

HB

416

(7)

HOUSE COMMITTEE REPORT

Date Referred to Committee: March 20, 2000

FURTHER REFERRALS:

Finance

Date of Committee Action: 03/21/00

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered:

HB 416

HOUSE BILL NO. 416

PROSTATE CANCER SCREENING

"An Act relating to insurance coverage for prostate cancer screening."

recommends it be replaced with the following committee substitute _____ the same title a new title

additional referral to _____ Committee
 attached amendment(s)

ADOPTS: _____ Letter of Intent

ATTACHES NEW FISCAL NOTE(S): (Dept) _____

APPROVES PREVIOUS: (Dept/Date) _____

fiscal note(s) _____

fiscal note(s) DOA

zero fiscal note(s) _____

zero fiscal note(s) CED

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
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CHAIR'S SIGNATURE _____

HB 416
Prostate Cancer Screening

Testimony by Michael H. Miller

House Health, Education & Social Services Committee

HB 416, Prostate Cancer Screening
Testimony by Michael H. Miller
House Labor and Commerce Committee
March 17, 2000

Mr. Chairman and members of the committee,

My name is Michael H. Miller. I am an advanced prostate cancer patient and prostate cancer advocate. I became a four-year survivor of prostate cancer on January 17, 2000. At the time of my diagnosis in 1996, I was given 17 to 35 months to live. An aggressive clinical (experimental) trial program has enabled me to be here today to urge your support for HB 416.

In 1996, the Legislature passed SB 253, a bill requiring insurers to cover the cost of annual prostate cancer screening for men 50 years or older. HB 416 would amend that law by requiring this screening be covered at age 40, and at age 35 for men at high risk of contracting this disease. "High risk" is defined in the bill as a person who is an African-American or who has a family history of prostate cancer.

According to the American Cancer Society, this year 1.2 million Americans will contract cancer and 552,000 will die of the disease. In our state, an estimated 1,500 Alaskans, or four a day, will contract cancer this year, 200 more people on an annual basis than three years ago. An estimated seven hundred Alaskans will die of cancer this year, 2 per day, or 58 per month. Prostate cancer accounts for 29% of all the male-related cancers and 11% of cancer-related deaths in men.

This year, approximately 715 men in Alaska will be diagnosed with cancer, nearly one quarter with prostate cancer. Of the estimated 354 men that will die of cancer this year in Alaska, about five percent will die from prostate cancer. African American men have a 32 percent higher risk of contracting this disease than others.

In 1979, Dr. Gerald Murphy, a Seattle oncology/urologist, developed the Prostate Specific Blood Antigen (PSA) test to help diagnose prostate cancer. The test became available to all doctors in 1990. A decade old, this test has led to a decrease in the prostate cancer mortality rate. In 1976, there was a 30.0% mortality rate for men with prostate cancer. In 2000, that mortality rate is expected to drop to 17.7%, due in large part to the PSA test.

Today, more and more young men are being diagnosed with prostate cancer. According to the American Cancer Society, 209,900 men in the United States were diagnosed with prostate cancer in 1997, and 41,800 died of the disease. About 23 percent or 47,600 of those diagnosed that year were under age 65.

As a patient who was diagnosed with prostate cancer at the age 43, I know that prostate cancer in men under 65 tends to be more aggressive in nature. Early detection, especially for men who are high risk, is the best way to save lives. I have a vested interest in this legislation because my two sons have up to six times a higher risk of contracting prostate cancer because I have the disease.

Located in your packet is a page listing statistical information from the 1999 Alaska Cancer Registry (reported data from 1996) and the 2000 American Cancer Society - Cancer Facts & Figures indicating the prostate cancer risk by age groupings. Statistics for 1999 and 2000 show that less than one in 10,000 a man is predicted to contract prostate cancer before age 40. In 1999, statistics for the 40-59-age group show one in 57 men will contract the disease. The 2000 statistics show a greater occurrence in this age group, with 1 in 53. Four years ago the statistics in the 40-59 age group were 1 in 59. If this trend continues, in 2008, men in this age group will have one in 35 chance of contracting prostate cancer.

With an aging baby-boomer society, more and more men will be diagnosed with prostate cancer. It would be prudent for the State of Alaska and the insurance industry to make an investment in preventative health care maintenance for men starting prostate cancer screening at the age of 35 for those at high risk and age 40 for others. HB 416 will help men be diagnosed at a younger age, saving both lives and money.

The 1999 Alaska Cancer Registry report shows that only two men aged 40 to 44 were diagnosed with prostate cancer in Alaska in 1996, and 10 in the 45 to 49 age group. I was one of those two men in 1996. At age 43, I was diagnosed with advanced prostate cancer. If the PSA test had been made available to me at age 40, I would probably have been diagnosed with early stage prostate cancer and my disease might not have spread.

Prostate cancer has left me unable to work. I, like many cancer survivors, am receiving Social Security Disability Income and State Disability Retirement. The average cost for prostate cancer treatment is \$6,000.00 to \$10,000.00 annually. My expenses are running \$12,000 to \$15,000 annually. It is cost effective to catch and treat this disease early on, rather than pay for the long-term cost of treatment, estimated at \$48,690 per person (refer to the Pay Now...Pay Later page - second column from left).

HB 416 should not cause insurance premiums to increase. Although insurers generally oppose mandates, when SB 253 was passed in 1996, an Aetna representative testified that Aetna would not oppose this bill if the Legislature felt the benefits of the screening would outweigh the small costs. He said an argument could be made that early detection should result in more efficient treatment and ultimately avoid high catastrophic treatment costs.

Men dying of prostate cancer are leaving behind spouses, children and many family members and friends. While we have made great strides in the United States in cancer treatment research, too many men are still being lost at too young an age.

Over the last four years approximately 800 Alaska men have been diagnosed with prostate cancer. Many of their sons will also contract this disease. Let's give men an opportunity to be diagnosed at an earlier age. Those with a five-year survival rate from this disease, have a 100 percent chance they will die of another cause.

I would like to leave my two sons the best possible gift, an opportunity for them to be screened for prostate cancer at an earlier age, because the odds are they will contract the disease at a younger age than I did.

I urge your support of HB 416 for the future health and well being of all Alaskan families. Thank you for time.

PAY NOW... OR PAY LATER

<p>IF YOU DO THIS (from age 35 to 65)</p>	<p>Bicycle or run for aerobic exercise</p>	<p>Eat 10 slices of low-fat cheese pizza per week (the tomato sauce contains cancer-fighting lycopene)</p>	<p>Use SPF-15 sunscreen once per day, 365 days per year</p>	<p>Quit smoking cigarettes or cigars</p>	<p>Brush and floss regularly</p>	<p>Eat a cup of oatmeal a day</p>	<p>Limit alcohol intake to one or two drinks per day</p>	<p>Swim (a low-impact way to minimize joint stress and improve flexibility)</p>	<p>Sleep 8 hours per night</p>	<p>IF YOU DO THIS (from age 35 to 65)</p>
<p>YOU'LL ONLY SPEND</p>	<p>\$3,200 (for four bikes) \$4,830 (for 57 pairs of shoes)</p>	<p>\$18,720</p>	<p>\$6,857</p>	<p>\$0 - \$300 for stop-smoking programs, some including a 10-week course of nicotine gum or patches</p>	<p>\$1,210 for toothbrushes, toothpaste and floss</p>	<p>\$2,738</p>	<p>\$21,900 to \$43,800 for wine or beer</p>	<p>\$5,700 - \$16,200 for yearly memberships at public pool</p>	<p>\$1,950 - \$3,300 for three good queen or king-size mattresses</p>	<p>YOU'LL ONLY SPEND</p>
<p>BUT IF YOU HAVE/GET</p>	<p>Cardiovascular disease</p>	<p>Prostate cancer</p>	<p>Skin cancer</p>	<p>Lung cancer or oral cancers</p>	<p>Tooth decay or gum disease</p>	<p>Colon cancer</p>	<p>Alcohol-related liver disease</p>	<p>Osteoarthritis</p>	<p>Automobile (and other) accidents caused by sleep deprivation</p>	<p>BUT IF YOU HAVE/GET</p>
<p>IT WILL COST</p>	<p>\$44,200 for bypass surgery \$21,760 for angioplasty \$103,576 to recover from stroke</p>	<p>\$48,690 from diagnosis until death</p>	<p>\$9,349 for one hospital stay. Doctors' fees and follow-up care are extra</p>	<p>\$29,200 from diagnosis to death for lung cancer. \$12,739 for one hospital stay to treat oral cancer.</p>	<p>\$1,400 - \$4,500 for dentures. \$2,000 - \$4,000 for each full-mouth surgical treatment for gum disease</p>	<p>\$51,865 from diagnosis until death</p>	<p>\$304,567 for a transplant</p>	<p>\$19,392 for one in-hospital treatment</p>	<p>Your life. You tell us what it's worth!</p>	<p>IT WILL COST</p>

NATIONAL MEN'S HEALTH FOUNDATION (EXCERPTED FROM MEN'S HEALTH MAGAZINE)

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Alaska Cancer Registry

February 1999

Percentage of Population (Probability) Developing Invasive Cancers at Certain Ages by Sex, US, 1992-1994²

		Birth to 39	40 to 59	60-79	Birth to Death
All Sites*	Male	1.68 (1 in 60)	8.23 (1 in 12)	36.69 (1 in 3)	46.64 (1 in 2)
	Female	1.94 (1 in 52)	9.05 (1 in 11)	22.21 (1 in 5)	38.00 (1 in 3)
Breast	Female	0.44 (1 in 227)	3.94 (1 in 25)	6.89 (1 in 15)	12.52 (1 in 8)
Colorectal	Male	0.06 (1 in 1,667)	0.88 (1 in 114)	4.19 (1 in 24)	5.88 (1 in 17)
	Female	0.05 (1 in 2,000)	0.68 (1 in 147)	3.18 (1 in 31)	5.72 (1 in 17)
Lung	Male	0.04 (1 in 2,500)	1.39 (1 in 72)	6.69 (1 in 15)	8.43 (1 in 12)
	Female	0.03 (1 in 3,333)	1.00 (1 in 100)	3.88 (1 in 26)	5.55 (1 in 18)
Prostate	Male	Less than 1 in 10,000	1.74 (1 in 57)	16.40 (1 in 6)	18.85 (1 in 5)

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*Excludes basal and squamous cell skin cancers and in situ carcinomas except urinary bladder.

Data source: NCI Surveillance, Epidemiology, and End Results Program, 1997

1998, American Cancer Society, Inc.

CANCER FACTS & FIGURES 2000

Probability of Developing Invasive Cancers Over Selected Age Intervals, by Sex, United States, 1994-1996*

		Birth to 39 (%)	40 to 59 (%)	60 to 79 (%)	Birth to Death (%)
All sites †	Male	1.61 (1 in 62)	8.17 (1 in 12)	33.65 (1 in 3)	43.56 (1 in 2)
	Female	1.94 (1 in 52)	9.23 (1 in 11)	22.27 (1 in 4)	38.11 (1 in 3)
Breast	Female	0.43 (1 in 235)	4.06 (1 in 25)	6.88 (1 in 15)	12.56 (1 in 8)
Colon & Rectum	Male	0.06 (1 in 1,579)	0.85 (1 in 124)	3.97 (1 in 29)	5.64 (1 in 18)
	Female	0.05 (1 in 1,947)	0.67 (1 in 149)	3.06 (1 in 33)	5.55 (1 in 18)
Lung & Bronchus	Male	0.04 (1 in 2,592)	1.29 (1 in 78)	6.35 (1 in 16)	8.11 (1 in 12)
	Female	0.03 (1 in 2,894)	0.94 (1 in 106)	3.98 (1 in 25)	5.69 (1 in 18)
Prostate	Male	Less than 1 in 10,000	1.90 (1 in 53)	13.69 (1 in 7)	15.91 (1 in 6)

*Of those free of cancer at beginning of age interval. Based on cancer cases diagnosed during 1994-1996. The "1 in" statistic and the inverse of the percentage may not be equivalent due to rounding.

†Excludes basal and squamous cell skin cancers and in situ carcinomas except urinary bladder.

Source: DEVCAN Software, Version 4.0, Surveillance, Epidemiology, and End Results Program, 1973-1996, Division of Cancer Control and Population Sciences, National Cancer Institute.

American Cancer Society, Surveillance Research

Table 1. Age Distribution of Invasive Cancers - Alaska, 1996

Site of Cancer	All Ages		00-04		05-09		10-14		15-19		20-24		25-29		30-34		35-39		40-44	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Cervix Uteri	26		0	0.0%	0	0.0%	0	0.0%	0	0.0%	2	7.7%	3	11.5%	3	11.5%	3	11.5%	3	11.5%
Corpus Uteri	35		0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	2.9%	0	0.0%	6	17.1%
Uterus NOS	0		0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Ovary	33		0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	3.0%	1	3.0%	3	9.1%	6	18.2%
Vagina	1		0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Vulva	1		0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Other Female Genital Organs	0		0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Male Genital System	192		0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.5%	2	1.0%	5	2.6%	3	1.6%	5	2.6%
Prostate	175		0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2	1.1%
Testis	17		0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	5.9%	2	11.8%	5	29.4%	3	17.6%	3	17.6%
Penis	0		0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Other Male Genital Organs	0		0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Urinary System	91		0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2	2.2%	1	1.1%	2	2.2%	3	3.3%
Urinary Bladder (including in situ)	53		0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2	3.8%	1	1.9%	1	1.9%	1	1.9%
Kidney and Renal Pelvis	33		0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	3.0%	2	6.1%
Ureter	3		0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Other Urinary Organs	2		0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Eye & Orbit	3		2	66.7%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Brain & Nervous System	27		1	3.7%	1	3.7%	0	0.0%	0	0.0%	0	0.0%	1	3.7%	2	7.4%	3	11.1%	4	14.8%
Brain	27		1	3.7%	1	3.7%	0	0.0%	0	0.0%	0	0.0%	1	3.7%	2	7.4%	3	11.1%	4	14.8%
Cranial Nerves & Other	0		0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%

Table 1. Age Distribution of Invasive Cancers - Alaska, 1996

Site of Cancer	All Ages		45-49		50-54		55-59		60-64		65-69		70-74		75-79		80-84		85+	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Cervix Uteri	26		4	15.4%	2	7.7%	3	11.5%	1	3.8%	1	3.8%	1	3.8%	0	0.0%	0	0.0%	0	0.0%
Corpus Uteri	35		2	5.7%	2	5.7%	6	17.1%	7	20.0%	5	14.3%	1	2.9%	1	2.9%	3	8.6%	1	2.9%
Uterus NOS	0		0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Ovary	33		5	15.2%	2	6.1%	3	9.1%	2	6.1%	4	12.1%	4	12.1%	1	3.0%	0	0.0%	1	3.0%
Vagina	1		0	0.0%	0	0.0%	1	100.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Vulva	1		0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	100.0%	0	0.0%	0	0.0%
Other Female Genital Organs	0		0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Male Genital System	192		13	6.8%	12	6.3%	24	12.5%	25	13.0%	33	17.2%	39	20.3%	15	7.8%	10	5.2%	5	2.6%
Prostate	175		10	5.7%	12	6.9%	24	13.7%	25	14.3%	33	18.9%	39	22.3%	15	8.6%	10	5.7%	5	2.9%
Testis	17		3	17.6%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Penis	0		0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Other Male Genital Organs	0		0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Urinary System	91		3	3.3%	8	8.8%	17	18.7%	8	8.8%	16	17.6%	15	16.5%	9	9.9%	4	4.4%	3	3.3%
Urinary Bladder (including in situ)	53		2	3.8%	4	7.5%	8	15.1%	6	11.3%	11	20.8%	6	11.3%	6	11.3%	3	5.7%	2	3.8%
Kidney and Renal Pelvis	33		0	0.0%	4	12.1%	9	27.3%	2	6.1%	5	15.2%	7	21.2%	1	3.0%	1	3.0%	1	3.0%
Ureter	3		0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2	66.7%	1	33.3%	0	0.0%	0	0.0%
Other Urinary Organs	2		1	50.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	50.0%	0	0.0%	0	0.0%
Eye & Orbit	3		0	0.0%	1	33.3%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Brain & Nervous System	27		3	11.1%	2	7.4%	5	18.5%	2	7.4%	2	7.4%	1	3.7%	0	0.0%	0	0.0%	0	0.0%
Brain	27		3	11.1%	2	7.4%	5	18.5%	2	7.4%	2	7.4%	1	3.7%	0	0.0%	0	0.0%	0	0.0%
Cranial Nerves & Other	0		0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%

Prostate

Data Definition: Incidence data were obtained from the Alaska Cancer Registry using primary site ICD-O-2 code C61.9, excluding morphology codes 9590-9989. Mortality data were obtained from Alaska State death certificates using the underlying cause of death ICD-9 codes 185.

1996 Alaska Residents

Incidence and Mortality Summary by Sex

rates per 100,000 population age-adjusted to 1970 U.S. population

<u>Incidence</u>	<u>Male</u>
In situ cancer	0
Invasive cancer	175
Incidence rate	100.8
1995 U.S. rate*	137.2

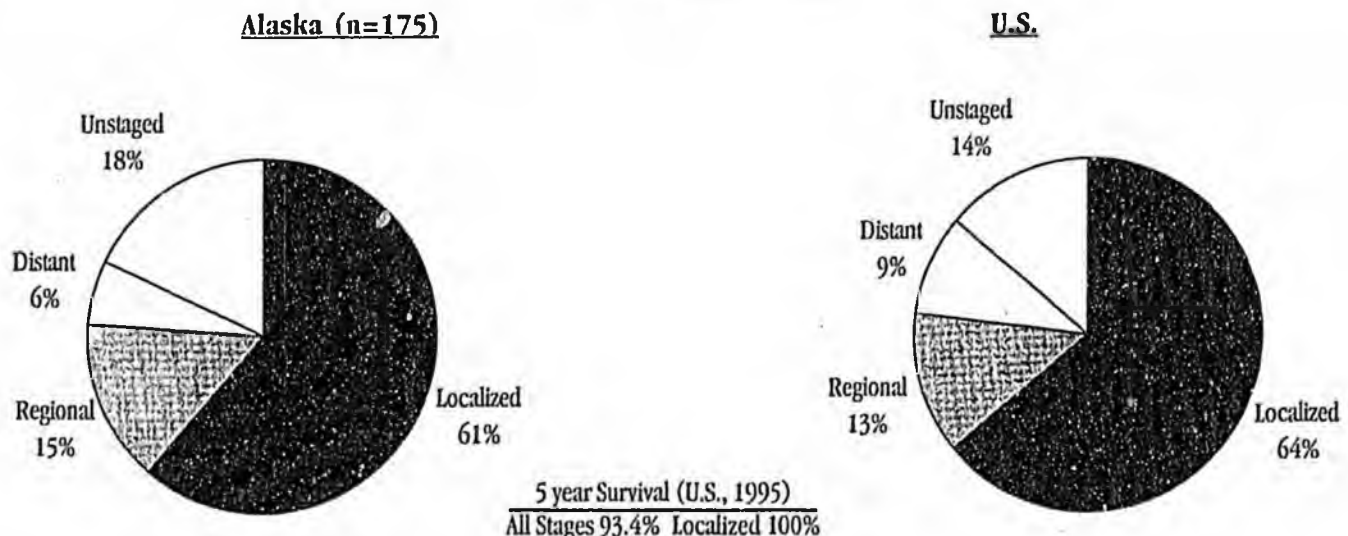
*Excludes in situ cases

<u>Mortality</u>	<u>Male</u>
Deaths	18
Mortality rate	12.5
1995 U.S. rate	24.9

Invasive Prostate Cancer by Borough/Census Area

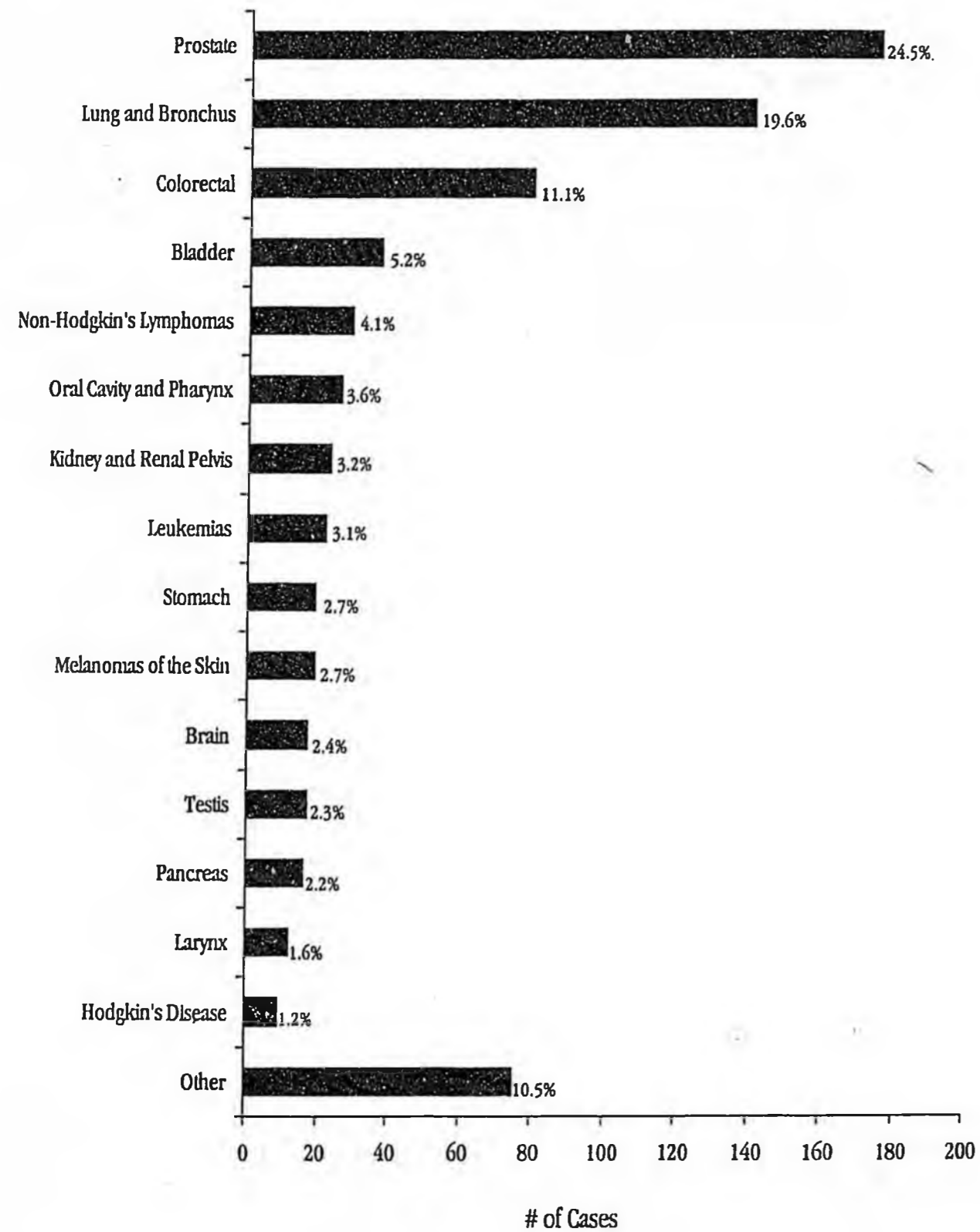
Aleutians East	0	Kenai Peninsula	21	Skagway-Hoonah-Angoon	2
Aleutians West	1	Ketchikan Gateway	6	Southeast Fairbanks	2
Anchorage	63	Kodiak Island	7	Valdez-Cordova	7
Bethel	0	Lake and Peninsula	0	Wade Hampton	0
Bristol Bay	0	Matanuska-Susitna	7	Wrangell-Petersburg	3
Denali	0	Nome	3	Yakutat	0
Dillingham	1	North Slope	1	Yukon-Koyukuk	3
Fairbanks North Star	23	Northwest Arctic	0	Unknown	5
Haines	1	Prince of Wales-Outer Ketchikan	2		
Juneau	13	Sitka	4		

Stage at Diagnosis



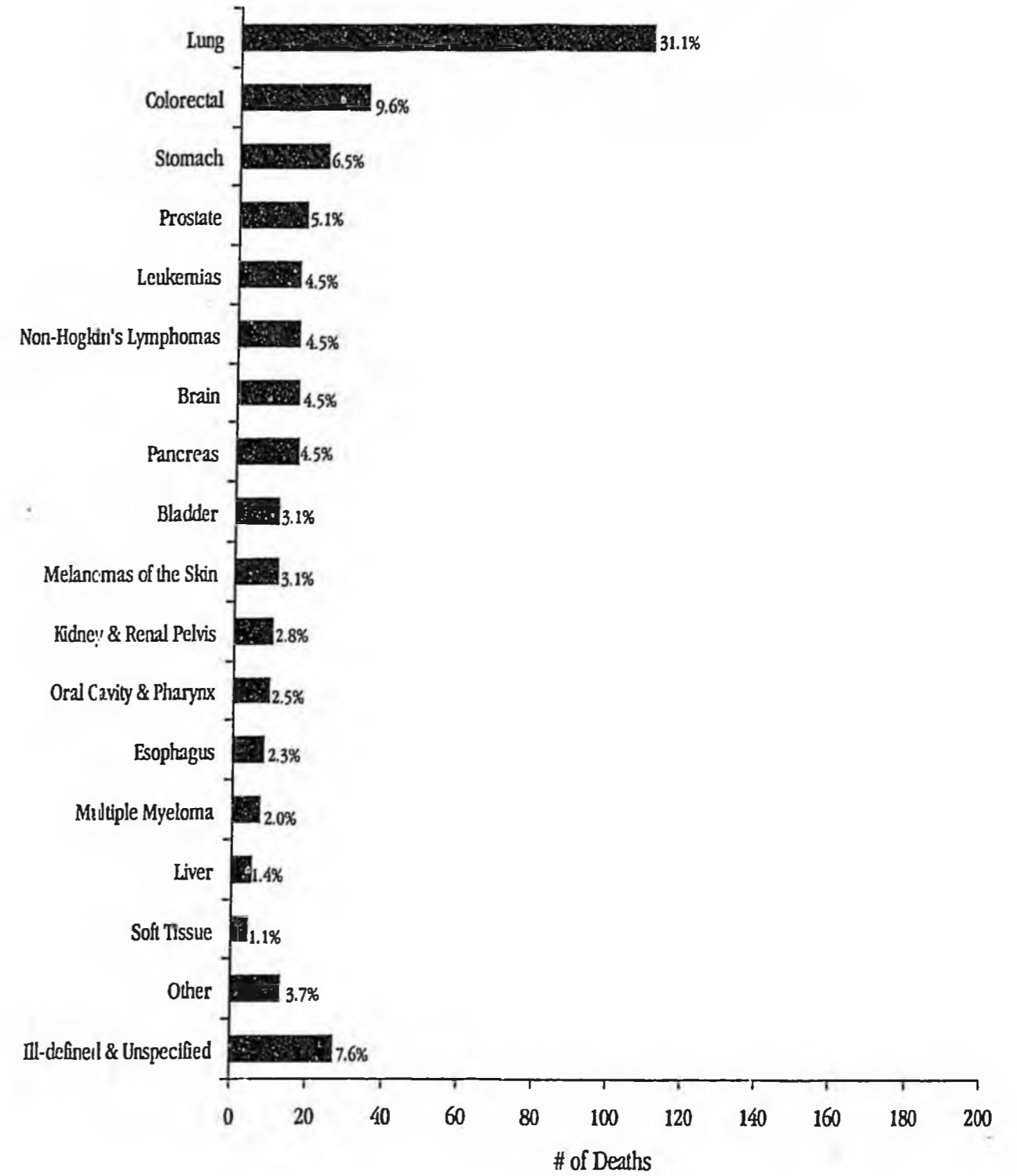
Percent of Cancer Cases by Site

1996 Male Invasive Cancer Cases (n=715) - Alaska Residents



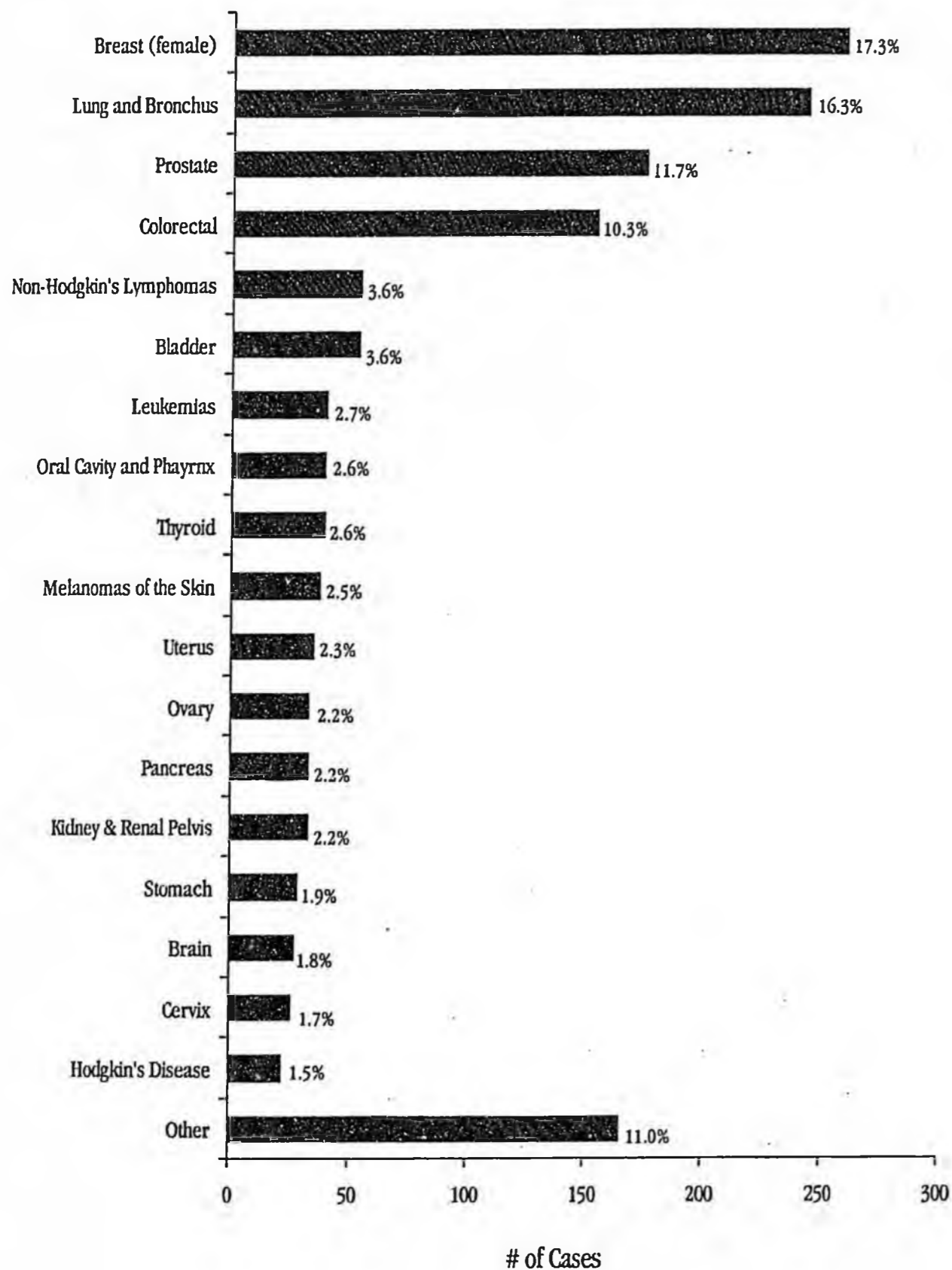
Percent of Cancer Deaths by Site

1996 Male Cancer Deaths (n=354) - Alaska Residents



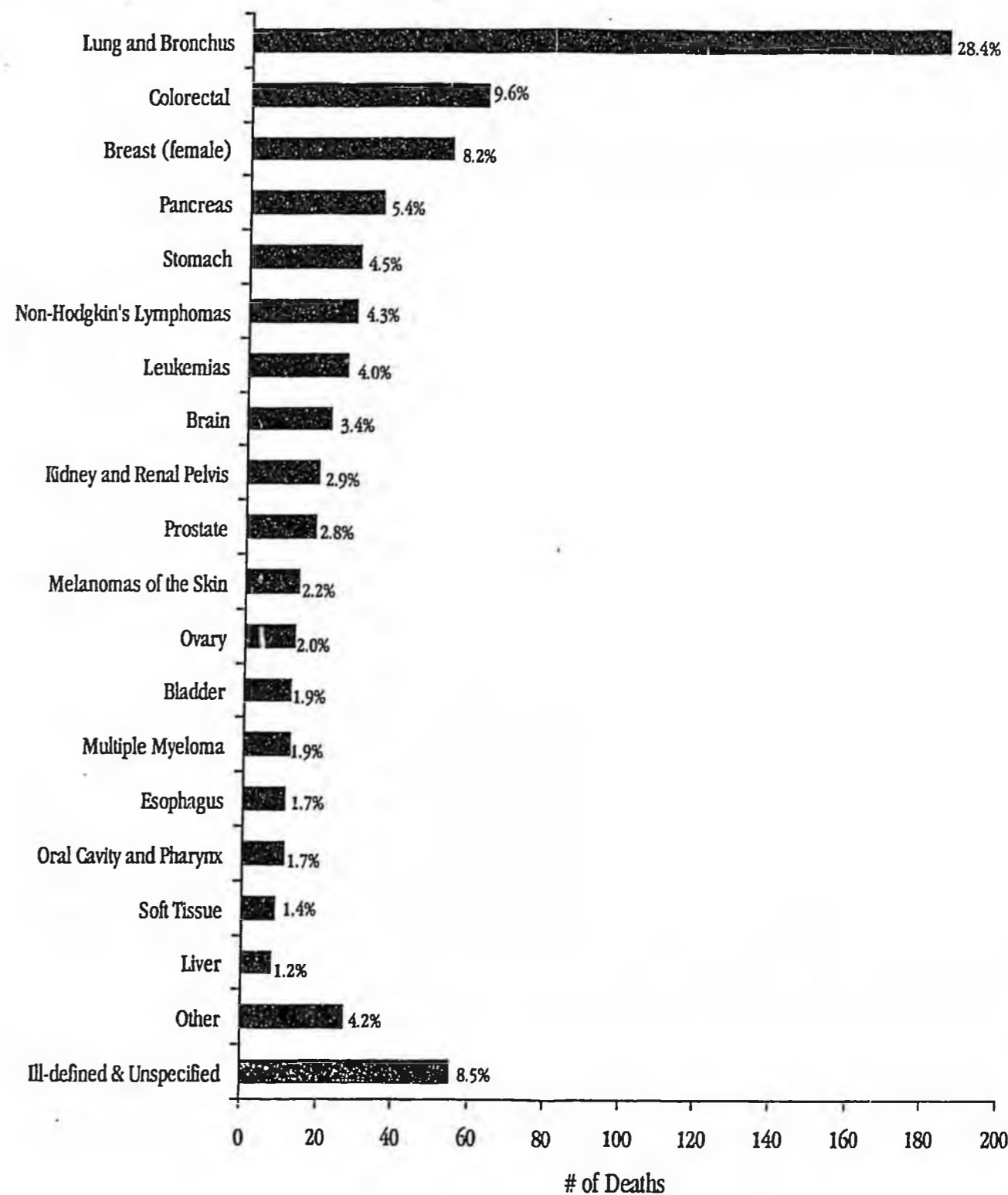
Percent of Cancer Cases by Site

1996 Invasive Cancer Cases (n=1495) - Alaska Residents



Percent of Cancer Deaths by Site

1996 Cancer Deaths (n=648) - Alaska Residents



CANCER: BASIC FACTS

What Is Cancer?

Cancer is a group of diseases characterized by uncontrolled growth and spread of abnormal cells. If the spread is not controlled, it can result in death. Cancer is caused by both external (chemicals, radiation, and viruses) and internal (hormones, immune conditions, and inherited mutations) factors. Causal factors may act together or in sequence to initiate or promote carcinogenesis. Ten or more years often pass between exposures or mutations and detectable cancer. Cancer is treated by surgery, radiation, chemotherapy, hormones, and immunotherapy.

Can Cancer Be Prevented?

All cancers caused by cigarette smoking and heavy use of alcohol could be prevented completely. The ACS estimates that in 2000 about 171,000 cancer deaths are expected to be caused by tobacco use, and about 19,000 cancer deaths may be related to excessive alcohol use, frequently in combination with tobacco use.

Scientific evidence suggests that about one-third of the 552,200 cancer deaths expected to occur in 2000 are expected to be related to nutrition and other lifestyle factors and could also be prevented. Certain cancers are related to viral infections—for example, hepatitis B virus (HBV), human papillomavirus (HPV), human immunodeficiency virus (HIV), human T-cell leukemia/lymphoma virus-I (HTLV-I), and others—and could be prevented through behavioral changes. In addition, many of the 1.3 million skin cancers that are expected to be diagnosed in 2000 could have been prevented by protection from the sun's rays.

Regular screening examinations by a health care professional can result in the detection of cancers of the breast, colon, rectum, cervix, prostate, testis, oral cavity, and skin at earlier stages, when treatment is more likely to be successful. Self examinations for cancers of the breast and skin may also result in detection of tumors at earlier stages. The screening-accessible cancers listed above account for about half of all new cancer cases. The 5-year relative survival rate for these cancers is about 80%. If all Americans participated in regular cancer screenings, this rate could increase to 95%.

Who Is at Risk of Developing Cancer?

Anyone. Since the occurrence of cancer increases as individuals age, most cases affect adults middle-aged or older. Nearly 80% of all cancers are diagnosed at ages 55 and older. Cancer researchers use the word risk in different ways. *Lifetime risk* refers to the probability that an individual, over the course of a lifetime, will develop

cancer or die from it. In the US, men have a 1 in 2 lifetime risk of developing cancer, and for women the risk is 1 in 3.

Relative risk is a measure of the strength of the relationship between risk factors and the particular cancer. It compares the risk of developing cancer in persons with a certain exposure or trait to the risk in persons who do not have this exposure or trait. For example, smokers have a 10-fold relative risk of developing lung cancer compared with nonsmokers. This means that smokers are about 10 times more likely to develop lung cancer (or have a 900% increased risk) than nonsmokers. Most relative risks are not this large. For example, women who have a first-degree (mother, sister, or daughter) family history of breast cancer have about a 2-fold increased risk of developing breast cancer compared with women who do not have a family history. This means that women with a first-degree family history are about two times or 100% more likely to develop breast cancer than women who do not have a family history of the disease.

All cancers involve the malfunction of genes that control cell growth and division. About 5% to 10% of cancers are clearly hereditary, in that an inherited faulty gene predisposes the person to a very high risk of particular cancers. The remainder of cancers are not hereditary, but result from damage to genes (mutations) that occurs throughout our lifetime, either due to internal factors, such as hormones or the digestion of nutrients within cells, or external factors, such as chemicals and sunlight.

How Many People Alive Today Have Ever Had Cancer?

The National Cancer Institute estimates that approximately 8.4 million Americans alive today have a history of cancer. Some of these individuals can be considered cured, while others still have evidence of cancer and may be undergoing treatment.

How Many New Cases Are Expected to Occur This Year?

About 1,220,100 new cancer cases are expected to be diagnosed in 2000. Since 1990, approximately 13 million new cancer cases have been diagnosed. These estimates do not include carcinoma in situ (noninvasive cancer) of any site except urinary bladder, and do not include basal and squamous cell skin cancers. Approximately 1.3 million cases of basal and squamous cell skin cancers are expected to be diagnosed this year.

Leading Sites of New Cancer Cases and Deaths—2000 Estimates*

Cancer Cases by Site and Sex		Cancer Deaths by Site and Sex	
Male	Female	Male	Female
Prostate 180,400	Breast 182,800	Lung & bronchus 89,300	Lung & bronchus 67,600
Lung & bronchus 89,500	Lung & bronchus 74,600	Prostate 31,900	Breast 40,800
Colon & rectum 63,600	Colon & rectum 66,600	Colon & rectum 27,800	Colon & rectum 28,500
Urinary bladder 38,300	Uterine corpus 36,100	Pancreas 13,700	Pancreas 14,500
Non-Hodgkin's lymphoma 31,700	Non-Hodgkin's lymphoma 23,200	Non-Hodgkin's lymphoma 13,700	Ovary 14,000
Melanoma of the skin 27,300	Ovary 23,100	Leukemia 12,100	Non-Hodgkin's lymphoma 12,400
Oral cavity 20,200	Melanoma of the skin 20,400	Esophagus 9,200	Leukemia 9,600
Kidney 18,800	Urinary bladder 14,900	Liver 8,500	Uterine corpus 6,500
Leukemia 16,900	Pancreas 14,600	Urinary bladder 8,100	Brain 5,900
Pancreas 13,700	Thyroid 13,700	Stomach 7,600	Stomach 5,400
All Sites 619,700	All Sites 600,400	All Sites 284,100	All Sites 268,100

*Excludes basal and squamous cell skin cancer and in situ carcinomas except urinary bladder.

Five-Year Relative Survival Rates* by Stage at Diagnosis, 1989-1995

Site	All Stages %	Local %	Regional %	Distant %	Site	All Stages %	Local %	Regional %	Distant %
Breast (female)	85	96	77	21	Ovary	50	95	79	28
Colon & rectum	61	90	65	8	Pancreas	4	18	6	1
Esophagus	12	25	13	2	Prostate†	92	100	—	32
Kidney	60	88	61	10	Stomach	21	60	21	2
Larynx	65	81	53	41	Testis	95	99	97	74
Liver	5	15	5	1	Thyroid	95	100	92	43
Lung & bronchus	14	49	20	2	Urinary bladder	81	93	49	6
Melanoma	88	95	58	13	Uterine cervix	70	91	48	13
Oral	53	81	43	22	Uterine corpus	84	95	64	25

*Rates are adjusted for normal life expectancy and are based on cases diagnosed from 1989-1995, followed through 1996.

†The rate for local stage represents local and regional stages combined.

Local: An invasive malignant cancer confined entirely to the organ of origin. **Regional:** A malignant cancer that 1) has extended beyond the limits of the organ of origin directly into surrounding organs or tissues; 2) involves regional lymph nodes by way of lymphatic system; or 3) has both regional extension and involvement of regional lymph nodes. **Distant:** A malignant cancer that has spread to parts of the body remote from the primary tumor either by direct extension or by discontinuous metastasis to distant organs, tissues, or via the lymphatic system to distant lymph nodes.

Source: Surveillance, Epidemiology, and End Results Program, 1973-1996, Division of Cancer Control and Population Sciences, National Cancer Institute.

American Cancer Society, Surveillance Research

Early Detection: At present, only biopsy yields a certain diagnosis, and because of the "silent" course of the disease, the need for biopsy is likely to be obvious only after the disease has advanced. Researchers are focusing on ways to diagnose pancreatic cancer before symptoms occur.

Treatment: Surgery, radiation therapy, and chemotherapy are treatment options that can extend survival and/or relieve symptoms in many patients but are not likely to produce a cure for most. Clinical trials with several new agents may offer improved survival and should be considered an option.

Survival: For all stages combined, the 1-year relative survival rate is only 19%, and the 5-year rate is 4%.

PROSTATE

New Cases: An estimated 180,400 new cases in the US during 2000. Prostate cancer incidence rates remain significantly higher in black men than in white men. Between 1989 and 1992, prostate cancer incidence rates increased dramatically, probably due to earlier diagnosis in men without any symptoms, by increased use of prostate-specific antigen (PSA) blood test screenings. Prostate cancer incidence rates are now declining; rates peaked in 1992 among white men and in 1993 among black men.

Deaths: An estimated 31,900 deaths in 2000, the second leading cause of cancer death in men. During 1992-1996, prostate cancer mortality rates declined significantly (-2.5% per year). Although mortality rates are declining among white and black men, rates in black men remain more than twice as high as rates in white men.

Signs and Symptoms: Weak or interrupted urine flow; inability to urinate, or difficulty starting or stopping the urine flow; the need to urinate frequently, especially at night; blood in the urine; pain or burning on urination; continual pain in lower back, pelvis, or upper thighs. Most of these symptoms are nonspecific and may be similar to those caused by benign conditions such as infection or prostate enlargement.

Risk Factors: The incidence of prostate cancer increases with age; more than 75% of all prostate cancers are diagnosed in men over age 65. Black Americans have the highest prostate cancer incidence rates in the world; the disease is common in North America and Northwestern Europe and is rare in Asia, Africa, and South America. Recent genetic studies suggest that strong familial predisposition may be responsible for 5%-10% of prostate cancers. International studies suggest that dietary fat may also be a factor.

Early Detection: Men age 50 and older who have at least a 10-year life expectancy should talk with their health care professional about having a digital rectal exam of the prostate gland and a prostate-specific antigen (PSA) blood test every year. Men who are at high risk for prostate cancer (black men or men who have a history of prostate cancer in close family members) should consider beginning these tests at an earlier age.

Treatment: Depending on age, stage of the cancer, and other medical conditions of the patient, surgery and radiation should be discussed with the patient's physicians. Hormones and chemotherapy or combinations of these options might be considered for metastatic disease. Hormone treatment may control prostate cancer for long

periods by shrinking the size of the tumor, thus relieving pain and other symptoms. Careful observation without immediate active treatment ("watchful waiting") may be appropriate, particularly for older individuals with low-grade and/or early stage tumors.

Survival: Seventy-nine percent of all prostate cancers are discovered in the local and regional stages; the 5-year relative survival rate for patients whose tumors are diagnosed at these stages is 100%. Over the past 20 years, the survival rate for all stages combined has increased from 67% to 92%. Survival after a diagnosis of prostate cancer continues to decline beyond five years. According to the most recent data, 67% of men diagnosed with prostate cancer survive 10 years and 52% survive 15 years.

SKIN

New Cases: Approximately 1.3 million cases a year of highly curable basal cell or squamous cell cancers. They are more common among individuals with lightly pigmented skin. The most serious form of skin cancer is melanoma, which is expected to be diagnosed in about 47,700 persons in 2000. Since the early 1970s, the incidence rate of melanoma has increased significantly on average 4% per year from 5.7 per 100,000 in 1973 to 13.8 in 1996. Incidence rates are more than 10 times higher in whites than in blacks. Other important skin cancers include Kaposi's sarcoma and cutaneous T-cell lymphoma.

Deaths: An estimated 9,600 deaths this year, 7,700 from melanoma and 1,900 from other skin cancers.

Signs and Symptoms: Any change on the skin, especially a change in the size or color of a mole or other darkly pigmented growth or spot. Scaliness, oozing, bleeding, or change in the appearance of a bump or nodule, the spread of pigmentation beyond its border, a change in sensation, itchiness, tenderness, or pain.

Risk Factors: Excessive exposure to ultraviolet radiation; fair complexion; occupational exposure to coal tar, pitch, creosote, arsenic compounds, or radium; family history; and multiple nevi (moles) or atypical nevi.

Prevention: The sun's ultraviolet rays are strongest during the midday hours (10 a.m.-4 p.m.); exposure at these times should be limited or avoided. When outdoors, cover as much skin as possible with a hat that shades the face, neck, and ears, and a long-sleeved shirt and long pants. Sunscreen comes in various strengths, graded by the solar protection factor (SPF). Use a sunscreen with an SPF of 15 or higher. Because of the possible link between severe sunburns in childhood and greatly increased risk of melanoma in later life, children, in particular, should be protected from the sun.

Early Detection: Early detection is critical. Recognition of changes in skin growths or the appearance of new growths is the best way to find early skin cancer. Adults should practice skin self-exam regularly. Suspicious lesions should be evaluated promptly by a physician. Basal and squamous cell skin cancers often take the form of a pale, waxlike, pearly nodule, or a red, scaly, sharply outlined patch. A sudden or progressive change in a mole's appearance should be checked by a physician. Melanomas often start as small, mole-like growths that increase in size and change color. A simple ABCD rule outlines the warning signals of melanoma: A is for asymmetry. One half of the mole does not match the other half. B is for border irregularity. The edges are ragged, notched, or blurred. C is for color. The pigmentation is not uniform, with variable degrees of tan, brown, or black. D is for diameter greater than 6 millimeters. Any sudden or progressive increase in size should be of particular concern.

Treatment: There are five methods of treatment for basal cell cancer and squamous cell cancer: surgery (used in 90% of cases), radiation therapy, electrodesiccation (tissue destruction by heat), cryosurgery (tissue destruction by freezing), and laser therapy for early skin cancer. For malignant melanoma, the primary growth must be adequately excised, and it may be necessary to remove nearby lymph nodes. Removal and microscopic examination of all suspicious moles is essential. Advanced cases of melanoma are treated with radiation therapy, immunotherapy, or chemotherapy according to the characteristics of the case.

Survival: For basal cell or squamous cell cancers, cure is highly likely if detected and treated early. Malignant melanoma can spread to other parts of the body quickly; however, when detected in its earliest stages, and with proper treatment, it is highly curable. The 5-year relative survival rate for patients with malignant melanoma is 88%. For localized malignant melanoma, the 5-year relative survival rate is 95%; and rates for regional and distant disease are 58% and 13%, respectively. About 82% of melanomas are diagnosed at a localized stage.

URINARY BLADDER

New Cases: An estimated 53,200 new cases in 2000. Bladder cancer incidence rates are significantly declining in the 1990s. Overall, bladder cancer incidence is about four times higher in men than in women, and two times higher in whites than in blacks.

Deaths: An estimated 12,200 deaths in 2000. Since the early 1970s, mortality rates for bladder cancer have decreased significantly in both whites and blacks.

Trends in 5-Year Relative Survival Rates* by Race and Year of Diagnosis, United States, 1974-1994

Site	White			African American			All Races		
	Relative 5-Year Survival Rate (%)			Relative 5-Year Survival Rate (%)			Relative 5-Year Survival Rate (%)		
	1974-76	1980-82	1989-94	1974-76	1980-82	1989-94	1974-76	1980-82	1989-94
All Sites	50	52	62†	39	40	47†	49	51	60†
Brain	22	25	30†	27	31	38†	22	25	30†
Breast (female)	75	77	87†	63	66	71†	75	76	85†
Uterine cervix	70	68	72†	64	61	59	69	67	70
Colon	50	56	64†	46	49	52†	50	55	63†
Uterine corpus	89	83	87†	61	54	54	88	82	84†
Esophagus	5	7	13†	4	5	9†	5	7	12†
Hodgkin's disease	71	75	83†	69	72	76	71	74	82†
Kidney	52	51	62†	49	55	58†	52	52	61†
Larynx	66	69	67	59	58	56	66	68	66
Leukemia	35	39	44†	31	33	31	34	38	43†
Liver	4	4	6†	1	2	2†	4	3	5†
Lung & bronchus	13	14	15†	11	12	11	12	13	14†
Melanoma	80	83	88†	66‡	60§	69‡	80	83	88†
Multiple myeloma	24	28	28†	27	29	30	24	28	29†
Non-Hodgkin's lymphoma	48	52	52†	48	50	41†	47	51	51†
Oral cavity	55	55	55	36	31	32	53	53	53
Ovary	37	39	50†	41	39	46†	37	39	50†
Pancreas	3	3	4†	3	5	4†	3	3	4†
Prostate	68	75	95†	58	65	81†	67	73	93†
Rectum	49	53	61†	42	38	53†	48	52	61†
Stomach	15	16	19†	17	19	21	15	18	21†
Testis	79	92	96†	76‡	90‡	90	79	92	95†
Thyroid	92	94	96†	88	94	88	92	94	95†
Urinary bladder	74	79	84†	47	58	62†	72	78	82†

*Rates are adjusted for normal life expectancy and are based on cases diagnosed from 1989 to 1994, followed through 1995.

†The difference in rates between 1974-76 and 1989-94 is statistically significant ($p < 0.05$).

‡The standard error of the survival rate is between 5 and 10 percentage points.

§The standard error of the survival rate is greater than 10 percentage points.

Data source: NCI, Surveillance, Epidemiology and End Results Program, 1998.

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Prostate Cancer Screening

The impact of screening on the survival of men with prostate cancer remains controversial. This is natural because clinical trials have not been published that appropriately test the impact of screening on survival. Most prostate cancer experts would agree that prostate cancer screening improves our ability to detect prostate cancer at an earlier stage of the disease. However, there is no consensus that patients benefit from early detection of prostate cancer. The heart of this controversy is the question of whether radical prostatectomy or radiation therapy cure or prolong the survival of men with early prostate cancer.

In our September, 1998, issue we explained why we think early detection and treatment of prostate cancer can save your life. In brief, I think that modern screening methods are detecting potentially life-threatening cancers before they have escaped the prostate gland. It is already clear that families with men affected by prostate cancer are highly motivated to seek genetic testing and undergo screening. If you are interested in how I reached this conclusion, I would suggest you reread the September, 1998, issue. At this time, we are more concerned with the details of how best to screen and at what age to start. If you have a family history of prostate cancer I recommend that you begin at age 35. Otherwise, I recommend that you start at 45 years.

If you follow all of the prevention ideas we have discussed, please do not think this means that you will not get prostate cancer and you do not need to be screened. Some of the men in the selenium and vitamin E clinical trials we discussed still developed prostate cancer and died. The prevention measures we recommend reduce but do not eliminate the entire risk of developing prostate cancer. Nothing can substitute for due diligence because we do not know the true causes of this disease.

Reference:

O. Bratt, et al. "Sons of Men with Prostate Cancer: Their Attitudes Regarding Possible Inheritance of Prostate Cancer, Screening, and Genetic Testing." *Urology* 50: 360-365, 1997.

using the digital rectal exam and the PSA will detect many cancers that are small, slow growing and of no threat to the patient. Thus, this argument goes that screening detects cancers that either can not be cured or do not need to be cured!

These twin objections have led many prostate cancer experts to conclude that the side effects of screening, which include anxiety and possible complications from needless surgery and radiation therapy, exceed any possible benefit. If they are right, then the appropriate treatment for newly diagnosed prostate cancer should be watchful waiting.

The only real solution to this controversy is to conduct randomized controlled trials comparing survival of men who are screened with those who are not. A number of trials are currently active in North America and Europe. The first report from one of these trials was published in a recent issue of *Prostate*. The results were quite dramatic and have proved very controversial.

The study in question was conducted in the Canadian Province of Quebec and began in 1988. The report encompassed the results from 1988 through 1996. The study took the 46,193 men registered to vote in Quebec City and its surrounding Metropolitan area and assigned them to be screened or not screened. Those who were assigned to screening were sent a letter offering a PSA test and digital rectal exam. If either of these two were abnormal, transrectal ultrasound and prostate biopsy were performed.

Only about 23% of those offered screening actually underwent screening. On the other hand, about 6% of the men in the control group sought out screening on their own.

The first screening visit detected 244 cancers in 8,137 men (3%), 15 of which were metastatic. The subsequent annual screening visits detected an additional 123 cases, none of which proved to be metastatic. Only five of these patients have died of prostate cancer, four of whom were detected during the initial screening visit! At the first screening visit, 14% of the cancers were detected by digital rectal exam in men with a normal PSA. At all subsequent visits, no cancers were detected by digital rectal exam in the presence of a normal PSA. For this reason, the investigators only recommend digital exams with the first screening visit.

The death rate for prostate cancer among the men who were randomly assigned to screening and showed up for screening was more than 60% lower than that seen in the control group or among the men who were offered screening but did not take part. In the control group 6% of the men sought out screening on their own. Their death rate for prostate cancer was also more than 60% lower than for patients who were not screened. This study showed that men who were screened, regardless of the reason, were much less likely to die of prostate cancer than those who were not screened.

Of the 367 cancers detected during screening, subsequent treatment is

known in 339: 155 patients had a radical prostatectomy, 109 received radiation therapy, and 75 received hormonal therapy alone, largely complete androgen ablation. A majority of the men who had surgery or radiation therapy also received hormonal therapy. Thus, in this study early detection led to early, aggressive treatment.

This report encompasses only the first eight years of the study. Given the long natural history of prostate cancer, it is still too early to assess the full impact of screening. This is only one of the several current trials designed to test the value of prostate cancer screening. The scientific community will await longer follow up on this trial and confirmation by other investigators before concluding that screening saves lives. I suspect that these additional steps will also be required before major organizations such as the American Cancer Society or the National Cancer Institute will recommend screening.

What should you do? I am a medical oncologist and like all medical oncologists, I do not perform either radiation or surgery and do not benefit financially from the use of these treatment modalities. I do believe that early detection and aggressive treatment of prostate cancer is important and saves lives. I read the results of this trial as confirming my good judgment. I think it certain that the results of the Canadian trial will prove to be essentially correct: until proven otherwise I recommend to my patients and their families that they participate in screening for prostate cancer. The major

mistake being made is that some experts in this field grossly underestimate the benefits of aggressive surgery, radiation therapy, and hormonal therapy on the survival of men with early prostate cancer.

References:

F. Labrie, et al. "Screening Decreases Prostate Cancer Death: First Analysis of the 1988 Quebec Prospective Randomized Controlled Trial." *The Prostate* 38: 83-91, 1999.

The next reference is to the clinical trial that shows the most impressive impact of early treatment on survival of prostate cancer patients.

M. Bolla, et al. "Improved survival in patients with locally advanced prostate cancer treated with radiotherapy and goserelin." *New England Journal of Medicine* 337: 295-300, 1997.

Profile of Michael H. Miller

Michael H. Miller was born in Portland, Oregon. He graduated from Central Washington State (now University) in Ellensburg, Washington in 1975 with a Bachelor of Arts degree in education with an emphasis in physical education and psychology. While there he received the "Outstanding College Athlete of America Award" and was an eight-time NAIA All-American. As an age-group swimmer, Michael swam competitively from 1961 to 1970 for the Portland YMCA and the Multnomah Athletic Club.

In 1975 Michael moved to Juneau, Alaska to coach the Glacier Swim Club. "My focus as a coach was to educate the student-athletes to be well-rounded individuals." In ten of the 14 years as coach of the Glacier Swim Club he took a team to the Jr. Nationals. Swimmers from the program have gone on to represent Division I through III schools and NAIA schools. The team boasted an average of 62 percent best times at meets, and an average 83 percent best times at national level competitions.

Michael served in a number of leadership roles representing Alaska Swimming. He was Age Group Chair and Senior Chair for Alaska Swimming, a coach for the 1991 Elite Training Camp (Eagle) at the United States Olympic Training Center in Colorado Springs, Colorado, and recipient of the Phillips '66 Outstanding Service Award in 1995. He serves as National Interscholastic Swim Coaches Association Zone VIII Representative for Alaska since being selected in 1996.

On January 17, 1996, Michael was diagnosed with metastatic prostate cancer and had a 17 to 35 month survival prognosis. He became one of 20 people in the U.S. to participate in the Prostate Cancer Southwest Oncology Group clinical trial administered by the Oregon Health Sciences University. Today, through this experimental treatment, his cancer is in stable position.

Shortly after being diagnosed, Michael began giving talks locally with high school students to share his story and increase awareness about prostate cancer, a disease which, if caught early while still in the localized stage, has a 99-100 percent success rate.

Since his first talk (September 1996) at a Juneau Douglas High School government class, Michael has spoken to over 3,000 students and 630 teachers in Juneau. He got students in Juneau involved in collecting 1,260 signatures for the National Prostate Cancer Coalition signature drive and spearheaded the passage of House Joint Resolution 29, supporting an increase in federal funding for prostate cancer research. To date, Alaska is the only state to pass such a resolution and serves as a model for other states, most notably, California, Washington, Oregon, Oklahoma and Florida. He has spoken with **16,022 people** in Alaska, California, North Dakota, Oregon, Washington State and Wisconsin about the disease, including students, Rotary groups, Chambers of Commerce, businesses and others.

Since 1997, Michael has been the "starter" and speaker for Prostate Cancer runs in Anchorage and Juneau. He recently (August 8-9, 1998) chaired and was a panelist in two panel discussions in the Northwest Prostate Cancer Forum. He was a panelist in the 1997 Oregon Prostate Cancer Conference in Portland, Oregon, and serves as a member of the American Cancer Society Northwest Division Prostate Cancer Task Force which serves Alaska, Oregon and Washington State. Michael was asked to attend the United States Senate Congressional Hearing on Capitol Hill in Washington,

D.C. on September 23-24, 1997, for the American Cancer Society Prostate Cancer Advocacy event during Prostate Cancer Awareness Week.

On September 19, 1998, Michael organized a Candlelight Vigil to promote "The March" in Washington, D.C. where first lady Susan Knowles and Bishop Michael W. Warfel were the featured speakers. On September 23-26, 1998, Michael attended The March Event and helped lobby for additional federal funds for prostate cancer research.

On September 1, 1998, the Food and Drug Administration (FDA) had a review of the experimental drug "Suramin" in conjunction with hexasodium in Bethesda, Maryland. Michael became a **pioneer** by submitting a video along with his one page statement for the Oncologic Drugs Advisory Committee to review. According to JoAnn Minors, FDA Cancer Liaison Program Staff member the FDA had never reviewed a patient's testimony via video. Today, the Food and Drug Administration has implemented a video review process for patients who cannot attend the review meeting in person. Michael is very appreciative and thankful to Dr. Karen M. Templeton-Somers, Center for Drug Evaluation and Research who gave permission to submit his testimony on video.

On September 25, 1998, Michael attended the National Prostate Cancer Coalition (NPCC) national press conference where 550,000 petition signatures were delivered to Senate members on Capitol Hill. At this event, NPCC C.E.O. Jay Hedlund arranged for Michael to be the **first person** to sign a large petition for media purposes.

On December 2, 1998 at the Alaska Health Summit, Michael became the first cancer survivor to receive the **Barbara Berger Award** from the Alaska Health Education Consortium. The award recognizes outstanding dedication and vision in health education and promotion in Alaska. On December 10, 1998, the National Prostate Cancer Coalition and the American Foundation for Urologic Disease named Michael as the recipient of the **Activist Award**, which recognizes the commitment, activism and accomplishment of outstanding advocates who lead the fight against prostate cancer in their community and beyond. Bob Samuels, NPCC Chairman and Beth Kobliner-Shaw were also recipients of the Activist Award. Senators Ted Stevens and Richard Shelby, along with Representative Louis Stokes were also recognized with the Distinguished Leadership Award at the Washington, D.C. gala dinner. Senator Bob Dole and Archbishop Desmond Tutu received the Lifetime Achievement Award.

On May 14-15, 1999, Michael was a guest speaker at the US TOO North Dakota State Prostate Cancer Symposia with Dr. Judd W. Moul, Director of the Center for Prostate Disease Research and Len Dawson, former Kansas City Chiefs Quarterback.

"I want to help educate the public, especially men, that men's health care is vital and that one in five men will be diagnosed. However, it is encouraging that if detected early through non-invasive screenings, men can increase their chances of being classified in the curable status," he said.

Michael also said that through his public outreach efforts, he hopes to encourage men to take the initiative towards good health and help those diagnosed to make good choices for themselves and their families. He hopes to leave a gift to his sons by advocating for increased funding so their chance of prostate cancer is reduced or eliminated. With his own diagnosis of advanced prostate cancer, his sons have up to a ten times higher chance of coming down with the disease.

Michael has been married for 25 years to his lovely wife, Judy. They have three children, Todd, 21, Chris, 19, and Jena, 14.

MICHAEL H. MILLER
SPEAKING ENGAGEMENT

1996 TO 2000 TOTALS

JUNEAU – 6,947 people divided by 43 months = 162 people per month

OTHER ALASKAN CITIES – Anchorage	= 5,116
Beluga	= 30
Eagle River	= 105
Fairbanks	= 300
Kenai	= 301
Ketchikan	= 8
Palmer	= 30
Petersburg	= 255
Prudhoe Bay	= 95
Sitka	= 370
Soldotna	= 853

7,463 people divided by 43 months = 173 people per month

ALASKA – 14,410 people divided by 43 months = 335 people per month

OVERALL

TOTAL - 16,022 people divided by 43 months = 373 people per month



Health, Education, and Social Services
Committee
Alaska State Legislature
House of Representatives

Sponsor Statement HB 416

"An Act relating to insurance coverage for prostate cancer screening."

The House HESS Committee is the Sponsor of HB 416 to provide a forum for a discussion on whether it is appropriate to mandate that insurance companies cover the cost of annual prostate cancer screening at an earlier age than what is now required.

Mike Miller, a four-year survivor of prostate cancer, made the HESS Committee aware of the need for this bill. He has educated himself on the prevention of this deadly disease and has spent a lot of time advocating for earlier screening so others do not have to suffer what he has gone through. He is here and will testify on the bill and answer your questions.

FISCAL NOTE

STATE OF ALASKA
2000 LEGISLATIVE SESSION

BILL NO. HB 416 (L&C)

Revision Date/Time _____	Dept. Affected _____	Administration _____
Title <u>An Act relating to insurance coverage</u>	BRU _____	<u>Centralized Administrative Services</u>
for prostate cancer screening.	Component <u>Retirement and Benefits</u>	_____
Sponsor <u>Health, Education & Social Services</u>	_____	_____
Requester <u>Labor and Commerce</u>	Component No. _____	<u>64</u>

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURE	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES ()						
-------------------------------	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (1029 P/E Retire)						
TOTAL

Estimate of any current year (FY2000) cost: _____

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

Lowering the qualifying ages for prostate cancer screening will increase state employee health insurance costs by approximately \$20.0 per year. Because employer contributions to the State's health plans are capped, this increase will be borne by state employees.

Prepared by: <u>Guy Bell, Director</u>	Phone <u>465-4471</u>
Division <u>Retirement and Benefits</u>	Date/Time <u>3/6/00 3:19 PM</u>
Approved by Commissioner: <u>Robert Poe, Jr. Alison M. Elger</u>	Date <u>3/6/00</u>
Agency <u>Department of Administration</u>	

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FISCAL NOTE

STATE OF ALASKA
2000 LEGISLATIVE SESSION

BILL NO. HB 416

Revision Date/Time (Note if correction) _____ Dept. Affected Community & Economic Development
 Title An Act relating to insurance coverage for prostate BRU Insurance
cancer screening. Component Insurance
 Sponsor H (HEG)
 Fiequester (F) L&C Component No. 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
-----------------------------	--	--	--	--	--	--

CHANGE IN REVENUES ()						
-------------------------------	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

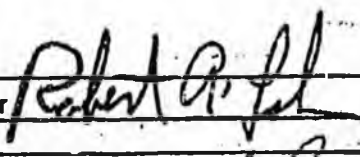
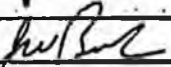
Estimate of any current year (FY2000) cost: 0.0

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

There is no fiscal impact on this component.

Prepared by: Robert A. Lohr  Phone 269-7900
 Division Insurance Date/Time 3-2-00 3:13 PM
 Approved by Commissioner Deborah B. Sedwick  Date 3-9-00
 Agency Community & Economic Development

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(7)

HOUSE COMMITTEE REPORT

Date Referred to Committee: February 16, 2000

FURTHER REFERRALS:

HES

Date of Committee Action: 17 MAR 2000

The LABOR AND COMMERCE Committee considered:

HB 416

HOUSE BILL NO. 416

PROSTATE CANCER SCREENING

"An Act relating to insurance coverage for prostate cancer screening."

recommends it be replaced the same title
with the following committee substitute _____ a new title

additional referral to _____ Committee
 attached amendment(s)

ADOPTS: _____ Letter of Intent

ATTACHES NEW FISCAL NOTE(S): (Dept) APPROVES PREVIOUS: (Dept/Date)
 fiscal note(s) DOR 3/6/00 fiscal note(s) _____

zero fiscal note(s) DCEP; zero fiscal note(s) _____

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
<i>[Signature]</i>			<input checked="" type="checkbox"/>	
<i>John Brier</i>	<input checked="" type="checkbox"/>			
<i>[Signature]</i>			<input checked="" type="checkbox"/>	
<i>[Signature]</i>	<input checked="" type="checkbox"/>			
<i>Nan Roteby</i>	<input checked="" type="checkbox"/>			

CHAIR'S SIGNATURE *Nan Roteby*

3-17-2000