How Do You MEASURE UP?

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

16th Edition

2018

Cancer Action Network℠
American Cancer Society®

EMBARGOED UNTIL AUG. 9, 2018 at 12:01 AM EST

Our 16th Edition

The 16th edition of *How Do You Measure Up?* illustrates how your state stands on issues that play a critical role in reducing cancer incidence and death. Every day, legislators at the state and local levels are making decisions that affect cancer patients and their families. Policy decisions, such as access to health insurance coverage for lifesaving cancer screenings and treatment, access to cancer drugs, investments in research, tobacco control and prevention policies, and funding for prevention and screening programs are all issues that could be decided by state and local lawmakers. Changes in laws for the better can affect millions of people, exponentially expanding and enhancing the efforts of American Cancer Society Cancer Action Network to eliminate cancer as a major health problem.

Table of Contents

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

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

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

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

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

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

To become a member of ACS CAN, visit www.acscan.org/donate.

How Do You Measure Up?

Our 16th Edition

We're closer than ever to a day when a cancer diagnosis is no longer life threatening. We have a better understanding of the causes of many cancers and what we need to do to prevent the disease. Thanks to investments in cancer research that have led to an astounding number of scientific breakthroughs, we can better treat the disease by more accurately targeting cancer cells and have improved screenings that help detect cancer earlier. Today, we also know that by living an active lifestyle, eating a healthful diet, not using tobacco products and getting recommended screenings, **we can prevent nearly half of all cancer deaths.**

Achieving a world free from the pain and suffering of cancer requires a comprehensive public policy agenda. Our mission, and thus our work, includes a strong focus on preventing cancer, seeking new cures and treatments and ensuring all Americans have access to the medical care that could save their lives. We also support the determination and courage of cancer patients and survivors by working to improve their quality of life both during treatment and after it has ended.

The 16th edition of *How Do You Measure Up?* illustrates where states stand on issues that play a critical role in reducing suffering and death from cancer. The goal of every state should be to pass policies in accordance with guidelines set by the American Cancer Society Cancer Action Network (ACS CAN) based on evidence of proven policy solutions. Achieving "green" denotes policies that align with ACS CAN policy criteria on each map measuring cancer prevention and access issues. By implementing the solutions set forth in this report, lawmakers can stand and fight back against this disease – preventing it before it starts, helping those who have been diagnosed to find the care they need, and ultimately saving lives. Additionally, these public policy approaches have the potential to save millions and perhaps billions of dollars through health care cost reductions and increased worker productivity.

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

How does your state measure up?

Access to Care

Ensuring All Americans Have Access to Affordable, Quality Health Insurance

Access to Care Introduction

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

Access to health care is a significant determinant in whether an individual diagnosed with cancer will survive. Individuals without health insurance are more likely to be diagnosed with cancer at a later stage and more likely to die from the disease.[1] The American Cancer Society Cancer Action Network (ACS CAN) believes all Americans should have access to affordable, quality health insurance.

Fortunately, in recent years there has been an increase in the number of Americans who have health insurance coverage.[2] Since the creation of insurance marketplaces in 2014, Americans have had access to comprehensive coverage that includes many consumer protections that are vitally important to cancer patients – insurance companies can no longer deny coverage or charge more due to pre-existing conditions, insurers may no longer impose arbitrary caps on coverage, and all insurance offered to individuals must cover a broad set of benefits called essential health benefits.

However, challenges remain. Many cancer patients encounter difficulty finding specialists who participate in their insurance plan's network, affording their prescription medications, and understanding their out-of-pocket expense liability because of the lack of transparency around prescription drug formularies and insurance company practices.

In addition, there has been a great deal of debate at the federal level regarding the fate of the marketplaces. In 2017, Congress spent considerable time debating legislative proposals that would repeal and replace the Affordable Care Act (ACA). None of the proposals debated would have provided equivalent patient protections critical to cancer patients as those existing under current law. ACS CAN and other patient groups were successful in deterring those efforts. While the Affordable Care Act and most of its provisions remain law, federal and state regulatory and legislative approaches have the potential to seriously impact access to insurance and health care for cancer patients and survivors.

Access to Care

Ensuring All Americans Have Access to Affordable, Quality Health Insurance

Federal Activities

On October 12, 2017, the Department of Health and Human Services (HHS) announced that it would immediately stop funding the cost-sharing reduction (CSR) subsidies provided for under the Affordable Care Act. Under the law, individuals whose income is between 100 and 250 percent of the federal poverty level (FPL) qualify for subsidies to help them afford the out-of-pocket costs related to their health insurance coverage (e.g., deductibles, copayments, coinsurance). Insurers are required to provide lower-cost CSR plans to qualifying individuals and families – and until October 2017, the federal government subsidized those plans by reimbursing the insurers. In no longer making the CSR payments, the insurers still have to provide the benefits, but now they no longer receive the reimbursement. To make up for the lost subsidies, as predicted, insurers raised premiums for plan year 2018. Nationally, the unsubsidized premium for the lowest-cost bronze plan in the individual markets increased an average of 17 percent, and the lowest-cost silver plan increased an average of 32 percent.[3] These increases are especially challenging for individuals who do not qualify for subsidized coverage.

Additionally, the current administration chose to reduce significantly its education and outreach funding in 2017,[4] meaning significant reductions in engagement efforts to consumers about plan year 2018 open enrollment and plan options. While enrollment numbers for plan year 2018 appear to be similar to previous years despite this significantly reduced federal effort, concerns remain about enrollment trends in future years and the abilities of non-governmental groups to continue outreach and enrollment efforts.

In December 2017, as part of the tax bill,[5] Congress repealed the individual mandate penalty beginning January 1, 2019. This provision of the ACA requires individuals to pay a fine if they fail to maintain health insurance. Removing this incentive for staying insured in 2019 is likely to have negative effects on marketplaces. The nonpartisan Congressional Budget Office has estimated that repealing the mandate will result in the number of insured individuals decreasing by four million in 2019, and 13 million in 2027, and premiums increasing by about 10 percent for each of the next 10 plan years.[6]

Finally, the administration has implemented or proposed several regulatory changes that impact state efforts and access to insurance. On April 9, 2018, the administration finalized a rule that weakens the Essential Health Benefit coverage standards. Early in 2018 the administration also proposed two rules – one expanding access to Association Health Plans[7] and one expanding access to Short-Term Limited Duration policies[8] – that would segment the market, increase premiums for comprehensive health plans, and leave enrollees in these plans with inadequate coverage.

State Activities

As states face uncertainty from the federal government, many states have implemented policies that seek to improve the individual market for their constituents.

State Individual Mandates

With the federal individual mandate penalty expiring at the end of 2018, a few states have begun considering state-level individual mandates requiring state residents to maintain health insurance. Massachusetts implemented a state individual mandate requirement before the implementation of the ACA and never rescinded it, thus this state mandate will be maintained once the federal one ceases to be enforced.[9]

Success Story

Individuals with cancer can be vulnerable under the best of circumstances, but when natural disasters strike, those vulnerabilities can become scarier, costlier and even deadly. That is why when Puerto Rico suffered one of the most destructive Atlantic storms on record, Hurricane Maria, the American Cancer Society Cancer Action Network (ACS CAN) stepped up to ensure that many cancer patients received the help they needed. ACS CAN was able to arrange care for four patients at the National Institutes for Health in Bethesda, MD as well as connect health care providers with American Cancer Society (ACS) colleagues to provide care for some cancer patients at their facilities around the country. ACS CAN also worked with the American Society for Radiology Oncology (ASTRO) and ACS to better coordinate, offer transportation, and assist with communications on the ground in Puerto Rico. The Hope Lodge at ACS became a center for donations and resources to cancer patients and their families. Regional ACS staff moved into hospitals and communities to provide basic necessities like food and water.

From a policy standpoint, health care providers on the U.S. mainland did not know if they would be reimbursed for the care they provided cancer patients from Puerto Rico who were enrolled in Medicaid. In some cases, this unknown created barriers to care for cancer patients because providers assumed Puerto Rico did not have sufficient money to reimburse the costs of treatment. Therefore, ACS CAN advocated for a temporary fix to remove the cap on Medicaid for Puerto Rico, cover for Puerto Rico's cost-sharing obligations at least temporarily, and increase the overall dollars available for Medicaid to remove barriers to getting proper cancer care.

ACS CAN conducted extensive conversations with Senate Finance staff, House Energy & Commerce staff, and the Centers for Medicaid and Medicare Services (CMS) and the Office of Management and Budget (OMB) about this issue.

When the budget deal was announced in February, there was good news for Puerto Rico. Included in the package was $4.9 billion to increase the cap for Puerto Rico's (and the Virgin Islands') Medicaid program for two years. It also waived the requirement that the two territories come up with the matching dollars for the program to provide some temporary relief for the Puerto Rican government. Although it's not everything Puerto Rico needs in health care, it made an impact towards improving the situation for cancer patients and survivors on the island.

State Regulatory Actions

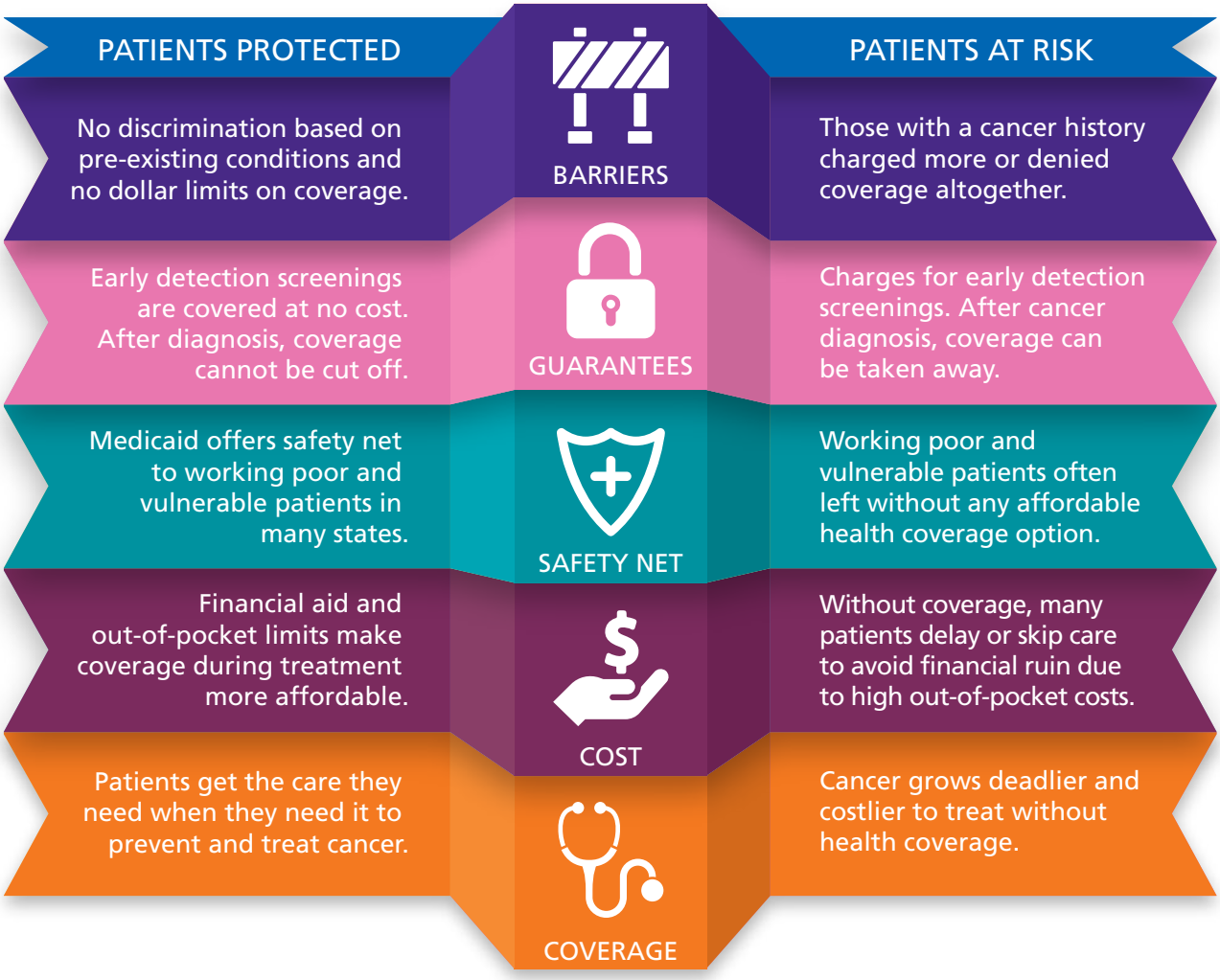
With the federal administration seemingly intent on enacting federal regulations that would expand access to short-term limited duration policies, some states are maintaining, or are looking to impose, requirements that would prohibit or minimize their expansion. For example, New York state law permits short-term limited duration policies, but requires these plans to abide by the consumer protections required for ACA-compliant plans.[10] These requirements (absent in the federal proposal) protect cancer patients and other consumers who choose to enroll in short-term plans, and protect the market from serious risk segmentation – where healthy individuals enroll in cheap plans and individuals who are sick or who have preexisting conditions have no choice but to buy comprehensive plans that have significantly higher premiums.

Ensuring All Americans Have Access to Affordable, Quality Health Insurance

COVERAGE COUNTS IN THE CANCER FIGHT

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

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



1332 Waivers

Since 2017, a number of states have used the authority available under section 1332 of the ACA to request waivers of certain ACA provisions in order to test new programs or make state-specific changes to insurance markets. To apply for a waiver, a state must pass legislation authorizing the application, hold a public comment period about the waiver, and then submit the request to the federal Centers for Medicare and Medicaid Services (CMS). Alaska successfully used this process to establish a reinsurance program, which helps to protect insurers from very high claims; it's a way to stabilize the insurance market and is an important factor in limiting rising insurance premiums. As a result, premiums in the Alaska marketplace decreased 22 percent in 2018.[11] With the hopes of stabilizing or decreasing premiums, several other states have followed or are attempting to follow Alaska's example.

Prescription Drug Formulary Legislation

Cancer patients often need to choose a health plan based, in part, on the plan's prescription drug coverage because not all health plans cover every prescription drug. Unfortunately, due to a lack of transparent drug coverage and cost-sharing information, patients often must buy plans without knowing whether their drug is covered or affordable. Even if patients could easily find drug coverage and cost-sharing information, a health insurer may change the formulary in the middle of the plan year. This practice of switching the formulary mid-year is known as non-medical switching.

ACS CAN is supporting legislation in several states that improves prescription drug formulary transparency by requiring health insurers to make publicly available all drugs covered under each plan, including those administered in a doctor's office, and the dollar cost a patient would have to pay for each drug. Equally important are legislative proposals that ensure the formulary that was disclosed to the consumer at the time they enrolled remains in effect throughout the plan year. This legislation prohibits negative mid-year formulary changes that would cause the patient to pay more out of pocket or lose coverage of a drug in the middle of a plan year.

Missed Opportunity

This year, the Oregon Legislature considered strong prescription drug formulary legislation that would have improved the transparency of prescription drug benefits by requiring health insurers to make publicly available a complete list of all drugs covered under each plan marketed to consumers. This legislation would have also required that prescription drug formularies include an exact dollar amount or a dollar range for any drug covered. This bill went further than many other state proposals of its kind by also prohibiting health insurers from making changes to prescription drug formularies in the middle of a plan year. Despite strong bipartisan support from legislators in both chambers and advocacy by numerous patient and disease organizations, the bill did not advance. This was a significant missed opportunity, leaving cancer patients and other consumers without the information they need to buy a health plan that covers the drugs they need at a price they can afford. ACS CAN along with its partners will continue to urge the Oregon Legislature to pass this legislation.

Increased Access to Medicaid

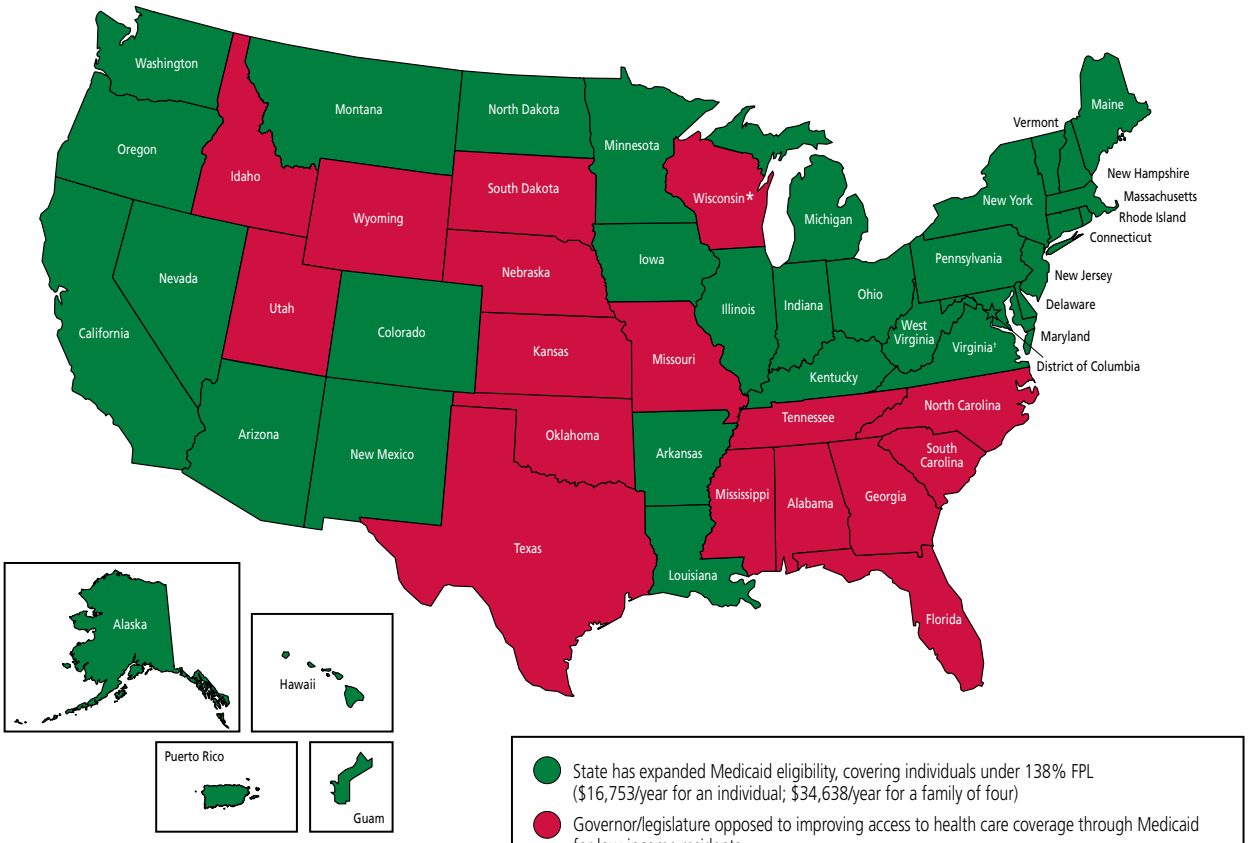
Extending Coverage and Improving Outcomes

The Challenge

More than 1.7 million Americans will hear the words "you have cancer" in 2018.[1] Many of these newly diagnosed individuals will have more challenges surviving the disease, because they earn less income and thus have limited access to affordable health care coverage.[2] The health care coverage provided by state Medicaid programs helps reduce these cancer disparities by offering millions of low-income Americans access to timely and appropriate cancer screening and early detection services, as well as accessible and affordable treatment services and care that span the cancer continuum.

An estimated 2.3 million individuals (children and adults under age 65) with a history of cancer

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



How Do You Measure Up?

Source: ACS CAN and Kaiser Family Foundation: New Estimates of Eligibility for ACA Coverage among the Uninsured
Note: U.S. Territories received additional ACA funding for their Medicaid programs, however expansion of eligibility was not a requirement to receive funds.
*State provides low income residents access to health care coverage, not consistent with the provisions of the federal health care law / ACA
As of July 1, 2018
♦ Legislative or regulatory changes made in 2018
† Effective January 1, 2019

1115 Waivers – Work Requirements

In January 2018, CMS released new public policy guidance and approved the first 1115 waiver requesting permission to condition Medicaid eligibility on employment or participation in job training or volunteer activities. ACS CAN has been on record voicing serious concerns about work requirements for cancer patients and survivors.

Many cancer patients in active treatment are often unable to work or require significant work modifications due to their treatment.[11, 12, 13] Research suggests that between 40 and 85 percent of cancer patients stop working while receiving cancer treatment, with absences from work ranging from 45 days to six months depending on the treatment.[14] ACS CAN opposes conditioning Medicaid eligibility on completion of work or community engagement requirements which could result in a significant number of cancer patients, recent survivors, and many other individuals managing serious, chronic illnesses being denied access to the timely, appropriate and lifesaving health care and treatment services provided through the state's Medicaid program.

Cancer patients and recent survivors could be among the significant number of people who could lose their Medicaid eligibility because of these requirements. Indiana estimates 15 percent of enrollees, while Ohio estimates as much as 50 percent of enrollees will lose eligibility.[15, 16] Losing access to health care coverage could make it difficult or impossible for an individual to have their cancer diagnosed at an earlier, more treatable, less costly stage. For a patient who is mid-treatment, a loss of health care coverage could seriously jeopardize their chance of survival. Losing access to one's cancer care team could be a matter of life or death for a cancer patient or survivor. The financial toll that the coverage loss would have on individuals and their families could be devastating.

As of June 2018, Kentucky, Indiana and Arkansas have received permission from CMS to impose work, job training and/or community engagement requirements as a condition of eligibility for enrollment in state Medicaid programs. An additional 8 states are awaiting a decision from CMS on their pending 1115 waivers seeking permission to impose work requirements.

Note: Work requirements, as well as other enrollment and eligibility restrictions, are currently under litigation. On January 24, 2018, the National Health Law Program (NHeLP), the Equal Justice Center and the Southern Poverty Law Center filed suit in federal court to block the Kentucky waiver on the grounds it violates the Administrative Procedure Act (APA) and violates the section 1115 waiver requirement.[17] The lawsuit identifies work requirements as one of the violations of the APA.

rely on the health care coverage provided by their state Medicaid program to help them fight and prevent recurrence of this disease.[3] In 2013 alone, 32 percent of pediatric cancer patients (age 19 and younger) had Medicaid coverage when they were diagnosed.[4] State Medicaid programs also provide low-income women screened and diagnosed with breast or cervical cancer through state Breast and Cervical Cancer Early Detection Programs (BCCEDP) a pathway to comprehensive health care and cancer treatment services.[5] The health care coverage provided through state Medicaid programs is proven to improve health outcomes and reduce the burden of cancer.[6, 7, 8]

Over the past several years, an increased number of states have sought greater flexibility in administering the Medicaid program from the Centers for Medicare and Medicaid Services (CMS) through 1115 Research and Demonstration Waivers.

Increased Access to Medicaid

Extending Coverage and Improving Outcomes

ACS CAN has actively reviewed and provided public comment on these waivers at the state and federal level. ACS CAN's most important consideration in evaluating these waivers is to understand the impact that these demonstration projects could have on cancer patients', survivors',and enrollees' access to preventive services and treatment. We urge all lawmakers to consider this vulnerable population as changes to this important program are considered. Many of the 1115 waivers have proposed including provisions that have been shown to adversely impact efforts to fight cancer, such as:

- Limiting or restricting eligibility (work requirements, drug testing, waiving retroactive eligibility);
- Imposing cost sharing (copayments, premiums);
- Penalizing enrollees for non-compliance with various programs or wellness requirements (lock-outs – up to one year, higher cost-sharing – e.g. charging fees to those individuals who use tobacco);
- Eliminating benefits/services (non-emergency medical transportation); and
- Placing limits on the length of program eligibility (e.g. five-year limits).

Volunteer Story

In the spring of 2018, two ACS CAN volunteers were critical in our efforts to defeat a Minnesota bill that would have required individuals enrolled in the state's Medicaid program to complete work or community engagement requirements as a condition of eligibility. Dr. Richard Zera, division chief of surgical oncology at Hennepin County Medical Center and Minnesota Cancer Alliance Steering Committee member, testified before legislators about the ramifications that this measure would have on his patients. He explained the dramatic side effects experienced by patients in cancer treatment including nausea, vomiting, diarrhea, fatigue, pain, issues with concentration and retention of information, arm or leg swelling, persistent numbness and persistent fatigue and shortness of breath. Dr. Zera made clear how work can become impossible given the limited capabilities of cancer patients and sometimes survivors too.

Adrienne Frank, a four-time cancer survivor, also testified explaining how the bill could have resulted in her being denied access to lifesaving treatment services. When just 24 years old, Adrienne was diagnosed with oral cancer and she suffered through multiple recurrences (one of which took months to detect), which led to her employer terminating her for failure to complete the job qualifications given her health restrictions in 2014. Not only did Adrienne lose her job, but also her health insurance. She was left to take care of her four-year-old son with no job and no insurance, while battling cancer. Her social worker informed her that she was eligible for Medicaid and helped her enroll in in the program, providing her affordable and comprehensive access to surgery and other treatment services. While she wanted to go back to work to earn an income for her family, she was just too sick during chemotherapy to work – suffering from many of the symptoms Dr. Zera outlined in his testimony. Adrienne's cancer care team informed her that if she didn't focus on getting better, she might succumb to the disease and not live to see her son grow up, so she spent the limited energy she had raising her son and trying to beat this awful disease. Working, volunteering or completing job training activities while fighting cancer was not possible for Adrienne. Today, Adrienne is cancer-free and is back to work, but if she was required to work while also going through treatment or denied access to Medicaid for an inability to comply with a work requirement, she may not have survived to share her story with members of the Minnesota legislature.

Dr. Zera and Adrienne's stories illuminate the harmful impact that work requirements could have on cancer patients, survivors and individuals managing other chronic conditions. Tying Medicaid eligibility to employment or completion of job or community engagement activities could seriously disadvantage cancer patients and deny individuals life-preserving and lifesaving care. Their advocacy paid off – the bill was defeated and Governor Mark Dayton formally communicated his opposition to the bill.

Dr. Richard Zera Minnetonka, MN
Adrienne Frank, Minneapolis, MN

Increased Access to Medicaid

Extending Coverage and Improving Outcomes

Medicaid Benefits and Services Necessary for Cancer Patients

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

Data indicates that these policy proposals, especially those that result in the limiting or restriction of eligibility, will significantly reduce enrollment in the Medicaid program, thus denying access to prevention and treatment services for individuals and families enrolled in the Medicaid program.[9, 10] Preservation of eligibility and access to health care coverage through state Medicaid programs is critical for continuing to make progress against cancer for those low-income Americans who depend on the program for cancer prevention, early detection, diagnostic, treatment and survivorship care services.

The Solution

In order for states to improve health outcomes and reduce cancer disparities for their state residents, low-income individuals and families need access to critical coverage that can prevent cancer and save lives. ACS CAN encourages state policymakers to broaden eligibility for the Medicaid program in the 17 states that currently do not provide low-income childless adults earning less than $16,753 a year (for an individual) access to affordable health care coverage. We urge state policymakers to advance and support policies that protect and improve low-income Americans' access to health care, which has proven to improve health outcomes and reduce the burden of cancer.[18, 19, 20] We also ask states to invest in evidence-based, quality-improvement programs that emphasize primary and preventive care through integrated care coordination, disease management and patient navigation programs.

Maintaining access to comprehensive and affordable health care coverage through state Medicaid programs is a matter of life and survivorship for millions of low-income cancer patients and survivors. Preventing cancer is much less expensive than treating it and ensuring that low-income individuals and families have access to comprehensive, affordable health care coverage is one of the most critical ways to assure states are successfully reducing cancer incidence and mortality.

Success Story

Virginia

Nearly 400,000 low-income Virginians will be provided access to health care coverage thanks to the bipartisan group of state legislators who voted to increase access to Medicaid during the final budget negotiations in the 2018 General Assembly session.

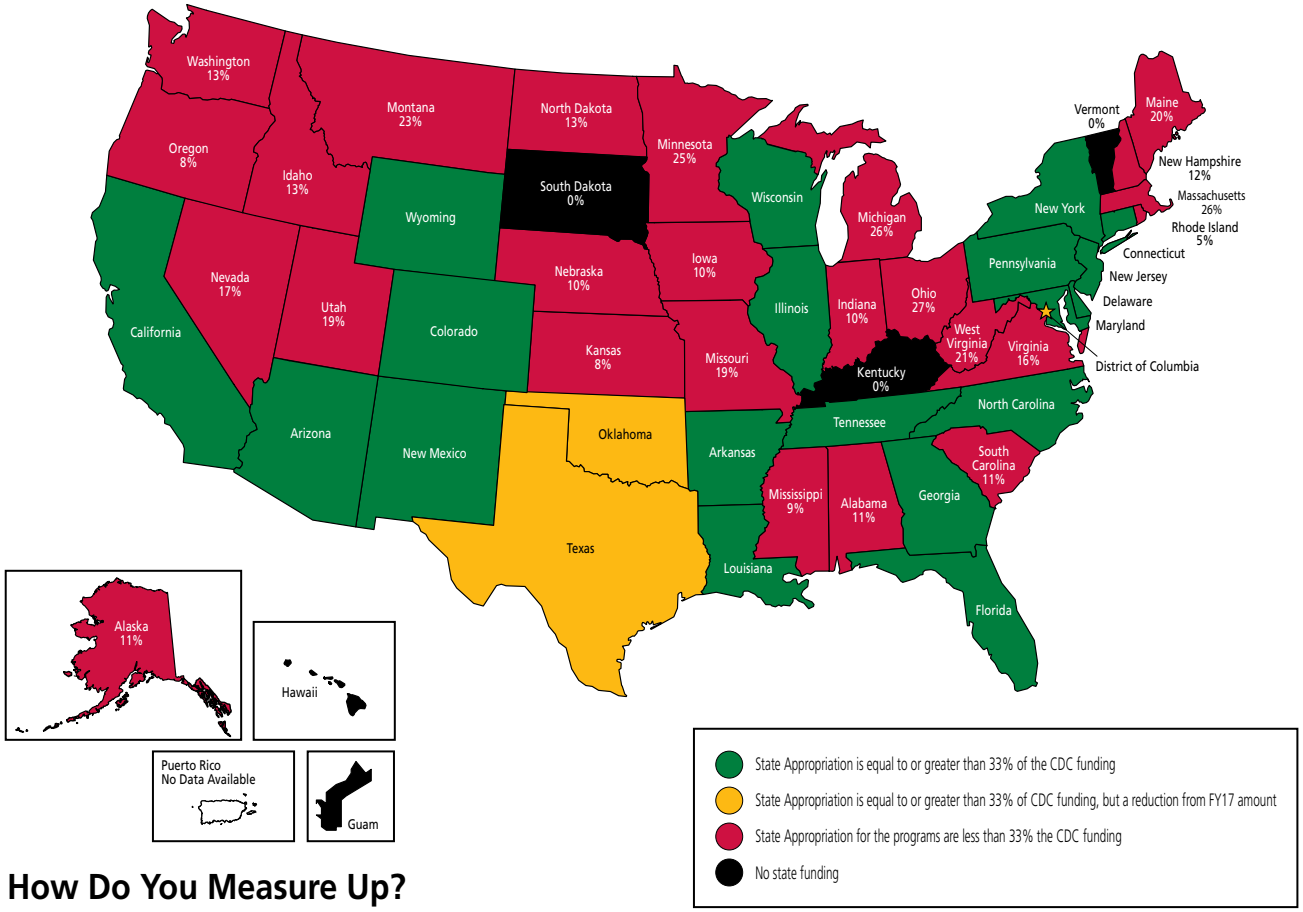
This decision will enable more low-income Virginians to access affordable health care services they need, like seeing a doctor regularly, receiving potentially lifesaving cancer screenings such as mammograms and colonoscopies, and if needed, cancer treatments. By increasing access to health coverage through the state's Medicaid program, lawmakers are increasing the likelihood that more Virginians will have their cancers detected at an earlier, more treatable stage, when treatment is far less expensive and survival rates are greater.

However, language included in the budget deal will require low-income Virginians to attend school, work or job training or participate in some type of community engagement for upward of 80 hours a month in order to receive benefits. This requirement could be seriously challenging for cancer patients and survivors. Cancer is an incredibly difficult disease to treat and its side effects can often leave patients unable to complete simple tasks of daily living. These effects often extend beyond active treatment into long-term survivorship wherein patients sometimes experience permanent nerve damage, chronic pain, fatigue and infections. In such cases, tying patients' health care to work requirements could prove impossible and potentially even deadly.

ACS CAN will work closely with state and federal regulators to make our concerns clear and mitigate potential complications for patients and survivors from these requirements.

Increasing access to Medicaid happened thanks to more than five years of tireless efforts made by ACS CAN volunteers, staff, coalition partners and a bipartisan group of state legislators who understand the importance of making health care accessible to Virginians.

State Appropriations for Breast and Cervical Cancer Screening Programs - Fiscal Year 2017-2018



How Do You Measure Up?

Source: 2017-2018 data from the Centers for Disease Control and Prevention and unpublished data collected from ACS CAN and ACS Divisions, including input from NBCCEDP directors.

The Challenge

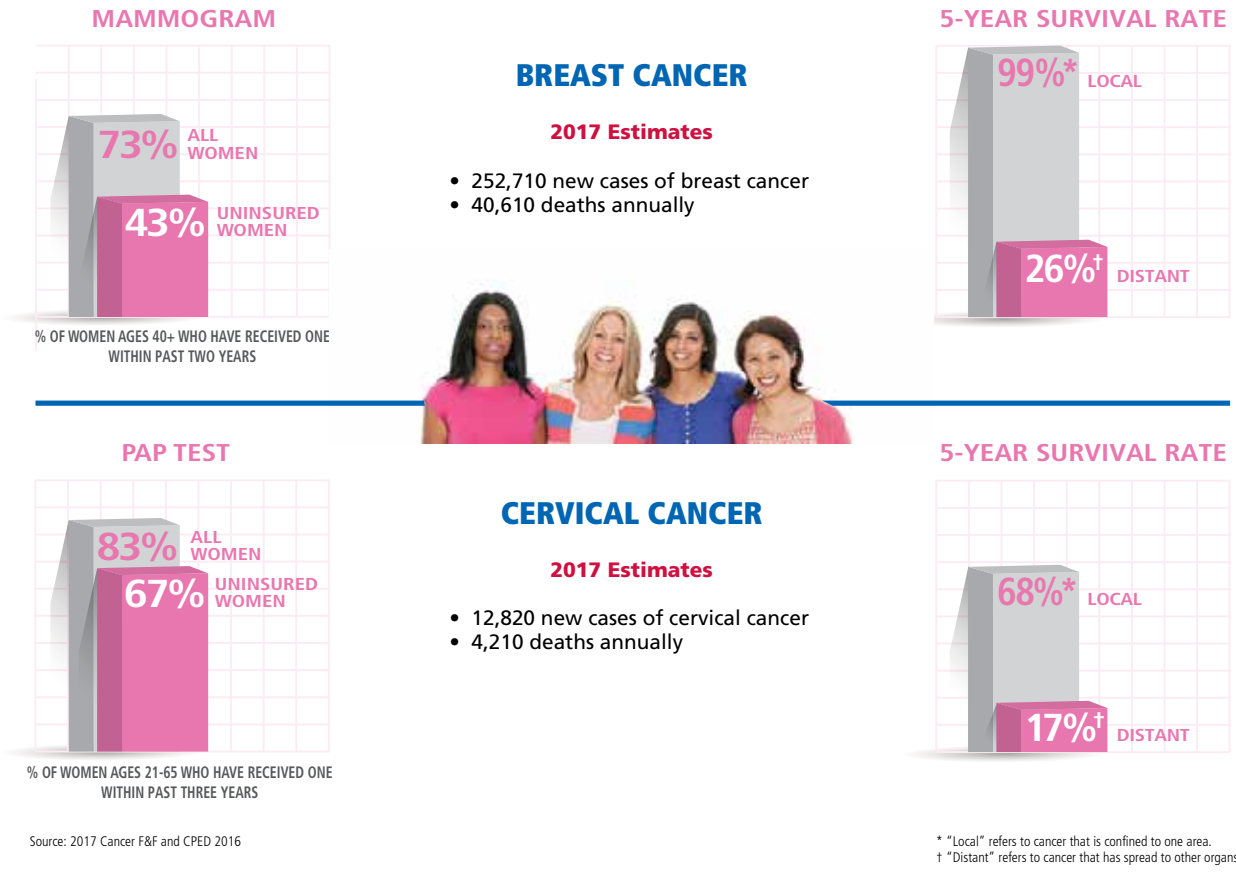
In 2018, it is estimated that nearly 280,000 women will be diagnosed with breast or cervical cancer[1] – many of whom will be low-income uninsured or underinsured individuals. Countless numbers of these newly diagnosed women will lack access to comprehensive, affordable health care coverage that would allow them to receive timely and appropriate cancer screening and diagnostic services. They will face increased risk of developing a later stage breast or cervical cancer diagnosis with lower rates of survival.[2, 3, 4, 5] Uninsured women have lower cancer screening rates - only 31 percent of uninsured women (age 40 and older) have received a mammogram in the past two years, compared to 68 percent of insured women.[6] Likewise, only 61 percent of uninsured women (21 to 65 years of age) have received a Pap test in the past three years, compared to 84 percent of insured women.[7]

Low-income, uninsured and underinsured women are provided access to breast and cervical cancer screening and early detection services through the Breast and Cervical Cancer Early Detection Program (BCCEDP). In 1990, Congress authorized the Centers for Disease Control and Prevention (CDC) to administer the BCCEDP and to provide states millions of dollars in funding to deliver direct screening, prevention and early detection services to eligible women. All fifty states, the District of Columbia, six U.S. territories, and 13 American Indian/Alaskan Native tribes or tribal organizations receive BCCEDP funding.

Through the BCCEDP, states are focused on providing a variety of screening, prevention and early detection services and implementing key evidence-based strategies to reduce structural barriers to screening. BCCEDP services include:

- Direct screening, diagnostic testing and follow-up services;
- Patient navigation and case management;
- Educational information;
- Quality assurance, data management and program evaluation; and
- A pathway to treatment services if diagnosed through the program.

Breast and Cervical Cancer Facts and Figures



Source: 2017 Cancer F&F and CPED 2016

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

Breast and Cervical Cancer Early Detection Program

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

Since 1991, the BCCEDP has served more than 5.3 million women, diagnosing nearly 65,000 breast cancers and over 4,400 cervical cancers. Although many women gained access to affordable, comprehensive health care coverage under the federal health care law, millions of women continue to meet the eligibility requirements for the program but due to inadequate federal and state supplemental funding, only one in 10 eligible women is served by BCCEDP.

The Solution

State investment in the BCCEDP is one of the most important factors for ensuring all eligible low-income, uninsured and underinsured women have access to the screening and early detection services provided by the program. The American Cancer Society Cancer Action Network (ACS CAN) advocates for states to appropriate $1 for every $3 in federal funds to ensure that no woman eligible for the program is denied access to cancer screening and early detection services.

Nineteen states are meeting or exceeding ACS CAN's goal, while another 31 states and D.C. are falling short of this goal, with Hawaii, Kentucky, South Dakota and Vermont investing zero ($0) state funds into this lifesaving program.

In 2016 alone, the BCCEDP provided breast cancer screening and diagnostic services to over 285,000 eligible women, diagnosing more than 2,500 invasive breast cancers. The program has screened 140,000 women for cervical cancer, diagnosing nearly 200 women with invasive cervical cancers and detecting nearly 6,000 premalignant cervical cancer lesions, 39 percent of which were high-grade.[8]

Increasing funding for each state's BCCEDP will expand the reach of the federal program and ensure women have access to these lifesaving cancer screening, diagnostic and treatment services. Without adequate funding at both the state and federal level, the BCCEDP will continue to leave millions of underserved women exposed to cancer diagnoses at later stages, when survival is less likely and costs of treatment are highest.

Success Story

Florida

After a well-coordinated campaign, the Florida Legislature approved total state funding of $1.83 million for the Mary Brogan Breast & Cervical Cancer Early Detection Program. While it was an overall decrease for the program, it marks the first time that all of the funding is from a dedicated, recurring source, meaning that it will be included in each year's base budget. This constitutes a $1.53 million increase in recurring revenue and marks the seventh year in a row that the Legislature has invested state dollars in the program.

This is a significant win that the Florida team has worked toward for the better part of a decade. It will provide more stability for the Florida Department of Health, which oversees the Mary Brogan Program, and help ensure that more medically underserved women in Florida receive these lifesaving screenings. The long-term public health dividends will continue year after year.

Of course, this would not have been possible if not for all of the contributions the Florida team made, not just this year, but every year this issue has been a priority. ACS CAN staff worked with the American Cancer Society on a coordinated, statewide petition drive in partnership with our Making Strides Against Breast Cancer events. Two amazing breast cancer survivors, who received their treatment through the program, worked on a media campaign and met with legislators to share their stories. Fourteen coalition partners joined our efforts to demonstrate the widespread support for the program. Our lobbying team was tenacious and our volunteers helped to keep the pressure on elected officials.

Breast and Cervical Cancer Early Detection Program

Detect and Protect

Success Story

Nevada

Sometimes change takes time. Clearly the time was worth the effort and patience associated with the effort to secure state funding to support Nevada's Women's Health Connection (WHC). For the past twenty years, the WHC program operated without any state funding - instead it operated with federal funding – from the Centers for Disease Control and Prevention (CDC) and private donations.

Nearly every fiscal year, WHC had to turn eligible women away from the program, ultimately denying them access to timely and appropriate cancer screening and early detection services, because of a lack of funding to support the program through the end of the fiscal year. Unfortunately, the state's failure to appropriate funding for WHC was not unusual - Nevada had been ranked 50th in appropriating state funds to support public health programs, failing to invest state funds in cancer control and prevention programs, as well as other chronic disease programs.

In an effort to advance our advocacy efforts, ACS CAN's Nevada team, led by our Government Relations Director, Tom McCoy, convened breast cancer roundtables held throughout the state. The roundtables brought together diverse stakeholders, including cancer control leadership, health systems partners, legislators, and other key breast and cervical cancer advocates, to discuss opportunities to address known barriers to breast and cervical cancer screening, diagnostic testing and treatment services, as well as to begin charting a course for policy change. A constant theme throughout these discussions was securing state appropriations that would support and broaden the reach of the WHC program.

In 2017, these efforts culminated during ACS CAN's Cancer Day at the Capitol – which focused on securing state funding for WHC. Encouraged by the leadership of Assemblywoman Teresa Benitez-Thompson, who sponsored the breast cancer funding legislation, ACS CAN volunteers and a number of breast cancer survivors met with their state legislators imploring them to support the legislation that would provide the first state funding for WHC. In the last days of the legislative session, the Senate and Assembly unanimously passed legislation, resulting in $1 million dollar in state funds to support the WHC program for the FY 2018-2019 biennial budget. As a result of this action, thousands of additional Nevada women will gain access to a broad range of lifesaving breast and cervical cancer services, including screenings, diagnostic testing and patient navigation services.

Breast and Cervical Cancer Treatment through Medicaid

A Lifeline for Women Diagnosed with Breast and Cervical Cancer

The Challenge

Women screened and diagnosed with breast or cervical cancer through states Breast and Cervical Cancer Early Detection Program (BCCEDP) are provided a pathway to comprehensive health care and cancer treatment services through their state Medicaid program. In 2000, Congress passed the Breast and Cervical Cancer Treatment Act (BCCT), which provides states with federal funding to help cover the cost for comprehensive health care and cancer treatment services through Medicaid for low-income women diagnosed with cancer through the state's BCCEDP. Every year, thousands of low-income, uninsured and underinsured women access lifesaving health and cancer treatment care because of this BCCT eligibility option.

Recently, some states have considered proposals aimed at eliminating or limiting eligibility for Medicaid, including women eligible for the program through the BCCT option. States have proposed work or community engagement requirements, mandatory cost-sharing and other personal responsibility requirements, including non-compliance penalties such as lock-outs that could deny BCCT women and other cancer patients and survivors access to lifesaving health care and cancer treatment services. These penalties could result in a loss of coverage for countless individuals enrolled in the program making it difficult or impossible for cancer patients to continue receiving treatment services and seriously jeopardizing their chance of survival. Being denied access to one's cancer care team could be a matter of life or death for a cancer patient or survivor and the financial toll that the coverage loss would have on individuals and their families could be devastating.

Other states have considered proposals eliminating funding for the BCCT, based on the assumption that women have gained access to comprehensive and affordable health care coverage under the federal health care law and therefore do not need coverage through the BCCT.

Millions of women in the United States remain uninsured without adequate, affordable and comprehensive health care coverage.[1] The lifesaving cancer treatment services provided through the Medicaid BCCT option of the BCCEDP is often the only coverage available to help women treat their breast or cervical cancer. State efforts aimed at limiting or eliminating eligibility for Medicaid are short-sighted and could adversely impact the health outcomes and chances for survivorship for countless women across the country.

The Solution

We urge states to maintain eligibility for Medicaid and preserve access to quality, affordable, accessible, and comprehensive health care coverage. Preservation of the BCCT eligibility option is a matter of life and survivorship for thousands of low-income breast and cervical cancer patients in all fifty states. The treatment services provided by a state's Medicaid program allow women to start treatment faster, at earlier stages of cancer when the disease is easier and less costly to treat, typically resulting in better patient[2] outcomes. It is imperative that state lawmakers protect eligibility and maintain adequate funding for the BCCT eligibility option. The American Cancer Society Cancer Action Network (ACS CAN) strongly opposes any attempts to limit or eliminate eligibility or reduce funding for this lifesaving cancer treatment option.

Access to Colorectal Screening

Screening Now, Preventing for Life

The Challenge

Colorectal cancer is the third most common cancer in men and women and the second leading cause of cancer death among men and women combined in the United States. This year alone, an estimated 50,630 colorectal cancer deaths are expected to occur[1] – despite it being one of the most preventable cancers.

Screening helps to detect the disease early when treatment is more likely to be successful and when, in some cases, the disease can be prevented altogether by the detection and removal of precancerous polyps. Yet, only approximately 63 percent of Americans age 50 and older are up-to-date with their colorectal cancer screening.[2, 3] This means that more than one in three adults age 50 and older are not getting tested as recommended. Barriers often cited to colorectal cancer screening include no usual source of care, inadequate insurance coverage, logistical factors (e.g. transportation, scheduling), lack of a family history or symptoms, feelings of

Success Story

South Carolina

Senator Thomas Alexander was awarded the National Award for Distinguished State Leadership, a prestigious honor bestowed by the National Colorectal Cancer Roundtable. Co-founded by the American Cancer Society (ACS) and the Centers for Disease Control and Prevention, the National Colorectal Cancer Roundtable is a proud collaboration of over 100 public, private and voluntary organizations, including ACS CAN, committed to fighting colorectal cancer. Senator Alexander was given this award because of his support of ACS and ACS CAN's mission to save lives from colorectal cancer in the 80% by 2018 effort (see above for campaign description.)

The Roundtable commended the senator for his leadership within the South Carolina legislature to ensure funding for colorectal cancer screening programs that serve medically underserved and uninsured populations. The University of South Carolina Center for Colon Cancer Prevention (CCPN) is part of The Center for Colon Cancer Research founded in 2002, with funding from an $11 million National Institutes of Health Center for Biomedical Research Excellence (COBRE) grant. CCPN received an additional $1 million in state funding in 2018 to support colon cancer prevention and early detection through screenings, in part, thanks to Senator Alexander's support.

In addition to fostering basic research, the CCPN has developed a robust outreach program aimed at promoting knowledge of colorectal cancer and the importance of preventive screening. Awareness, education and screening programs throughout South Carolina have been funded by agencies such as the BlueCross BlueShield Foundation of South Carolina, the South Carolina Legislature, the American Cancer Society, the Duke Endowment, and the South Carolina Cancer Alliance. Partnerships with the South Carolina Gastroenterology Association, CVS Caremark, and BlueCross BlueShield of South Carolina have been instrumental in promoting screening in medically underserved communities across the State. Consequently, South Carolina has rapidly become a national leader in statewide advocacy efforts aimed at increasing screening rates and reducing the morbidity of colorectal cancer.

embarrassment or fear, and no recommendation from a health professional.[4]

In total, it is estimated that more than 140,250 people will be diagnosed with colorectal cancer this year.[5] Individuals less likely to get screened are those who are younger than 65, are racial/ethnic minorities, have lower education levels and lack health insurance.[6]

The Solution

80% by 2018 and Beyond!

In 2014, the National Colorectal Cancer Roundtable (NCCRT), the American Cancer Society (ACS), and the American Cancer Society Cancer Action Network (ACS CAN) spearheaded an initiative to substantially reduce colorectal cancer as a major health problem by working

toward the shared goal of 80 percent of adults age 50 and older being regularly screened for colorectal cancer by 2018. Since the launch of this initiative more than 1,600 partners have signed the pledge, including hundreds of state and local government officials, and national screening rates are steadily increasing. ACS recently updated its guidelines for colorectal cancer screenings to begin at age 45. ACS is evaluating how to incorporate these new guidelines into its work related to 80% by 2018, but anticipates that lowering the age will spur new motivation for adults to get screened.

In 2015, an additional 3,785,600 adults (>50 years) were screened.[7] If screening prevalence remains at this level, an estimated 39,700 additional colorectal cancer cases and 37,200 deaths can be prevented through 2030.[8] In addition, colorectal cancer screening rates in community health centers have increased more than five percentage points since the launch of the 80% by 2018 initiative.[9]

States are making incremental progress towards improving their screening rates, but no state has achieved the 80 percent screening rate goal. Massachusetts and New Hampshire continue to have the highest screening rates in the nation, screening approximately 76 percent of their state residents age 50 and older. Georgia, Idaho, Mississippi, Montana, Nevada, New Mexico, Oklahoma, Texas and Wyoming have screening rates well below the national average of 69 percent and have a long way to go to reach 80 percent.[10]

The 80% by 2018 initiative is transitioning to a new campaign – the "80% Pledge." ACS CAN will support the effort to build on the incredible work and infrastructure that has been built to increase colorectal cancer screenings and save lives from this disease. ACS CAN continues to urge state policymakers to help address known barriers to screening rates, by making colorectal cancer a priority and working across all sectors to increase screening rates in their states. Specifically, state policymakers can:

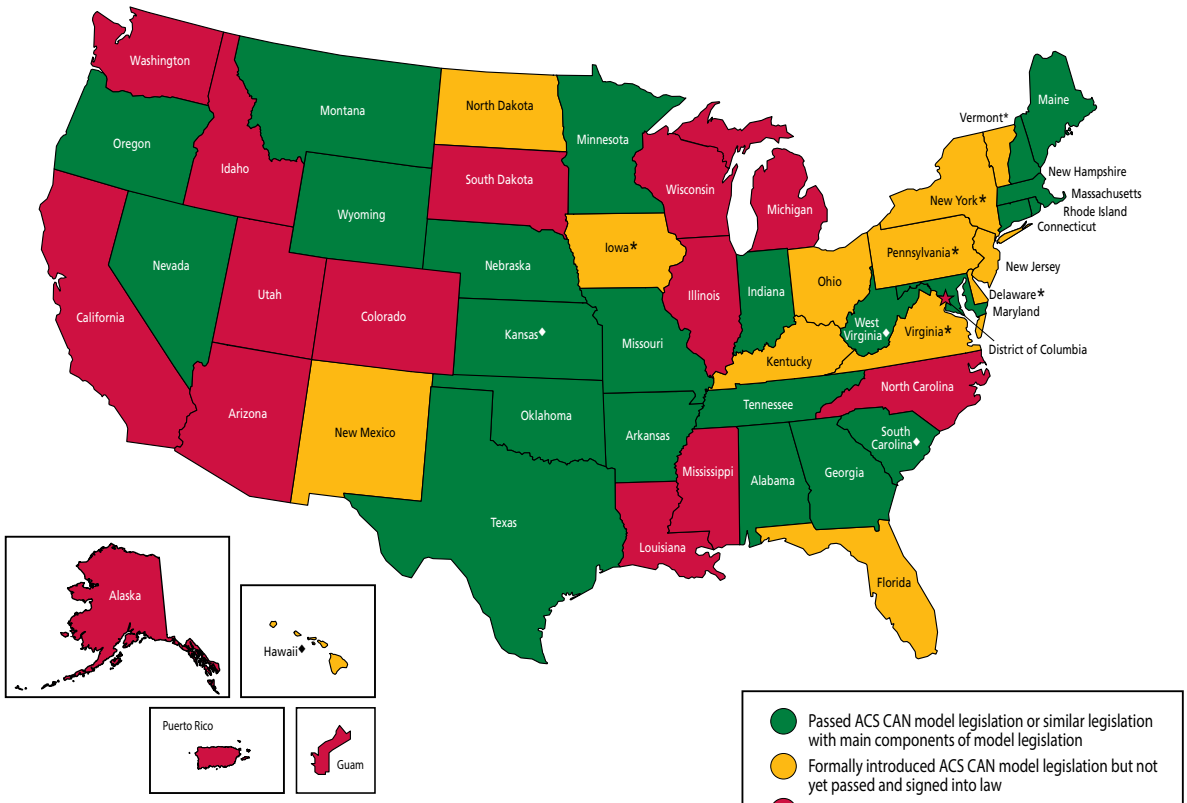
- Appropriate funds to establish or invest in the state colorectal cancer screening and control programs. Increased state investment would broaden the reach of the CDC's Colorectal Cancer Control Program (CRCCP), a program that supports 23 states, six universities and one American Indian tribe by focusing on increasing screening rates among target populations through evidence-based health systems interventions.[11] Programs should raise public awareness about colorectal cancer screening and improve access to screening, including patient navigation and treatment services. Programs should use evidence-based patient and provider interventions to promote screening and reduce barriers to eligible adults;

- Support policies that require insurers to cover follow-up colonoscopies after a positive stool test, and guarantee that patients do not face out-of-pocket costs for polyp removal, anesthesia, pre-screening consultations or laboratory services related to the screening colonoscopy;

- Support evidence-based educational efforts to improve uptake of preventive services, particularly in disparate populations; and

- Reach out to ACS CAN representatives in your state to find out how to get involved. Through collaborative efforts with state policymakers, health care providers, health systems, community members and business leaders, we can reach this challenging, yet achievable goal.

Establishing a Palliative Statewide Expert Advisory Council



How Do You Measure Up?

Source: ACS CAN
As of July 1, 2018
*DE, IA, NY, PA, VA, VT have not passed the model legislation but have statewide programs in place that closely align with the main tenets of the model legislation
♦ Legislative or regulatory changes made in 2018

The Challenge

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

Palliative Care

Improving Quality of Life for Cancer Patients

The Solution

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

Studies show cancer patients receiving palliative care during chemotherapy are more likely to complete their cycle of treatment, stay in clinical trials and report a higher quality of life than similar patients who do not receive palliative care.[1] Research demonstrates that palliative care improves symptom distress, quality of life, patient and family well-being and, in some settings (e.g., advanced lung cancer), survival. Palliative care also reduces unnecessary use of hospitals, diagnostic

Success Story

West Virginia

ACS CAN and its coalition partners are proud to have worked with Del. Amy Summers (R-Taylor) to pass legislation in West Virginia to improve patients' quality of life by increasing access to and awareness of palliative care services.

Through her firsthand experience as a nurse, Del. Summers saw the benefits of an effective palliative care program. After fighting cancer herself and helping many others through their cancer journeys, including her own brother, she introduced the palliative care legislation in January of 2018. It was signed into law by Gov. Jim Justice (R-W.Va.) in March of 2018.

This legislation will establish a palliative care advisory coalition, bringing together experts to address barriers to patients receiving palliative care and identify innovative solutions for West Virginians. The council will emphasize provider training, patient awareness and overall access to palliative care.

To kick-off the campaign, ACS CAN held a Patient Quality of Life Forum at the Charleston Area Medical Cancer Center. The forum was a policy discussion with key stakeholders on quality of life and palliative care. The coalition also held a panel discussion with George Blough, WV ACS CAN advocate and cancer survivor, Del. Summers and a general and pediatric palliative care physician highlighted how palliative care provided throughout the course of any type of serious illness achieves the triple aim of better patient experience, better quality of care and lowered health care costs.

Del. Summers received the Distinguished Advocacy Award for leading efforts on the state's palliative care bill, alongside her efforts as the lead sponsor of West Virginia's new indoor tanning law, prohibiting anyone under age 18 from using an indoor tanning device.

Pillars of Palliative Care

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/nausea

Communication and Support for resolving family/ patient/physician questions concerning goals of care

Coordination of care transitions across health care settings

and treatment interventions, and non-beneficial intensive care.[2] Recent research also shows palliative care increases satisfaction in caregivers of patients with cancer.[3]

To benefit from palliative care, patients and families must be aware of these services, and be able to access them in their local hospital or other care settings. In addition, health professionals in training must learn from direct experience at the bedside with high-quality palliative care teams.

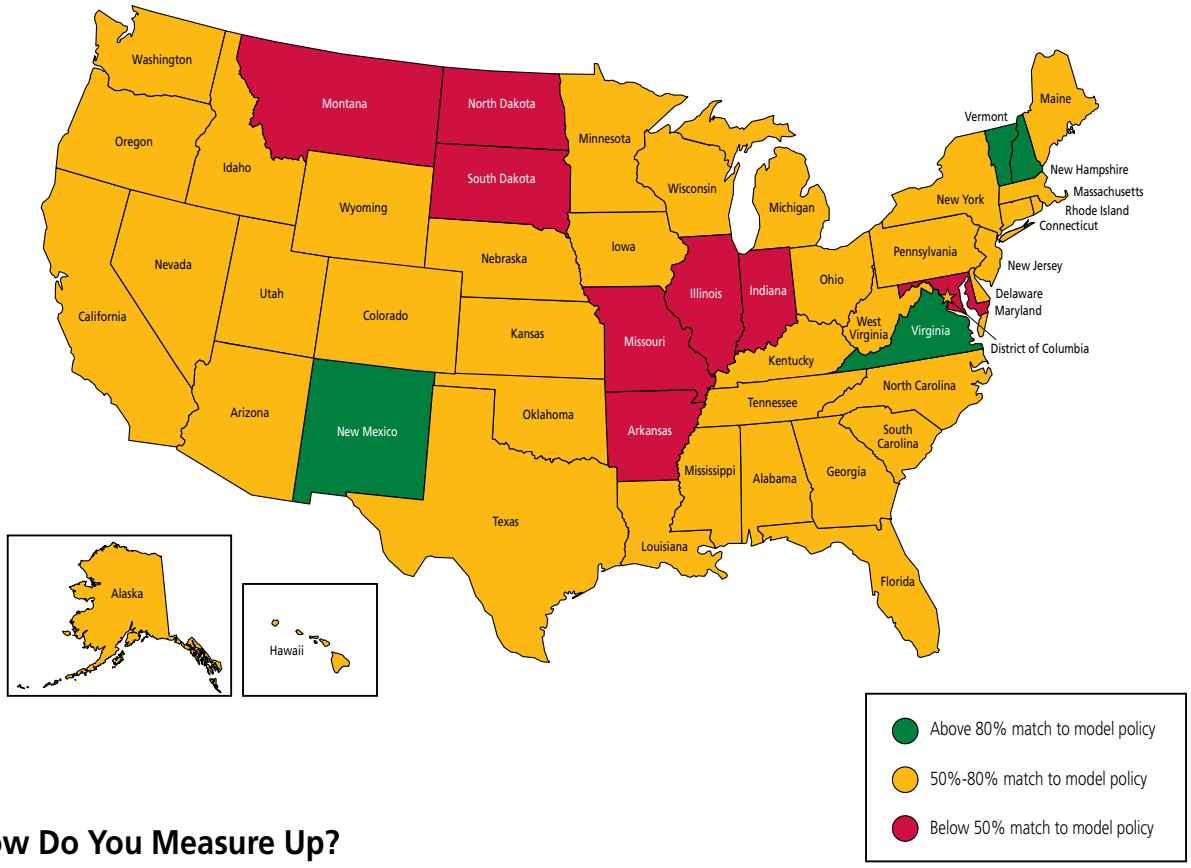
The American Cancer Society Cancer Action Network (ACS CAN) has created model state legislation that establishes a Palliative Care Advisory Council comprised of state experts to build out robust palliative care programs. The model legislation empowers the state health department to provide palliative care information through their website and through other channels for medical professionals, patients, families, caregivers and the public. It also improves access to palliative care services by encouraging routine screening of patients for palliative care needs. Furthermore, it helps facilitate continuing education for health professionals, students of medicine, nursing and other professionals, including improving workforce training in pain assessment, management, responsible prescribing and use of prescription monitoring programs. ACS

CAN urges lawmakers to adopt this, or similar legislation, in their states. This legislation has consistently received bipartisan support and in just four years, ACS CAN model language or similar bills have been passed in 23 states.

Did You Know?

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

2018 Pain Policy in the States



How Do You Measure Up?

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

The Challenge

Pain is one of the most feared symptoms for cancer patients and survivors. Nearly 60 percent of patients in active treatment and 30 percent of patients who have completed treatment experience pain. Pain can be caused by the cancer itself, for instance, when tumors interfere with normal body function. Pain can also be caused by cancer treatments. Research has concluded that about one-quarter of women who have had breast cancer surgery have significant and persistent breast pain six months after the procedure.

Despite the fact that millions of cancer patients and survivors experience chronic pain, it remains a highly stigmatized issue. But given proper attention, most pain can be treated and relieved. Integrative pain care that includes non-drug therapies along with medications is effective in keeping cancer patient

pain under control, though proven effective, non-drug therapies, like physical therapy or cognitive behavioral therapy, are often not reimbursed by insurers. While not the only tool, opioid medications are recognized as a mainstay of treatment for moderate to severe cancer pain and can be a beneficial treatment for managing serious, persistent pain for patients in active cancer treatment as well as cancer survivors. If left untreated, chronic pain can have long-term negative effects, including prolonged recovery and a weakened immune system. It can also affect a patient's quality of life, their ability to sleep, eat, work and carry on every aspect of their daily life. Additionally, significant disparities continue to be documented in pain treatment, with medically underserved and socioeconomically disadvantaged populations experiencing disproportionately restricted access.

The Solution

As a nation, we must take steps to identify balanced solutions that address the opioid epidemic, while not creating unintended barriers to access opioid medications for cancer patients and others with serious chronic illness. ACS CAN continues to represent the voices of cancer patients and survivors in such efforts. As such, ACS CAN supports balanced policies such as:

- Creating and maintaining prescription drug monitoring programs that allow doctors and pharmacies to work together to curb misuse and abuse, while also helping to ensure care coordination;
- Funding federal research to develop new evidence-based pharmacological and non-pharmacological pain treatments - increasing provider education on pain management;
- Ensuring that public and private insurance programs cover the range of evidence-based pain treatments in a way that is accessible and affordable for patients; and
- Creating effective drug take-back programs that provide cancer and other patients with a safe way to dispose of unused medication.

Did You Know?

According to recent research,

- 48% of cancer patients were told by doctors that their pain treatment options were limited by laws, guidelines or insurance coverage;
- 27% of cancer patients and survivors were unable to get their prescription pain medication because a pharmacist would not fill it, even though they had the medication in stock; and
- Both physicians and patients support policies to address the opioid epidemic—but they also agree that extreme policies that compromise access to care for patients should be rejected.[1]

Success Story

Maine

Maine continues to have success in protecting access to pain medications for cancer patients and ensuring balanced pain policy. In 2016, Maine's governor proposed legislation that would have significantly limited cancer patients' access to necessary pain medications. ACS CAN worked with many partners like the Maine Medical Association, Maine Hospital Association, the Maine Hospice Council, and individual hospital systems to propose amendments that protected access to pain medication for pain associated with a cancer diagnosis.

In late 2016 and 2017, Maine's Department of Health and Human Services proposed rules that contradicted the intent of the Legislature and imposed arbitrary time limits on access to pain medication for cancer patients. Once again, ACS CAN worked with partners to submit comments in opposition to the changes in the proposed rule. When the administration rejected these comments, legislative action was necessary. ACS CAN worked with its partners to submit recommended changes. This ongoing collaboration was effective and the legislature's Health and Human Services Committee unanimously supported a bill that amended the final rule to once again protect cancer patients who legitimately need these drugs in order to maintain their quality of life. The bill was passed by the Legislature in June 2017 and signed by the Governor.

In 2018, ACS CAN has been working with partners to monitor the impact of changes to opioid prescribing laws to ensure there are not unintended consequences. Early results indicate a reduction in pain medication prescribing overall, however, opioid addiction and related deaths continue to be a problem. ACS CAN will continue to work with partners to ensure pain policies strike a balance that reduces inappropriate use of pain medications without impeding access to necessary relief for individuals fighting pain from cancer and other causes. In addition, we continue to work on efforts to increase access to and education about palliative care, which will help patients better manage pain and other symptoms related to cancer, as well as ensure medications are appropriately prescribed and utilized in the ways they are intended.

HANGING IN THE BALANCE

A Special Section on the Impact of Pain Policy

We're in the midst of a national epidemic related to opioid abuse and misuse. As lawmakers scramble to address this crisis, a flurry of legislation is being passed in states that can have unintended consequences. In 2015, there were fewer than 80 state legislative proposals introduced related to pain management/opioid issues while in 2018, there have been more than 470 state legislative proposals introduced regarding the same issues. Although well intended, these swift actions in many cases are leaving people, like cancer patients and survivors, facing unnecessary barriers to accessing the pain relief they legitimately need.

The American Cancer Society Cancer Action Network (ACS CAN) strives to be the voice of cancer patients in this nationwide debate, emphasizing the need for a balanced approach to curbing opioid misuse and abuse while maintaining access to pain relief for patients. Since 2000, ACS CAN has worked with the American Cancer Society and the University of Wisconsin (UW) to produce a state Pain Policy Report Card. With the drastically changing landscape of pain management in the last decade, and particularly in the last three years, ACS CAN worked with the UW to update the evaluative criteria in this report card to capture the latest in policy trends, good and bad, to give states an overall rating indicating whether they are doing well, making progress or falling behind when it comes to passing and implementing balanced pain policies. Because our evaluation criteria has changed, states' grades in our 2018 Pain Report Card cannot be compared to past report ratings. The new criterion has been applied to state laws, regulations and policies that were in place as of December 31, 2017. The Pain Report Card is available for download here: www.acscan.org/painreportcard.

ACS CAN emphasizes the need for a balanced approach to curbing opioid misuse and abuse while maintaining access to pain relief for patients.

Legislative Proposals Introduced Related to Pain Management/Opioid Issues

2015
< 80 Proposals

2018
> 470 Proposals

STATE PAIN POLICY REPORT CARD

What's New

- Updated methodology reflecting current trends in pain and opioid policies, including restrictions on opioid dosing and prescription durations for long-term treatment;
- New section on state prescription drug monitoring programs;
- In-depth information and direct links to the laws, regulations and policies evaluated for each state available in an interactive database http://lawatlas.org; and
- State-specific report cards with details about state ratings, available at www.acscan.org/painreportcard.

Policy Definitions and Prescription Limits

How does the state define key terms, like "addiction," "practice of medicine," or "unprofessional conduct" that could affect the provisions of pain management? Are there limits on the amount, length or strength of prescriptions for controlled substances, and/or opioids? Are these definitions or limits reasonable and based on policy models?

Efforts to Assess and Improve Pain Treatment

Does state policy recognize that reducing controlled substance-related harms, while essential, should not cause barriers for patients legitimately in need? How is pain management officially evaluated by regulatory agencies? What resources does the state provide to practitioners and facilities to improve the treatment of pain?

Expectations of Healthcare Practitioners for Pain Treatment

Is the standard of practice for practitioners to integrate treatment options, individualize plans for care, and assess patient functioning? Do these expectations incentivize appropriate treatment that actively involves the patient? Are benefits and risks of treatment considered and monitored?

Prescription Drug Monitoring Programs

What is the time limit for submitting data to the Prescription Drug Monitoring Program (PMP)? Are PMP data shareable with other states' programs? Are practitioners required to register with and check the PMP, as well as participate in training to use the program? Is the PMP used to identify patterns indicating inappropriate use of monitored medications? Is the impact of the PMP evaluated and reported and, if so, what outcomes are evaluated and to whom are the outcomes reported?

Prevention Introduction

Many cases of cancer are preventable by changing behaviors such as avoiding tobacco use. According to a recent study, at least 42 percent of newly diagnosed cancers in the U.S. are potentially avoidable, including 19 percent that are caused by smoking and 18 percent that are caused by a combination of excess body weight, physical inactivity, excess alcohol consumption and poor nutrition.[1] Also, many of the more than 5 million skin cancer cases that are diagnosed annually could be prevented by protecting skin from excessive sun exposure and avoiding indoor tanning devices.[2]

Tobacco

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

We have made progress in the last few decades by implementing comprehensive tobacco control strategies. The most recent data available suggests 7.6 percent of high school students nationwide smoke cigarettes – a lower rate than ever before.[4] Despite the proven health risks, 15.5 percent of U.S. adults, approximately 37.8 million people, still smoke cigarettes, according to the most recent 2016 data.[5]

There is more to the story, though, when it comes to seeing a decline in smoking. The problem with tobacco dependence goes beyond just smoking and it affects certain populations more than others. In 2017, 19.6 percent of high school students reported current use of any tobacco product, 9.2 percent of which reported using more than one kind of tobacco product. In 2015, 20.1 percent of U.S. adults used any tobacco product, 3.9 percent of which reported using more than one kind of tobacco product. Proven population-level interventions that focus on the diversity of tobacco product use are important to reducing tobacco-related disease and death in the U.S.[6]

There are three proven ways to reduce tobacco use and secondhand smoke exposure. Like a three-legged stool, each component works in conjunction with the others, and all three are necessary to overcome this country's tobacco epidemic.

- Increase the price of tobacco products through regular and significant tobacco tax increases of at least $1.00 per pack of cigarettes with an equivalent rate on other tobacco products;
- Implement comprehensive smoke-free policies; and
- Adequately fund evidence-based tobacco prevention and cessation programs.

In addition to these three proven tobacco control policy interventions, the American Cancer Society Cancer Action Network (ACS CAN) pursues other evidence-based policies that will prevent and reduce tobacco use including raising the age of sale for tobacco products to 21, restricting the sale of flavored tobacco products and limiting the quantity and location of tobacco retailers. Additionally, increased access to cessation coverage in Medicaid and private insurance plans, as well as hard-hitting media campaigns like the Centers for Disease Control and Prevention's (CDC) national *Tips from Former Smokers* campaign, have supported people who use tobacco in quitting permanently.[9, 10]

According to the U.S. Surgeon General, more than 20 million premature deaths over the past half century can be attributed to cigarette use in the U.S.[3]

2017 high school students reported as currently using tobacco by product:

- 11.7 percent use e-cigarettes (1,730,000 students)
- 7.6 percent use cigarettes (1,120,000 students)
- 7.7 percent use cigars, cigarillos, or little cigars (1,130,000 students)
- 5.5 percent use smokeless tobacco (810,000 students)
- 3.3 percent use hookahs (480,000 students)
- 0.8 percent use pipe tobacco (120,000 students)
- 0.7 percent use bidis (small hand-rolled cigarettes)[7] (100,000 students)

2015 adults reported as currently using tobacco by product:

- 15.1 percent of adults used cigarettes (36.5 million adults)
- 3.5 percent used electronic cigarettes (e-cigarettes) (7.9 million adults)
- 3.4 percent used cigars, cigarillos, or filtered little cigars (7.8 million adults)
- 2.3 percent used smokeless tobacco (5.1 million adults)
- 1.2 percent used regular pipes, water pipes, or hookahs[8] (2.7 million adults)

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

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

Prevention

Stopping Cancer Before It Starts

Did You Know?

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

Healthy Eating and Active Living Environments

While 18 percent of all cancers are tied to poor nutrition, physical inactivity, excess weight and excess alcohol consumption,[12] there are policy interventions that provide increased access to affordable healthy foods and increased physical activity opportunities.[13] It will take multi-faceted policy approaches across populations, systems, and environments to enhance nutrition and physical activity and reduce obesity rates by removing barriers, changing social norms and increasing awareness. Reducing the risk of cancer can only occur when all levels of government collaborate with public, private and community sector partners to decrease obesity rates, improve nutrition and increase physical activity.

Indoor Tanning

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

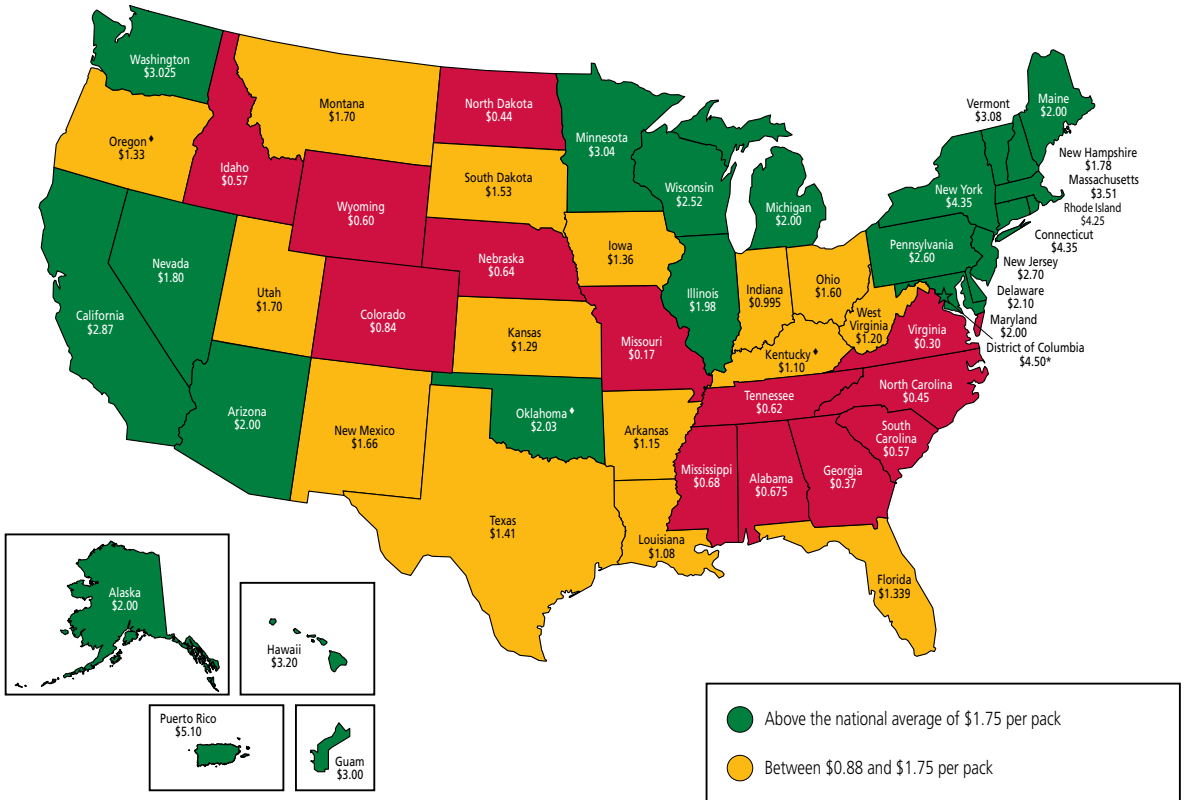
Tobacco Excise Taxes

Raising the Price, Ending the Addiction

The Challenge

While the personal toll of tobacco is high, this deadly product also costs the U.S. economy billions of dollars in health care costs and lost worker productivity. Total health care spending, public and private, is around $170 billion each year.[1] In fact, smoking-related health costs and productivity losses in the U.S. amount to roughly $19.16 per pack of cigarettes sold.[2] Despite this, the average retail price of a pack of cigarettes in the U.S. remains at $6.43.[3]

2018 State Cigarette Excise Tax Rates



How Do You Measure Up?

Tobacco taxes for Puerto Rico and Guam are not included in the national average.
Rates in effect as of 7/1/18
♦ Legislative or regulatory changes made in 2018
*Effective Oct. 1, 2018. Not considered in the current national average.

Tobacco Excise Taxes

Raising the Price, Ending the Addiction

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

As of July 1, 2018, the average state cigarette excise tax was $1.75 per pack, but state cigarette excise tax rates vary widely, from a low of 17 cents per pack in Missouri to a high of $4.35 in New York and Connecticut and $5.10 in Puerto Rico. Since 2000, all but two states – Missouri and North Dakota – have raised their cigarette taxes in nearly 140 separate instances.[4]

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

The tobacco industry knows how effective significant tobacco tax increases are and works hard to keep taxes low – often times going as far as proposing small tax increases that they know are too insignificant to have any effect on tobacco sales, consumption or incidence of tobacco-related diseases.

The Solution

American Cancer Society Cancer Action Network (ACS CAN) recommends regularly increasing cigarette taxes by a minimum of $1.00 per pack to have a meaningful public health impact. States should also regularly increase the tax on OTP at a rate equivalent to the state's tax on cigarettes. Additionally, dedicating tobacco tax revenues to tobacco prevention and cessation programs, along with other programs that help prevent cancer and benefit cancer patients, can help amplify the benefits of a tax increase and further reduce suffering and death from tobacco-related diseases.

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

A Win-Win-Win for States

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

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

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

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

Missed Opportunity

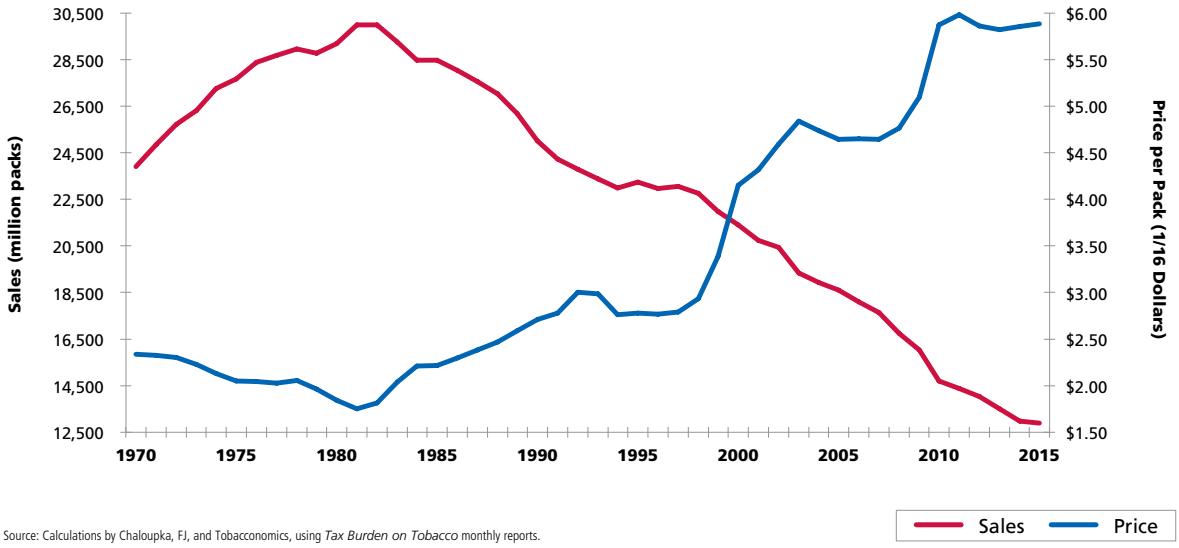
Kentucky now has the second-highest smoking rates for adults and youths among all 50 states, according to the most recent data from the Centers for Disease Control and Prevention. When Kentucky lawmakers were presented with the opportunity to raise the tobacco tax during the 2018 legislative session, this dangerously high rate of people addicted to tobacco should have motivated them to take decisive action on a large cigarette tax increase. A significant tobacco tax increase would have helped reduce consumption, save lives, generate revenue, and save money on preventable health care costs. Research shows that markedly higher cigarette taxes deliver an especially strong public health impact by significantly increasing the sale price of cigarettes, even in the face of targeted coupons and discounts from the tobacco industry, which they design to undercut the effectiveness of the tax. Yet, even when provided with all the facts, Kentucky House and Senate decision-makers missed this real opportunity, choosing instead to adopt a relatively low cigarette tax increase amount of only 50 cents per pack to fill their budget gaps, but fail to improve public health. States that enact such low cigarette tax increases typically fall prey to the tobacco industry's deadly price manipulation strategies that seek to keep cigarettes attractive and affordable. Because of the Legislature's failure to increase the price of tobacco significantly, we can expect little change to the fact that 2,900 Kentucky youths will become addicted to cigarettes this year, and 119,000 Kentucky kids alive today will ultimately die prematurely from smoking.

The Power of Advocacy

Tobacco Excise Taxes

Raising the Price, Ending the Addiction

Cigarette Prices and Cigarette Sales, United States, Inflation Adjusted, 1970-2015



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

Success Story

Oklahoma

The Oklahoma legislature began the calendar year in 2018 with unfinished business regarding a cigarette tax increase. Significant tobacco tax increases are proven to reduce tobacco use and, therefore, decrease the toll this deadly product puts on the state. Late in 2017, the state's Supreme Court ruled that the cigarette tax increase as adopted by the legislature was unconstitutional as it was passed during the last five days of session and failed to receive the necessary three-fourths vote.

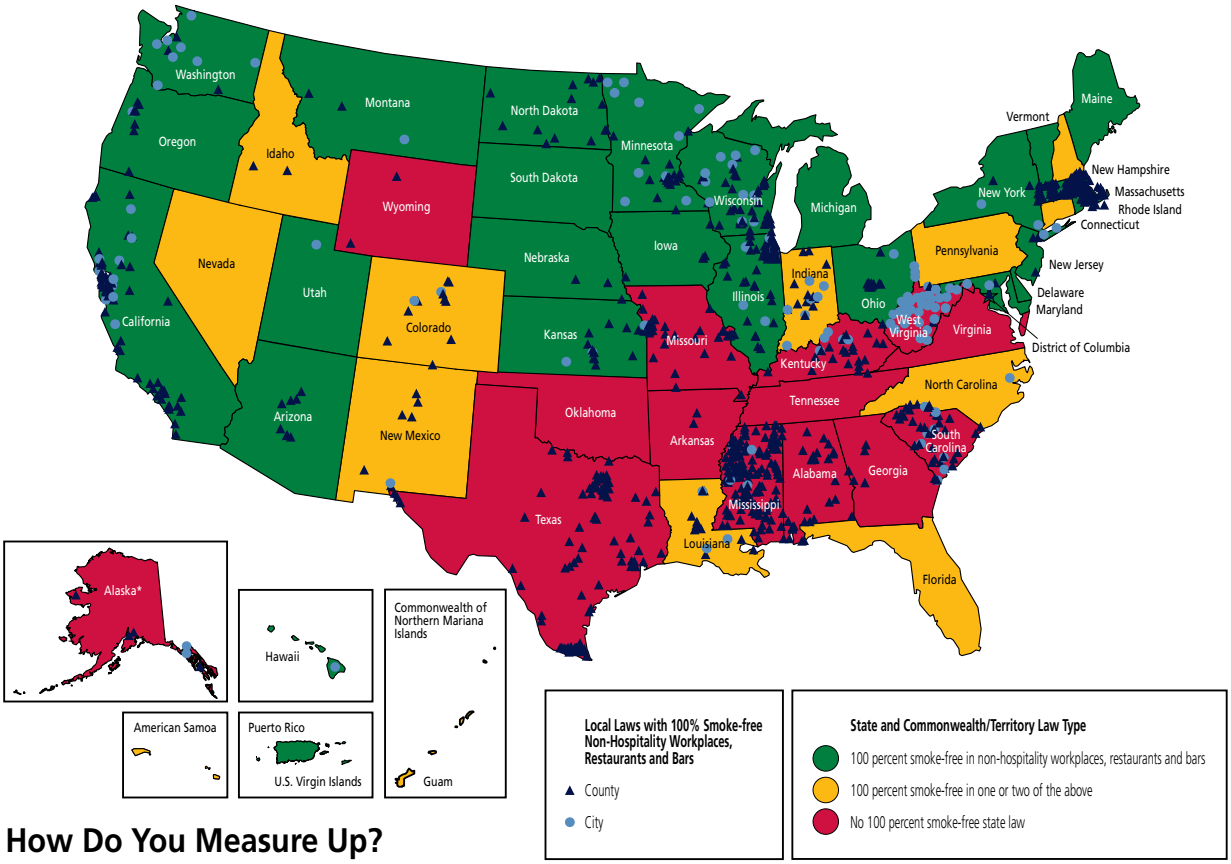
Early in 2018, Gov. Mary Fallin called a special session to address carryover issues from the 2017 legislative session including revisiting the cigarette tax increase. Throughout the special session and during the legislative session, Fallin continued to advocate for a significant cigarette tax to be included in any budget proposal that reached her desk. After extensive advocacy efforts from ACS CAN staff and volunteers and other health and education groups, legislative leadership finally succeeded in constructing a viable revenue package that included a lifesaving $1.00 per pack cigarette tax increase. Fallin signed the bill as adopted by the required three-fourths legislative majority.

The $1.00 per pack cigarette tax increase is estimated to prevent more than 17,000 young people in Oklahoma from becoming adults who smoke.

Smoke-free Laws

Everyone Has the Right to Breathe Smoke-free Air

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



How Do You Measure Up?

Note: American Indian and Alaska Native sovereign tribal laws are not reflected on this map.
Source: American Nonsmokers' Rights Foundation U.S. Tobacco Control Laws Database(c), 07/01/18
In effect as of July 1, 2018
*Law is scheduled to go into effect on October 1, 2018.

The Challenge

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

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

As of July 1, 2018, 25 states, Puerto Rico, the U.S. Virgin Islands, the District of Columbia and 976 municipalities across the country have laws in effect that require 100 percent smoke-free workplaces, including restaurants and bars.[7]

Smoke-free Laws

Everyone Has the Right to Breathe Smoke-free Air

Seventeen of these states, as well as Puerto Rico and the U.S. Virgin Islands, also include gaming facilities in their comprehensive smoke-free laws. Nationwide, nearly 60 percent of the U.S. population lives in a place with a comprehensive smoke-free law covering workplaces, including restaurants and bars.[8]

The American Cancer Society Cancer Action Network (ACS CAN) advocates for everyone's right to breathe smoke-free air so no one is forced to choose between their health and a paycheck. Yet, certain segments of the population, such as hospitality and gaming facility workers in states or communities without comprehensive laws, continue to be denied their right to breathe smoke-free air.

The Solution

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

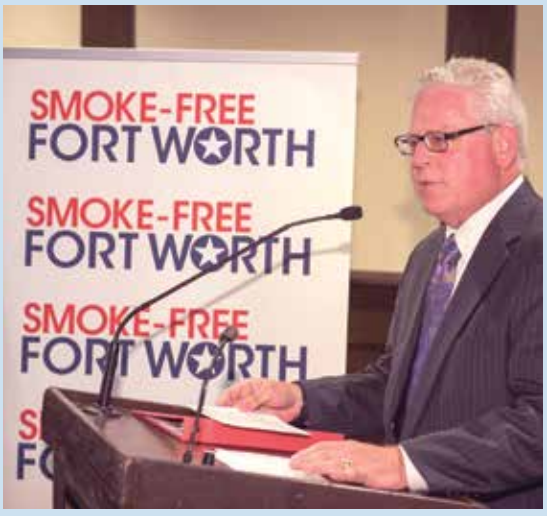
ACS CAN urges state and local officials to pass and protect comprehensive smoke-free laws in all workplaces, including restaurants, bars and gaming facilities, to protect the health of all employees and patrons. These laws should include electronic cigarettes, cigars and hookah as well. Lawmakers are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

Did You Know?

Smoke-free laws are good for business.

- The 2014 Surgeon General's report estimated the economic value of lost wages, fringe benefits, and services associated with premature death due to secondhand smoke exposure to be $5.7 billion per year nationwide. This estimate excludes the losses due to disease and far underestimates the total economic impact of secondhand smoke.[11]
- Research strongly indicates that smoke-free laws are good for businesses, for workers, and for customers. Research published in leading scientific journals has shown consistently and conclusively that smoke-free laws have no adverse effects on the hospitality industry, and actually benefit businesses.[12, 13, 14]

Success Story



During 2017, significant progress was made in many communities across the Rio Grande Valley in Texas to protect residents from exposure to secondhand smoke. By the end of 2017, the number of cities with comprehensive smoke-free ordinances in the state had increased to 88 cities, up from 58 cities the year before, protecting 12.4 million Texas residents and bringing Texas even closer to having 50 percent of the state's total population protected by smoke-free ordinances.

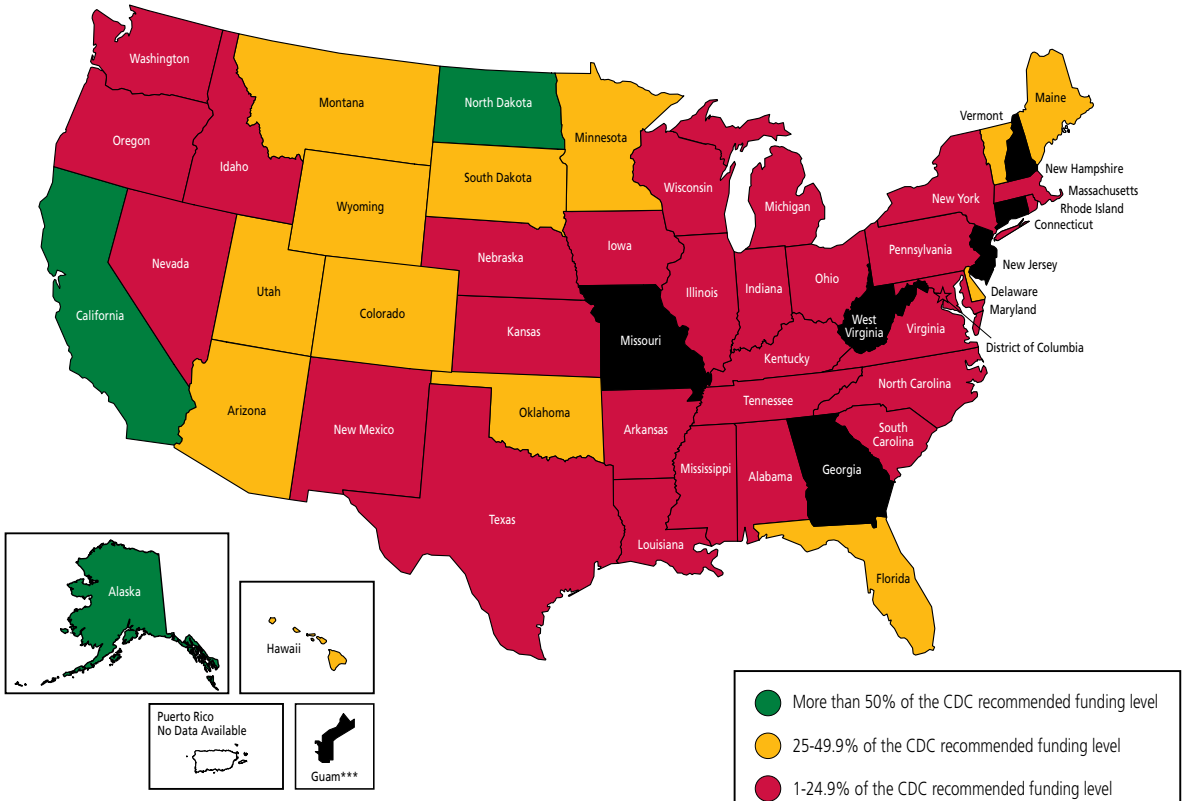
Notably, Fort Worth - with a population of more than 850,000, making it the 16th-largest city in the U.S. – became the last of Texas' large cities to join the list of smoke-free cities when the Council adopted a comprehensive ordinance in December, 2017. The success of the Fort Worth effort is the result of more than a decade of work educating the public and Council Members on the importance of a strong smoke-free ordinance that would protect all workers, including bars, restaurants and casinos. Because of this hard work, today no employee in Fort Worth has to choose between their health and a paycheck.

The work done across Texas in 2017 was recognized by Americans for Nonsmokers' Rights Foundation with their Indoor Air Challenge Award, the organization's top public health award. It was given to Texas for enacting the greatest number of local smoke-free workplace laws in any U.S. state. ACS CAN encourages Texas decision-makers to continue building on this progress to protect more workers and the public from the deadly toxins found in secondhand smoke.

Tobacco Control Program Funding

Supporting People in Their Attempts to Quit and Keeping Kids from Starting

Fiscal Year 2018 State Funding for Tobacco Control



How Do You Measure Up?

Source for Tobacco Prevention Funding, unless otherwise noted: Robert Wood Johnson Foundation, Campaign for Tobacco-Free Kids, American Cancer Society Cancer Action Network, American Heart Association, American Lung Association, and Americans for Nonsmokers' Rights. Broken Promises to Our Children: A State-by-State Look at the 1998 State Tobacco Settlement 19 Years Later. December 2017. Available at http://www.tobaccofreekids.org/microsites/statereport2017/. Source for Funding Recommendations: Centers for Disease Control and Prevention (CDC). *Best Practices for Comprehensive Tobacco Control Programs - 2014*. Atlanta, GA: U.S. Department of Health and Human Services, CDC, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014. ***Data for Guam provided by local ACS CAN staff.

The Challenge

One of the most effective ways to reduce death and disease from tobacco use is to prevent the addiction in the first place. While smoking rates have declined overall in recent years, 95 percent of people who smoke still tried their first cigarette before the age of 21.[1] Many young people who use tobacco do not identify the type of tobacco they use as a tobacco product or do not identify the tobacco product as harmful.[2] It's imperative that steps are taken to ensure programs are in place to protect the next generation from a lifetime of addiction.

In a disturbing trend, state legislatures have gutted tobacco prevention and cessation program funding across the country. Twenty-three states and the District of Columbia experienced a decline in tobacco control funding in fiscal year 2018. North Dakota's program funding was cut from over

100 percent of the CDC-recommended level to just 53.9 percent.[3] Connecticut and West Virginia have allocated no state funding for tobacco prevention and cessation programs. Not a single state currently funds tobacco prevention programs at the CDC-recommended level.

The 2014 U.S. Surgeon General's report on tobacco concluded that comprehensive statewide and community tobacco prevention and cessation programs reduce tobacco use by keeping young people from becoming addicted and helping individuals who use tobacco to quit.[4] The report called for states to fully fund these programs at levels recommended by the Centers for Disease Control and Prevention (CDC) as part of a comprehensive strategy to accelerate progress in eliminating death and disease caused by tobacco use.

Despite the well-established link between comprehensive tobacco prevention and cessation programs and reductions in tobacco use, most states are falling behind when it comes to adequately funding these programs. Although states are estimated to collect $27.5 billion in fiscal year 2018 in tobacco taxes and Master Settlement Agreement (MSA) payments (billions of dollars in yearly installments the tobacco companies agreed to pay states and territories as compensation for costs associated with tobacco-related diseases), they are slated to spend only 2.6 percent of that revenue on programs to reduce tobacco use.[5] Only two states – California and Alaska – fund their programs at over 90 percent of the CDC-recommended level. It would only take 12 percent of existing annual state tobacco tax and settlement revenue to fund all state programs at CDC-recommended levels.[6]

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

Tobacco Control Program Funding

Supporting People in Their Attempts to Quit and Keeping Kids from Starting

State Tobacco Control Funding - FY 2018

State	State Tobacco Prevention Funding Allocations (FY18)*	CDC Recommended Spending	Tobacco Prevention Spending % of CDC Recommended
California	$327.8 million	$347.9 million	94.2%
Alaska	$9.5 million	$10.2 million	93.1%
North Dakota	$5.3 million	$9.8 million	53.9%
Delaware	$6.4 million	$13.0 million	48.9%
Hawaii	$6.6 million	$13.7 million	48.1%
Colorado	$24.2 million	$52.9 million	45.7%
Oklahoma	$19.0 million	$42.3 million	45.0%
Wyoming	$3.7 million	$8.5 million	43.6%
Vermont	$3.6 million	$8.4 million	42.4%
Minnesota	$20.6 million	$52.9 million	38.9%
South Dakota	$4.5 million	$11.7 million	38.5%
Utah	$7.2 million	$19.3 million	37.4%
Montana	$5.2 million	$14.6 million	35.8%
Florida	$68.6 million	$194.2 million	35.3%
Maine	$5.3 million	$15.9 million	33.0%
Arizona	$17.8 million	$64.4 million	27.6%
New Mexico	$5.7 million	$22.8 million	24.9%
Arkansas	$8.9 million	$36.7 million	24.3%
Mississippi	$8.4 million	$36.5 million	23.1%
Maryland	$10.6 million	$48.0 million	22.0%
Oregon	$8.2 million	$39.3 million	20.7%
New York	$39.3 million	$203.0 million	19.4%
Idaho	$2.7 million	$15.6 million	17.4%
Iowa	$4.1 million	$30.1 million	13.5%
Nebraska	$2.6 million	$20.8 million	12.4%
Pennsylvania	$15.8 million	$140.0 million	11.3%
Indiana	$7.5 million	$73.5 million	10.2%
South Carolina	$5.0 million	$51.0 million	9.8%
Louisiana	$5.8 million	$59.6 million	9.7%
Ohio	$12.5 million	$132.0 million	9.5%
Virginia	$8.5 million	$91.6 million	9.3%
Wisconsin	$5.3 million	$57.5 million	9.2%
District of Columbia	$0.9 million	$10.7 million	8.7%
Tennessee	$6.2 million	$75.6 million	8.2%
Massachusetts	$3.7 million	$66.9 million	5.6%
Illinois	$7.3 million	$136.7 million	5.3%
Kentucky	$2.6 million	$56.4 million	4.6%
Nevada	$1.0 million	$30.0 million	3.2%
Kansas	$0.8 million	$27.9 million	3.0%
Rhode Island	$0.4 million	$12.8 million	2.9%
Alabama	$1.3 million	$55.9 million	2.3%
Washington	$1.4 million	$63.6 million	2.2%
North Carolina	$2.1 million	$99.3 million	2.1%
Texas	$4.5 million	$264.1 million	1.7%
Michigan	$1.6 million	$110.6 million	1.4%
Georgia	$0.9 million	$106.0 million	0.9%
New Hampshire	$0.1 million	$16.5 million	0.8%
New Jersey	$0.5 million	$103.3 million	0.5%
Missouri	$48,500	$72.9 million	0.1%
Connecticut	$0 million	$32.0 million	0.0%
West Virginia	$0 million	$27.4 million	0.0%
Guam***	$0.0	N/A	N/A

Source for Tobacco Prevention Funding, unless otherwise noted: Robert Wood Johnson Foundation, Campaign for Tobacco-Free Kids, American Cancer Society Cancer Action Network, American Heart Association, American Lung Association, and Americans for Nonsmokers' Rights. Broken Promises to Our Children: A State-by-State Look at the 1998 State Tobacco Settlement 19 Years Later. December 2017. http://www.tobaccofreekids.org/microsites/statereport2017/.
Source for Funding Recommendations: Centers for Disease Control and Prevention (CDC). *Best Practices for Comprehensive Tobacco Control Programs - 2014.* Atlanta, GA: U.S. Department of Health and Human Services, CDC, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.
***Data for Guam provided by local ACS CAN staff.

The Solution

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

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

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

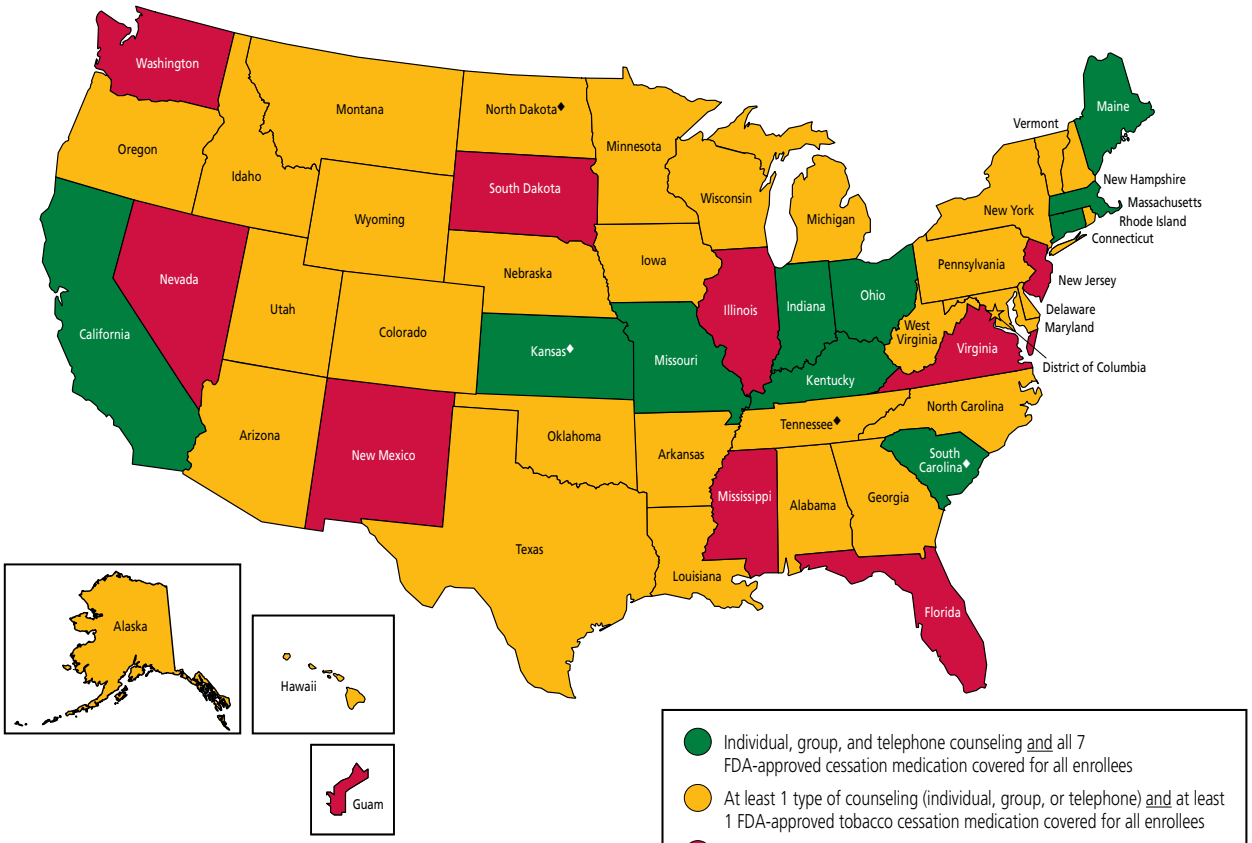
Did You Know?

The more states spend on comprehensive tobacco control programs, the greater the reductions in tobacco use. The longer states invest in such programs, the greater and quicker the impact and the more cost savings experienced. Cost savings result from tobacco control program investments in the form of reductions in smoking-caused pregnancy and birth complications, smoking-triggered asthma and respiratory illness, including those caused by secondhand smoke, and other smoking-caused diseases such as strokes, heart disease and cancer.[8]

- California's tobacco control program reduced health care costs by $134 billion from 1989 to 2008, by spending only $2.4 billion on the program during the same time period.[9]
- Massachusetts estimates an annual health care cost savings of $85 million from its tobacco control investments, averaging a savings of $2 for every $1 spent.[10]
- A 2011 study found that Washington state saved more than $5.00 in tobacco-related hospitalization costs for every $1.00 spent during the first 10 years of its program.[11]

Despite the well-established link between comprehensive tobacco prevention and cessation programs and reductions in tobacco use, most states are falling behind when it comes to adequately funding these programs.

Medicaid Coverage of Tobacco Cessation Treatments (Traditional Medicaid)



How Do You Measure Up?

Source unless otherwise noted: Singleterry J, Jump Z, DiGiulio A, et al. State Medicaid Coverage for Tobacco Cessation Treatments and Barriers to Coverage – United States, 2014-2015. *MMWR* 2015; 64(42): 1194-9. Updates provided through correspondence with the American Lung Association.
*Coverage in only some plans or only for pregnant women does not count as coverage for all enrollees.
♦ Legislative or regulatory changes made in 2018

The Challenge

As previously discussed, there are proven strategies to prevent children and adults from using tobacco products and to help those who currently use tobacco to quit. But quitting isn't easy. Among all current U.S. adults who smoke, nearly seven out of every 10 reported in 2015 that they wanted to quit completely.[1] It may take up to 10 attempts to successfully quit smoking.[2]

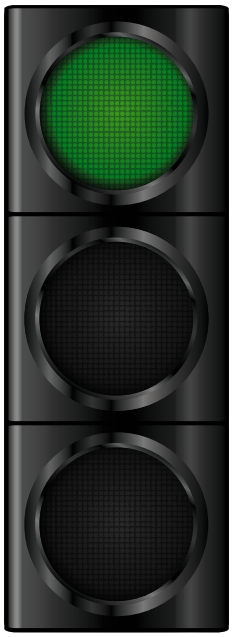
Those individuals who rely on Medicaid for their health care have a smoking rate that is higher than the overall adult smoking rate and more than double that of individuals with private insurance – 25.3 percent of adults using Medicaid smoke,

compared with 15.5 percent of adults overall and 11.8 percent of adults with private insurance.[3] Despite this high smoking rate, in 2013, only 23 percent of people on Medicaid who smoked received cessation medications.[4] All tobacco users, including those enrolled in Medicaid, need access to a range of treatments to determine which cessation tools work best for them. Research shows that the most effective tobacco cessation treatments combine cessation counseling and medications approved for that purpose by the Food and Drug Administration (FDA).

While Medicaid programs in all 50 states and the District of Columbia provide access to some tobacco cessation coverage, many gaps in coverage exist. Currently, only 11 states – California, Connecticut, Indiana, Kansas, Kentucky, Ohio, Maine, Massachusetts, Missouri, North Dakota, and South Carolina – provide comprehensive tobacco cessation coverage in Medicaid that includes individual, group and telephone counseling, including reimbursement through the state quitline, and all seven FDA-approved tobacco cessation medications.

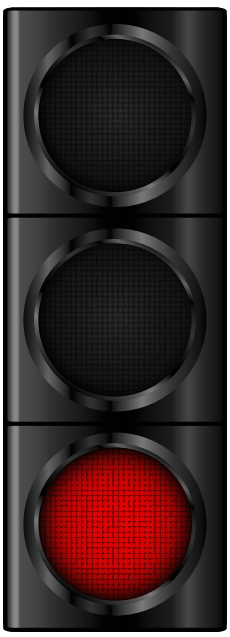
Even when state Medicaid programs cover cessation services, they often put procedures in place that limit a patient's access to the medications and counseling they need to quit, such as copays or limits on the duration of treatment. When tobacco users have access to more cessation medication and counseling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

Comprehensive Cessation Benefits Should Include Coverage for:



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

A Comprehensive Cessation Benefit Poses No Barriers to Accessing Services:



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

Tobacco Cessation Services in Medicaid

Closing the Gaps in Coverage

The Solution

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

Given the great need for cessation services in the Medicaid population, the American Cancer Society Cancer Action Network (ACS CAN) advocates that Medicaid programs provide a comprehensive cessation benefit that covers individual, group and telephone-based counseling and all FDA-approved tobacco cessation medications without cost-sharing or other barriers to accessing care.

Covering tobacco cessation services for all tobacco users in all health plans, especially those enrolled in Medicaid, is critical to reducing tobacco use, saving lives, and ultimately saving money. In addition to providing all FDA-approved tobacco cessation medications and all three types of counseling, ACS CAN advocates that state Medicaid programs reimburse state quitlines for the telephone counseling services they provide to their patients. Ensuring that Medicaid covers phone counseling provided by quitlines increases the capacity of a state's quitline and provides an added layer of sustainability, insulating it from state budget cuts. Having a centralized state quitline is part of a comprehensive tobacco control program and ensures quality of services and allows for effective surveillance and evaluation of these services. Additionally, state Medicaid dollars receive a federal match, so allocating Medicaid dollars to reimburse quitlines means more funding for this vital service.

Success Story

Comprehensive, Barrier-Free Tobacco Cessation Saves Lives, Improves Health, Reduces Health Care Costs

Kansans continue to use tobacco at high rates, with 17 percent of adults smoking and particularly high rates among Medicaid participants at 36 percent. Tobacco use is especially prevalent and deadly among Kansans with serious mental illness and substance use disorders. Despite this high level of tobacco use, very few Medicaid participants are utilizing available tobacco cessation benefits. After years of collaborative work led by the National Alliance on Mental Illness – NAMI Kansas, to support tobacco cessation among Kansans with mental illness, it became clear that the limited cessation coverage available through the Medicaid program was a barrier to improved health among Kansans with mental illness and substance use disorders. Medicaid beneficiaries were limited to one quit attempt per year and counseling was only covered for pregnant women.

ACS CAN, NAMI Kansas, the American Heart Association, and other health advocates worked to strengthen tobacco cessation benefits available to Medicaid participants. Legislation was introduced by Sen. Barbara Bollier to allow multiple quit attempts using pharmacotherapy as well as individual, telephone, and group counseling. Leading up to a hearing on this bill, NAMI Kansas released an economic analysis by a health economist at University of Kansas demonstrating the potential economic benefits of stronger tobacco cessation treatment. Following an outpouring of support from health groups and advocates, the senate public health and welfare committee voted unanimously to advance the legislation. Unfortunately, the bill was not allowed to come up for a vote in the full senate because of unrelated issues. Undeterred, senate public health and welfare chairwoman, Vicki Schmidt, introduced the legislation in a new bill and the committee again advanced it with unanimous support. After that bill was blocked from coming up for a vote, we worked with legislative supporters to pass the policy by a budget proviso during the legislative veto session. Starting July 1, all Kansas Medicaid participants who use tobacco will be eligible to access individual, telephone, and group tobacco cessation counseling as well as coverage for up to four quit attempts per year using FDA-approved pharmacotherapy treatments.

Did You Know?

- Tobacco use by those who rely on Medicaid for their health care results in tobacco-related disease making up 15 percent of total Medicaid expenditures ($40 billion dollars per year),[5] — an average of $833 million per state.[6]
- During a period of two years, when Massachusetts covered pharmacotherapy, counseling and outreach, it spent about $183 per participant, and saved an estimated $571 per participant in annual hospital costs. For every $1 spent, it received $3.12 in medical savings for cardiovascular conditions alone. For every $1 spent, it received a $2.12 return on investment.[7]

The Challenge

For the majority of Americans who do not use tobacco, the greatest behavioral risk factors for cancer are diet, levels of physical activity, amount of alcohol consumption and weight.[1] Approximately 18 percent of all cancers are caused by poor diet, physical inactivity, excess weight and excess alcohol consumption.[2] In fact, excess weight increases the risk for 13 cancers.[3]

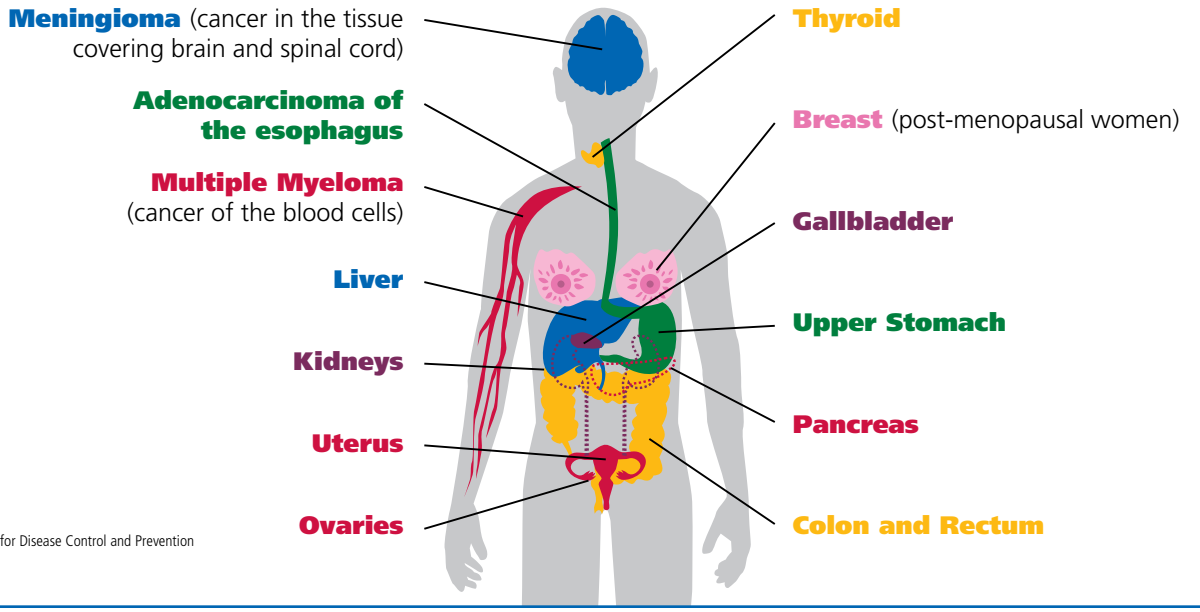
While rates of excess weight and obesity have begun to level off over the past decade, currently 69 percent of adults[4] and 32 percent of young people ages two through 19[5] are overweight or obese. These high rates of childhood obesity and excess weight are particularly troubling because children who are overweight are much more likely to remain so as adults.

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

The Solution

The American Cancer Society's Guidelines on Nutrition and Physical Activity for Cancer Prevention recommend that individuals achieve and maintain a healthy weight; adopt a physically active lifestyle; consume a healthy diet with an emphasis on plant-based foods; and limit consumption of alcoholic beverages.[11]

13 Cancers Are Associated with Overweight and Obesity



Source: Centers for Disease Control and Prevention

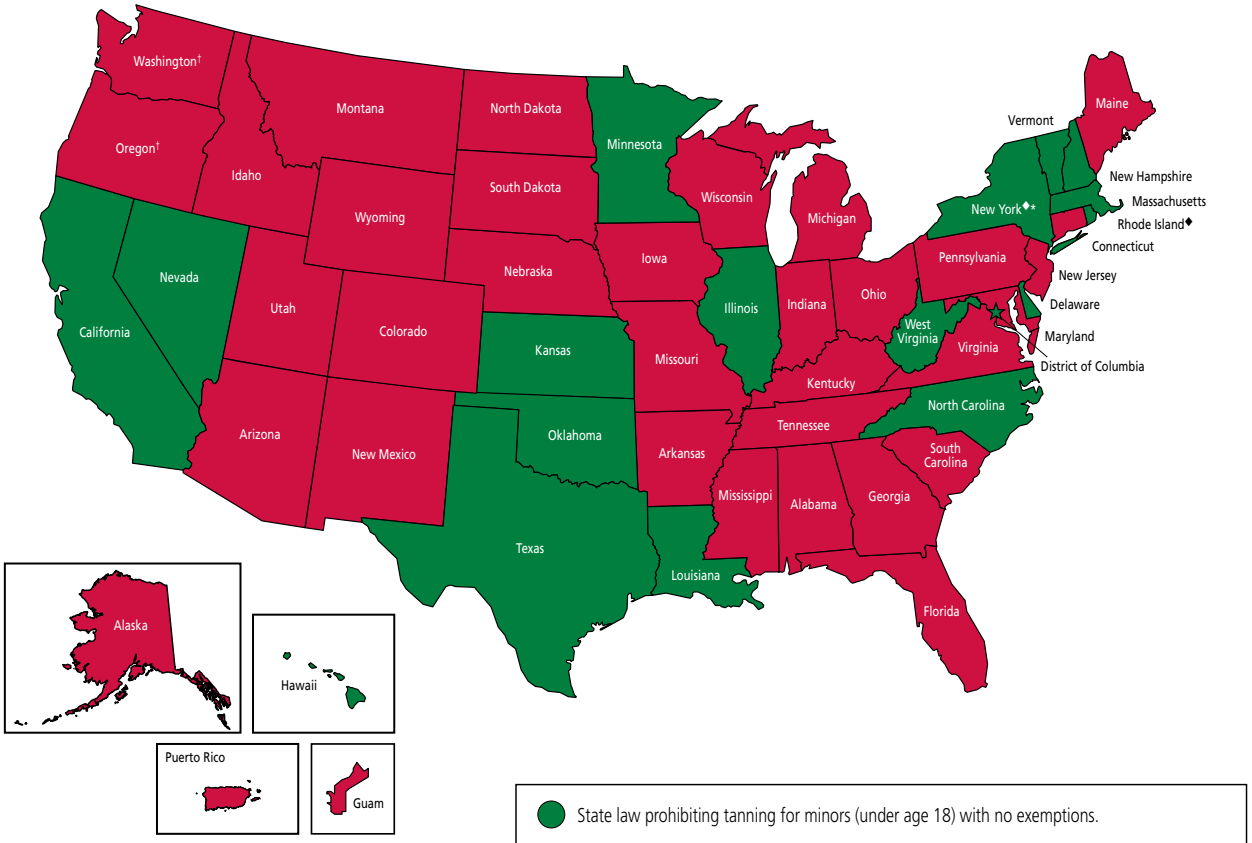
The guidelines also recommend that public, private and community organizations work collaboratively at all levels of government to implement policy and environmental changes that increase access to affordable, healthy foods; decrease access to foods with low nutritional value; and provide safe, accessible places for physical activity.[12] Multi-faceted policy approaches across a population can significantly enhance nutrition and physical activity and reduce obesity rates by removing barriers, changing social norms and increasing awareness.

ACS CAN supports well-designed sugary drink taxes as a part of this broader strategy to reduce cancers caused by poor diet, physical inactivity and excess weight. Existing evidence suggests taxing sugary drinks reduces consumption, but we must continue to increase the evidence about the effectiveness of these taxes and the most impactful tax structures. Thus far, very few cities and no states have passed sugary drink taxes of at least one cent per ounce. Each tax design proposed or passed has been structured differently in terms of price, which beverages are included, who pays the tax and where the funding goes. ACS CAN has developed a specific set of criteria designed to reduce consumption and generate investments back into the effort to reduce our overall obesity rates. ACS CAN will consider each tax proposal on a case-by-case basis to assess its health impact and alignment with our criteria.

Indoor Tanning

Protecting Kids from an Increased Cancer Risk

State Laws Prohibiting Minors from Using Tanning Devices



How Do You Measure Up?

Sources: Health Policy Tracking Service & Individual state bill tracking
† There is no medical indication for the use of a tanning device in the diagnosis or treatment of a disease.
♦ Legislative or regulatory changes made in 2018

The Challenge

Skin cancer is the most commonly diagnosed cancer in the U.S. Rates have continued to rise over the past 30 years,[1] though new evidence suggests young non-Hispanic white women may be experiencing a recent decline of melanoma, the deadliest type of skin cancer.[2] In 2018, an estimated 95,550 invasive skin cancers (the majority being melanoma) will be diagnosed in the U. S. Additionally, millions of cases of basal and squamous cell skin cancers will also be diagnosed.[3] It's estimated that 13,460 men and women will die of skin cancer this year in the U.S., and 9,320 of those deaths will be from melanoma.[4]

Exposure to ultraviolet (UV) radiation, through sunlight and indoor tanning devices, is the most avoidable risk factor for skin cancer. Despite the serious risks, misconceptions about indoor tanning exist, due, in large part, to misleading advertising and health claims put forth by the tanning industry.[5, 6] Young people are especially susceptible to the tanning industry's misleading marketing tactics aimed directly at this impressionable group through back-to-school, prom and homecoming specials.[7] This strategy is working as teens continue to tan at high rates despite the risks.

The most recent data indicates that one in nine high school girls used a tanning device, with numbers increasing to one in six by their senior year.[8] The use of indoor tanning devices by young people is a serious concern because studies show using an indoor tanning device before the age of 35 increases the risk of melanoma by 59 percent, squamous cell carcinoma by 67 percent and basal cell carcinoma by 29 percent.[9, 10] Risk for melanoma increases with the number of total hours, sessions and years that indoor tanning devices are used.[11, 12, 13] Melanoma is currently the second most common cancer among females aged 15 to 29, and the third most common cancer among females aged 25 to 29.[14]

The Solution

Age restriction laws that prohibit the use of indoor tanning devices for individuals under the age of 18 are effective in deterring minors from using tanning devices and can help to reduce skin cancer incidence and mortality rates across the country.[15, 16, 17, 18] Therefore, to protect young people from the damaging effects of UV radiation, the American Cancer Society Cancer Action Network (ACS CAN) recommends laws that prohibit individuals under 18 from using tanning devices with no exceptions. With usage rates increasing as teens get older, it is critical to protect all persons under the age of 18, not just younger teens. States need to ensure that these laws are enforced through licensing and fining tanning facilities, as well as clear avenues for consumers to file complaints. These enforcement measures and oversight mechanisms should be in place to guarantee that young people are not gaining access to these dangerous devices.

Volunteer Story

ACS CAN volunteer, Courtney Jusino, played a big role in the campaign to prohibit minors from using indoor tanning devices in Rhode Island. This issue was important to Courtney because she had previously worked in a tanning salon, used indoor tanning devices frequently starting at the age of 14, and was unfortunately diagnosed with skin cancer as a result. She fell for the myth that a base tan was a safe tan, which is often promoted by the tanning industry to mislead young people into using indoor tanning devices. Courtney learned the hard way that frequent tanning has devastating consequences and now she is on a mission to prevent young people from suffering as she did. She supports this bill that would ensure that young people can no longer using tanning devices, which passed during the 2018 session.

Courtney Jusino, Cranston, Rhode Island

Indoor Tanning

Protecting Kids from an Increased Cancer Risk

Success Story

New York

As New York's legislative session wound down, ACS CAN volunteers from across the state came together to secure the passage of legislation to prohibit the use of indoor tanning devices by anyone under 18. The bill was stalled in the Senate before ACS CAN volunteers answered the call to action and used their most powerful tool: their voices!

Approximately 130 volunteers gathered in Albany for ACS CAN's Day at the Capitol and urged lawmakers to help protect kids from dangerous exposure to carcinogenic indoor tanning devices. For weeks afterwards, volunteers continued to make their voices heard by emailing, calling and writing to lawmakers and the media about the dangers of indoor tanning devices. Eventually, their hard work paid off, and the bill passed the Senate and will be signed into law.

Among those fighting for change were Maggie Biggane and Collette Coyne. Both Maggie and Collette lost their daughters, Mollie and Collette, to melanoma. Their stories are a poignant reminder of why we must aggressively work to reduce the risk factors related to skin cancer. This victory belongs to all of ACS CAN's New York volunteers like Maggie and Collette who executed a tremendous outreach campaign and to the strong coalition of supporters that leant their influence to successfully pass this measure to protect New York kids.

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

State Preemption over Local Public Health Policies

A Threat to Innovative Public Policy Solutions

Did You Know?

The type of preemption that takes away authority of lower levels of government is known as "ceiling preemption,"[1] while "floor preemption" sets a minimum standard that does not limit the authority of lower levels of government.[2] Floor preemption can be an effective tool in public health policy whereby everyone receives equal protection across local communities, but local communities still have the power to go above and beyond the minimum standard.

The Challenge

Local governments have the power to pass laws that impact their community's health, happiness and prosperity. However, preemption—when a higher level of government revokes local authority[3]—can restrict local lawmakers' ability to pass innovative and proactive public health policies. Many important public health policies are often developed and passed at the local level, long before state legislatures take action. While states should set a minimum standard for public health protections, they should not prevent local governments from going above and beyond that minimum standard. If citizens benefit from greater local control, it is often special interests that benefit from preemption. In fact, Big Tobacco has labeled preemption its "first priority."[4]

Smoke-free laws serve as an example of what role preemption can play in public health. The smoke-free movement began at the local level and eventually inspired 25 states to pass comprehensive smoke-free laws.[5] In many cases, advocates learned over time how to improve these laws at the local level to make them as effective and impactful as possible. Now smoke-free environments are the expectation and reality in the majority of workplaces, including bars and restaurants around the country. However, in states that preempt local activity, many citizens remain exposed to secondhand smoke

Missed Opportunity

Arizona

Arizona was among the states where preemption over local sugary drink taxes was proposed. The law will prohibit local jurisdictions from taxing food products differently from one another and from taxing manufacturers, wholesalers, distributors or containers. This language could, in effect, eliminate the option for local jurisdictions to tax sugary drinks, among other foods. The Arizona example is of particular interest because no city in Arizona has even proposed a local sugary drink tax. ACS CAN staff in Arizona acted quickly to try to defeat the bill, but the bill's path had already been cleared for its quick passage. Now, communities in Arizona will not have the option to tax sugary drinks or explore similar options to help children and adults maintain a healthy weight as a way to reduce cancer risk.

State Preemption over Local Public Health Policies

A Threat to Innovative Public Policy Solutions

because their state governments do not pass comprehensive laws and their local governments are not allowed to act.

Raising the age of sale of tobacco products serves as another example of how preemption can stifle progress on an issue. In previous years, the tobacco industry succeeded in preempting local control over youth access laws. Now, as the debate continues over whether to raise the age of sale of tobacco products to 21, some localities have no authority to implement this policy option because of the earlier preemption by the tobacco industry. To make matters worse, some states have started new campaigns to pass preemption over the regulation of all tobacco products, halting future progress on emerging issues.

Additionally, there are threats to preempt local jurisdictions' ability to tax sugary drinks. Organized efforts to preempt sugary drink taxes have been attempted in states that have not even considered the issue at the local level yet. Not all attempts at preemption have been successful, but where states have passed preemption over public health policies, localities have been severely limited in their public policy options for achieving intended outcomes.

Success Story

Georgia

During the 2018 legislative sessions, various state legislatures attempted to preempt local communities from acting on tobacco control measures and sugary drink restrictions, among other public health issues. One such broad effort was undertaken in Georgia. Bills were introduced that would have preempted local governments from restricting or regulating anything that is already regulated by the United States Department of Agriculture (USDA), the United States Food and Drug Administration (FDA), or the Georgia Department of Agriculture. To translate, if this bill would have passed, local governments could not regulate tobacco products, foods or beverages. This would have stopped ACS CAN and its partners from working on policies related to restrictions on the sale of tobacco products as well as healthy eating and active living policies like reducing the sale of sugary drinks.

ACS CAN acted quickly in Georgia to defeat these measures by activating its grassroots network in opposition of these bills. One preemption bill was voted down on the House floor, but the effort resurfaced during the budget process. Once again, ACS CAN sprang into action generating calls into lawmakers' offices to pressure them to vote against preemption. In the end, we were successful and preemption over tobacco products and foods and beverages failed. That means local communities can continue to work on policies related to tobacco, healthy eating and active living as a form of cancer prevention.

The Power of Advocacy

The Solution

Passing public health policies at the local level creates community debate, education, and engagement opportunities that might not exist at the state or federal level.[6] This engagement leads to a broader and deeper understanding among the public as to the goals and importance of these public health approaches and can result in more sustainable policies.[7, 8] Once preemption is put in place, it is nearly impossible to remove[9, 10] so preemption defense should be a consideration when pursuing public health campaigns.

The American Cancer Society Cancer Action Network (ACS CAN) works at the local, state and federal levels, thus it supports each level of government's ability to implement policies to protect the public's health. To continue future advocacy efforts to reduce suffering and death from cancer, the right of local governments to pass public health policies must be preserved.

References

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

1 Ward E. Association of Insurance with Cancer Care Utilization and Outcomes. *CA: A Cancer Journal for Clinicians.* 2008; 58(1).
2 Kaiser Family Foundation. Key Facts About the Uninsured Population. November 29, 2017. https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/
3 Kaiser Family Foundation. How Premiums are Changing in 2018. November 29, 2017. https://www.kff.org/health-reform/issue-brief/how-premiums-are-changing-in-2018/
4 Centers for Medicare and Medicaid Services. Policies Related to the Navigator Program and Enrollment Education for the Upcoming Enrollment Period. August 31, 2017. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Policies-Related-Navigator-Program-Enrollment-Education-8-31-2017pdf.pdf
5 Public Law No. 115-97.
6 Congressional Budget Office. Repealing the Individual Health Insurance Mandate: An Updated Estimate. November 8, 2017. https://www.cbo.gov/publication/53300
7 See Keith, Katie. The Association Health Plan Proposed Rule: What It Says And What It Would Do. Health Affairs Blog. January 5, 2018. https://www.healthaffairs.org/do/10.1377/hblog20180104.347494/full/
8 See Appleby, Julie. Trump Administration Proposes Rule To Loosen Curbs On Short-Term Health Plans. Kaiser Health News. February 20, 2018. https://khn.org/news/trump-administration-unveils-proposed-rule-to-loosen-restrictions-on-short-term-health-plans/
9 Gasteier, Audrey Morse. With The Federal Individual Mandate Gone, States Might Step Up: Lessons From Massachusetts. Health Affairs Blog. January 16, 2018. https://www.healthaffairs.org/do/10.1377/hblog20180108.464274/full/
10 K. Lucia, J. Giovannelli, S. Corlette et al., State Regulation of Coverage Options Outside of the Affordable Care Act: Limiting the Risk to the Individual Market, The Commonwealth Fund, March 2018, available at http://www.commonwealthfund.org/~/media/files/publications/fund-report/2018/mar/lucia_state_regulation_alternative_coverage_options.pdf.
11 Alaska Office of the Governor. Federal Government to Distribute $58 Million to Alaska Reinsurance Program in 2018. February 9, 2018. https://gov.alaska.gov/newsroom/2018/02/federal-government-to-distribute-58-million-to-alaska-reinsurance-program-in-2018/

Increased Access to Medicaid: Extending Coverage and Improving Outcomes

1 American Cancer Society. *Cancer Facts & Figures 2018.* Atlanta: American Cancer Society; 2018.
2 Ibid.
3 Analysis provided to ACS CAN by Avalere Health. *Coverage of patients with cancer in Medicaid under the AHCA.* Analysis performed June 2017.
4 Ibid.
5 Centers For Disease Control and Prevention. National Breast and Cervical Cancer Early Detection Program (NBCCEDP). https://www.cdc.gov/cancer/nbccedp/about.htm. Accessed April 2018.
6 Aparna Soni, Kosali Simon, John Cawley, Lindsay Sabik, "Effect of Medicaid Expansions of 2014 on Overall and Early-Stage Cancer Diagnoses", *American Journal of Public Health* 108, no. 2 (February 1, 2018): pp. 216-218.
7 Dehkordy, SF, Hall, K, West, B, et al.. "Medicaid Expansion Improves Breast Cancer Screening for Low Income Women." November 30, 2015. <https://www2.rsna.org/timssnet/Media/pressreleases/14_pr_target.cfm?id=1849>
8 Ungar, Laura. "More KY Medicaid Patients Get Preventative Care." *Courier Journal.* August 7, 2015. Web <http://www.courier-journal.com/story/life/wellness/2015/08/05/preventive-care-rises-among-kentucky-medicaid-patients/31190973/>
9 Wisconsin Badger Care Reform, June 7, 2017, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wi/wi-badgercare-reform-pa.pdf.
10 Ohio Department of Medicaid Group VIII Work Requirement and Community Engagement 1115 Demonstration Waiver, http://medicaid.ohio.gov/Portals/0/Resources/PublicNotices/GroupVIII/Detail-GroupVIII-021618.pdf?ver=2018-02-16-092910-683.
11 Whitney RL, Bell JF, Reed SC, Lash R, Bold RJ, Kim KK, et al. Predictors of financial difficulties and work modifications among cancer survivors in the United States. *J Cancer Surviv.* 2016; 10:241. doi: 10.1007/s11764-015-0470-y.
12 de Boer AG, Taskila T, Tamminga SJ, et al. Interventions to enhance return to work for cancer patients. *Cochrane Database Syst Rev.* 2011; 16(2): CD007569. doi: 10.1002/14651858.CD007569.pub2.
13 Stergiou-Kita M, Pritlove C, van Eerd D, Holness LD, Kirsh B, Duncan A, Jones J. The provision of workplace accommodations following cancer: survivor, provider, and employer perspectives. J Cancer Surviv. 2016; 10:480. doi:10.1007/s11764-015-0492-5.
14 Ramsey SD, Blough DK, Kirchhoff AC, et al. Washington State Cancer Patients Found to be at Greater Risk for Bankruptcy then People Without a Cancer Diagnosis," Health Affairs, 32, no. 6, (2013): 1143-1152.
15 Wisconsin Badger Care Reform, June 7, 2017, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wi/wi-badgercare-reform-pa.pdf.
16 Ohio Department of Medicaid Group VIII Work Requirement and Community Engagement 1115 Demonstration Waiver, http://medicaid.ohio.gov/Portals/0/Resources/PublicNotices/GroupVIII/Detail-GroupVIII-021618.pdf?ver=2018-02-16-092910-683.

17 Jane Perkins, Catherine McKee & Leonardo Cuello. Summary of Lawsuit Filed Against HHS Approval of Kentucky Waivers. January 24, 2018. http://www.healthlaw.org/issues/medicaid/summary-of-lawsuit-filed-against-hhs-approval-of-kentucky-waivers#.WoXXbFWnGHs. Accessed April 2018.
18 Aparna Soni, Kosali Simon, John Cawley, Lindsay Sabik, "Effect of Medicaid Expansions of 2014 on Overall and Early-Stage Cancer Diagnoses", *American Journal of Public Health* 108, no. 2 (February 1, 2018): pp. 216-218.
19 Dehkordy, SF, Hall, K, West, B, et al.. "Medicaid Expansion Improves Breast Cancer Screening for Low Income Women." November 30, 2015. <https://www2.rsna.org/timssnet/Media/pressreleases/14_pr_target.cfm?id=1849>
20 Ungar, Laura. "More KY Medicaid Patients Get Preventative Care." *Courier Journal*. August 7, 2015. Web http://www.courier-journal.com/story/life/wellness/2015/08/05/preventive-care-rises-among-kentucky-medicaid-patients/31190973/

Breast and Cervical Cancer Early Detection Program: Detect and Protect

1 American Cancer Society. Cancer Facts & Figures 2018. Atlanta: American Cancer Society; 2018.
2 Ibid.
3 American Cancer Society. Cancer Treatment & Survivorship Facts & Figures 2016-2017. Atlanta: American Cancer Society; 2016
4 American Cancer Society. Breast Cancer Facts & Figures 2017-2018. Atlanta: American Cancer Society, Inc. 2017.
5 American Cancer Society. Cancer Prevention & Early Detection Facts & Figures Tables and Figures 2018. Atlanta: American Cancer Society; 2018.
6 Ibid.
7 Ibid.
8 Centers for Disease Control and Prevention. National Breast and Cervical Cancer Early Detection Program (NBCCEDP) – About the Program - https://www.cdc.gov/cancer/nbccedp/about.htm. Accessed March 2018.

Breast and Cervical Cancer Treatment through Medicaid: A Lifeline for Women Diagnosed With Breast and Cervical Cancer

1 Ranji U, Rosenweig C, Gomez I, Salganicoff A. 2017 Kaiser Women's Health Survey. Kaiser Family Foundation. March 2018.
2 Miller JW, Hanson V, Johson GD, Roaylty JE, Richardson LC. From cancer screening to treatment: Service delivery and referral in the National Breast and Cervical Cancer Early Detection Program. *Cancer*. 2014; 120(16): 2549- 56.

Access to Colorectal Screening: Screening Now, Preventing for Life

1 American Cancer Society. Cancer Facts & Figures 2018. Atlanta: American Cancer Society; 2018.
2 American Cancer Society. Cancer Prevention & Early Detection Facts & Figures 2017-2018. Atlanta: American Cancer Society; 2017.
3 Fecal occult blood test (FOBT) or fecal immunochemical test (FIT) within the past year.; a sigmoidoscopy within the past five years; or a colonoscopy within the past 10 years.
4 American Cancer Society. *Colorectal Cancer Facts & Figures 2017-2019.* Atlanta: American Cancer Society; 2017.
5 American Cancer Society. Cancer Facts & Figures 2018. Atlanta: American Cancer Society; 2018.
6 American Cancer Society. Cancer Prevention & Early Detection Facts & Figures 2017-2018. Atlanta: American Cancer Society; 2017.
7 National Health Interview Survey (NHIS)
8 Ibid.
9 Health Resources & Services Administration. National Health Center Data 2016. Accessed March 2018. https://bphc.hrsa.gov/uds/datacenter.aspx#fn14
10 American Cancer Society. Cancer Prevention & Early Detection Facts & Figures 2017-2018. Atlanta: American Cancer Society; 2017.
11 CDC's CRCCP Grantees: Alabama, Arkansas, California, Colorado, Delaware, District of Columbia, Florida
Great Plains Tribal Chairmen's Health Board, Idaho, Kentucky, Louisiana State University, Maine, Mary Hitchcock Memorial Hospital (NH), Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New York State, Oregon, Rhode Island, South Dakota, University of Chicago, University of Puerto Rico, University of South Carolina, University of Wisconsin, Virginia, Washington, West Virginia University

Palliative Care: Improving Quality of Life for Cancer Patients

1 Temel J.S., Greer J.A., Muzikansky A., et al., Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer. (2010, August 19). New England Journal of Medicine. 363:733-742.
2 Source: Meier DE, Brawley OW, Palliative Care and Quality of Life, Journal of Clinical Oncology 2011,29: 2750-2752.
3 McDonald, J, et. al. Impact of early palliative care on caregivers of patients with advanced cancer: cluster randomised trial. (2017 January). Annals of Oncology. 28 (1): 163-168.

References

4 May, P. et. al., Palliative Care Teams' Cost-Saving Effect Is Larger For Cancer Patients With Higher Numbers Of Comorbidities. (2016 January). Health Affairs. 35:44-53

5 McCarthy I.M., Robinson C., Huq S., Philastre M., Fine R.L. (2015, February). Cost savings from palliative care teams and guidance for a financially viable palliative care program. Health Services Research. 2015 Feb; 50(1):217-36, Epub 2014 Jul 15.

6 Morrison R.S., Dietrich J., Ladwig S., Quill T., Sacco J., Tangeman J., Meier D.E. (2011, March). Palliative care consultation teams cut hospital costs for Medicaid beneficiaries. Health Affairs (Millwood). 2011 Mar; 30(3):454-63.

Cancer Pain Control: Striving for Balance

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

Prevention: Stopping Cancer Before It Starts

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

2 Ibid.

3 U.S. Department of Health and Human Services (HHS). (2014). The Health Consequences of Smoking–50 Years of Progress: A Report of the Surgeon General. Atlanta, GA: HHS, Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health (OSH). Printed with corrections, January 2014.

4 https://www.cdc.gov/mmwr/volumes/67/wr/mm6722a3.htm#modalIdString_CDCTable_0

5 Centers for Disease Control and Prevention. Current Cigarette Smoking Among Adults—United States, 2016. Morbidity and Mortality Weekly Report 2018;67(2):53-59.

6 U.S. Department of Health and Human Services (HHS). (2014). The Health Consequences of Smoking–50 Years of Progress: A Report of the Surgeon General. Atlanta, GA: HHS, Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health (OSH). Printed with corrections, January 2014.

7 https://www.cdc.gov/mmwr/volumes/67/wr/mm6722a3.htm#modalIdString_CDCTable_0

8 Centers for Disease Control and Prevention. Current Cigarette Smoking Among Adults—United States, 2016. Morbidity and Mortality Weekly Report 2018;67(2):53-59.

9 Xu X., Alexander R.L., Simpson S.A., et al. (2014). A Cost-Effectiveness Analysis of the First Federally Funded Antismoking Campaign. *American Journal of Preventive Medicine* 2015;48(3):318–25.

10 McAfee T, Davis KC, Shafer P, Patel D, Alexander RL, Bunnell, R. Increasing the Dose of Television Advertising in a National Antismoking Media Campaign: Results from a Randomised Field Trial. *Tob Control* 2015 Dec 16.doi: 10.1136/tobaccocontrol-2015-052517.

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

12 Kushi L.H., Doyle C., McCullough m., et at. (2012). American Cancer Society guidelines on Nutrition and Physical Activity for Cancer Prevention: Reducing the Risk of Cancer With Healthy Food Choices and Physical Activity. *CA: Cancer A Journal for Clinicians.* 2012; 62:30-67.

13 Guy GP, Berkowitz Z, Jones SE, Olsen E, Miyamoto JN, Michael SL, et al. State indoor tanning laws and adolescent indoor tanning. *Am J Public Health.* 2014; 104(4):e69-74.

14 Mayer JA, Woodruff SI, Slymen DJ, et al. Adolescents' use of indoor tanning: a large-scale evaluation of psychosocial, environmental, and policy-level correlates. *Am J Public Health.* 2011; 101(5):930-8.

15 Watson M, Holman DM, Fox KA, et al. Preventing skin cancer through reduction of indoor tanning: current evidence. *Am J Prev Med.* 2013;44: 682-689.

16 Sinclair C, Makin JK. Implications of lessons learned from tobacco control for tanning bed reform. *Pre Chronic Dis.* 2013; 10:120186. doi: http://dx.doi.org/10.5888/pcd10.120186.

17 https://www.tobaccofreekids.org/problem/toll-us

Tobacco Excise Taxes: Raising the Price, Ending the Addiction

1 Campaign for Tobacco-Free Kids. Toll of Tobacco in the United States. http:// www.tobaccofreekids.org/facts_issues/toll_us. Accessed April 10, 2017.

2 Ibid.

3 The Tax Burden on Tobacco. Historical Compilation, Volume 51, 2016.

4 Campaign for Tobacco-Free Kids. Cigarette Tax Increases By State Per Year 2000-2018. January 12, 2018. Available at https://www.tobaccofreekids. org/research/factsheets/pdf/0275.pdf.

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

1 U.S. Department of Health and Human Services (HHS). *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General.* 2006. Atlanta, GA: HHS, Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health (OSH).

2 HHS. *How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease – A Report of the Surgeon General.* 2010. Atlanta, GA: HHS, CDC, National Center for Chronic Disease Prevention and Health Promotion, OSH.

3 HHS. *The Health Consequences of Smoking–50 Years of Progress: A Report of the Surgeon General.* Atlanta, GA: HHS, CDC, National Center for Chronic Disease Prevention and Health Promotion, OSH. Printed with corrections, January 2014.

4 HHS, 2010.

5 Max W., Sung H-Y, and Shi Y. (2012). Deaths from Secondhand Smoke Exposure in the United States: Economic Implications. American Journal of Public Health. 2012; 102: 2173-2180.

6 HHS, 2014.

7 American Nonsmokers' Rights Foundation. Overview List – How Many Smokefree Laws? January 2, 2018. Available at http://www.no-smoke.org/goingsmokefree.php?id=519.. Accessed February 8, 2018.

8 Ibid.

9 ACS CAN. Smoke-free. 2017. https://www.acscan.org/what-we-do/smoke-free.

10 HHS, 2014.

11 U.S. Department of Health and Human Services (HHS). (2014). *The Health Consequences of Smoking—50 Years of Progress: A report of the Surgeon General.* Atlanta, GA: U.S. Department of Health and Human Services, Center for Diseases Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. Printed with corrections, January 2014.

12 Scollo, M., A. Lal, Hyland, A. and S. Glantz (2003). Review of the Quality of Studies on the Economic Effects of Smoke-Free Policies on the Hospitality Industry. *Tobacco Control* 12: 13-20.

13 Scollo, M. and A. Lal (2004). Summary of Studies Assessing the Economic Impact of Smoke-free Policies in the Hospitality Industry. Melbourne: VicHealth Centre for Tobacco Control. http://www.vctc.org.au/tc-res/Hospitalitysummary.pdf.

14 Loomis, B.R.; Shafer, P.R.; van Hasselt, M., "The economic impact of smoke-free laws on restaurants and bars in 9 states," *Preventing Chronic Disease* 10: e128, August 1, 2013.

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

1 U.S. Department of Health and Human Services. E-Cigarette Use Among Youth and Young Adults. A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2016.

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

3 Robert Wood Johnson Foundation, Campaign for Tobacco-Free Kids, American Cancer Society Cancer Action Network, American Heart Association, American Lung Association, and Americans for Nonsmokers' Rights. B*roken Promises to Our Children: A State-by-State Look at the 1998 State Tobacco Settlement 19 Years Later.* December 2017. Available at http:// www.tobaccofreekids.org/microsites/statereport2018/. Accessed February 8, 2018.

4 U.S. Department of Health and Human Services. *The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General.* Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.

5 Robert Wood Johnson Foundation, Campaign for Tobacco-Free Kids, American Cancer Society Cancer Action Network, American Heart Association, American Lung Association, and Americans for Nonsmokers' Rights. *Broken Promises to Our Children: A State-by-State Look at the 1998 State Tobacco Settlement 19 Years Later.* December 2017. Available at http:// www.tobaccofreekids.org/microsites/statereport2018/. Accessed February 8, 2018.

6 Ibid.

7 CDC. *Best Practices for Comprehensive Tobacco Control Programs,* 2014. Atlanta, GA: HHS, CDC, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.

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

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

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

11 Dilley, et al.

References

Tobacco Cessation Services in Medicaid: Closing the Gaps in Coverage

1 Centers for Disease Control and Prevention. Quitting Smoking Among Adults—United States, 2000–2015. Morbidity and Mortality Weekly Report 2017;65(52):1457-64 [accessed 2017 Jan 24].
2 American Cancer Society. Guide to Quitting Smoking. http://www.cancer.org/healthy/stayawayfromtobacco/guidetoquittingsmoking/guide-to-quitting-smoking-pdf (accessed 26 Jul 2013).
3 Jamal A, Homa DM, O'Connor E, et al. Current Cigarette Smoking Among Adults – United States, 2005-2014. *MMWR* 2015; 64(44): 1233-1240.
4 Ku L, Bruen BK, Steinmetz E, and Bysshe T. Medicaid Tobacco Cessation: Big Gaps Remain In Efforts To Get Smokers To Quit. *Health Affairs*, 35, no.1 (2016):62-70
5 Xu X, Bishop EE, Kennedy SM, Simpson SA, Pechacek TF. Annual healthcare spending attributable to cigarette smoking: an update. *Am J Prev Med.* 2015;48(3):326–333. https://doi.org/10.1016/j.amepre.2014. 10.012.
6 Armour BS, Finkelstein EA, Fiebelkorn IC. State-level Medicaid expenditures attributable to smoking. *Prev Chronic Dis* 2009;6(3):A84. http://www.cdc.gov/pcd/issues/2009/jul/08_0153.htm. Accessed [May 19, 2014].Smoking-attributable Medicaid costs are updated from 2004 to 2013 dollars, using the Medical Consumer Price Index.
7 Richard P, West K, Ku L . The return on investment of a Medicaid Tobacco Cessation Program in Massachusetts. *PLoS ONE.* 2012; 7(1):e29665. doi:10.1371/journal.pone.0029665.

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

1 American Cancer Society. *Cancer Facts & Figures 2018.* Atlanta: American Cancer Society, 2018.
2 Ibid.
3 Lauby-Secretan B, Scoccianti C, Loomis D, et al. Body Fatness and Cancer – Viewpoint of the IARC Working Group. *N Engl J Med* 2016; 375: 8.
4 Centers for Disease Control and Prevention. Obesity and Overweight. September 2015. Available at http://www.cdc.gov/nchs/fastats/obesity-overweight.htm. Accessed February 22, 2016.
5 Fryar CD, Carroll MD, Ogden CL. Prevalence of Overweight and Obesity Among Children and Adolescents: United States, 1963–1965 Through 2011–2012. September 2014. Available at http://www.cdc.gov/nchs/data/ hestat/obesity_child_11_12/obesity_child_11_12.pdf. Accessed February 22, 2016.
6 U.S. Department of Health and Human Services and U.S. Department of Agriculture. Figure 2-9: Average Intakes of Added Sugars as a Percent of Calories per Day by Age-Sex Group, in Comparison to the Dietary Guidelines Maximum Limit of Less Than 10 Percent of Calories. *Dietary Guidelines for Americans, 2015-2010.* Available at http://health.gov/dietaryguidelines/2015/guidelines/chapter-2/a-closer-look-at-current-intakes-and-recommended-shifts/. Accessed July 17, 2016.
7 Ibid.
8 Rosinger A, Herrick K, Gahche J, Park S. Sugar-sweetened beverage consumption among U.S. adults, 2011–2014. NCHS Data Brief. No 270. Hyattsville, MD: National Center for Health Statistics. 2017.
9 Mozaffarian D, Hao T, Rimm EB, Willett WC, Hu FB. Changes in diet and lifestyle and long-term weight gain in women and men. *N Engl J Med.* 2011;364:2392-404.
10 Malik VS, Pan A, Willett WC, and Hu FB. Sugar-sweetened beverages and weight gain in children and adults: a systematic review and meta-analysis. *Am J Clin Nutr.* 2013 Oct; 98(4): 1084–1102.
11 Kushi L.H., Doyle C., McCullough M., et al. (2012). American Cancer Society Guidelines on Nutrition and Physical Activity for Cancer Prevention: Reducing the Risk of Cancer With Healthy Food Choices and Physical Activity. *CA: Cancer A Journal for Clinicians.* 2012; 62:30-67.
12 Ibid.

Indoor Tanning: Protecting kids from an increased Cancer Risk

1 American Cancer Society. (2018). *Cancer Facts & Figures 2018.* Atlanta, GA: American Cancer Society.
2 Holman DM, Freeman MB, Shoemaker ML. Trends in Melanoma Incidence Among Non-Hispanic Whites in the United States, 2005 to 2014. *JAMA Dermatol.* Published online January 31, 2018. doi:10.1001/jamadermatol.2017.5541
3 American Cancer Society. (2018). *Cancer Facts & Figures 2018.* Atlanta, GA: American Cancer Society.
4 Ibid.
5 U.S. House of Representatives Committee on Energy and Commerce Minority Staff. (2012, February). False and Misleading Information Provided to Teens by the Indoor Tanning Industry – Investigative Report.
6 United States of America Federal Trade Commission. (2010, May 13). In the Matter of Indoor Tanning Association, a corporation - Docket Number C-4290 Decision and Order. Available at ftc.gov/os/caselist/0823159/100519 tanningdo.pdf.
7 U.S. House of Representatives Committee on Energy and Commerce Minority Staff. (2012, February). False and Misleading Information Provided to Teens by the Indoor Tanning Industry – Investigative Report.
8 Centers for Disease Control and Prevention (CDC). (2014). Youth Risk Behavior Surveillance-United States, 2015. *MMWR.* 2016; 65(6).

9 The 59% increased risk is cited here: Boniol B., Autier P., Boyle P., Gandini S. (2012). Corrections: Cutaneous melanoma attributable to sunbed use: systematic review and meta-analysis. *British Medical Journal.* 2012; 345:e8503. Published December 2012; which is a correction of the original article cited here: Boniol B., Autier P., Boyle P., Gandini S. (2012). Cutaneous melanoma attributable to sunbed use: systematic review and meta-analysis. British Medical Journal. 2012; 345:e4757. Correction published December 2012; 345:e8503.
10 Wehner, et al. (2012, October). Indoor tanning and non-melanoma skin cancer: systematic review and meta-analysis. *British Medical Journal.*
11 Cokkinides V., Weinstock M., Lazovich D., Ward E., Thun M. Indoor tanning use among adolescents in the U.S., 1998-2004. *Cancer*. 2009; 115: 190-198.
12 American Cancer Society. Cancer Prevention and Early Detection Facts and Figures 2015. Atlanta: American Cancer Society; 2015.
13 Lazovich D, Vogel RI, Berwick M, Weinstock MA, Anderson KE, Warshaw EM. Indoor tanning and risk of melanoma: a case-control study in a highly exposed population. *Cancer Epidemiol Biomarkers Prev.* 2010;19: 1557-1568.
14 NAACCR Fast Stats: An interactive tool for quick access to key NAACCR cancer statistics. North American Association of Central Cancer Registries. http://www.naaccr.org/. (Accessed on 1-24-2018).
15 Guy, et al. (2014, February). State Indoor Tanning Laws and Adolescent IndoorTanning. *American Journal of Public Health.* Online.
16 Mayer JA, Woodruff SI, Slymen DJ, et al. Adolescents' use of indoor tanning: a large-scale evaluation of psychosocial, environmental, and policy-level correlates. *Am J Public Health.* 2011; 101(5):930-8.
17 Watson M, Holman DM, Fox KA, et al. Preventing skin cancer through reduction of indoor tanning: current evidence. *Am J Prev Med.* 2013;44: 682-689.
18 Sinclair C, Makin JK. Implications of lessons learned from tobacco control for tanning bed reform. *Pre Chronic Dis.* 2013; 10:120186. doi: http://dx.doi.org/10.5888/pcd10.120186.
19 El Ghissassi F, Bann R, Straif K, Grosse Y, Secretan B, Bouvard V, et al. A review of human carcinogens – part D: radiation. *Lancet Oncol.* 2009; 10(8):751-2.
20 Federal Register. General and plastic surgery devices: reclassification of ultraviolet lamps for tanning, henceforth to be known as sunlamp products and ultraviolet lamps intended for use in sunlamp products. Published June 2, 2014. Accessed March 10, 2016. https://www.federalregister.gov/articles/2014/06/02/2014-12546/general-and-plastic-surgery-devices-reclassification-of-ultraviolet-lamps-for-tanning-henceforth-to.
21 U.S. Department of Health and Human Services. The Surgeon General's call to action to prevent skin cancer. Washington, D.C.: U.S. Dept of Health and Human Services, Office of the Surgeon General; 2014.
22 Forster JL, Lazovich D, Hickle A, Sorensen G, Demierre MF. Compliance with restrictions on sale of indoor tanning sessions to youth in Minnesota and Massachusetts. J Am Acad Dermatol. Dec 2006;55(6):962-967.
23 Pichon LC, Mayer JA, Hoerster KD, et al. Youth access to artificial UV radiation exposure: practices of 3647 US indoor tanning facilities. *Arch Dermatol.* 2009;145: 997-1002.
24 Guy GP, Berkowitz Z, Jones SE, Olsen E, Miyamoto JN, Michael SL, et al. State indoor tanning laws and adolescent indoor tanning. *Am J Public Health. 2*014; 104(4):e69-74.
25 Mayer JA, Woodruff SI, Slymen DJ, et al. Adolescents' use of indoor tanning: a large-scale evaluation of psychosocial, environmental, and policy-level correlates. *Am J Public Health.* 2011; 101(5):930-8.
26 Watson M, Holman DM, Fox KA, et al. Preventing skin cancer through reduction of indoor tanning: current evidence. *Am J Prev Med.* 2013;44: 682- 689.

State Preemption over Local Public Health Policies: A Threat to Innovative Public Policy Solutions

1 Virginia Natural Resources Leadership Institute, Dillon's Rule: Legal Framework for Decision Making, available at htt;?//ien.arch.viginia.eud/vnrli/docs/briefs/Dillons_Rule_09.pef
2 National Policy & Legal Analysis Network (NPLAN) & Public Health Law Center, The Consequences of Preemption for Public Health Advocacy (2010), available at http://www.publichealthlawcenter.org/sites/default/files/resources/nplan-fs-consequences-2010.pdf
3 National Policy & Legal Analysis Network (NPLAN) & Public Health Law Center, The Consequences of Preemption for Public Health Advocacy (2010), available at http://www.publichealthlawcenter.org/sites/default/files/resources/nplan-fs-consequences-2010.pdf
4 Victor L. Crawford, Former Tobacco Institute Lobbyist, Journal of the American Medical Association, 7/19/95
5 American Nonsmokers' Rights Foundation. Overview List – How Many Smokefree Laws? January 2, 2018. Available at http://www.no-smoke.org/goingsmokefree.php?id=519.. Accessed February 8, 2018.
6 Public Health Law Center, Preemption and Movement Building in Public Health, Essentials of Preemption (2011), available at http://www.publichealthlawcenter.org/sites/default/files/resources/pw-fs-essentials-2010.pdf
7 Americans for Nonsmokers' Rights. Preemption: Tobacco Control's #1 Enemy. (2017) available at http://tobaccopolicycenter.org/wp-content/uploads/2017/11/770.pdf
8 Pertschuk, M. Pomeranz, J. Assessing the Impact of Federal and State Preemption in Public Health: A Framework for Decision Makers (2012) Journal Public Health Management Practice
9 Paul D Mowery et al., The Impact of State Preemption of Local Smoking Restrictions on Public Health Protections and Changes in Social Norms, J ENVIRON PUBLIC HEALTH 632629 (2012), available at http://www.hindawi.com/journals/jeph/2012/63269
10 National Policy & Legal Analysis Network (NPLAN) & Public Health Law Center, The Consequences of Preemption for Public Health Advocacy (2010), available at http://www.publichealthlawcenter.org/sites/default/files/resources/nplan-fs-consequences-2010.pdf

measure@cancer.org
www.acscan.org