North Dakota: A diverse coalition led by ACS CAN successfully urged the state to accept the federal funds, resulting in 32,000 individuals and families gaining access to health care coverage. A tenacious grassroots effort was a critical component of this win – with hundreds of volunteers responding to our calls to action, urging members of the legislature to accept the federal funds. The legislation passed both chambers with a comfortable majority and Governor Jack Dalrymple signed the authorizing bill into law days after the legislature adjourned.

Missed Opportunity

ACS CAN's efforts in Florida were not enough to convince the state legislature to accept the federal funds. Governor Rick Scott's support for Medicaid expansion greatly contributed to our advocacy in the Florida Senate, where Senator Joe Negron led the effort to reach an agreement that would allow the state to extend health care coverage to more than one million Floridians. However, a compromise deal could not be reached before the legislature adjourned. A diverse coalition came together to advocate for giving more low-income people access to Medicaid coverage, and we will continue our work to make sure that working, low-income individuals in Florida have access to adequate and affordable health care.

Funding for Breast and Cervical Cancer Screening

The Challenge

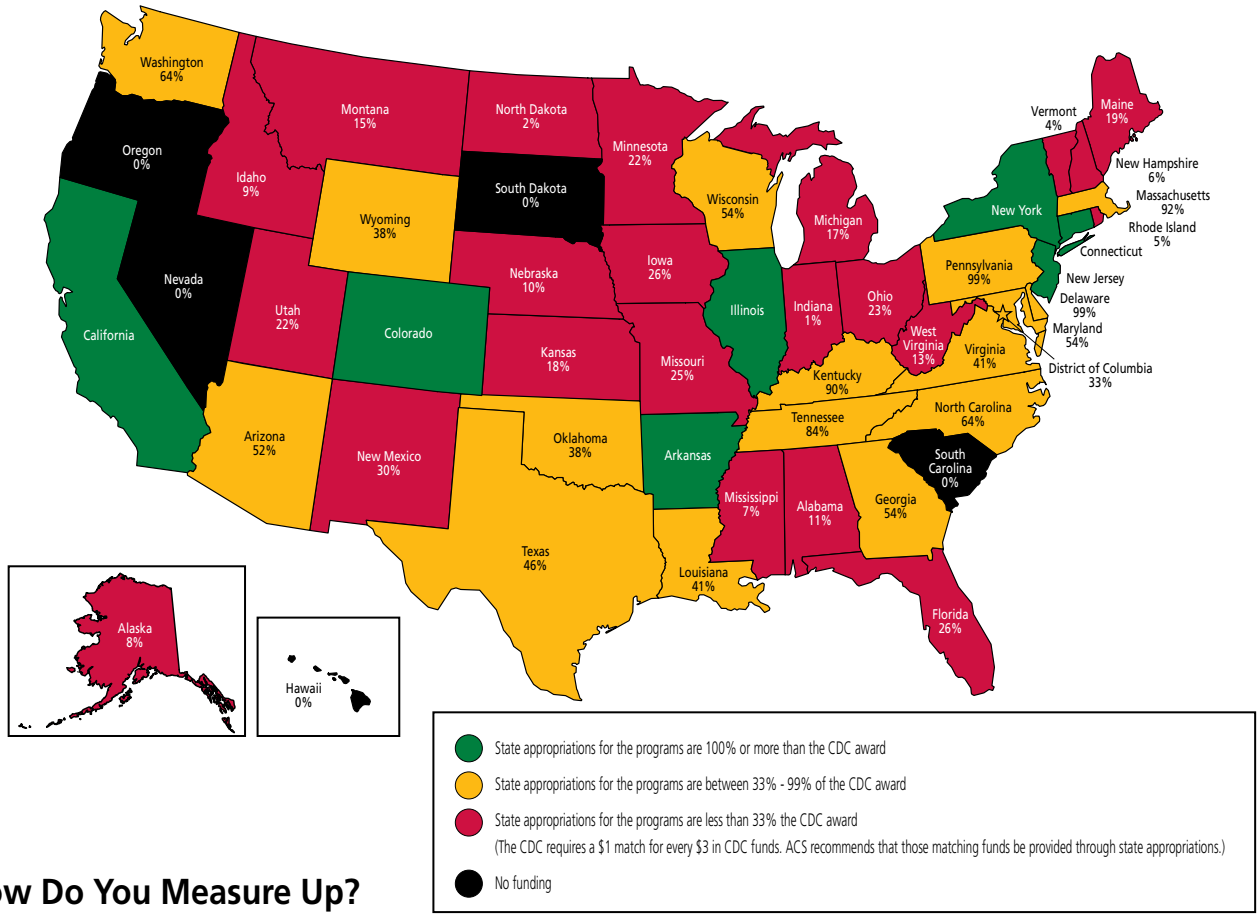
Early breast and cervical cancer detection saves lives. That is why the American Cancer Society recommends that women age 40 and older have yearly mammograms and that all adult women age 21 and older receive regular cervical cancer screenings.

Unfortunately, some Americans are forgoing preventive care and visits to the doctor due to financial concerns, making the need to protect women's access to preventive health services, including timely and appropriate access to breast and cervical cancer screenings, as important as ever.

The Facts – Breast Cancer

- Excluding skin cancer, breast cancer is the most frequently diagnosed cancer among U.S. women – an estimated 232,340 new cases of invasive breast cancer and 64,640 new cases of noninvasive breast cancer will occur this year.
- In 2013, an estimated 39,620 women will die from the disease, making it the second-leading cause of cancer death among women in the United States.
- A mammogram is the most accurate and cost-effective tool available to find breast cancer before symptoms appear. However, mammogram rates continue to be lower among Hispanic and Asian women, compared to white and African American women, as well as those who lack health insurance.

State Appropriations for Breast and Cervical Cancer Screening Programs - Fiscal Year 2012-2013



How Do You Measure Up?

American Cancer Society Cancer Action Network Updated July 1, 2013

Source: 2012-2013 data from the Centers for Disease Control and Prevention and unpublished data collected from ACS CAN and ACS Divisions, including input from NBCCEDP directors.

- 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 drastically to 24 percent.

The Facts – Cervical Cancer

- An estimated 12,340 new cases of cervical cancer will be diagnosed this year among women in the United States, and 4,030 women will die from the disease.
- 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 91 percent. However, when cervical cancer is diagnosed at an advanced stage, survival rates plummet to 16 percent.

The Changing Health Care Environment: Cancer Screening and the Uninsured

In partnership with state-administered breast and cervical cancer screening programs, the CDC's 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 care. Serving more than 4.3 million women and providing more than 10.7 million screening exams since 1991, the program has been able to detect more than 56,650 breast cancers, 3,200 invasive cervical cancers and 152,470 premalignant cervical lesions. In addition, women diagnosed through the program have access to treatment services through state Medicaid programs because of the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) of 2000. Currently, all 50 states and the District of Columbia are participating in the voluntary Medicaid treatment program.

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

The ACA is changing the layout of the health care system, but that does not mean that services provided by the NBCCEDP or the BCCPTA program will no longer be needed. In fact, according to a recent study by the George Washington University in collaboration with ACS CAN, the American Cancer Society, and the CDC, the current level of funding for the NBCCEDP is not enough to screen all women who would remain eligible for the program in 2014 and beyond. This is especially true for states that choose not to expand their Medicaid eligibility to individuals up to 133 percent of the federal poverty level, leaving those in the most need without access services.

While a vast majority of the population will have access to affordable health insurance in 2014, a number of people will continue to face barriers to care, including those who will not be required to have insurance, those who may not be able to afford a plan, or those who have a plan that does not cover preventive screening services. Others live in geographically isolated areas and communities with literacy-related barriers. With much of the eligible population gaining increased access to insurance, the NBCCEDP will be able to put a stronger focus on hard- to-reach populations by providing services to help women overcome barriers to care. In addition, the NBCCEDP can expand its focus to helping all women get screened since many women, even those with health insurance, face barriers including understanding risk and/or physician recommendations for additional screening/monitoring, awareness and education, and access to screening.

Program Cuts Putting Women at Risk

Nearly half of all states reduced funding for their Breast and Cervical Cancer Early Detection Program (BCCEDP), and these funding reductions are affecting low-income women in a number of different ways.

The Solution

Early breast cancer detection is the single most important factor to surviving the disease. However, lack of adequate insurance coverage makes people less likely to be screened for cancer and puts them at significantly greater risk for late-stage diagnosis of disease and poorer prognosis.

Program Cuts Putting Women at Risk

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

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

Note: Funding amounts are those that are lower in fiscal year 2013 than in fiscal year 2012.

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.

State policymakers must ensure that income and insurance status are not barriers to cancer screenings. State policies supporting education and the maintenance of their BCCEDP, through adequate funding or funding based on the need for services, are critical to ensuring all eligible women receive these lifesaving services.

In fiscal year 2013, NBCCEDP federal funding was reduced by 10 percent compared to 2012 due to the federal funding cuts known as sequestration and other federal funding cuts. This drastic cut will result in tens of thousands of fewer cancer screenings provided by the program. Any further state or federal funding cuts will have devastating consequences to women who rely on this proven program for raising awareness and providing lifesaving cancer screenings. ACS CAN and the One Voice Against Cancer Coalition are advocating for Congress to increase annual funding for this program to the full $275 million authorized in 2007.

In addition to the efforts to fund the program adequately at the federal level, states must take legislative action to support this lifesaving program as well. Several states have appropriated funds above the required match to expand their screening program capacities and thus serve more eligible women. Recognizing their fiscal constraints, a few states have leveraged funding from other public and private sources to expand the program's reach.

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

Success Story

State budget constraints continue to put cancer screening program funding at risk. However, several states are making meaningful investments in these critical safety net programs.

New Jersey: In recent years, funding for the New Jersey Cancer Education and Early Detection (NJCEED) Screening Program only allowed the program to serve 20 percent of the eligible population. A lack of funding resulted in growing waiting lists, providers turning patients away, and the closing of several screening sites. This past year, New Jersey volunteers and staff took the message of sites closing and the growing need for screening and treatment services to the governor and legislature. Coupled with the risk of additional screening site closures, ACS CAN successfully advocated for an additional $3.5 million in state funding for the program, resulting in a total state appropriation of $9.5 million, which will provide thousands of New Jersey residents' access to cancer screenings and life-saving treatment services.

Arizona: This past year, ACS CAN's advocacy efforts paid off for women seeking greater access to screening and treatment services. As a result of our efforts, women eligible for Well Woman HealthCheck Program (WWHP) can now receive low/no cost breast or cervical cancer screening services from any health care provider in the state. In addition, the Arizona legislature passed their FY 2013 budget with an additional $2 million, improving access to health care coverage and cancer treatment services for women diagnosed through the state's WWHP.

Legislative Call to Action

ACS CAN strongly urges states to follow the science when developing new screening and coverage legislation. Over the past several months, a number of breast cancer bills have been introduced mandating specific insurance coverage and/or dictating how physicians should practice medicine based on questionable research and data. Additionally, although technological innovation brings new tools to the market to find and treat diseases, not every new discovery is scientifically shown to be better and more effective than those that already exist. Many tools have been developed that have the ability to detect breast cancer early, including film and digital mammography (including tomosynthesis), magnetic resonance imaging (MRI), various ultrasound technologies, thermography, diaphanography, electronic impedance techniques, etc. However, among these technologies, only mammography has been shown to be effective for breast cancer screening in average-risk women.

While some of these efforts may be well-intended, implementing these types of mandates could result in overuse of tests that have not been shown to be effective and lead to increased anxiety among those undergoing them. As such, policymakers should perform a comprehensive analysis of the subject matter and the impact of legislation that dictates how medical professionals should practice medicine and mandates the use of new screening tests in their state. ACS CAN recommends that state mandates be consistent with American Cancer Society screening guidelines.

Colorectal Cancer Screening Coverage

The Challenge

Early detection is one of the most fundamental factors in diagnosis, successful treatment and reduced mortality for colorectal cancer. Colonoscopy, the most thorough colorectal cancer screening examination, allows for the identification and removal of polyps in the colon. By removing polyps before they become cancerous, cancer can be prevented before it begins.

The Affordable Care Act has made great strides in ensuring that all men and women have access to colonoscopy and other colorectal cancer screening exams by requiring that most insurance companies cover all United States Preventive Services Task Force (USPSTF) "A" and "B" recommended services with no cost sharing (copayments/deductibles) to the patient. The USPSTF gives an "A" recommendation for colorectal cancer screening, using either fecal occult blood testing, sigmoidoscopy or colonoscopy for people ages 50 to 75. However, the recommendations set forth by the USPSTF remain unclear as to what parts of the colonoscopy need to be covered with no cost sharing. This resulted in numerous patients being charged for their colonoscopy when a polyp was found and removed, effectively violating the requirement that no cost sharing be imposed for this preventive service. As such, the Department of Health and Human Services (HHS) released guidance in February 2013, clarifying that the polyp removal during colonoscopy is in fact part of the screening procedure and patients should not be charged for a diagnostic exam. The guidance set forth by HHS clarifies the law, but it does not mandate that insurers and providers cannot attempt to impose cost sharing on patients.

The Facts

- This year, an estimated 140,820 people will be diagnosed with colorectal cancer in the United States and about 50,830 will die from the disease,[1] making colorectal cancer the second leading cause of death among men and women in the U.S.[2]
- Of those who will die from colorectal cancer this year, screening could have saved more than half.[3]
- The rate of colorectal cancer screening is much lower among racial minorities and the medically underserved.[4]

The Solution

To ensure that all patients are able to receive a colonoscopy without having to worry about cost sharing for polyp removal, ACS CAN is asking that each state pass legislation that requires insurance companies to abide by the guidance issued by HHS. This would ensure that all eligible patients receive a no-cost colonoscopy regardless of whether a polyp is removed.

The Challenge

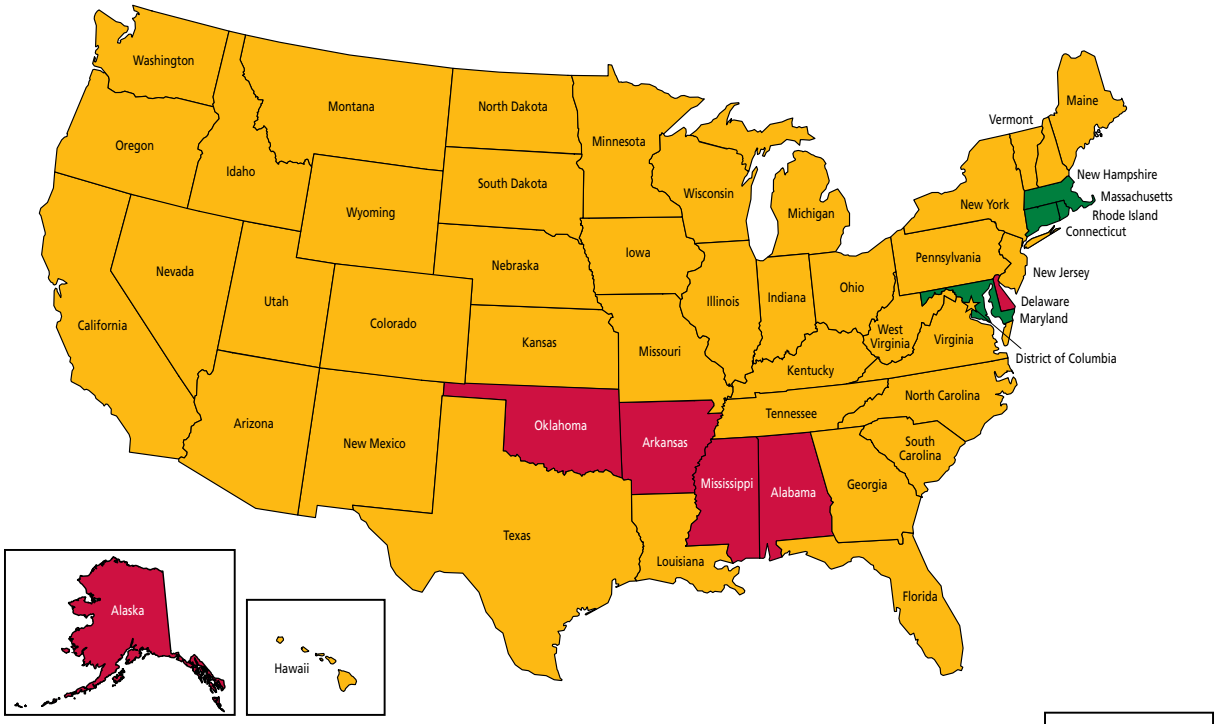
Thanks to modern medicine, people are living longer with serious, chronic and complex illness such as cancer. But today's health care system is fragmented in a way that makes it difficult to navigate – just when the medical needs of chronically ill patients are growing at a rapid rate.

Moreover, studies have consistently shown that these patients endure untreated pain and other symptoms, lengthy hospitalizations involving unwanted, often futile and costly medical treatments and low overall family satisfaction – particularly with the quality of their hospital care. Add to this scenario the fact that today's health care consumers, especially baby boomers, are aging and experiencing increased health care demands.

Palliative care is the new paradigm that can meet these rising demands. It is the medical subspecialty focused on providing relief from the symptoms, pain, and stress of serious illness. The goal is to improve quality of life for both the patient and the family. It is appropriate at any age and any stage of disease and can be provided along with curative treatment.

Palliative care provides interdisciplinary coordination and team-driven continuity of care that best responds to the episodic and longer-term nature of serious, multifaceted illness. And because palliative care efficiently uses hospital resources and delivery systems, it provides patients, medical institutions, the health care system and clinicians with an ongoing, effective and inclusive solution to a growing and difficult challenge.

Palliative Care Across the United States



How Do You Measure Up?

Source: ACS CAN – Points derived from 2012 National Palliative Care Report Card grade
A = 4 points, B= 3 points, C= 2 points, D= 1 point F= 0 points
Add one point if state is creating a palliative care/QOL advisory group or introduced ACS CAN state model legislation
Add one point if state introduced ACS CAN model legislation with two or more provisions
As of 7/1/13

The Facts

- By 2030, the number of people in the United States over the age of 85 is expected to double to 8.5 million.
- The prevalence of palliative care in U.S. hospitals with 50 or more beds has increased 157 percent over the past 11 years, yet millions of adults and children facing serious illness do not yet have access to palliative care services from the onset of disease to help ease their suffering.
- Palliative care is expected to increase as the public becomes more aware of its benefits. Recent public opinion research reveals that once people are informed about palliative care, 92 percent report they would be highly likely to consider it for themselves or their families if they had a serious illness.
- Palliative care programs provide higher-quality care for patients and a better bottom line for hospitals – reducing lengthy stays, lowering costs, and avoiding the often futile high utilization of critical care and other hospital resources.
  - — On average, palliative care consultation is associated with reductions of $1,700 per admission for live discharges and reductions of $4,900 per admission for patients who die in the hospital.
  - — This means savings of more than $1.3 million for a 300-bed community hospital and more than $2.5 million for the average academic medical center.

The Solution

Palliative care is essential to achieving the goal of excellent yet cost-effective care. It helps patients complete treatments, including rehabilitation to address impairments, and improves quality of life for patients, survivors, and caregivers. Studies show that cancer patients receiving palliative care during chemotherapy are more likely to complete their cycle of treatment, stay in clinical trials and report a higher quality of life than similar patients who did not receive palliative care.

According to a 2010 study conducted at Massachusetts General Hospital and released in the New England Journal of Medicine, patients with metastatic lung cancer who received palliative care showed improved quality of life and less depression, and lived nearly three months longer than patients who received usual care alone.

People facing serious illness want the types of services that palliative care provides – and they expect today's hospitals, cancer centers and other care settings to deliver. The pillars of palliative care involve:

- **Time** to devote to intensive family meetings and patient/family counseling
- **Expertise** in managing complex physical and emotional symptoms such as pain, shortness of breath, depression, and nausea
- **Communication and support** for resolving family/patient/physician questions concerning goals of care
- **Coordination** of care transitions across health care settings

The public recognizes the benefits of this added layer of support from a palliative care team focused on quality of life. The patient-centered, holistic information and clear communication these teams provide enable patients and families to share in the important decisions they need to make as a result of the illness and treatment options.

To benefit from palliative care, patients and families must be able to access these services in their local hospital or other care settings. In addition, health professionals in training must learn from direct experience at the bedside with high-quality palliative care teams. ACS CAN supports policy initiatives that train the health care workforce, invest in research, and improve patient access to palliative care.

ACS CAN urges legislators to help frame palliative care as a core component of quality care and tap the expertise of palliative care specialists and other stakeholders to advise development, implementation, and evaluation of statewide strategies and policies to:

1. **Educate the public about palliative care.** In partnership with state departments of health and community stakeholders, provide palliative care information online and through other channels to help consumers and clinicians understand palliative care and the benefits of integrating it with disease-directed treatment for all seriously ill adults and kids.

2. **Improve access to palliative care services.** Encourage policies requiring routine screening of patients for palliative care needs and facilitating access to palliative care services in all health care settings serving seriously ill adults and kids (e.g., hospitals, cancer centers, nursing homes, assisted living facilities, home care agencies).

3. **Boost generalist palliative care clinical skills.** Foster dissemination of proven training interventions and other strategies that enhance generalist palliative care competencies, including clinical communication skills, among all practicing health professionals and students of medicine, nursing, and other professions to align educational requirements and professional practices with current evidence demonstrating the importance of integrating palliative care alongside disease-directed treatment.

4. **Preserve access to pain therapies for people in pain.** Implement balanced policies that promote delivery of integrated pain care for all people facing pain, including preserving access to prescription medications and other therapies, as well as improving workforce training in pain assessment, management, responsible prescribing, and use of prescription monitoring programs.

Success Story

Four states passed legislation this session that focus on improving patient quality of life through palliative care. ACS CAN's model legislation's goals are to establish a state multi-disciplinary advisory council made up of state palliative care and health care experts and to empower the state health department to provide via its website a central point of current information designed to raise public, patient and provider awareness regarding palliative care in that state. Both Rhode Island and Connecticut were able to pass laws this session that incorporate many of the important components of the model legislation, including the establishment of a state multi-disciplinary expert advisory council.

Also this session, Maryland finally crossed the finish line with a palliative care bill after a three-year effort. Although ACS CAN had concerns about the bill when it was first introduced, we successfully advocated to strengthen the bill.

ACS CAN is hopeful that more states will pass legislation that meets our criteria, as was done in Rhode Island this session. With the evidence clear and the momentum building in all parts of the country, ACS CAN stands willing and able to work with all legislators who share the desire to create a health care system where palliative care is available.

Cancer Pain Control: Advancing Balanced State Policy

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. Still more troubling, significant pain treatment and access disparities in medically underserved and socioeconomically disadvantaged populations continue to be documented.

Generally recognized as a mainstay of treatment for moderate to severe cancer pain, opioid analgesics, or painkillers, pose particular policy challenges. These controlled substances tend to trigger a dueling policy and practice debate for physicians, who must consider the interface between providing pain relief and curbing diversion and abuse. Adding to the challenge, the growing misuse and abuse of prescription pain medicines and confusion about addiction, dependence and tolerance all contribute to patient and family fears about using pain medications, as well as health professionals' reluctance to prescribe them.

Combating illegal use of prescription drugs is necessary, but it is also important to ensure that well-intentioned efforts to curb drug abuse do not cause harm to the patients these medicines are intended to help. These challenges call out the need to promote balanced public policies that will make medications available to patients who need them while also keeping those medications away from those who intend to misuse them.

The Facts

- Pain associated with cancer can almost always be relieved, yet it is a problem in at least 60 percent of patients in active treatment, more than 60 percent with advanced disease and at least 30 percent after treatment concludes.
- Cancer-related pain can interfere with the ability of patients to adhere to recommended treatments and can devastate quality of life – affecting work, appetite, sleep and time with family and friends.
- Significant pain treatment disparities, as well as access to pain medicine disparities, exist among medically underserved populations.
- Treatment barriers also can occur due to stringent or unclear practice requirements found in state policies governing health care, and many authorities have called for the evaluation and improvement of such policy.
- Policies that encourage appropriate pain management, and consider it an expected part of health care practice, are preferable to those that provide no positive guidance to clinicians, use outdated terminology, or establish unduly strict prescribing requirements or ambiguous treatment standards.

The Role of State Policies Governing Pain Management Issues

The practice of health care professionals, including the legitimate use of pain medications, is governed by state policies. Such policies are intended to prevent illicit drug trafficking and abuse and substandard practice related to prescribing and patient care, and can recognize pain relief as an expected part of treating patients. However, in some states these policies can negatively affect legitimate health care practices and create undue burdens for clinicians and patients, resulting in interference with appropriate pain management. Studies also have shown that practitioners often are unaware of the legal standards established in law, which of course can impede conformity to such standards.

In response to these challenges, a series of reports has been developed to evaluate state policies that affect pain management. The most recent reports are titled "Achieving Balance in Federal and State Pain Policy: A Guide to Evaluation" (*Evaluation Guide 2012*) and "Achieving Balance in State Pain Policy: A Progress Report Card" (*Progress Report Card 2012*). *Evaluation Guide 2012* presents findings from a systematic, criteria-based evaluation of policies that have been adopted by the federal government, the 50 states and the District of Columbia; language identified using the evaluation criteria could either enhance pain care or, conversely, create treatment restrictions or ambiguities. Progress Report Card 2012 presents a grade for each state for 2012, based on the evaluation results, which can then be compared to a state's grade in previous years to measure improvement in policy over time. These are tools that can be used by government and nongovernment organizations, as well as policymakers, health care professionals and advocates, to understand the policy in their state that reinforces appropriate pain care or that can hinder patient access to effective treatment. Ultimately, policy improvement efforts guided by these resources will achieve more positive and consistent state policy governing the medical use of controlled substances for pain management (acute cancer and non-cancer pain), palliative care and end-of-life care.

The Solution

A state's ability to promote safe and effective pain management, while minimizing policy barriers to such practice, is dependent on the strength of its pain policies. Although the grade for a specific state (which is a simple metric representing policy quality) can be found in Progress Report Card 2012, a complete illustration of the policy language contributing to that grade is found in Evaluation Guide 2012.

Pain policy improvements without bedside implementation have little value. Many licensed practitioners are not fully aware of the policies that govern pain management, including prescribing pain medication. Professional licensing boards should disseminate widely and frequently the policies that affect practitioners and pain management. Improvements in a state's policy should also be communicated to those who implement the policy and are affected by it, including practitioners and the public, but also administrators, investigators and attorneys. Policy content must also be understood and adhered to. In this way, policy can contribute to safe and effective pain management practice while maintaining standards that minimize pain medication abuse and diversion.

ACS CAN challenges state legislatures to continue enacting policies that promote pain control and responsible pain

medicine prescription practices to relieve suffering and improve quality of patient care, while also preventing illegal use of prescription pain medicines. Policy makers also should work with ACS CAN, state pain initiatives and our many other community partners to increase opportunities for enhancing public awareness and professional education offerings about pain assessment, treatment options, and prescription practices so that patients receive better pain control and practitioners provide it.

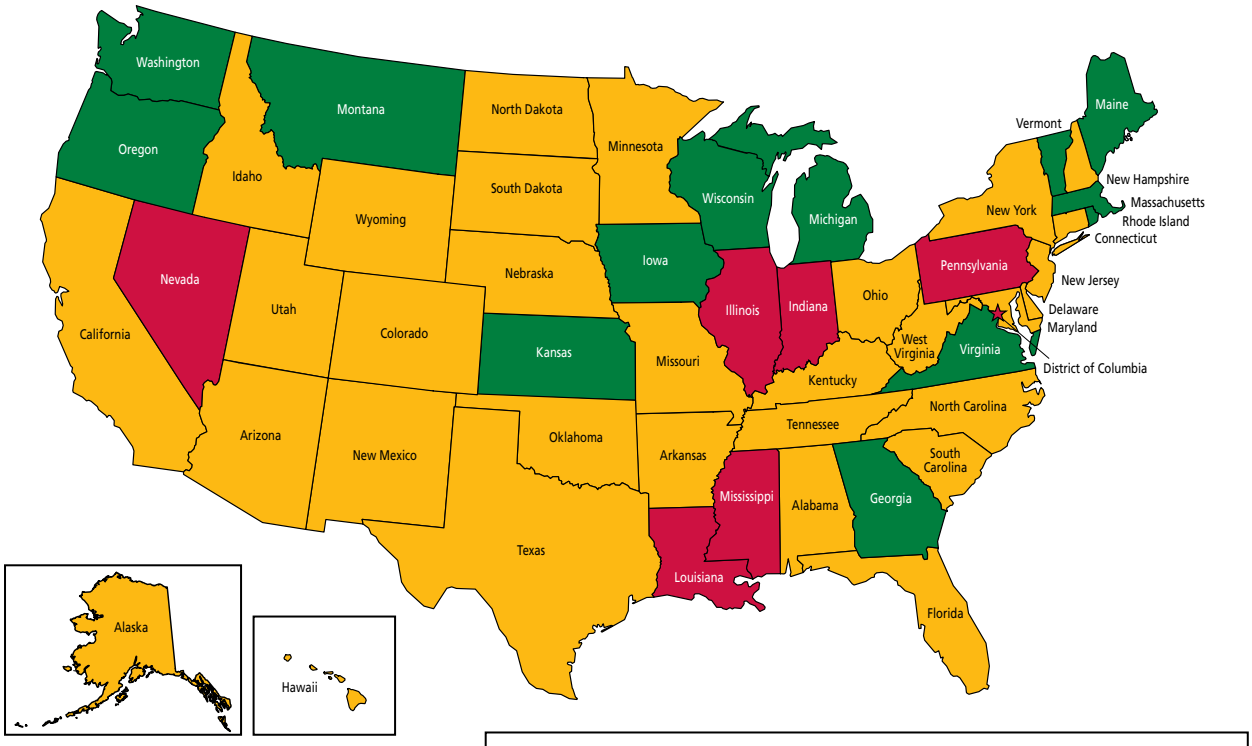
Success Story

Just six years ago, Georgia had a D+ grade on the Pain Progress Report Card, prepared by the University of Wisconsin's Pain and Policy Study Group. But with the right strategic plan and a coordinated coalition effort, the pain policy landscape has changed dramatically and the state now earns an A.

Over the past several years, ACS CAN and the statewide pain coalition in Georgia have worked to remove problematic language from state law and regulations while adding positive provisions to both and they have worked to get the state's medical, nursing and pharmacy boards to adopt model prescribing guidelines. It didn't happen overnight and it was not easy, but a committed coalition with numerous active partners along with a strategic plan that was designed specifically for Georgia made all the difference.

Several other states, including Delaware, Iowa, Montana and Wyoming, have also dramatically improved their grade in the past five years, thanks to targeted effort and the right strategic plan. ACS CAN stands ready to help lawmakers and advocates in all states with a strategic plan designed specifically for your state's unique policy situation in an effort to help all states get to an A grade.

Current Pain Policy in the States



How Do You Measure Up?

Source: Pain Policy Studies Group (PPSG) at the University of Wisconsin. For more information on this report card, please visit: http://www.painpolicy.wisc.edu/sites/www.painpolicy.wisc.edu/files/prc2012.pdf
As of 7/1/13

References

Tobacco Excise Taxes

1 The 2012 version of this report noted that the District of Columbia's cigarette tax was $2.86 per pack and Minnesota's was $1.60 per pack. These amounts included a sales tax collected at the wholesale level of approximately 36 cents. The tax rates, and resulting averages, reported in this year's version no longer include the sales tax amounts for those two locations. As a result, the average state excise tax is reported as approximately one cent lower than it would have been otherwise.
2 Centers for Disease Control and Prevention. *Sustaining State Programs for Tobacco Control: Data Highlights 2006.* Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2006.
3 Chaloupka FJ. "How Effective are Taxes in Reducing Tobacco Consumption?" Available at http://tigger.uic.edu/~fjc/Presentations/Papers/taxes_consump_rev.pdf.
4 Chaloupka FJ. "The Impact of Proposed Cigarette Price Increases." Policy Analysis No. 9, Health Science Analysis Project, Advocacy Institute, 1998. Available at http://tigger.uic.edu/~fjc/Presentations/Papers/hsap_policy9.pdf.
5 Centers for Disease Control and Prevention. Consumption of Cigarettes and Combustible Tobacco – United States, 2000-2011. *MMWR* 2012; 61(30): 565-569.
6 Centers for Disease Control and Prevention, 2012.

Smoke-Free Laws

1 U.S. Department of Health and Human Services. *How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking- Attributable Disease.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2010.
2 U.S. Department of Health and Human Services. *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2006.
3 Max W, Sung H-Y, and Shi Y. "Deaths from Secondhand Smoke Exposure in the United States: Economic Implications." *American Journal of Public Health* 2012; 102: 2173-2180.
4 U.S. Department of Health and Human Services. *How Tobacco Smoke Causes Disease: A Report of the Surgeon General.* Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2010.].
5 American Nonsmokers' Rights Foundation. Overview List – "How Many Smokefree Laws?" April 1, 2013. Available at http://www.no-smoke.org/pdf/mediaordlist.pdf.
6 Centers for Disease Control and Prevention. "State Smoke-Free Laws for Worksites, Restaurants and Bars – United States, 2000-2010." *MMWR* 2011; 60(15): 472-475.
7 King BA, Babb SD, Tynan MA, and Gerzoff RB. "National and State Estimates of Secondhand Smoke Infiltration Among U.S. MultiUnit Housing Residents." *Nicotine & Tobacco Research* 2012; Epub ahead of print.
8 Centers for Disease Control and Prevention. "Disparities in Secondhand Smoke Exposure – United States, 1988-2004 and 1999-2004." *MMWR.* 2008; 57: 744-747.
9 Centers for Disease Control and Prevention. "Vital Signs: Current cigarette smoking among adults aged 18 years—UnitedStates, 2009." *MMWR* 2010; 59: 1135–40.
10 U.S. Department of Health and Human Services, 2006.
11 U.S. Department of Health and Human Services, 2006.
12 Task Force on Community Preventive Services (http://www.thecommunityguide.org/tobacco/tobac-AJPM-recs.pdf). "Recommendations Regarding Interventions to Reduce Tobacco Use and Exposure to Environmental Tobacco Smoke." *American Journal of Preventive Medicine* 2001;20(2S):10-5.
13 Eriksen M and Chaloupka F. "The Economic Impact of Clean Indoor Air Laws." *CA: A Cancer Journal for Clinicians* 57(6): 367-378, November 2007.
14 Institute of Medicine. *Ending the Tobacco Problem: A Blueprint for the Nation.* Washington, D.C.: National Academies Press, 2007.
15 President's Cancer Panel. U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute. *Promoting Healthy Lifestyles: Policy, Program and Personal Recommendations for Reducing Cancer Risk.* 2006-2007 Annual Report: President's Cancer Panel. August 2007.
16 King BA, Alam S, Promoff G, et al. "Awareness and Ever Use of Electronic Cigarettes Among U.S. Adults, 2010-2011." *Nicotine & Tobacco Research* 2013; published online ahead of print.
17 King et al, 2013.

Emerging Tobacco Products

1 U.S. Department of Health and Human Services. *The Health Consequences of Using Smokeless Tobacco: A Report of the Advisory Committee to the Surgeon General.* Atlanta, GA, 1986.
2 Substance Abuse and Mental Health Services Administration. *Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings.* 2011. Available at http://www.samhsa.gov/data/NSDUH/2k10NSDUH/2k10Results.htm.
3 U.S. Department of Health and Human Services. *Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General.* Atlanta, GA, 2012.
4 Federal Trade Commission. "Federal Trade Commission Smokeless Tobacco Report for 2007 and 2008." 2011. Available at http://www.ftc.gov/opa/2011/07/tobacco.shtm.
5 American Cancer Society. *Cancer Prevention & Early Detection Facts & Figures, 2012.* Atlanta, GA, 2012.
6 Raad D, Gaddam S, Schunemann HJ, et al. "Effects of Water-Pipe Smoking on Lung Function: A Systematic Review and Meta-Analysis." Chest 2011; 139(4): 764-774.
7 Schubert J, Hahn J, Dettbarn G, et al. "Mainstream Smoke of the Waterpipe: Does This Environmental Matrix Reveal As Significant Source of Toxic Compounds?" *Toxicology Letters* 2011; 205(3):279-84.
8 Jacob P, Raddaha AH, Dempsey D, et al. "Nicotine, Carbon Monoxide and Carcinogen Exposure After a Single Use of a Water Pipe. *Cancer Epidemiology, Biomarkers, & Prevention* 2011; 20(11):2345-53.
9 Barnett TE, Curbow BA, Soule EK, et al. "Carbon Monoxide Levels Among Patrons of Hookah Cafes". *American Journal of Preventive Medicine* 2011; 40(3): 324-328.
10 Singh S, Soumya M, Saini A, et al. "Breath Carbon Monoxide Levels in Different Forms of Smoking." *The Indian Journal of Chest Diseases & Allied Sciences* 2011; 53(1): 25-28.
11 Eissenberg T and Shihadeh A. "Waterpipe Tobacco and Cigarette Smoking: Direct Comparison of Toxicant Exposure". *American Journal of Preventive Medicine* 2009; 37(6): 518-523.

Tobacco Cessation Services

1 All coverage status is as of December 2012.
2 American Cancer Society. *Cancer Facts & Figures 2011.* Atlanta, 2011.
3 Centers for Disease Control and Prevention. "Quitting Smoking Among Adults – United States 2001-2010". *MMWR.* 60:44, November 11, 2011.
4 Fiore MC, Bailey Jaen CR, Baker TB, et al. *Treating Tobacco Use and Dependence.* 2008 Update. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008.
5 Fiore et al, 2008.
6 Fiore, et al.

Tobacco Control Program Funding

1 Campaign for Tobacco-Free Kids. *A Broken Promise to Our Children: The 1998 State Tobacco Settlement 14 Years Later.* November 2012.
2 Centers for Disease Control and Prevention. "Smoking-Attributable Mortality, Years of Potential Life Lost and Productivity Losses—United States, 2000–2004." *MMWR* 2008; 57(45):1226–8.
3 Campaign for Tobacco-Free Kids, 2012.
4 Campaign for Tobacco-Free Kids, 2012.
5 Campaign for Tobacco-Free Kids, 2012.
6 Campaign for Tobacco-Free Kids, 2012.
7 Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs - 2007.* Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; October 2007.
8 Centers for Disease Control and Prevention, 2007.

Obesity, Nutrition and Physical Activity

1 Kushi LH, Doyle C, McCullough M, et al. "American Cancer Society Guidelines on Nutrition and Physical Activity for Cancer Prevention: Reducing the Risk of Cancer With Healthy Food Choices and Physical Activity." *CA: A Cancer Journal for Clinicians* 2012; 62:30-67.
2 Kushi et al, 2012.
3 Kushi et al, 2012.
4 Centers for Disease Control and Prevention. "Adult Participation in Aerobic and Muscle-Strengthening Physical Activities – United States, 2011." *MMWR* 2013; 62(17): 326-330.
5 Centers for Disease Control and Prevention. Youth Online: High School YRBS. 2011 Results. Available at http://apps.nccd.cD.C..gov/YouthOnline/App/Results.aspx?TT=&OUT=&SID=HS&QID=QNPA0DAY&LID=&YID=&LID2=&YID2=&COL=&ROW1=&ROW2=&HT=&LCT=&FS=&FR=&FG=&FSL=&FRL=&FGL=&PV=&TST=&C1=&C2=&QP=G&DP=&VA=CI&CS=Y&SYID=&EYID=&SC=&SO=. Accessed May 6, 2013.
6 U.S. Department of Agriculture and U.S. Department of Health and Human Services. "Figure 5-1: How Do Typical American Diets Compare to Recommended Intake Levels or Limits?" *Dietary Guidelines for Americans*, 2010. 7th Edition, Washington, D.C.: U.S. Government Printing Office, January 2011.
7 Kushi et al, 2012.
8 Kushi et al, 2012.
9 Rock CL, Doyle C, Damark-Wahnefried, et al. "Nutrition and Physical Activity Guidelines for Cancer Survivors." *CA: A Cancer Journal for Clinicians* 2012; published online ahead of print.
10 Flegal KM, Carroll MD, Kit BK and Ogden CL. "Prevalence of Obesity and Trends in the Distribution of Body Mass Index Among US Adults, 1999-2010." *Journal of the American Medical Association* 2012; 307(5).
11 Flegal et al, 2012.
12 Ogden CL, Carroll MD, Kit BK and Flegal KM. "Prevalence of Obesity and Trends in Body Mass Index Among US Children and Adolescents, 1999-2010." *Journal of the American Medical Association* 2012; 307(5).

13 Ogden C and Carroll M. "NCHS Health E-Stat: Prevalence of Obesity Among Children and Adolescents: United States, Trends 1963-1965 Through 2007-2008.". Division of Health and Examination Surveys, National Center for Health Statistics. Centers for Disease Control and Prevention. June 4, 2010. Available at http://www.cD.C..gov/nchs/data/hestat/obesity_child_07_08/obesity_child_07_08.htm.
14 Finkelstein EA, Trogdon JG, Cohen JW, Dietz W. "Annual Medical Spending Attributable to Obesity: Payer- and Service-Specific Estimates." *Health Affairs* 2009; 28(5): w822-w831.
15 Centers for Disease Control and Prevention. "Recommended Community Strategies and Measurements to Prevent Obesity in the United States." *MMWR* 2009; 58(7): 1-30.
16 Institute of Medicine and National Research Council, *Local Government Actions to Prevent Childhood Obesity.* Washington, D.C.: National Academies Press, 2009.
17 Institute of Medicine. *Accelerating Progress in Obesity Prevention: Solving the Weight of the Nation.* Washington, D.C.: National Academies Press, 2012.
18 White House Task Force on Childhood Obesity. *Solving the Problem of Childhood Obesity Within a Generation. Report to the President.* May 2010.
19 U.S. Department of Agriculture and U.S. Department of Health and Human Services. *Dietary Guidelines for Americans 2010.* Available at www.dietaryguidelines.gov.
20 U.S. Department of Health and Human Services. *2008 Physical Activity Guidelines for Americans*. Available at http://www.health.gov/paguidelines/.
21 Institute of Medicine, 2012.
22 Institute of Medicine. *Educating the Student Body: Taking Physical Activity and Physical Education to School.* Washington, D.C.: National Academies Press, 2013.
23 U.S. Department of Health and Human Services. *Physical Activity Guidelines for Americans Midcourse Report: Strategies to Increase Physical Activity Among Youth.* 2013. Available at www.health.gov/paguidelines.
24 Kahn EB, Ramsey LT, Brownson RC, et al. "The Effectiveness of Interventions to Increase Physical Activity: A Systematic Review." *American Journal of Preventive Medicine* 2002; 22(4):73-107.
25 Kahn et al, 2002.
26 Singh A, Uijtdewilligen L, Twisk JW, et al. "Physical Activity and Performance at School: A Systematic Review of the Literature Including a Methodological Quality Assessment." *Archives of Pediatrics & Adolescent Medicine* 2012;166(1):49-55.
27 Coe DP, Pivarnik JM, Womack CJ, et. al. "Effect of Physical Education and Activity Levels on Academic Achievement in Children." *Medicine & Science in Sports & Exercise* 2006;38:1515-1519.
28 Castelli DM, Hillman CH, Buck SM, and Erwin HE. "Physical Fitness and Academic Achievement in Third- and Fifth-Grade Students." *Journal of Sport & Exercise Physiology* 2007; 29:239-252.
29 Sallis, JF, McKenzie, TL, Kolody, B., Lewis, M., Marshall, S., Rosengard P. "Effects of Health-Related Physical Education on Academic Achievement." *SPARK. Research Quarterly for Exercise and Sport* 1999; 70(2): 127-134.
30 Institute of Medicine, 2013.

Indoor Tanning Beds

1 American Cancer Society. *Cancer Facts & Figures, 2013.* Atlanta: American Cancer Society; 2013.
2 Pichon LC, Mayer JA, Hoerster KD, et al. "Youth Access to Artificial UV Radiation Exposure: Practices of 3647 US Indoor Tanning Facilities." *Archives of Dermatology* 2009; 145(9):997-1002.
3 American Cancer Society, 2013.
4 American Cancer Society, 2013.
5 International Agency for Research on Cancer. *Exposure to Artificial UV Radiation and Skin Cancer: Working Group Reports*. 2006, Volume 1. Available at http://www.iarc.fr/en/publications/pdfs-online/wrk/wrk1/ ArtificialUVRad&SkinCancer.pdf.
6 International Agency for Research on Cancer. "The Association of Use of Sunbeds With Cutaneous Malignant Melanoma and Other Skin Cancers: A Systematic Review." *International Journal of Cancer* 2007; 120(5): 116-1122.
7 Wehner, et al. "Indoor Tanning and Non-Melanoma Skin Cancer: Systematic Review and Meta-Analysis." *British Medical Journal.* 2012; 345: e5909
8 Robinson JK, Kim J, Rosenbaum S, Ortiz S. "Indoor Tanning Knowledge, Attributes and Behavior Among Young Adults from 1988-2007." *Archives of Dermatology* 2008; 144(4): 484-488.
9 Centers for Disease Control and Prevention. "Youth Risk Behavior Surveillance System – United States, 2011." *MMWR* 2012; 61(SS04);1-162
10 Centers for Disease Control and Prevention. "Use of Indoor Tanning Devices by Adults – United States, 2010." *MMWR* 2012; 61(18):323-326.

Coverage: Cancer Care and the Affordable Care Act

1 Blumberg LJ and Buettgens M. "Why the ACA's Limits on Age-Rating Will Not Cause "Rate Shock": Distributional Implications of Limited Age Bands in Nongroup Health Insurance." Robert Wood Johnson Foundation and Urban Institute. March 2013. Available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf404637.
2 Curtis.
3 Curtis, Rick and Ed Neuschler, Institute for Health Policy Solutions, June 2012.
4 IOM, 2010.
5 IOM, 2010.
6 IOM, 2010.
7 http://www.statehealthfacts.org/comparetable.jsp?ind=964&cat=17#notes-1
8 http://cciio.cms.gov/Archive/Grants/exchanges-map.html
9 http://cciio.cms.gov/resources/factsheets/state-marketplaces.html
10 http://www.healthcare.gov/news/factsheets/2011/07/exchanges07112011b.html
11 http://cciio.cms.gov/resources/factsheets/state-marketplaces.html
12 http://cciio.cms.gov/resources/files/ffe-guidance-05-16-2012.pdf
13 http://www.healthcare.gov/law/full/patient-protection.pdf (pg. 130)
14 http://cciio.cms.gov/resources/factsheets/hie-est-grant-faq-06292012.html
15 The drug classification system will be defined using the US Pharmacopeial Convention (USP) standards, also used for Medicare Part D.

Increasing Access to Medicaid Coverage

1 Kaiser Family Foundation. *The Medicaid Program at a Glance*. 7235-02. 2009.
2 FamiliesUSA Medicaid Calculator. Available at: http://www.familiesusa.org/issues/medicaid/other/medicaid-calculator/medicaid-calculator.html, See also FamiliesUSA Medicaid Calculator Methodology Based on the U.S. Department of Commerce Economic Model. April 2008.
3 Kenney G, Dubay L, Zuckerman S, and Huntress M. "Opting Out of the Medicaid Expansion under the ACA: How Many Uninsured Adults Would not Be Eligible for Medicaid?" Urban Institute. July 2012.
4 Baiker, Katherine and Finkelstein, Amy. "The Effects of Medicaid Coverage: Learning from the Oregon Experiment." *New England Journal of Medicine* 2011; 365: 683-685.

Screening: Funding for Breast and Cervical Cancer Screening

1 American Cancer Society. Cancer Facts & Figures 2013. Atlanta: American Cancer Society; 2013.
2 American Cancer Society. Cancer Facts & Figures 2013. Atlanta: American Cancer Society; 2013.
3 American Cancer Society. Cancer Prevention and Early Detection Facts & Figures 2013. Atlanta: American Cancer Society; 2013.
4 National Cancer Institute. Surveillance, Epidemiology and End Results Survey. "SEER Stat Fact Sheet: Breast." 2013. Available at http://seer.cancer.gov/statfacts/html/breast.html.
5 American Cancer Society. Cancer Facts & Figures 2013. Atlanta: American Cancer Society; 2013.
6 American Cancer Society. Cancer Prevention and Early Detection Facts & Figures 2013. Atlanta: American Cancer Society; 2013.
7 National Cancer Institute. Surveillance, Epidemiology and End Results Survey. "SEER Stat Fact Sheet: Cervix Uteri." 2013. Available at http://seer.cancer.gov/statfacts/html/cervix.html.
8 Centers for Disease Control and Prevention. National Breast and Cervical Cancer Early Detection Program (NBCCEDP) – About the Program. Available at http://www.cdc.gov/cancer/nbccedp/about.htm. Accessed April 22, 2013.
9 Centers for Disease Control and Prevention. National Breast and Cervical Cancer Early Detection Program (NBCCEDP) – About the Program. Available at http://www.cdc.gov/cancer/nbccedp/about.htm. Accessed April 22, 2013.
10 Levy A, Bruen B, Ku L. "Health Care Reform and Women's Insurance Coverage for Breast and Cervical Cancer Screening." *Preventing Chronic Disease* 2012; 9.
11 Ward E, Halpern M, Schrag N, et al. "Association of Insurance with Cancer Care Utilization and Outcomes." *CA: A Cancer Journal for Clinicians* 2008; 58(1): 9-31.
12 Pyenson B. *Cancer Screening: Payer Cost/Benefit thru Employee Benefits Programs*. November 2005.

Colorectal Cancer Screening Coverage

1 American Cancer Society. *Cancer Facts & Figures 2013.* Atlanta: American Cancer Society; 2013.
2 American Cancer Society. *Cancer Prevention and Early Detection Facts & Figures 2013*. Atlanta: American Cancer Society; 2013.
3 American Cancer Society. *Cancer Prevention and Early Detection Facts & Figures 2013*. Atlanta: American Cancer Society; 2013.
4 American Cancer Society. *Cancer Prevention and Early Detection Facts & Figures 2013*. Atlanta: American Cancer Society; 2013.

Palliative Care: A New Paradigm for Managing Serious and Chronic Illness

1 Center to Advance Palliative Care. *Growth of Palliative Care in US Hospitals: 2012 Snapshot*. http://www.capc.org/capc-growth-analysis-snapshot-2011.pdf (accessed July 16, 2013).
2 Center to Advance Palliative Care. *2011 Public Opinion Research on Palliative Care: A Report Based on Research by Public Opinion Strategies*. Washington, D.C.. http://www.capc.org/tools-for-palliative-care-programs/marketing/public-opinion-research/2011-public-opinion-research-on-palliative-care.pdf (accessed July 16, 2013)
3 Morrison RS, Penrod JD, Cassel JB, et al. Cost savings associated with US hospital palliative care consultation programs. *Arch Intern Med*. 2008 Sep 8;168(16):1783-90.
4 Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. *N Engl J Med*. 2010 Aug 19;363(8):733-42.

888-NOW-I-CAN
www.acscan.org