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Final Report of the Commission to Study the Incidence of and Mortality Related to Cancer

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Executive Summary

The Commission to Study the Incidence of and Mortality Related to Cancer was established by Resolve 2013, Chapter 77 (Appendix A). The duties of the Commission are set forth in Resolve 2013, Chapter 77 (Appendix A). The Commission is charged with reviewing Maine's above average rates of cancer incidence and mortality and reviewing the State of Maine's current cancer prevention, detection and treatment goals and priorities. The duties include the following:

- Identify or review the State's current priorities and goals to reduce the incidence of and mortality from cancer;
- Identify the types of cancer with the highest incidence and mortality in the State, including the types of cancer whose incidence and mortality rates differ the most from national averages;
- Identify the risk factors, including preventable lifestyle risk factors such as tobacco use, diet, exercise and obesity, related to high relative rates of the incidence of and mortality from cancer;
- Identify the extent to which barriers to health care in the State contribute to cancer mortality;
- Make recommendations for legislative strategies to reduce the State's cancer incidence and mortality; and
- Make recommendations for how current State programs could further assist citizens through education and cancer prevention programs.

The Commission is required to submit a report, with findings and recommendations including suggested legislation, to the Joint Standing Committee on Health and Human Services in December 2013. The Commission met four times and developed the following recommendations for strategies to reduce Maine's cancer incidence and mortality.

ACCESS TO AFFORDABLE, HIGH QUALITY HEALTH CARE:

1. The Cancer Commission finds that access to quality health care is one of the most important factors impacting the incidence of and mortality from cancer in Maine.

Recommendation #1: The Commission strongly recommends that the State of Maine accept federal funding already set aside pursuant to the federal 2010 health care law, the Patient Protection and Affordable Care Act, known simply as the Affordable Care Act (ACA), to ensure access to affordable health care through Medicaid coverage for approximately 69,500 eligible low-income Maine residents.[1] This will have many benefits impacting cancer in Maine.

The Commission recommends sending letters to the Governor, the Commissioner of Health and Human Services and to the Joint Standing Committees on Health and Human Services and

[1] Medicaid is a federal and state funded program that pays the medical expenses of people who are unable to pay some or all of their own medical expenses. MaineCare is the name of Maine's Medicaid Program.

Appropriations and Financial Affairs advocating that the State of Maine take advantage of the opportunity to accept federal funding to preserve and expand Medicaid coverage for low-income Mainers in order to ensure the earliest possible medical interventions for cancer prevention, screening and treatment.

This proposal was supported by 9 members of the Commission and opposed by one member. One member was absent.

2. The ACA is the most significant health law to impact cancer care in decades.[2] The ACA includes over 100 provisions that benefit cancer patients.

Recommendation #2: The Commission recommends that the State of Maine do everything in its power to fully implement the ACA and support public awareness of its many benefits for the prevention, early detection and treatment of cancer.

The Commission recommends sending letters to the Joint Standing Committees on Health and Human Services and Insurance and Financial Services and the Commissioners of the Health and Human Services and Professional and Financial Regulation highlighting the benefits of the ACA relating to cancer, advocating for the full implementation of the new federal health care law, and addressing misinformation about the law. The Commission also recommends sending letters to Maine's major newspapers and reaching out to other media outlets.

This proposal was supported by 9 members of the Commission and opposed by one member. One member was absent.

3. The Commission finds that telemedicine may play a role in increasing access to high quality care to Maine residents.

Recommendation #3: The Commission recommends sending a letter to the Joint Standing Committee on Health and Human Services advocating for changes in State law that would enhance insurance coverage for telemedicine services – particularly if it increases access to quality health care for all aspects of cancer care – including, but not limited to, prevention, screening, treatment, palliative and survivorship care.

This proposal was supported by 9 members of the Commission; one member voted neither for nor against the proposal. One member was absent.

4. It is important for all residents to be able to access high value treatments. In some cases, oral chemotherapy drugs provide that opportunity.

Recommendation #4: The Commission recommends requiring health insurance policies that cover chemotherapy to include coverage for orally administered anticancer medications that is equivalent to the coverage provided for intravenously administered or injected anticancer

[2] http://smhs.gwu.edu/gwci/survivorship/casnp/healthpolicy/aca

medications without increasing patient cost sharing for chemotherapy medications to achieve this goal.

The Commission recommends sending a letter to the Joint Standing Committee on Insurance and Financial Services advocating for LD 627, "An Act Relating to Orally Administered Cancer Therapy," which proposes to require health insurance policies that cover chemotherapy to include coverage for orally administered anticancer medications that is equivalent to the coverage for chemotherapy administered intravenously or injected. As of October 2013, 27 states have enacted oral chemotherapy access laws.[3]

This proposal was supported by 9 members of the Commission; one member voted neither for nor against the proposal. One member was absent.

5. The Commission believes that a cancer patient should be able to choose between a specialty pharmacy or local community pharmacy based on what is best for the patient.

Recommendation #5: The Commission recommends sending a letter to the Joint Standing Committee on Insurance and Financial Services asking the committee to review the practice of insurers requiring that cancer patients use specialty pharmacies.

This proposal was supported by 9 members of the Commission; one member voted neither for nor against the proposal. One member was absent.

6. For some Maine residents, family planning clinics are their primary source of health care. Services provided at family planning clinics include pap smears for the prevention and early detection of cervical cancer, mammograms and education for the early detection of breast cancer, and colorectal cancer screening for the prevention and early detection of colorectal cancer.

Recommendation #6: The Commission supports sending a letter to the Joint Standing Committee on Health and Human Services advocating for the passage of LD 1247, "An Act to Expand Coverage of Family Planning Services," which proposes to expand Medicaid coverage for family planning services to low-income adults and adolescents.

This proposal was supported by 9 members of the Commission and opposed by one member. One member was absent.

TOBACCO PREVENTION AND CESSATION:

7. Tobacco is a major, yet preventable, risk factor for cancer. Smoking and tobacco use account for approximately 30% of all cancer deaths in the United States (U.S.) and 87% of lung cancer deaths.[4 5] Lung cancer is the leading cause of cancer death in Maine for both men and women.[6]

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[3] http://www.communityoncology.org/pdfs/COC%202013%20Oral%20Parity%20CPAN%20FF0318131.pdf
The 27 states are CA, FL, VA, LA, OR, WA, CO, NE, KS, IA, MN, IN, VT, OK, NY, NV, NM, HI, MD, CT, MA, IL, DE, MD, RI, UT and TX. (source: http://myeloma.org/ArticlePage.action?articleId=3708)

[4] *Harvard Report on Cancer Prevention, Cancer Causes and Control*, November/December, 1996.

Between the annual revenue from cigarette excise taxes and the over $50 million Maine receives each year from the MSA, the Commission finds it troublesome that the State's tobacco prevention and control program is funded at less than half of the federal Centers for Disease Control and Prevention (CDC) recommended level and that Medicaid recipients have not been receiving maximal assistance for tobacco cessation.

Recommendation #7: The Commission recommends that the State of Maine fund the tobacco prevention and control program at the level recommended by the CDC. The Commission recommends sending a letter to the Joint Standing Committees on Health and Human Services and Appropriations and Financial Affairs and the Commissioner of Health and Human Services advocating that both committees during budget deliberations look for opportunities to increase funding and State government accountability for tobacco prevention in Maine.

This proposal was supported by 9 members of the Commission; one member voted neither for nor against the proposal. One member was absent.

Recommendation #7-A: The Commission recommends sending a letter to the Joint Standing Committee on Appropriations and Financial Services in support of LR 2653, "An Act to Improve Education about and Awareness of Maine's Health Laws and Resources," which proposes to allocate $5 million in funds the State will receive under the Master Settlement Agreement to enhance enforcement of current tobacco prevention and control laws, improve public education about tobacco laws and restore funds to the Fund for a Healthy Maine.

The Commission also recommends sending letters to the Joint Standing Committees on Education and Cultural Affairs, Health and Human Services and Appropriations and Financial Services and the Commissioners of Education and Health and Human Services advocating for improving evidence-based education about the risks of tobacco use in K-12 schools and among the general public.

This proposal was supported by 9 members of the Commission; one member voted neither for nor against the proposal. One member was absent.

8. The Commission believes tax policy can continue to play a role in lowering tobacco use in Maine. Increasing the unit price for tobacco products has been shown to reduce consumption of tobacco products, particularly among young people.

Recommendation #8: The Commission recommends sending letters to the Joint Standing Committees on Health and Human Services, Taxation, and Appropriations and Financial Affairs advocating that those committees consider, during budget deliberations, increasing the cigarette excise tax by an amount that has been demonstrated to significantly decrease cigarette use (e.g., $1.50) and equalizing the tax on other tobacco products for the fundamental purpose of improving public health.

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[5] http://www.tobaccofreemaine.org/explore_facts/documents/Adult-Tobacco-Use.pdf
[6] Ibid.

This proposal was supported by 9 members of the Commission and opposed by one member. One member was absent.

OBESITY PREVENTION THROUGH NUTRITION AND PHYSICAL ACTIVITY:

9. Obesity is another significant preventable risk factor for cancer. Poor adult diet and obesity account for approximately 30% of total cancer deaths in the United States.[7] Well over half of Maine residents are either overweight or obese.[8] Maine CDC utilizes the Community and School Grants and Statewide Coordination appropriation of the Fund for a Healthy Maine (FHM) to strengthen local public health infrastructure, address tobacco use and obesity, and improve access to health care for adolescents.[9]

Recommendation #9: The Commission recommends sending a letter to the Joint Standing Committees on Health and Human Services, Education and Cultural Affairs, and Appropriations and Financial Affairs advocating that these committees during budget deliberations look for opportunities to increase funding and State government accountability of obesity prevention in Maine. Furthermore, the Commission recommends that more of the Fund for a Healthy Maine funds be used to promote and increase healthy eating and physical activity.

This proposal was supported by 9 members of the Commission; one member voted neither for nor against the proposal. One member was absent.

Recommendation #9-A: The Commission recommends legislation directing the Commissioner of Health and Human Services, in collaboration with the Director of the Maine Center for Disease Control and Prevention (Maine CDC) and the Commissioner of Education, to convene a working group to develop a long-term plan to promote healthy eating and physical activity and to increase physical education. See Appendix C for suggested legislation.

This proposal was supported by 9 members of the Commission and opposed by one member. One member was absent.

Recommendation #9-B: The Commission recommends sending a letter to the Joint Standing Committee on Education and Cultural Affairs advocating that the Committee consider legislative action to increase the quality and quantity of physical education in the education curriculum and to reduce the marketing and availability of unhealthy foods and beverages in schools. The Commission also recommends sending a letter to the Commissioner of Education asking that the department do everything in its power to promote physical activity and healthy nutritional choices in schools.

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[7] *Harvard Report on Cancer Prevention, Cancer Causes and Control*, November/December, 1996.
[8] *Nutrition, Physical Activity and Cancer: What's the Connection?,* presentation by Colleen Doyle, American Cancer Society, can be accessed at: http://www.maine.gov/legis/opla/cancerstudymtmatrls.htm
[9] *Summary of The Fund for a Healthy Maine Community and School Grants and Statewide Coordination Appropriation: Commission to Study the Incidence of and Mortality Related to Cancer*, Maine CDC, November 2013, can be accessed at: http://www.maine.gov/legis/opla/Community%20%20School%20Grants.pdf

This proposal was supported by 9 members of the Commission; one member voted neither for nor against the proposal. One member was absent.

10. The Commission believes that it will take a multi-pronged strategy and assistance from many evidence-based organizations to deal with the epidemic of obesity in Maine. The Commission believes that tax policy can have a positive influence on nutritional choices among Maine residents.

Recommendation #10: The Commission recommends sending a letter to the Joint Standing Committees on Health and Human Services and Education and Cultural Affairs asking that both committees seek information from the Department of Health and Human Services, Maine CDC, Department of Education and other relevant stakeholders about how State policies, including taxes, may reduce obesity and poor nutritional choices in Maine.

This proposal was supported by 9 members of the Commission; one member abstained from voting. One member was absent.

EVIDENCE-BASED SCREENING, IMMUNIZATION AND TESTING:

11. Prevention, evidence-based screening and immunizations should remain as primary strategies for reducing Maine's cancer burden. The Commission believes that the State of Maine should continue to promote early detection and evidence-based screening as recommended by the U.S. Preventive Services Task Force (USPSTF)[10] and evidence-based immunizations such as the hepatitis B virus and the human papilloma virus vaccinations. Additionally, the Commission finds that Maine CDC should consider promoting other evidence-based screening as new techniques are proven in the literature and supported by national evidence-based organizations like USPSTF.

Recommendation #11: The Commission recommends sending letters to the Governor, the Commissioner of Health and Human Services, and the Director of the Maine CDC advocating that the Maine CDC continue to support existing programs, namely the breast and cervical health programs and colorectal screening programs. The Department of Health and Human Services and Maine CDC should also seek opportunities to educate the public about the importance of cancer-related immunizations.

This proposal was supported by 9 members of the Commission; one member voted neither for nor against the proposal. One member was absent.

Recommendation #11-A: The Commission recommends sending a letter to the Joint Standing Committee on Health and Human Services encouraging the committee to get more information from the Maine CDC and other stakeholders about federal grant opportunities – including the status of existing grants and opportunities for potential future grants.

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[10] The USPSTF is an independent panel of experts in prevention and evidence-based medicine. Panelists are primary care providers, such as, pediatricians, family physicians, gynecologists/obstetricians, nurses and health behavior specialists.

12. The United States Preventive Services Task Force (USPSTF) is currently updating its lung cancer screening guidelines and the final recommendation statement is expected soon. The Commission believes that it is important to educate health care providers about the effective deployment of these new guidelines and the general public about the potential value of this new screening tool as well as the risks.

Recommendation #12: The Commission recommends sending a letter to the Joint Standing Committee on Health and Human Services suggesting that the committee convene a meeting of public and private-sector stakeholders to better understand how the new USPSTF guidelines for lung cancer screening will be promoted and implemented in Maine.

13. Radon is the second leading cause of lung cancer in the United States and is the number one cause of lung cancer among non-smokers.[11] Lung cancer is the leading cause of cancer death in Maine for both men and women.[12] Radon can be found in all parts of the U.S., but the rocks and soils of Maine create more radon than most other states.[13]

Recommendation #13: The Commission recommends that the Radon Program be funded and preserved. The Commission recommends sending a letter to the Joint Standing Committees on Health and Human Services and Appropriations and Financial Services advocating for General Fund funding of this program in the event that federal funding is discontinued.

This proposal was supported by 9 members of the Commission; one member voted neither for nor against the proposal. One member was absent.

Recommendation #13-A: The Commission recommends sending a letter to the Joint Standing Committees on Health and Human Services and Education and Cultural Affairs advocating that all public schools in Maine be tested for radon and undergo remediation, if necessary.

This proposal was supported by 9 members of the Commission; one member voted neither for nor against the proposal. One member was absent.

14. Arsenic is known to cause cancer and other serious health problems.[14] [15] For most people, diet and drinking water are the most important sources of exposure to arsenic. The current estimate is that one in 10 private wells in Maine has arsenic levels above the federal standard for community water supplies, and about half of Maine's population get their drinking water from a private well.

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[11] http://www.epa.gov/radon/healthrisks.html

[12] *Population-based Cancer Surveillance: State Perspective*, presentation by Dr. Molly Schwenn, Maine Cancer Registry, October 25, 2013 can be accessed at: http://www.maine.gov/legis/opla/cancerstudymtmatrls.htm

[13] http://www.miaqc.org/Maine%20Citizens%20Guide%20To%20Radon.pdf

[14] http://www.maine.gov/dhhs/mecdc/environmental-health/water/resources/arsenic.htm

[15] http://www.cancer.org/cancer/cancercauses/othercarcinogens/intheworkplace/arsenic

Recommendation #14: The Commission recommends sending a letter to the Joint Standing Committee on Health and Human Services suggesting that the Committee get more information about arsenic and its potential link to cancer from the Maine CDC, including their recent collaborative work with the National Cancer Institute and other research about arsenic's impact on cancer in the United States and Maine.

This proposal was supported by 9 members of the Commission; one member voted neither for nor against the proposal. One member was absent.

15. During the course of its work, the Commission found it difficult to get a full understanding of cancer-related prevention and treatment spending in the State of Maine.

Recommendation #15: The Commission recommends sending letters to the Joint Standing Committees on Health and Human Services and Appropriations and Financial Services suggesting that both committees seek further information and receive presentations about the Fund for a Healthy Maine fund and cancer-related spending in the State of Maine from the Department of Health and Human Services, Maine CDC. The Commission also recommends sending letters to the Commissioner of Health and Human Services and the Director of the Maine CDC advocating for more information and transparency in this regard.

This proposal was supported by 9 members of the Commission; one member voted neither for nor against the proposal. One member was absent.

16. The Commission finds that it had insufficient time to perform an in-depth review of all aspects of the State's above-average rates of cancer incidence and mortality and the State's current cancer prevention, early detection and treatment goals and priorities.

Recommendation #16: The Commission recommends legislation that will allow the Commission to continue its work. See Appendix D for suggested legislation.

This proposal was supported by 9 members of the Commission; one member voted neither for nor against the proposal. One member was absent.

I. INTRODUCTION

The Commission to Study the Incidence of and Mortality Related to Cancer was established by Resolve 2013, Chapter 77 (Appendix A). Pursuant to the resolve and the public law, 11 members were appointed to the Commission, two legislators from the Maine Senate, three legislators from the Maine House of Representatives, one representative of a statewide public health organization, one representative of a statewide voluntary nonprofit health organization representing cancer patients, one person representing a statewide organization of medical professionals, one person with expertise in cancer research and epidemiology, one person with expertise in the subject matter of the study, and the Director of the Maine Center for Disease Control and Prevention (Maine CDC) or the director's designee. A list of Commission members can be found in Appendix B.

The duties of the Commission are set forth in Resolve 2013, Chapter 77 (Appendix A). The Commission is charged with reviewing Maine's above average rates of cancer incidence and mortality and reviewing the State of Maine's current cancer prevention, detection and treatment goals and priorities. The duties include the following:

- Identify or review the State's current priorities and goals to reduce the incidence of and mortality from cancer;
- Identify the types of cancer with the highest incidence and mortality in the State, including the types of cancer whose incidence and mortality rates differ the most from national averages;
- Identify the risk factors, including preventable lifestyle risk factors such as tobacco use, diet, exercise and obesity, related to high relative rates of the incidence of and mortality from cancer;
- Identify the extent to which barriers to health care in the State contribute to cancer mortality;
- Make recommendations for legislative strategies to reduce the State's cancer incidence and mortality; and
- Make recommendations for how current State programs could further assist citizens through education and cancer prevention programs.

The Commission is required to submit a report, with findings and recommendations including suggested legislation, to the Joint Standing Committee on Health and Human Services in December 2013.

II. COMMISSION PROCESS

The Commission held meetings on October 25, November 8, November 21 and December 6, 2013. All meetings were open to the public and were broadcast by audio transmission over the Internet.

At the first meeting on October 25, 2013, the Chairs explained to members that the purpose of the Commission is to look at progress relating to cancer and to improve the State's response to

the epidemic. Commission members were reminded that, in addition to cancer facts and figures, it is important to consider the human aspect behind the statistics. The meeting included the following.

- Christopher Desalvo, a resident of York County, provided testimony and shared his personal story about how cancer has impacted his life. Mr. Desalvo's wife, Diane, passed away from lung cancer last year.
- Dr. Molly Schwenn, Director of the Maine Cancer Registry (MCR) at the Maine Center for Disease Control and Prevention (Maine CDC), presented information regarding the types of cancer with the highest incidence and mortality in Maine and the types of cancer whose incidence and mortality rates differ significantly from national rates.
- Randy Schwartz, Senior Vice President of Strategic Health Initiatives at the American Cancer Society, presented information about the risk factors for cancer, including preventable lifestyle risk factors.
- Dr. Schwenn reviewed the State of Maine's current priorities and goals to reduce the incidence of and mortality from cancer.
- Tim Cowan, Director of the Health Index Initiative, from MaineHealth provided information on what MaineHealth is doing to decrease cancer mortality and improve evidence-based screening in communities.
- Commission members discussed study priorities and future informational needs.
- The PowerPoint presentations of Dr. Molly Schwenn, Randy Schwartz and Tim Cowan can be found on the Cancer Commission's webpage at the following link: http://www.maine.gov/legis/opla/cancerstudymtmatrls.htm.

The second meeting of the commission took place on November 8, 2013. The meeting included the following.

- Jeff Bennett, a resident of Portland, shared his personal story about how cancer has impacted his life. Mr. Bennett was diagnosed with breast cancer in 2003 and attributes early detection and aggressive treatment to his survival. He has since dedicated his life to improved awareness for others.
- Colleen Doyle, Director of the Nutrition & Physical Activity program at American Cancer Society (ACS), presented information regarding the connection between nutrition, physical activity and cancer incidence, including the following recommendations:
    1. Maintain a healthy weight;
    2. Adopt a physically active lifestyle;
    3. Consume a healthy diet with an emphasis on plant sources; and
    4. Limit consumption of alcohol.
- Hilary Schneider from the American Cancer Society Cancer Action Network (ACS-CAN) spoke about the Affordable Care Act (ACA) and explained critical provisions, particularly for cancer patients, in the ACA.
- Christopher Nolan from the Office of Fiscal and Program Review presented current budgetary information and historical data on revenues and allocations to the Fund for Healthy Maine (FHM).

- The PowerPoint presentations of Colleen Doyle and Hilary Schneider can be found on the Cancer Commission's webpage at the following link: http://www.maine.gov/legis/opla/cancerstudymtmatrls.htm.
- Commission members discussed the preceding presentations and future informational needs.

At the third meeting November 21, 2013, Representative Paul McGowan, House Chair of the Commission, reminded members about their purpose and the need to put a personal face on the statistics of cancer. Staff recapped the Commission's process in the first two meetings as information gathering and differentiated the third meeting as a time to develop recommendations, determine consensus and decide priorities. The purpose of the fourth meeting is to fine-tune the commission's findings and recommendations for the final report. The third meeting included the following.

- Nancy Greene, a resident of Deer Isle, shared her personal story about how cancer has impacted her life. Ms. Greene was diagnosed with breast cancer in 2011. As a cancer survivor, she has become an advocate; spreading the word that greater breast density may increase the risk of getting breast cancer and may mask a tumor on a mammogram.
- Commission staff provided follow-up information handouts to clarify questions and information requests from the previous meeting.
- Commission members discussed their preliminary recommendations focused on:
    - Access to affordable and high quality health care;
    - Tobacco, including general awareness and tax policy;
    - Diet and obesity, including general awareness and tax policy;
    - Screening and testing; and
    - Education and prevention.

At the fourth and final meeting on December 6, 2013, Representative Paul McGowan, House Chair of the Commission explained that the Commission would briefly discuss cancer treatment trends and then focus on the meeting's main purpose of determining and voting on the Commission's findings and recommendations after hearing a personal story from another Maine resident about the impact of cancer. The fourth meeting included the following.

- Terry Kungel of the Maine Coalition to Fight Prostate Cancer shared his personal story about how cancer came into his life in 1964 when his grandfather was diagnosed with metastatic prostate cancer. After witnessing the ravages of the disease and seeing both his grandfather and later his father succumb to prostate cancer, he himself was diagnosed with prostate cancer in 2007. Having lost all four grandparents and both of his parents to cancer he has been intimately touched by "this awful disease." In 2008, after his own battle with cancer, he became heavily involved in the cancer community in Maine and he continues to advocate and facilitate support groups for men with cancer.
- Commission members discussed the issue of cancer treatment—trends, barriers and opportunities. For a summary of this discussion see the Background section of this report.

- Commission members discussed and voted on their findings and recommendations. For a summary of this discussion see the Findings and Recommendations section of this report.

III. VISION STATEMENT

This report is intended to guide action to reduce the incidence of and mortality from cancer in Maine. The Commission anticipates a future where Maine is no longer in the top tier of cancer statistics in this country, but rather becomes a national leader in demonstrating an integrated, collaborative response to cancer that reduces its presence among our families, friends and communities, and the number of deaths attributed to it. This will be accomplished by a more systematic, evidence-based campaign in education, prevention, early detection and high-value treatment. This will require leadership from State government to encourage a fully collaborative effort that engages non-profit organizations, public education, businesses, health care providers as well as the public.

It is clear from this study that a large number of cancer cases are preventable with the proper programs and targeted investments. No one, nor their loved ones, is free from the risk of cancer in Maine. In fact, cancer is the leading cause of death in Maine. The Commission believes its work and follow-through on implementation of the Commission's recommendations can reduce the risk for Maine people, reduce the pain and suffering from cancer, save precious lives, and reduce the financial burden this disease puts on our residents and State. The Commission welcomes you to join them in renewing and revitalizing the statewide commitment to changing the story of cancer in Maine. This report represents the first phase of this Commission's work; the Commission anticipates further opportunity to contribute to and help guide this critical work for the State of Maine.

BACKGROUND

Cancer is not a single disease, but a group of diseases that have in common the uncontrolled growth of abnormal cells. There are over 100 types of cancer and each has its own risk factors, disease progression, treatment and odds for survival.[16]

The Commission was charged with identifying the types of cancer with the highest incidence and mortality rates in the State of Maine, including those types of cancer whose incidence and mortality rates differ most from national rates.

I. Incidence and Mortality

The Maine Cancer Registry (MCR), within the Maine Center for Disease Control and Prevention (Maine CDC) is a statewide, population-based cancer surveillance system. Pursuant to State law, Title 22, Maine Revised Statutes, Chapter 55, the MCR collects information about newly diagnosed and treated cancers (with the exception of basal and squamous cell carcinomas of the

[16] http://www.mainecancerconsortium.org/Cancer+Plan_2011-2015_Final_10.14.10_Bookmarked.pdf

skin) among Maine residents. This information is used to understand Maine's cancer burden; identify areas of need for public health interventions; and improve cancer prevention, treatment and control.[17] MCR's Maine Annual Cancer Report 2013 is based on 2010 cancer incidence and mortality data, the latest data available at the time of the analysis.[18]

More than 8,200 (8,268) Maine residents were diagnosed with cancer in 2010. Maine's cancer incidence rate overall (all sites) for men and women (486.7 per 100,000) is higher than the national comparison rate (465.4 per 100,000)[19]. Maine's highest incidence cancers are lung, colorectal, prostate and breast.

The rate of lung cancer incidence in Maine for both men and women (73.2 per 100,000) is significantly higher than the national comparison rate (57.8 per 100,000). The incidence rate of other tobacco-related cancers (excluding lung cancer) for males in Maine is also higher than the national comparison rate (132.8 per 100,000 vs. 118.1 per 100,000).[20] [21] Other cancer incidence rates in Maine (ME) that are significantly higher than the national (U.S.) comparison rate are: bladder for both males and females (27.5 per 100,000 ME vs. 23.4 per 100,000 U.S.); leukemia for males (23.5 per 100,000 ME vs. 17.4 per 100,000 U.S.); and esophagus for males (13.0 per 100,000 ME vs. 7.8 per 100,000 U.S.).[22]

More than 3,200 (3,247) Maine residents died due to cancer in 2010 – nearly a third (957 residents) died from cancer of the lung and bronchus. Although Maine's overall cancer death rate is declining,[23] it remains higher than the national rate at 186.6 per 100,000 Maine residents compared to the national rate of 171.4 per 100,000.

Lung cancer is the leading cause of cancer death in Maine for both men and women.[24] Maine's death rate due to lung and bronchus cancer for both men and women is also higher than the national rate. The death rate for lung and bronchus cancer for Maine women is 47.0 per 100,000 compared to the national rate of 39.2 per 100,000; and for Maine men, the death rate is 66.1 per 100,000 which is higher (but not statistically higher) than the national rate of 59.9 per 100,000. The lung cancer death rate for men in Maine has declined since 1969; however, the rate for women steadily increased from 1969 until about 10 years ago and may now be at a plateau or beginning to decline. [25]

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[17] http://www.maine.gov/dhhs/mecdc/population-health/mcr/about/index.htm

[18] Incidence and mortality rates are calculated per 100,000 and are age-adjusted to year 2000 U.S. standard population. Additionally, due to the predominantly white population in Maine, all statistical comparisons in the report involving national estimates are based on rates for whites.

[19] Estimates of national incidence data are used for comparisons and are derived from the Surveillance, Epidemiology and End Results (SEER) Program at the National Cancer Institute. The SEER dataset, also known as SEER 9, used in the MCR's Maine Annual Cancer Report 2013 represents about 9.4% of the U.S. population.

[20] http://www.maine.gov/dhhs/mecdc/population-health/mcr/reports/documents/2010_incidence_2010_mortality.pdf.

[21] The tobacco-related cancers, excluding lung, are laryngeal, oral cavity and pharynx, esophageal, stomach, pancreatic, kidney and renal pelvis, urinary bladder, cervical and acute myeloid leukemia.

[22] http://www.maine.gov/dhhs/mecdc/population-health/mcr/reports/documents/2010_incidence_2010_mortality.pdf

[23] *Population-based Cancer Surveillance: State Perspective*, presentation by Dr. Molly Schwenn, Maine Cancer Registry, October 25, 2013 can be accessed at: http://www.maine.gov/legis/opla/cancerstudymtmatrls.htm

[24] Ibid.

[25] Ibid.

Other cancer death rates in Maine which are higher than the national rate are: other tobacco-related cancers (excluding lung) for men (53.6 per 100,000 ME vs. 47.8 per 100,000 U.S.); male bladder (11.6 per 100,000 ME vs. 8.1 per 100,000 U.S.); male esophagus (11.1 per 100,000 ME vs. 7.8 per 100,000 US.); and female myeloma (3.8 per 100,000 ME vs. 2.4 per 100,000 U.S.).

It should be noted that surveillance has an important role in monitoring Maine's cancer burden and in pointing ways to move forward. Health care providers, policymakers and other stakeholders should use the data that the Maine CDC gathers about the State of Maine and reflect it back to the State's current goals and priorities.

II. Risk Factors

Growing older is an important risk factor for cancer.[26] Maine's population is the oldest in the nation, with a median age of 42.7 years. According to MCR, 56% of cancers in Maine are diagnosed at or after 65 years of age. As Maine's population continues to age, the State's burden of cancer grows.[27] However, it should be noted that the incidence and death rates presented in this report are age-adjusted so that we can see differences between Maine and U.S. rates without the factor of age.

Remarkably, two preventable risk factors, tobacco use and obesity, account for roughly 60% of cancer deaths in the United States. With these two risk factors, prevention can eliminate the need for a cure.

Tobacco accounts for approximately 30% of total cancer deaths in the United States.[28] Using tobacco products or regularly being around tobacco smoke (environmental or secondhand smoke) increases the risk of cancer.[29] Adult smoking rates in Maine are higher than the national rate. In 2011, the adult smoking rate was 23% in Maine compared to 20% in the U.S.[30] As of 2011, 86% of adult smokers in Maine had their first cigarette before 19 years of age.[31] One of the primary goals of Maine CDC's Partnership for a Tobacco-Free Maine (PTM) is to prevent young people from starting to smoke. The younger someone starts to smoke, the more likely that person will continue to smoke. Currently in Maine, about 10,400 (15%) high school students smoke tobacco and approximately 79,000 are exposed to second-hand smoke at home.[32]

Obesity is another significant preventable risk factor for cancer. Poor adult diet and obesity also account for approximately 30% of total cancer deaths in the United States.[33] As of 2012, Maine's adult obesity rate is 28.4%.[34] Obesity is associated with increased risk for the following

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[26] http://www.cancer.gov/cancertopics/wyntk/cancer/page3

[27] *Population-based Cancer Surveillance: State Perspective*, presentation by Dr. Molly Schwenn, Maine Cancer Registry, October 25, 2013 can be accessed at: http://www.maine.gov/legis/opla/cancerstudymtmatrls.htm

[28] *Harvard Report on Cancer Prevention, Cancer Causes and Control*, November/December, 1996.

[29] http://www.cancer.gov/cancertopics/wyntk/cancer/page3

[30] http://tobaccofreemaine.org/explore_facts/documents/Adult-Tobacco-Use.pdf

[31] http://www.tobaccofreemaine.org/explore_facts/documents/Youth-Tobacco-Use.pdf

[32] http://www.tobaccofreekids.org/facts_issues/toll_us/maine

[33] *Harvard Report on Cancer Prevention, Cancer Causes and Control*, November/December, 1996.

[34] http://fasinfat.org/states/me/

cancer types: esophagus, pancreas, colon and rectum, breast (postmenopausal), endometrium, kidney, thyroid and gallbladder. In fact, due to the prevalence of obesity in Maine, the Maine CDC has included this group of cancers in its annual cancer report for the first time in 2012 and again this year.[35] In Maine, as of 2012, 64.2% of adults (18 years of age or older) are either overweight (35.8%) or obese (28.4%).[36]

Other less common risk factors for cancer include: family history of cancer, some viruses and bacteria, alcohol, ionizing and ultra-violet radiation, and certain chemical and other substances.[37] The risk of developing cancer can be greatly reduced by avoiding some risk factors; however, other risk factors, such as family history, cannot be avoided.

III. Treatment

At the fourth and final meeting, Commission members allotted time to talk issues relating to cancer treatment – trends, barriers and opportunities.

One of the major emerging trends in cancer care and treatment is cancer survivorship care. The number of cancer survivors in the United States is growing – from 3 million in 1971, to 9.8 million in 2001, to 11.7 million in 2007.[38] Because of advances in prevention, early detection and treatment, people are living longer after cancer diagnosis. However, cancer survivors often face physical, emotional, psychosocial, spiritual and financial challenges as a result of their cancer diagnosis and treatment.[39]

Another significant trend in cancer care is oral chemotherapy, which is discussed later in this report. The emergence of oral chemotherapy drugs, which are taken at home, has huge implications for both patients and community cancer centers.[40] Some chemotherapy treatments are only available in oral form. Private insurance plans generally cover intravenous chemotherapy as a medical benefit. However, in many states, including Maine, insurance companies cover oral chemotherapy as a prescription drug benefit, which often means the patient is required to pay a portion of the total cost of the drug with no annual out-of-pocket limit. The costs can be significant as many oral chemotherapy drugs are classified as specialty tier drugs. In addition, it is important to ensure that cancer patients are taking these drugs as prescribed and are reporting any side effects to their provider. Oral chemotherapy drugs may fundamentally change the existing business model for community cancer centers. The change is potentially problematic because staff time involved in assisting patients with obtaining their oral chemotherapy medications is significant and not billable.[41]

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[35] http://www.maine.gov/dhhs/mecdc/population-health/mcr/reports/documents/2010_incidence_2010_mortality.pdf
[36] *Nutrition, Physical Activity and Cancer: What's the Connection?*, presentation by Colleen Doyle, American Cancer Society, can be accessed at: http://www.maine.gov/legis/opla/cancerstudymtmatrls.htm
[37] http://www.cancer.gov/cancertopics/wyntk/cancer/page3
[38] http://www.cancer.gov/newscenter/newsfromnci/2011/survivorshipMMWR2011
[39] http://www.cdc.gov/cancer/survivorship/basic_info/index.htm
[40] http://www.accc-cancer.org/oncology_issues/articles/JanFeb2012/JF12-Mancini.pdf
[41] Ibid.

One of the major barriers to effective cancer treatment is access to quality health care, which is also discussed later in this report. Patients who are uninsured or underinsured are not getting the preventive care they need and are more likely to be diagnosed with late-stage cancer. One of the oncologists serving on the Commission observed that he is seeing more advanced presentations of cancer in younger people. In addition, because Maine is geographically expansive and predominantly rural, access to cancer care can be a challenge. One Commission member, a practicing oncologist, said it is not uncommon for breast cancer patients to choose a mastectomy over radiation treatments because traveling long distances frequently for radiation treatments is cost prohibitive for the patient.

Another barrier is a lack of understanding among consumers, health care providers and lawmakers about the full scope of services and benefits that palliative care can provide cancer patients.[42] Palliative care is medical care that specializes in the relief of pain, symptoms and stress of serious illnesses, such as cancer. Commission members discussed the need for more education of cancer patients regarding pain and symptom management. In July 2013, two pieces of federal legislation were introduced that aim to reduce suffering and improve the quality of life of patients undergoing care for serious illnesses, such as cancer, by improving access to palliative care.[43]

The Commission believes there is an opportunity for cancer care in the State of Maine to be more efficient and, as a result, more effective and appropriate. Maine's population is relatively small and the number of health care institutions is limited in comparison with many other states. Streamlining the cancer care pathways for patients should not be difficult in Maine.

Both "under-treatment," for those without health insurance, for example, and "over-treatment," such as unnecessary treatments for elderly cancer patients, are important considerations. Health care providers must be conscious of the right amount of treatment to avoid impairing the quality of life for an elderly patient or prescribing unnecessary treatment for a younger patient that may be doing more harm than good. Patients should have access to multi- and inter-disciplinary teams so that cancer treatment is a patient-informed decision-making process. Fundamentally, the cancer patient should be treated as a human being, not as a disease.

[42] http://acscan.org/qualityoflife
[43] Ibid.

FINDINGS AND RECOMMENDATIONS

The Commission was charged with making recommendations for strategies to reduce Maine's cancer incidence and mortality.

ACCESS TO AFFORDABLE, HIGH QUALITY HEALTH CARE:

FINDING #1:

The Cancer Commission finds that access to quality health care is one of the most important factors impacting the incidence of and mortality from cancer in Maine. Prevention, screening, early diagnosis, effective treatment of cancer (including palliative care and survivorship care) all depend on access to affordable and high quality health care. It is important that all of our residents have access to quality care. The uninsured, underinsured and underserved are more likely to be diagnosed with late-stage cancer and to die as a result of the disease.

RECOMMENDATION #1:

The Commission strongly recommends that the State of Maine accept federal funding already set aside pursuant to the federal 2010 health care law, the Patient Protection and Affordable Care Act, known simply as the Affordable Care Act (ACA), to ensure access to affordable health care through Medicaid coverage for approximately 69,500 eligible low-income Maine residents.[44] This will have many benefits impacting cancer in Maine.

LR 2357, "An Act to Increase Health Security by Expanding Federally Funded Health Care for Maine People," sponsored by House Speaker Mark Eves proposes to expand federally funded health care to low-income Maine residents, effective the first day of the quarter in which the State plan amendment is approved.

The Commission recommends sending letters to the Governor, the Commissioner of Health and Human Services and to the Joint Standing Committees on Health and Human Services and Appropriations and Financial Affairs advocating that the State of Maine take advantage of the opportunity to accept federal funding to preserve and expand Medicaid coverage for low-income Mainers in order to ensure the earliest possible medical interventions for cancer prevention, screening and treatment.

This proposal was supported by 9 members of the Commission and opposed by one member. One member was absent.

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[44] Medicaid is a federal and state funded program that pays the medical expenses of people who are unable to pay some or all of their own medical expenses. MaineCare is the name of Maine's Medicaid Program.

FINDING 2:

The ACA is the most significant health law to impact cancer care in decades.[45] The ACA includes over 100 provisions that benefit cancer patients. The following are examples of some key provisions. Under the ACA, insurance companies cannot deny coverage because of a pre-existing condition and cannot charge higher premiums for those with health conditions, such as cancer. Under the ACA, there will be no more lifetime limits on benefits starting in 2014.

RECOMMENDATION #2:

The Commission recommends that the State of Maine do everything in its power to fully implement the ACA and support public awareness of its many benefits for the prevention, early detection and treatment of cancer.

The Commission recommends sending letters to the Joint Standing Committees on Health and Human Services and Insurance and Financial Services and the Commissioners of the Health and Human Services and Professional and Financial Regulation highlighting the benefits of the ACA relating to cancer, advocating for the full implementation of the new federal health care law, and addressing misinformation about the law. The Commission also recommends sending letters to Maine's major newspapers and reaching out to other media outlets.

This proposal was supported by 9 members of the Commission and opposed by one member. One member was absent.

FINDING #3:

Maine is the most rural state in the nation and is geographically expansive.[46] Access to quality health care may prove more difficult for residents in certain parts of Maine. The Commission finds that telemedicine may play a role in increasing access to high quality care to Maine residents.

The Commission learned of legislation that will be introduced during the Second Regular Session of the 126th Maine Legislature and may have a positive impact on access to quality cancer care. LR 2342, "Resolve, Directing the Department of Health and Human Services to Amend MaineCare Rules as They Pertain to the Delivery of Covered Services via Telecommunications Technology" proposes to allow nurses and behavioral health specialists to be reimbursed for provided telemedicine services via MaineCare similar to the way in which medical doctors, physician assistants and family medical practitioners are reimbursed.

At the time of this report, the legislation was not fully drafted, but the Commission generally supports efforts to increase access to and enhance insurance coverage for telemedicine services.

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[45] http://smhs.gwu.edu/gwci/survivorship/casnp/healthpolicy/aca

[46] https://bangordailynews.com/2012/03/26/business/census-maine-most-rural-state-in-2010-as-urban-centers-grow-nationwide/

RECOMMENDATION #3:

The Commission recommends sending a letter to the Joint Standing Committee on Health and Human Services advocating for changes in State law that would enhance insurance coverage for telemedicine services – particularly if it increases access to quality health care for all aspects of cancer care – including, but not limited to, prevention, screening, treatment, palliative and survivorship care.

This proposal was supported by 9 members of the Commission; one member voted neither for nor against the proposal. One member was absent.

FINDING #4:

As stated earlier, the Commission believes that access to affordable health care is critical. Maine is the most rural state in the nation[47] and Maine's population is the oldest in the nation. It is important for all residents to be able to access high value treatments. In some cases, oral chemotherapy drugs provide that opportunity. Long and repeated trips for intravenous (IV) chemotherapy are a burden for cancer patients, particularly those who are older residents living in rural communities. Furthermore, some chemotherapy treatments are only available in an oral form. Since 2012, eight of the 11 oncology drugs approved by the Federal Drug Administration are oral treatments with no IV equivalent[48].

Private insurance plans generally cover IV chemotherapy as a medical benefit including a co-pay and limit on the annual out-of-pocket cost. In many states, such as Maine, insurance companies cover oral chemotherapy as a prescription drug benefit, which often requires the patient to pay a portion of the total cost of the drug with no annual out-of-pocket limit. These out of pocket costs can often be significant as many oral chemo therapy drugs are classified as specialty tier drugs.

RECOMMENDATION #4:

The Commission recommends requiring health insurance policies that cover chemotherapy to include coverage for orally administered anticancer medications that is equivalent to the coverage provided for intravenously administered or injected anticancer medications without increasing patient cost sharing for chemotherapy medications to achieve this goal. LD 627, "An Act Relating to Orally Administered Cancer Therapy," which proposes this requirement, was introduced during the First Regular Session of the 126th Maine Legislature and was referred to the Joint Standing Committee on Insurance and Financial Services. The Committee voted to carry over the bill to the Second Regular Session of the 126th Maine Legislature.

The Commission recommends sending a letter to the Joint Standing Committee on Insurance and Financial Services advocating for changes in State law that would require health insurance policies that cover chemotherapy to include coverage for orally administered anticancer

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[47] https://bangordailynews.com/2012/03/26/business/census-maine-most-rural-state-in-2010-as-urban-centers-grow-nationwide/

[48] http://blog.dana-farber.org/insight/2013/01/better-coverage-for-oral-chemo-why-it-matters/

medications that is equivalent to the coverage for chemotherapy administered intravenously or injected. As of October 2013, 27 states have enacted oral chemotherapy access laws.[49]

This proposal was supported by 9 members of the Commission; one member voted neither for nor against the proposal. One member was absent.

FINDING #5:

Specialty pharmacies are drug outlets that distribute high-cost medications that may require special handling outside the capability of a local retail pharmacy. [50] Insurance providers are attracted to specialty pharmacies, because they offer services for patients taking therapies at home and because these pharmacies have fewer overhead expenses since most are mail-order.[51] Oral oncolytic medications, which are cancer treatment drugs taken by mouth to kill cancer cells or to stop them from dividing, are an example of high-cost medications that may be taken at home. Oral oncolytic drugs include, but are not limited to, oral chemotherapy/small molecules or monoclonal antibodies. However, specialty outlets sometimes require patients to receive months' worth of a drug at once. If a person's cancer treatment regimen changes, as is often the case, this could result in unnecessary waste and cost. The Commission believes that a cancer patient should be able to choose between a specialty pharmacy or local community pharmacy based on what is best for the patient.

RECOMMENDATION #5:

The Commission recommends sending a letter to the Joint Standing Committee on Insurance and Financial Services asking the committee to review the practice of insurers requiring that cancer patients use specialty pharmacies.

This proposal was supported by 9 members of the Commission; one member voted neither for nor against the proposal. One member was absent.

FINDING #6:

For some Maine residents, family planning clinics are their primary source of health care. Services provided at family planning clinics include pap smears for the prevention and early detection of cervical cancer, mammograms and education for the early detection of breast cancer, and colorectal cancer screening for the prevention and early detection of colorectal cancer. Finding breast, cervical and colorectal cancers at an early stage increases the opportunity for effective treatment and patient survival.[52] [53]

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[49] http://www.communityoncology.org/pdfs/COC%202013%20Oral%20Parity%20CPAN%20FF0318131.pdf
The 27 states are CA, FL, VA, LA, OR, WA, CO, NE, KS, IA, MN, IN, VT, OK, NY, NV, NM, HI, MD, CT, MA, IL, DE, MD, RI, UT and TX. (source: http://myeloma.org/ArticlePage.action?articleId=3708)

[50] http://www.curetoday.com/index.cfm/fuseaction/article.PrintArticle/article_id/29

[51] Ibid.

[52] http://www.acscan.org/pdf/breastcancer/factsheets/state-facts/Maine.pdf

[53] http://www.cancer.gov/cancertopics/factsheet/detection/colorectal-screening

RECOMMENDATION #6:

The Commission supports sending a letter to the Joint Standing Committee on Health and Human Services supporting legislation that expands Medicaid coverage for family planning services to low-income adults and adolescents. LD 1247, "An Act to Expand Coverage of Family Planning Services," which proposes this requirement, was introduced during the First Regular Session of the 126th Maine Legislature and was referred to the Health and Human Services Committee. The Committee voted to carry over the bill to the Second Regular Session of the 126th Legislature. LD 1247 provides for a family planning State plan amendment to cover people up to 200% of the federal poverty level (FPL). For 2013-2014, 200% FPL for a family of one is $22,980, for a family of two is $31,020, and for a family of three is $39,060.

This proposal was supported by 9 members of the Commission and opposed by one member. One member was absent.

TOBACCO PREVENTION AND CESSATION:

FINDING #7:

Tobacco is a major, yet preventable, risk factor for cancer. Smoking and tobacco use account for approximately 30% of all cancer deaths in the United States (U.S.) and 87% of lung cancer deaths.[54] [55] Tobacco use increases the risk for at least 10 types of cancer. Lung cancer is the leading cause of cancer death in Maine for both men and women.[56]

In 1998, 46 states and six U.S. territories and the nation's four largest tobacco manufacturers finalized the tobacco master settlement agreement (MSA) in settlement of litigation to collect health related expenses caused by smoking tobacco.[57] The next year, the Fund for a Healthy Maine (FHM) was established by the Maine Legislature (Title 22, Maine Revised Statutes, section 1511). Since State fiscal year 2000, tobacco settlement payments from tobacco manufacturers under the MSA have been deposited into the FHM.

Pursuant to Maine law, FHM allocations are limited to prevention and health promotion purposes, including smoking prevention, cessation and control activities, including, but not limited to, reducing smoking among the children of the State of Maine.

Between the annual revenue from cigarette excise taxes and the over $50 million Maine receives each year from the MSA, the Commission finds it troublesome that the State's tobacco prevention and control program is funded at less than half of the federal Centers for Disease Control and Prevention (CDC) recommended level and that Medicaid recipients have not been receiving maximal assistance for tobacco cessation.

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[54] *Harvard Report on Cancer Prevention, Cancer Causes and Control*, November/December, 1996.
[55] http://www.tobaccofreemaine.org/explore_facts/documents/Adult-Tobacco-Use.pdf
[56] Ibid.
[57] *Final Report of the Commission to Study Allocations of the Fund for a Healthy Maine*, 125th Maine Legislature, December 2011 can be accessed at: http://www.maine.gov/legis/opla/fhmreportdoc1.pdf

The Campaign for Tobacco-free Kids ranks states based on funding for state tobacco prevention programs (data sources include, but are not limited to, the Robert Wood Johnson Foundation, American Cancer Society Cancer Action Network; American Heart Association; and the American Lung Association). According to the ranking, Maine's annual funding in State fiscal year 2013 was $7.5 million; whereas, the CDC recommended spending level for the same period was $18.5 million. To put it another way, Maine's tobacco prevention spending is approximately 40.7% of the recommended level.[58]

Additionally, the Commission learned that approximately $1.6 million dollars in allocated funds in the FHM fund in State fiscal year 2013 were not spent, including over $540,000 in tobacco prevention and control program funds and approximately $490,000 allocated for school-based programs.[59] Given the importance of tobacco as a significant preventable risk factor for many of the leading cancers and the tobacco use rates in Maine, particularly among certain populations, the State of Maine needs to do a better job spending all dollars allocated to it as there is a clearly a need for more work on this front.

RECOMMENDATION #7:

The Commission recommends that the State of Maine fund the tobacco prevention and control program at the level recommended by the CDC.

The Commission recommends sending a letter to the Joint Standing Committees on Health and Human Services and Appropriations and Financial Affairs and the Commissioner of Health and Human Services advocating that both committees during budget deliberations look for opportunities to increase funding and State government accountability for tobacco prevention in Maine. The Department of Health and Human Services, Maine CDC and the Maine Legislature need to take responsibility for tobacco prevention and cessation in Maine. The Commission recommends that more tobacco prevention and control programs funds be used for the purpose of increasing awareness, particularly among young people in Maine, about the relationship between tobacco use and cancer.

This proposal was supported by 9 members of the Commission; one member voted neither for nor against the proposal. One member was absent.

RECOMMENDATION #7-A:

The Commission recommends the passage of LR 2653, "An Act to Improve Education about and Awareness of Maine's Health Laws and Resources," sponsored by Commission member Representative Megan Rochelo. This bill proposes to allocate $5 million in funds the State will receive under the MSA to enhance enforcement of current tobacco prevention and control laws, improve public education about tobacco laws and restore funds to the Fund for a Healthy Maine.

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[58] http://www.tobaccofreekids.org/content/what_we_do/state_local_issues/settlement/FY2013/1.%202012%20State%20Report%20-%20Full.pdf

[59] http://www.maine.gov/legis/opla/2013BalancesDAFSJune302013FHM.pdf

The Commission recommends sending a letter to the Joint Standing Committee on Appropriations and Financial Services in support of Rep. Rochelo's bill.

The Commission recommends sending a letter to the Joint Standing Committees on Education and Cultural Affairs, Health and Human Services and Appropriations and Financial Services and the Commissioners of Education and Health and Human Services advocating for improving evidence-based education about the risks of tobacco use in K-12 schools and among the general public.

This proposal was supported by 9 members of the Commission; one member voted neither for nor against the proposal. One member was absent.

FINDING #8:

The Commission believes tax policy can continue to play a role in lowering tobacco use in Maine. Increasing the unit price for tobacco products has been shown to reduce consumption of tobacco products, particularly among young people. A 10% price increase results in approximately a 4% decrease in tobacco use.[60] At one time Maine was a leader in this health policy initiative with one of the highest cigarette excise taxes in the nation. Maine has dropped from that position and currently has the second lowest tax in New England at $2 per pack, just ahead of New Hampshire at $1.78 per pack.

RECOMMENDATION #8:

The Commission recommends sending letters to the Joint Standing Committees on Health and Human Services, Taxation, and Appropriations and Financial Affairs advocating that those committees consider, during budget deliberations, increasing the cigarette excise tax by an amount that has been demonstrated to significantly decrease cigarette use (e.g., $1.50) and equalizing the tax on other tobacco products for the fundamental purpose of improving public health. Increasing the cigarette tax has not only been shown to discourage use of tobacco products, but may also generate additional revenue for tobacco prevention and cessation programs in Maine.

This proposal was supported by 9 members of the Commission and opposed by one member. One member was absent.

OBESITY PREVENTION THROUGH NUTRITION AND PHYSICAL ACTIVITY:

FINDING #9:

Obesity is another significant preventable risk factor for cancer. Poor adult diet and obesity account for approximately 30% of total cancer deaths in the United States.[61] Well over half of Maine residents are either overweight or obese.[62]

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[60] http://www.tobaccofreemaine.org/explore_facts/documents/Adult-Tobacco-Use.pdf

[61] *Harvard Report on Cancer Prevention, Cancer Causes and Control*, November/December, 1996.

Pursuant to Title 22, Maine Revised Statutes, section 1511, FHM allocations are limited to prevention and health promotion purposes, including prevention, education and treatment activities concerning unhealthy weight and obesity.

Maine CDC utilizes the Community and School Grants and Statewide Coordination appropriation of the FHM to strengthen local public health infrastructure, address tobacco use and obesity, and improve access to health care for adolescents.[63] The Commission is troubled that allocations within this appropriation program have been declining steadily over the last 10 years, from about $9 million in State fiscal years 2008-2009 to roughly $5 million in State fiscal years 2012-2013 and that funding has been eliminated for school health coordinators.[64] The Commission is also troubled that considerably more funds within the FHM has been shifted to MaineCare seed money over the past several years. In State fiscal year 2012, almost $8 million of the FHM fund was allocated to MaineCare; about $19.6 million in State fiscal year 2013; and approximately $26 million and $25 million in State fiscal years 2014 and 2015 respectively.[65]

Obesity prevention should focus on establishing strong nutrition standards for all foods and beverages sold or served in schools; increasing the quality and quantity of physical education in K – 12 schools; and reducing the marketing of unhealthy foods and beverages, particularly to youth.

RECOMMENDATION #9:

The Commission recommends sending a letter to the Joint Standing Committees on Health and Human Services, Education and Cultural Affairs, and Appropriations and Financial Affairs advocating that these committees during budget deliberations look for opportunities to increase funding and State government accountability of obesity prevention in Maine. Furthermore, the Commission recommends that more of the Fund for a Healthy Maine funds be used to promote and increase healthy eating and physical activity.

This proposal was supported by 9 members of the Commission; one member voted neither for nor against the proposal. One member was absent.

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[62] *Nutrition, Physical Activity and Cancer: What's the Connection?,* presentation by Colleen Doyle, American Cancer Society, can be accessed at: http://www.maine.gov/legis/opla/cancerstudymtmatrls.htm

[63] *Summary of The Fund for a Healthy Maine Community and School Grants and Statewide Coordination Appropriation: Commission to Study the Incidence of and Mortality Related to Cancer*, Maine CDC, November 2013, can be accessed at: http://www.maine.gov/legis/opla/Community%20%20School%20Grants.pdf

[6464] *Fund for a Healthy Maine (FHM) Allocations Through 126th Legislature 1st Special Session*, prepared by the Office of Fiscal and Program Review (OFPR) and updated 11/7/2013, can be accessed at the following link: http://www.maine.gov/legis/opla/cancerstudyFHMStatusreport.pdf

[65] *Fund for a Healthy Maine Budgeted Allocations and Uses SFY 12-13* and *Fund for a Healthy Maine Budgeted Allocations and Uses SFY 14-15*, prepared by the Office of Fiscal and Program Review (OFPR can be found at the following link: http://www.maine.gov/legis/opla/cancerstudymtmatrls.htm

RECOMMENDATION #9-A:

The Commission recommends legislation directing the Commissioner of Health and Human Services, in collaboration with the Director of the Maine Center for Disease Control and Prevention (Maine CDC) and the Commissioner of Education, to convene a working group to develop a long-term plan to promote healthy eating and physical activity and to increase physical education. The legislation will also direct the Commissioner of Health and Human Services to engage the various stakeholders in developing an evidence-based strategy to prevent obesity which is a significant preventable risk factor for cancer. The legislation will require the working group to report back to the Joint Standing Committees on Health and Human Services and Education and Cultural Affairs no later than February 1, 2015 with findings and recommendations. See Appendix C for suggested legislation.

This proposal was supported by 9 members of the Commission and opposed by one member. One member was absent.

RECOMMENDATION #9-B:

The Commission recommends sending a letter to the Joint Standing Committee on Education and Cultural Affairs advocating that the Committee consider legislative action to increase the quality and quantity of physical education in the education curriculum and to reduce the marketing and availability of unhealthy foods and beverages in schools. The Commission also recommends sending a letter to the Commissioner of Education asking that the department do everything in its power to promote physical activity and healthy nutritional choices in schools.

This proposal was supported by 9 members of the Commission; one member voted neither for nor against the proposal. One member was absent.

FINDING #10:

The Commission believes that it will take a multi-pronged strategy and assistance from many evidence-based organizations to deal with the epidemic of obesity in Maine. Again, the Commission believes that tax policy can have a positive influence on nutritional choices among Maine residents. The largest source of calories in Americans' diets is sugar-sweetened beverages.[66] As stated earlier in this report, well over half of Maine residents are either overweight or obese.[67] Like cigarette taxes, price increases on food and drink items, such as sugar-sweetened beverages, may reduce obesity and the health risks associated with a lifetime of poor nutritional choices.

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[66] *Nutrition, Physical Activity and Cancer: What's the Connection?,* presentation by Colleen Doyle, American Cancer Society, can be accessed at: http://www.maine.gov/legis/opla/cancerstudymtmatrls.htm

[67] Ibid.

RECOMMENDATION #10:

The Commission recommends sending a letter to the Joint Standing Committees on Health and Human Services and Education and Cultural Affairs asking that both committees seek information from the Department of Health and Human Services, Maine CDC, Department of Education and other relevant stakeholders about how State policies, including taxes, may reduce obesity and poor nutritional choices in Maine. Both committees should receive annual updates, including the latest evidence, research and findings, from Maine CDC, the Maine Department of Education and interested parties on best practices used to increase physical activity and proper nutrition in K-12 schools and the general public as a whole.

This proposal was supported by 9 members of the Commission; one member abstained from voting. One member was absent.

EVIDENCE-BASED SCREENING, IMMUNIZATION AND TESTING:

FINDING #11:

Prevention, evidence-based screening and immunizations should remain as primary strategies for reducing Maine's cancer burden. The Commission believes that the State of Maine should continue to promote early detection and evidence-based screening as recommended by the U.S. Preventive Services Task Force (USPSTF)[68] and evidence-based immunizations such as the hepatitis B virus and the human papilloma virus vaccinations.

Additionally, the Commission finds that Maine CDC should consider promoting other evidence-based screening as new techniques are proven in the literature and supported by national evidence-based organizations like USPSTF. Expansion of evidence-based screening should target those cancers in Maine with incidence and mortality rates above the national rate. Screening must follow the appropriate protocols and be utilized as recommended.

Maine CDC's Comprehensive Cancer Control program identifies and facilitates statewide and community-based opportunities to reduce the burden of cancer in Maine through promotion of cancer prevention and early detection activities, as well as policy, systems and environmental changes. This program developed and oversees the Colorectal Cancer Control program with the goal of increasing colorectal screening. Currently, the Colorectal Cancer Control program supports approximately 300 colonoscopies per year through contracted health systems to program eligible low-income, uninsured and underinsured men and women 50 to 64 years of age who are at or below 250% of the federal poverty level.[69] According to Maine CDC, federal funding for the Colorectal Cancer Control program ends June 29, 2014. The US CDC has not announced as

[68] The USPSTF is an independent panel of experts in prevention and evidence-based medicine. Panelists are primary care providers, such as, pediatricians, family physicians, gynecologists/obstetricians, nurses and health behavior specialists.

[69] Department of Health and Human Services, Maine CDC responses to questions relating to federal grants and State grant programs can be accessed at the following link: http://www.maine.gov/legis/opla/cancerstudyQuestionsfromNov8meeting.pdf

of November 2013 whether there will be a new competitive funding opportunity announcement.[70]

Maine CDC's Breast and Cervical Health program manages a statewide breast and cervical cancer early detection screening program for low-income, uninsured and underinsured women 35 to 64 years of age who are at or below the 250% federal poverty level.[71] In November 2013, there were approximately 6,200 eligible women enrolled in this program.[72] According to Maine CDC, the US CDC grant that supports various aspects of the cancer program, including the Breast and Cervical Health program and the Comprehensive Cancer Control program and the Maine Cancer Registry, is in the second year of a five-year grant cycle.[73]

The Maine CDC should also continue to educate the public about cancer-related immunizations. People who have long-term infections with hepatitis B virus (HBV) are at higher risk for liver cancer.[74] In fact, chronic infection with hepatitis B causes 80% of all primary liver cancers worldwide.[75] Because of this, the hepatitis B vaccine is considered one of the first anti-cancer vaccines by the U.S. Food and Drug Administration.[76]

In addition, almost all cervical cancers are caused by human papillomavirus (HPV).[77] There are many types of HPV. Some HPV types can cause changes on a woman's cervix that can lead to cervical cancer over time. Two HPV vaccines are available to protect against the types of HPV that cause most cervical, vaginal and vulvar cancers. However, it is recommended that females who are vaccinated against HPV still need to have regular Pap tests to screen for cervical cancer.[78]

RECOMMENDATION #11:

The Commission recommends sending letters to the Governor's Office, the Commissioner of Health and Human Services, and the Director of the Maine CDC advocating that the Maine CDC continue to support existing programs, namely the breast and cervical health programs and colorectal screening programs. The Department of Health and Human Services and Maine CDC should continue to seek opportunities to enhance funding for these programs, particularly federal grants for prevention and screening, to institute patient reminder systems, make system and

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[70] Department of Health and Human Services, Maine CDC responses to questions relating to federal grants and State grant programs can be accessed at the following link:
http://www.maine.gov/legis/opla/cancerstudyQuestionsfromNov8meeting.pdf

[71] *Summary of Cancer Related Programs: Maine CDC* can be accessed at the following link:
http://www.maine.gov/legis/opla/CancerRelatedPrograms.pdf

[72] Ibid.

[73] Department of Health and Human Services, Maine CDC responses to questions relating to federal grants and State grant programs can be accessed at the following link:
http://www.maine.gov/legis/opla/cancerstudyQuestionsfromNov8meeting.pdf

[74] http://www.cancer.org/treatment/treatmentsandsideeffects/treatmenttypes/immunotherapy/immunotherapy-cancer-vaccines

[75] http://www.hepb.org/professionals/hepb_and_liver_cancer.htm

[76] Ibid.

[77] http://www.cdc.gov/cancer/cervical/basic_info/risk_factors.htm

[78] http://www.cdc.gov/cancer/cervical/basic_info/prevention.htm

policy changes that promote screenings, and determine a plan for the colorectal screening program once the funding outlook is determined. The Department of Health and Human Services and Maine CDC should also seek opportunities to educate the public about the importance of cancer-related immunizations.

This proposal was supported by 9 members of the Commission; one member voted neither for nor against the proposal. One member was absent.

RECOMMENDATION #11-A:

The Commission recommends sending a letter to the Joint Standing Committee on Health and Human Services encouraging the committee to get more information from the Maine CDC and other stakeholders about federal grant opportunities – including the status of existing grants and opportunities for potential future grants.

FINDING #12:

The United States Preventive Services Task Force (USPSTF) is currently updating its lung cancer screening guidelines and the final recommendation statement is expected soon. The draft guidelines recommend annual low-dose computed tomography (CT) screening for individuals at high risk for lung cancer. High risk individuals include former smokers, 55 to 79 years of age, who have smoked the equivalent of a pack a day for 30 years and have smoked within the past 15 years.[79] In 2011, the adult smoking rate in Maine was 23% and 32% of adults in Maine are former smokers.[80] Tobacco use accounts for at least 30% of all cancer deaths and 87% of lung cancer deaths in the United States.[81] Lung cancer is the leading cause of cancer death in Maine for both men and women.[82]

The Commission believes that it is important to educate health care providers about the effective deployment of these new guidelines and the general public about the potential value of this new screening tool as well as the risks.

RECOMMENDATION #12:

The Commission recommends sending a letter to the Joint Standing Committee on Health and Human Services suggesting that the committee convene a meeting of public and private-sector stakeholders to better understand how the new USPSTF guidelines for lung cancer screening will be promoted and implemented in Maine.

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[79] http://www.lung.org/about-us/our-impact/top-stories/new-lung-cancer-screening.html
[80] http://www.tobaccofreemaine.org/explore_facts/Maine_facts_and_stats.php
[81] http://www.cancer.org/cancer/cancercauses/tobaccocancer/tobacco-related-cancer-fact-sheet
[82] Ibid.

FINDING #13:

Radon is the second leading cause of lung cancer in the United States and is the number one cause of lung cancer among non-smokers.[83] As mentioned earlier in this report, lung cancer is the leading cause of cancer death in Maine for both men and women.[84] Radon is a naturally occurring radioactive gas that enters homes primarily through soil, gas and water.[85] Radon can be found in all parts of the U.S., but the rocks and soils of Maine create more radon than most other states.[86]

The State of Maine began its participation in the United States Department of Environmental Protection (US EPA) State Indoor Radon Grant program in 1990. Prior to 1990, radon outreach and education was funded by the General Fund. When the 1989 Radon Registration Act - Title 22, Maine Revised Statutes, chapter 165 – was enacted, General Fund monies were eliminated with the intention that revenue from registration fees required by the Radon Registration Act would be sufficient to offset the costs of the registration program, education and outreach.[87] In State fiscal year 2013, the regulatory program revenue was approximately $25,000 and the average annual federal grant award for all the years since 1990 has been approximately $170,000.[88]

The Commission is concerned that federal funding for Maine's Indoor Radon Program is scheduled to end June 30, 2014. Maine CDC is exploring ways to fulfill its duties pursuant to Title 22, chapter 165 if funding ends in June 2014.

RECOMMENDATION #13:

The Commission recommends that the Radon Program be funded and preserved. The Commission recommends sending a letter to the Joint Standing Committees on Health and Human Services and Appropriations and Financial Services advocating for General Fund funding of this program in the event that federal funding is discontinued.

This proposal was supported by 9 members of the Commission; one member voted neither for nor against the proposal. One member was absent.

RECOMMENDATION #13-A:

The Commission recommends sending a letter to the Joint Standing Committees on Health and Human Services and Education and Cultural Affairs advocating that all public schools in Maine

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[83] http://www.epa.gov/radon/healthrisks.html

[84] *Population-based Cancer Surveillance: State Perspective*, presentation by Dr. Molly Schwenn, Maine Cancer Registry, October 25, 2013 can be accessed at: http://www.maine.gov/legis/opla/cancerstudymtmatrls.htm

[85] http://physics.umaine.edu/public-service/educational-outreach/radon-in-air-and-water/

[86] http://www.miaqc.org/Maine%20Citizens%20Guide%20To%20Radon.pdf

[87] Department of Health and Human Services, Maine CDC responses to questions relating to federal grants and State grant programs can be accessed at the following link: http://www.maine.gov/legis/opla/cancerstudyQuestionsfromNov8meeting.pdf

[88] Ibid.

be tested for radon and undergo remediation, if necessary. The School Revolving Renovation Fund, established in Title 30-A, section 6006-F, may be used to make loans to school administrative units for school repair and renovation needs, including, but not limited to, improving air quality in a school building and undertaking other health, safety and compliance repairs.

This proposal was supported by 9 members of the Commission; one member voted neither for nor against the proposal. One member was absent.

FINDING #14:

Arsenic is known to cause cancer and other serious health problems.[89] [90] Arsenic is found naturally in the bedrock throughout much of Maine. People can be exposed to arsenic in different ways, including through food and drinking water, in the workplace and through contact with pressure-treated wood containing arsenic. For most people, diet and drinking water are the most important sources of exposure to arsenic. It is important to study the different routes of exposure and more research needs to be conducted.

Arsenic exposure through drinking water depends on where you live and whether you get your water from a private well or from a system that must meet the regulatory standard for arsenic content. The current estimate is that one in 10 private wells in Maine has arsenic levels above the federal standard for community water supplies, and about half of Maine's population get their drinking water from a private well. Some private wells in Maine have very high arsenic levels.[91]

The Commission finds that studies from other countries (i.e., parts of Southeast Asia and South America) where high levels of arsenic in drinking water are more prevalent have found higher risks of cancers in the bladder, kidney, lung, skin, and less consistently, colon and liver. However, more research is needed in the United States as few parts of the country have large populations that rely on well water and with high levels of arsenic in primary drinking water sources like we have in some areas of Maine. During the final meeting of the Commission, Commission members learned that Maine CDC has been participating in such research. Maine CDC has been working collaboratively with the National Cancer Institute, New Hampshire and Vermont to research bladder cancer etiology in a case-control study with focus on roles of tobacco exposure, occupation, and other environmental factors and family history. However, the Commission did not have enough time to request a presentation or to discuss the topic more fully.

Maine CDC's Drinking Water Program implements the laws and regulations aimed at reducing exposure of public water system customers to harmful contaminants, including arsenic.[92] Maine

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[89] http://www.maine.gov/dhhs/mecdc/environmental-health/water/resources/arsenic.htm
[90] http://www.cancer.org/cancer/cancercauses/othercarcinogens/intheworkplace/arsenic
[91] http://www.usgs.gov/newsroom/article.asp?ID=2656#.UqoGAdGA20U
[92] Department of Health and Human Services, Maine CDC responses to questions relating to federal grants and State grant programs can be accessed at the following link:
http://www.maine.gov/legis/opla/cancerstudyQuestionsfromNov8meeting.pdf

CDC has worked to increase testing of private wells for arsenic. According to Maine CDC, testing for arsenic has increased from 22% of private well owners in 2003 to 42% in 2009. In 2013, Maine CDC was awarded a two-year grant of $150,000 annually that will enable Maine CDC to fund three Healthy Maine Partnerships to promote private well water testing and provide 450 arsenic test kits for distribution.[93] The grant will also support education and awareness efforts.

RECOMMENDATION #14:

The Commission recommends sending a letter to the Joint Standing Committee on Health and Human Services suggesting that the Committee get more information about arsenic and its potential link to cancer from the Maine CDC, including their recent collaborative work with the National Cancer Institute and other research about arsenic's impact on cancer in the United States and Maine.

This proposal was supported by 9 members of the Commission; one member voted neither for nor against the proposal. One member was absent.

FINDING #15:

During the course of its work, the Commission found it difficult to get a full understanding of cancer-related prevention and treatment spending in the State of Maine. This was exacerbated by the current Administration's recently implemented policy limiting Executive Branch participation in interim Legislative meetings to written communication only. The Commission was required, as were other legislative study groups and joint standing policy committees, to submit questions to departments in writing. Furthermore, the Executive Branch agencies were allowed to respond in writing only and did not participate in any of the Commission's four meetings. The one exception is the participation of Commission member, Dr. Molly Schwenn, Director of the Maine Cancer Registry, who served on behalf of the Director of the Maine CDC. Dr. Schwenn presented information at the first meeting and participated in all four meetings.

As stated earlier in this report, the Commission is concerned that:

- The State's tobacco prevention and control program is funded at less than half of the recommended level[94] and that Medicaid recipients have not been receiving maximal assistance for tobacco cessation;

- Approximately $1.6 million in allocated funds in the Fund for a Healthy Maine (FHM) fund in State fiscal year 2013 were not spent, including approximately $540,000 in

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[93] Department of Health and Human Services, Maine CDC responses to questions relating to federal grants and State grant programs can be accessed at the following link:
http://www.maine.gov/legis/opla/cancerstudyQuestionsfromNov8meeting.pdf

[94] http://www.tobaccofreekids.org/content/what_we_do/state_local_issues/settlement/FY2013/1.%202012%20State%20Report%20-%20Full.pdf

tobacco prevention and control program funds and almost $490,000 allocated for school-based programs[95]; and

- Allocations within the Community and School Grant and Statewide appropriation program of the FHM have been declining steadily over the last 10 years, from about $9 million in State fiscal years 2008-2009 to about $5 million in State fiscal years 2012-2013 and that funding has been eliminated for school health coordinators.[96]

RECOMMENDATION #15:

The Commission recommends sending letters to the Joint Standing Committees on Health and Human Services and Appropriations and Financial Services suggesting that both committees seek further information and receive presentations about the Fund for a Healthy Maine fund and cancer-related spending in the State of Maine from the Department of Health and Human Services, Maine CDC. The Commission also recommends sending letters to the Commissioner of Health and Human Services and the Director of the Maine CDC advocating for more information and transparency in this regard.

This proposal was supported by 9 members of the Commission; one member voted neither for nor against the proposal. One member was absent.

FINDING #16:

The Commission finds that it had insufficient time to perform an in-depth review of all aspects of the State's above-average rates of cancer incidence and mortality and the State's current cancer prevention, early detection and treatment goals and priorities. Maine's cancer burden is great; in 2010, over 8,200 residents were diagnosed with cancer and over 3,200 residents died due to cancer.[97]

As this report demonstrates, the Commission discussed the following issue areas at length: access to quality health care, risk factors – particularly preventable risk factors, and evidence-based screening, immunizations and testing. However, treatment, palliative and survivorship care are examples of important issues that warrant further deliberation.

RECOMMENDATION #16:

The Commission recommends legislation that will allow the Commission to continue its work. The legislation will require the Commission to hold additional meetings after the adjournment of Second Regular Session of the 126th Maine Legislature and to submit a final report no later than November 5, 2014 for presentation to the First Regular Session of the 127th Legislature. The

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[95] http://www.maine.gov/legis/opla/2013BalancesDAFSJune302013FHM.pdf

[96] *Fund for a Healthy Maine (FHM) Allocations Through 126th Legislature 1st Special Session*, prepared by the Office of Fiscal and Program Review (OFPR) and updated 11/7/2013, can be accessed at the following link: http://www.maine.gov/legis/opla/cancerstudyFHMStatusreport.pdf

[97] http://www.maine.gov/dhhs/mecdc/population-health/mcr/reports/documents/2010_incidence_2010_mortality.pdf

Joint Standing Committee on Health and Human Services may introduce a bill related to the Commission's final report to the First Regular Session of the 127th Legislature. See Appendix D for suggested legislation.

This proposal was supported by 9 members of the Commission; one member voted neither for nor against the proposal. One member was absent.

APPENDIX A

Authorizing Joint Order
Resolve 2013, Chapter 77

APPROVED | CHAPTER
JULY 16, 2013 | 77
BY GOVERNOR | RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND AND THIRTEEN

H.P. 1143 - L.D. 1574

Resolve, Establishing the Commission To Study the Incidence of and Mortality Related to Cancer

Emergency preamble. Whereas, acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, this legislation needs to take effect before the expiration of the 90-day period in order to allow this commission sufficient time to conduct its work; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

Sec. 1. Commission established. Resolved: That the Commission To Study the Incidence of and Mortality Related to Cancer, referred to in this resolve as "the commission," is established; and be it further

Sec. 2. Commission membership. Resolved: That the commission consists of no more than 11 members as follows:

1. The President of the Senate shall appoint:

A. Two members of the Senate, including a member from each of the 2 parties holding the largest number of seats in the Legislature. The President of the Senate shall give preference in making one of the appointments to a member who serves on the Joint Standing Committee on Health and Human Services; and

B. One person representing a statewide public health organization;

2. The Speaker of the House of Representatives shall appoint:

A. Three members of the House of Representatives, including members from each of the 2 parties holding the largest number of seats in the Legislature. The Speaker of the House shall give preference in making one of the appointments to a member who serves on the Joint Standing Committee on Health and Human Services; and

B. One person representing a statewide organization of medical professionals, one person representing a statewide voluntary nonprofit health organization that represents cancer patients, one person who possesses expertise in cancer research or epidemiology and one person who possesses expertise in the subject matter of the study; and

3. The Director of the Maine Center for Disease Control and Prevention within the Department of Health and Human Services or the director's designee; and be it further

Sec. 3. Chairs. Resolved: That the first-named Senate member is the Senate chair and the first-named House of Representatives member is the House chair of the commission; and be it further

Sec. 4. Appointments; convening of commission. Resolved: That all appointments must be made no later than 10 days following the effective date of this resolve. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been made. The chairs of the commission shall call and convene the first meeting of the commission within 15 days of the effective date of this resolve. If a majority of but not all appointments have been made within 10 days of the effective date of this resolve, the chairs may request authority and the Legislative Council may grant authority for the commission to meet and conduct its business; and be it further

Sec. 5. Meetings. Resolved: That the commission is authorized to meet up to 4 times to accomplish its duties; and be it further

Sec. 6. Duties. Resolved: That the commission shall review the State's above-average rates of cancer incidence and mortality and the State's current cancer prevention, detection and treatment goals and priorities.

The commission shall gather information and data from public and private entities as necessary to:

1. Identify or review the State's current priorities and goals to reduce the incidence of and mortality from cancer;

2. Identify the types of cancer with the highest incidence and mortality in the State, including the types of cancer whose incidence and mortality rates differ the most from national averages;

3. Identify the risk factors, including preventable lifestyle risk factors such as tobacco use, diet, exercise and obesity, related to high relative rates of the incidence of and mortality from cancer;

4. Identify the extent to which barriers to health care in the State contribute to cancer mortality;

5. Make recommendations for legislative strategies to reduce the State's cancer incidence and mortality; and

6. Make recommendations for how current state programs could further assist citizens through education and cancer prevention programs; and be it further

Sec. 7. Cooperation. Resolved: That the Commissioner of Health and Human Services and the Director of the Maine Center for Disease Control and Prevention within the Department of Health and Human Services, the Commissioner of Administrative and Financial Services and the Commissioner of Education, and any other relevant department, shall provide information and data to the commission as necessary for its work, within existing resources; and be it further

Sec. 8. Staff assistance. Resolved: That the Legislative Council may provide necessary staffing services to the commission; and be it further

Sec. 9. Report. Resolved: That, no later than December 4, 2013, the commission shall submit a report that includes its findings and recommendations, including suggested legislation, to the Joint Standing Committee on Health and Human Services in the Second Regular Session of the 126th Legislature; and be it further

Sec. 10. Outside funding. Resolved: That the commission shall seek funding contributions to fund 50% of the costs of the study. All funding is subject to approval by the Legislative Council in accordance with its policies. If sufficient contributions to fund 50% of the study have not been received within 30 days after the effective date of this resolve, no meetings are authorized and no expenses of any kind may be incurred or reimbursed.

Emergency clause. In view of the emergency cited in the preamble, this legislation takes effect when approved.

APPENDIX B

Membership List
Commission to Study the Incidence of and Mortality Related to Cancer

Commission to Study the Incidence of and Mortality Related to Cancer

Resolve 2013, Ch. 77
October 2013

Appointment(s) by the President

Sen. Colleen M. Lachowicz - Chair
1 Kelsey Street, Apt. #2
Waterville, ME 04901
207-692-7143

Senate Member

Sen. Thomas B. Saviello
60 Applegate Lane
Wilton, ME 04294
207-645-3420

Senate Member

Ed Miller
American Lung Association
122 State Street
Augusta, ME 04330
207-624-0308

Representing a statewide public health organization

Appointment(s) by the Speaker

Rep. Paul D. McGowan – Chair
41 River Road
Cape Neddick, ME 03902
207-351-2585

House Member

Rep. Carol A. McElwee
54 Pioneer Avenue
Caribou, ME 04736
207-498-8605

House Member

Rep. Megan M. Rochelo
PO Box 2433
Biddeford, ME 04005
207-929-0110

House Member (1 from HHS Committee)

Andrew Hertler MD
Harold Alfond Center for Cancer Care
361 Old Belgrade Road
Augusta, ME 04330
207-621-6100

Representing experts in study subject matter

Susan Miesfeldt MD
Maine Medical Center
100 Campus Drive, Suite 108
Scarborough, ME 04074
207-396-7787

Representing cancer research or epidemiology

Commission to Study the Incidence of and Mortality Related to Cancer

Resolve 2013, Ch. 77
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Hilary Schneider American Cancer Society Cancer Action Network 1 Bowdoin Mill Island, Suite 300 Topsham, ME 04086 207-373-3707	Representing a statewide voluntary nonprofit health organization
Tracey Weisberg MD Maine Center for Cancer Medicine 100 Campus Drive, Suite 108 Scarborough, ME 04074 207-885-7600	Representing a statewide organization of medical professionals
Molly Schwenn MD Maine Cancer Registry 11 State House Station 4th Floor, Key Plaza Augusta, ME 04333 207-287-5196	Director of Maine Center for Disease Control and Prevention or designee

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Staff:
Karen Nadeau-Drillen
OPLA – 287-1670
Alison Ames
OPLA – 287-1670

APPENDIX C

Suggested Legislation
Recommendation #9-A

Suggested Legislation – Commission to Study the Incidence of and Mortality Related to Cancer

(Recommendation #9-A)

Resolve, To Establish a Working Group to Develop an Evidence-based Strategy to Prevent Obesity in Maine

Sec. 1. Working Group. Resolved: That the Commissioner of Health and Human Services, in conjunction with the Director of the Maine Center for Disease Control and Prevention and the Commissioner of the Education, shall convene a working group to develop a long-term plan to promote healthy eating and physical activity and to increase physical education in schools; and be it further

Sec. 2. Participants. Resolved: That Commissioner of Health and Human Services shall invite the participation of various stakeholders in developing an evidence-based strategy to prevent obesity, which is a significant preventable risk factor for cancer; and be it further

Sec. 4. Report. Resolved: That by February 1, 2015, the working group shall submit a written report of the findings under this resolve and any recommendations, including suggested legislation, to the Joint Standing Committees on Health and Human Services and Education and Cultural Affairs. The Joint Standing Committees on Health and Human Services and Education and Cultural Affairs may each submit a bill to the First Regular Session of the 127th Legislature relating to the subject matter of this report.

SUMMARY

This bill directs the Commissioner of Health and Human Services, in conjunction with the Director of the Maine Center for Disease Control and Prevention and the Commissioner of Education, to convene a working group to develop a long-term, evidenced-based strategy to prevent obesity, which is a significant risk factor for cancer.

APPENDIX D

Suggested Legislation
Recommendation #16

Suggested Legislation – Commission to Study the Incidence of and Mortality Related to Cancer

(Recommendation #16)

Resolve, To Continue the Work of the Commission To Study the Incidence of and Mortality Related to Cancer

Emergency preamble. Whereas, acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, this legislation needs to take effect before the expiration of the 90-day period in order to allow this commission sufficient time to conduct its work; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

Sec. 1. Resolve 2013, c. 77, §9, amended. Resolved: That Resolve 2013, c. 77, § 9 is amended to read:

That, ~~no later than December 4, 2013,~~ the commission shall submit ~~a~~ an interim report no later than December 15, 2013, and a final report no later than November 5, 2014, that includes its findings and recommendations, including suggested legislation, to the Joint Standing Committee on Health and Human Services in the ~~Second~~ First Regular Session of the ~~126th~~ 127th Legislature; and be it further

Sec. 2. Retroactive effective date. Resolved: That the Resolve applies retroactively to December 15, 2013.

Emergency clause. In view of the emergency cited in the preamble, this legislation takes effect when approved.

SUMMARY

This bill authorizes the Commission to Study the Incidence of and Mortality Related to Cancer to continue its work during the interim between the Second Regular Session of the 126th Legislature and the First Regular Session of the 127th Legislature. The bill directs the commission to submit a final report to the Joint Standing Committee on Health and Human Services no later than November 5, 2014.