ALASKA LEGISLATURE COMMITTEE FILES 1999-2000 8672

10116 SENATE LABOR & COMMERCE

HB
416

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.

Alaska State Capitol, Room 106 • Juneau, Alaska 99801
(907) 465-3759 phone • (907) 465-4587 fax

No: 1

FISCAL NOTE

Bill Version: HB 416
(H) Publish Date: 3/20/00

STATE OF ALASKA
2000 LEGISLATIVE SESSION

Revision Date/Time (Note if correction) ________
Title: An Act relating to insurance coverage for prostate cancer screening.
Sponsor: H (HES)
Requester: (H) L&C

Dept. Affected: Community & Economic Development
BRU: Insurance
Component: Insurance
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)

FUND SOURCE	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
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
Division: Insurance
Phone: 269-7900
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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No: 2

FISCAL NOTE

Bill Version: HB 416
(H) Publish Date: 3/20/00

STATE OF ALASKA
2000 LEGISLATIVE SESSION

Revision Date/Time
Title: An Act relating to insurance coverage for prostrate cancer screening.
Sponsor: Health, Education & Social Services
Requester: Labor and Commerce

Dept. Affected: Administration
BRU: Centralized Administrative Services
Component: Retirement and Benefits
Component No. 64

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						
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: Guy Bell, Director
Phone: 465-4471
Division: Retirement and Benefits
Date/Time: 3/6/00 3:19 PM
Approved by Commissioner: Robert Poe, Jr. [signature: Alison M. Elgee]
Date: 3/6/00
Agency: Department of Administration

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HB 416

Prostate Cancer Screening

Testimony by Michael H. Miller

Senate Labor and Commerce Committee

HB 416, PROSTATE CANCER SCREENING

TESTIMONY BY MICHAEL H. MILLER

ASSOCIATED MEDICAL COSTS – ESTIMATE

An estimated 175 Alaskan men are diagnosed with prostate cancer each year and approximately 18 Alaskan men per year die of the disease. Using this as a basis and in accordance with the Alaska Cancer Registry figures from 1996 published in February 1999 there have been approximately 700 Alaskan men diagnosed and 72 Alaskan men have died from prostate cancer. This leaves us with 628 men that are still living. 292 men are between the ages of 40-64, 46.5% of the 628. Of the 175 Alaskan men diagnosed each year 73 Alaskan men are between the ages of 40-64 (working age men), and 24 of these men are between the ages of
40-50, making up 33.0% of the 73 men between the ages of 40-64. Listed below is a summary of associated costs due to the disease.

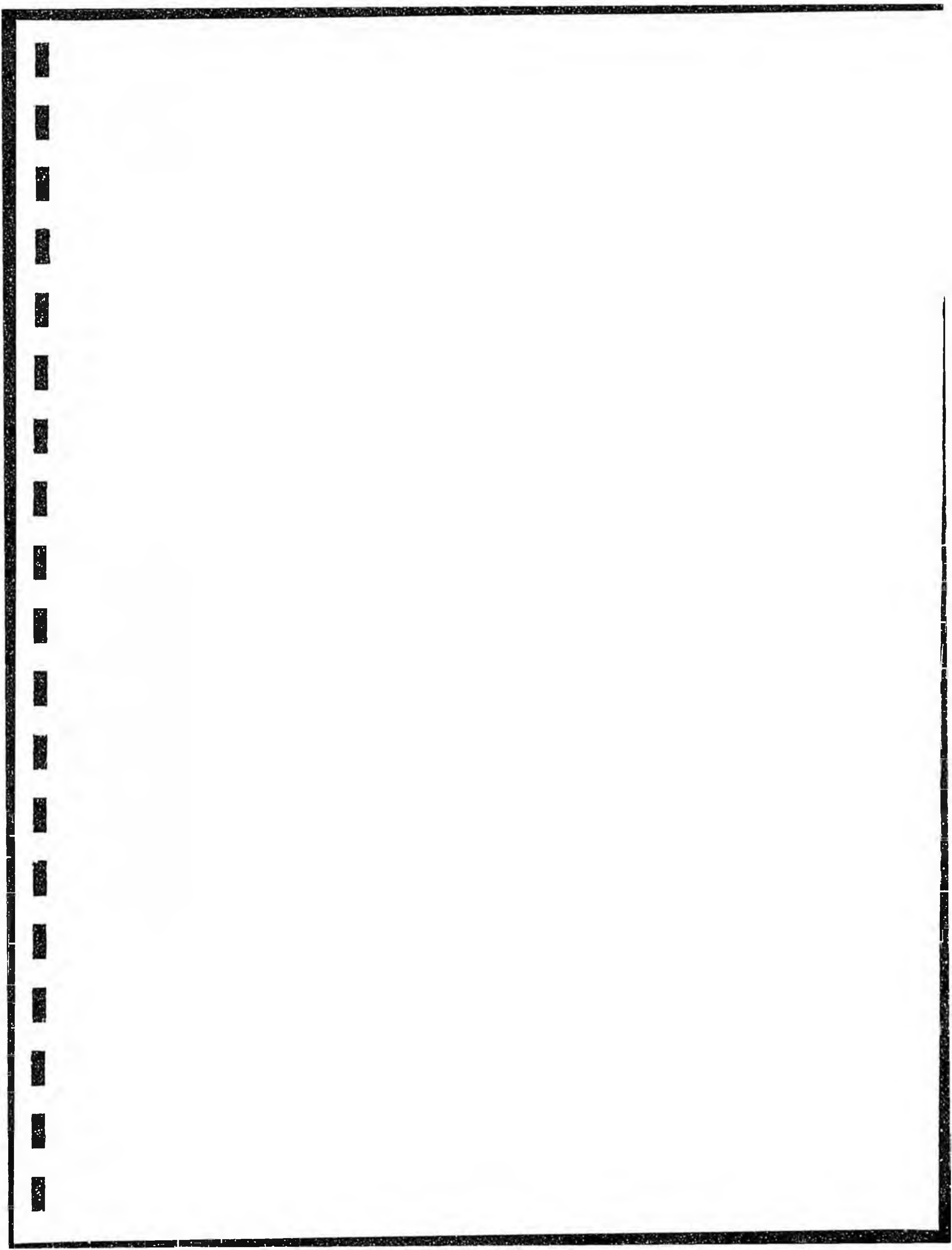
A. 628 men over 4 years x $8,000.00 (average cost per year) = $5,024,000.00 or 1.26 million per year.

B. 292 men over 4 years x $8,000.00 (average cost per year) = $2,336,000.00 or $584,000.00 per year.

C. 24 men per year (40-50 years) x 4 years x $8,000.00 per year = $768,000.00 or $192,000.00
   Note: If this expenditure continues by the year 2008 the cost = 1,535,000.00.

FY '99 State of Alaska Disability Retirement expenditure amounted to 7.2 million from PERS. In FY '90 the PERS Disability Retirement expenditure equaled 2.8 million. This area should be of concern to the Alaska State Legislators.

Final Notes: Per Dianne Lemmonn, Head Research Nurse at the Oregon Health Sciences University - 95.0% of the men diagnosed with prostate cancer have a radical prostatectcomy. The percentage of men who stay continent after this procedure is at 96%. Today, 90% of the surgeons who do a radical prostatectomy have patients stay continent. Impotence varies from man to man.
Cost of a Radical Prostatecomy is $20,000.00
Cost of Seed Implantation is $25,000.00



HB 416, Prostate Cancer Screening
Testimony by Michael H. Miller
Senate Labor and Commerce Committee

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. Eariy 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 a 1 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 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, are 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).

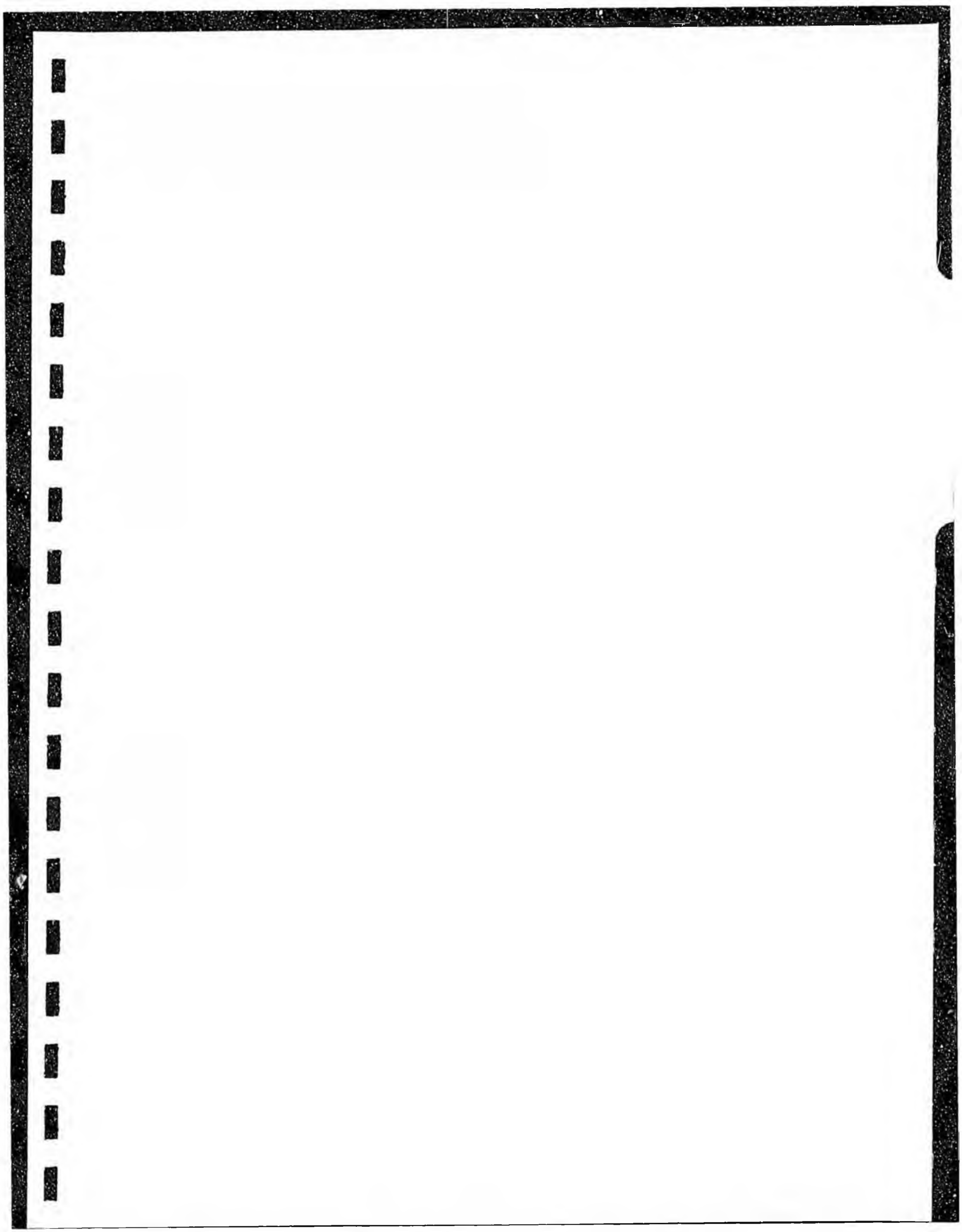
HB 416 should not cause insurance premiums to increase. Although insurers generally oppose mandates, when SB 253 was passed in 1996, an Aetna representative testified that Aetna would not oppose this bill if the Legislature felt the benefits of the screening would outweigh the small costs. He said an 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 700 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

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

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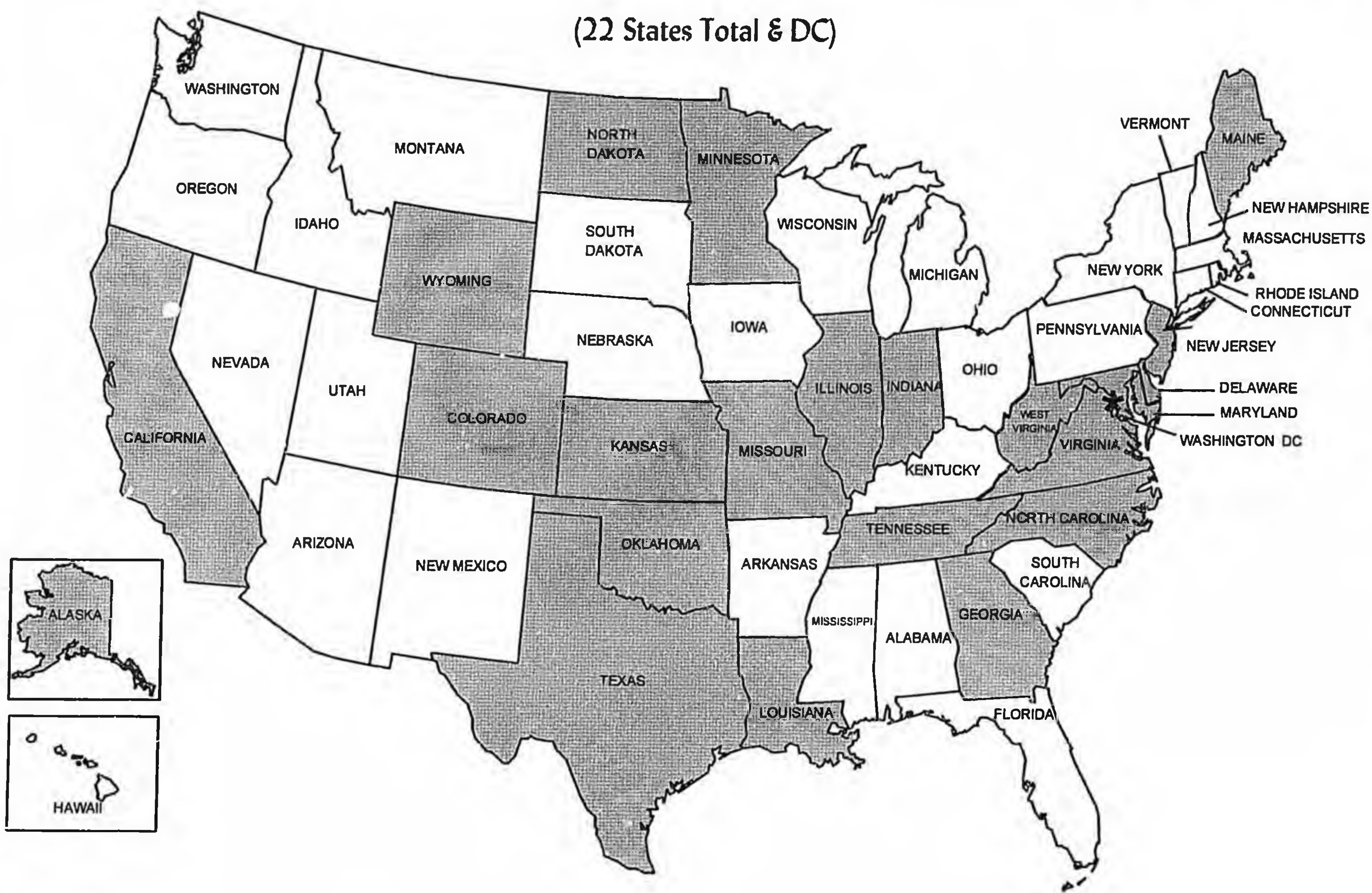
States with Mandated Benefits for Prostate Cancer Screening as of 6/20/99

(22 States Total & DC)



Sources: American Cancer Society fact sheet, "Prostate Cancer: State Facts", 4/99
National Cancer Institute, State Cancer Legislative Database, 6/99

Alaska Cancer Registry
February 1999

Percentage of Population (Probability) Developing Invasive Cancers at Certain Ages by Sex, US, 1992-1994[2]

		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 #	00-04 %	05-09 #	05-09 %	10-14 #	10-14 %	15-19 #	15-19 %	20-24 #	20-24 %	25-29 #	25-29 %	30-34 #	30-34 %	35-39 #	35-39 %	40-44 #	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 #	45-49 %	50-54 #	50-54 %	55-59 #	55-59 %	60-64 #	60-64 %	65-69 #	65-69 %	70-74 #	70-74 %	75-79 #	75-79 %	80-84 #	80-84 %	85+ #	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

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

*Excludes in situ cases

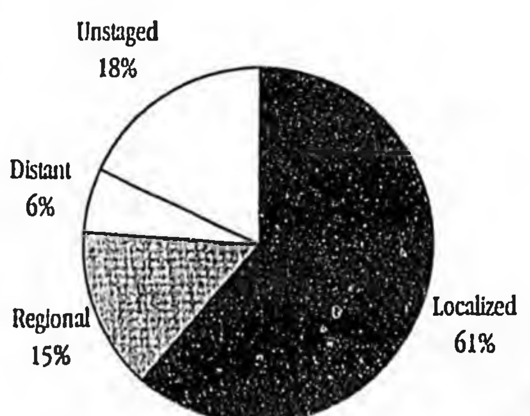
Mortality	Male
Deaths	18
Mortality rate	12.5
1995 U.S. rate	24.9

Invasive Prostate Cancer by Borough/Census Area

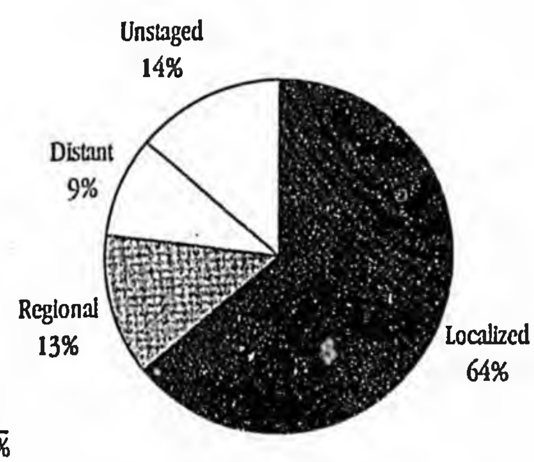
Area	Count	Area	Count	Area	Count
Aleutians East	0	Kenai Peninsula	21	Skagway-Hoonah-Angoon	2
Aleutians West	1	Ketchikan Gateway	6	Southeast Fairbanks	2
Anchorage	63	Kodiak Island	7	Valdez-Cordova	7
Bethel	0	Lake and Peninsula	0	Wade Hampton	0
Bristol Bay	0	Matanuska-Susitna	7	Wrangell-Petersburg	3
Denali	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

Alaska (n=175)



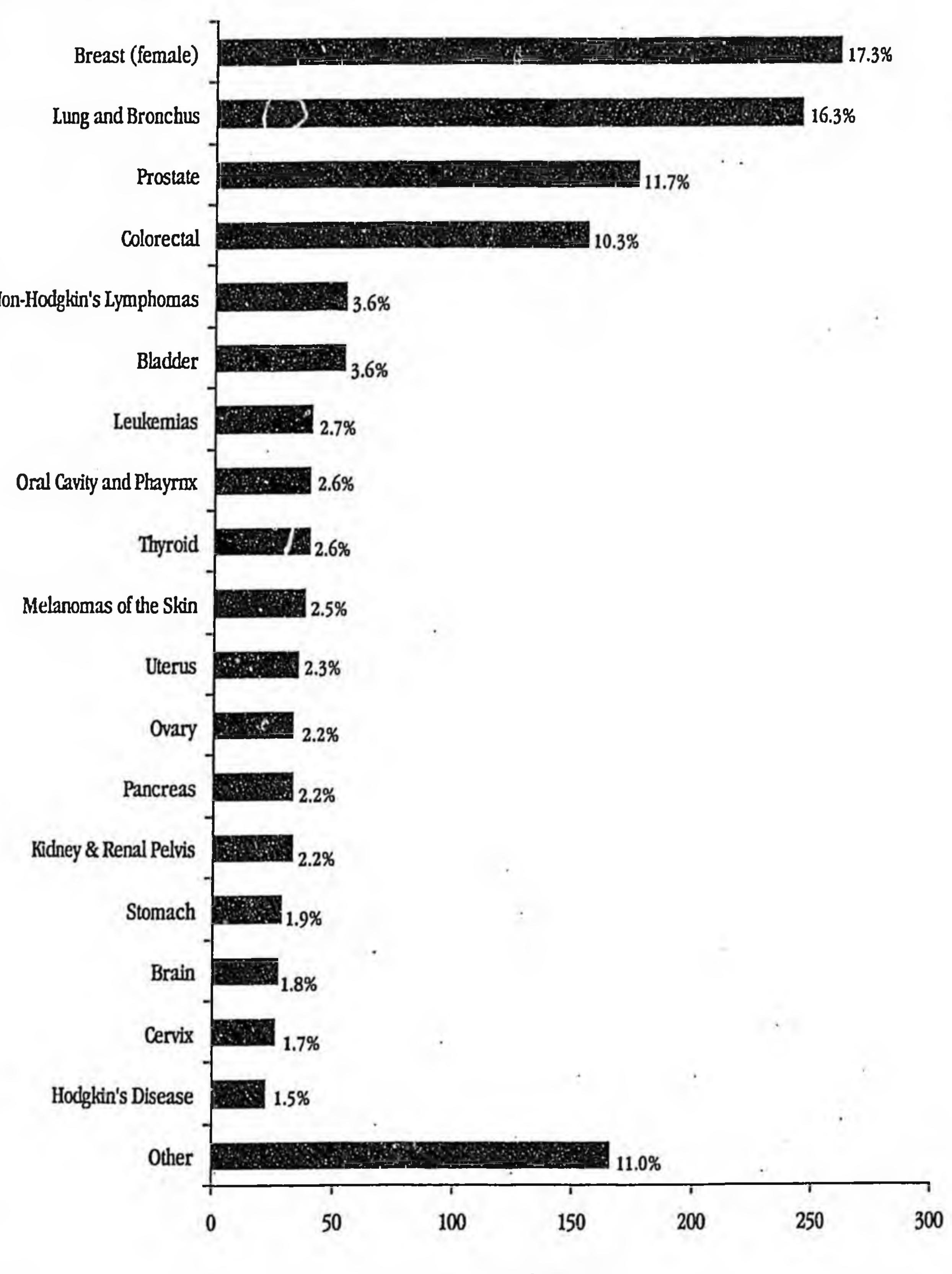
U.S.



5 year Survival (U.S., 1995)
All Stages 93.4% Localized 100%

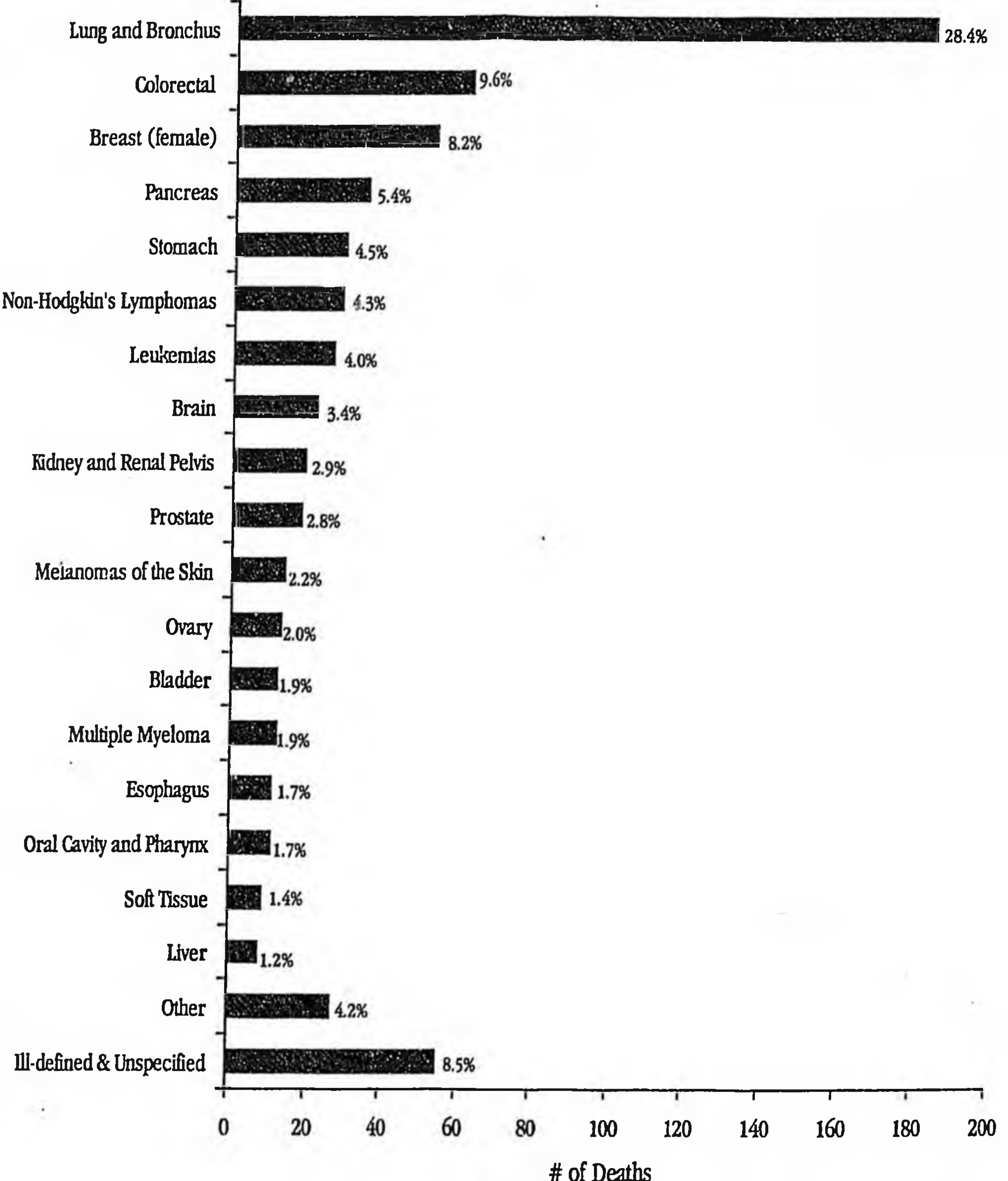
Percent of Cancer Cases by Site

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



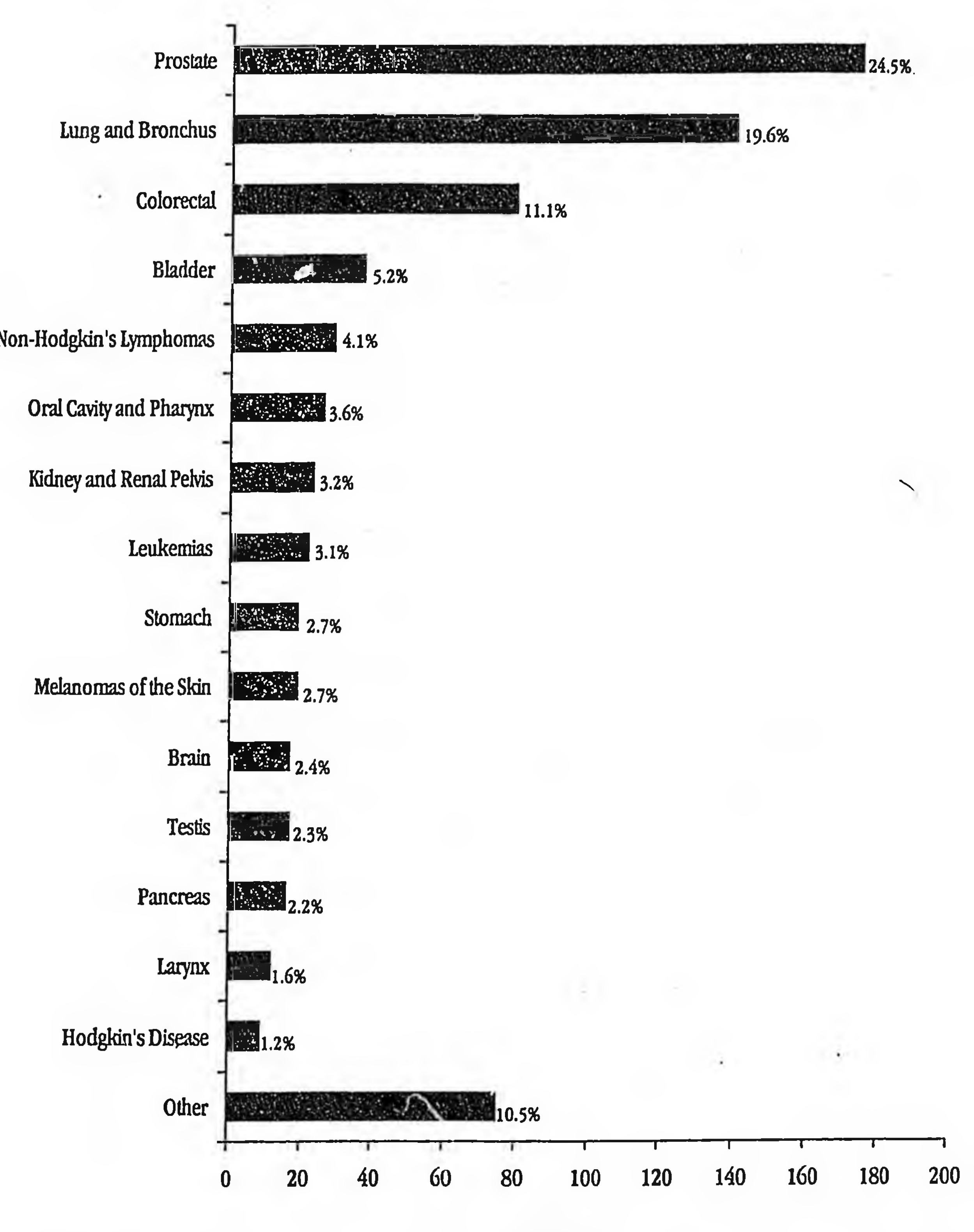
Percent of Cancer Deaths by Site

1996 Cancer Deaths (n=648) - Alaska Residents



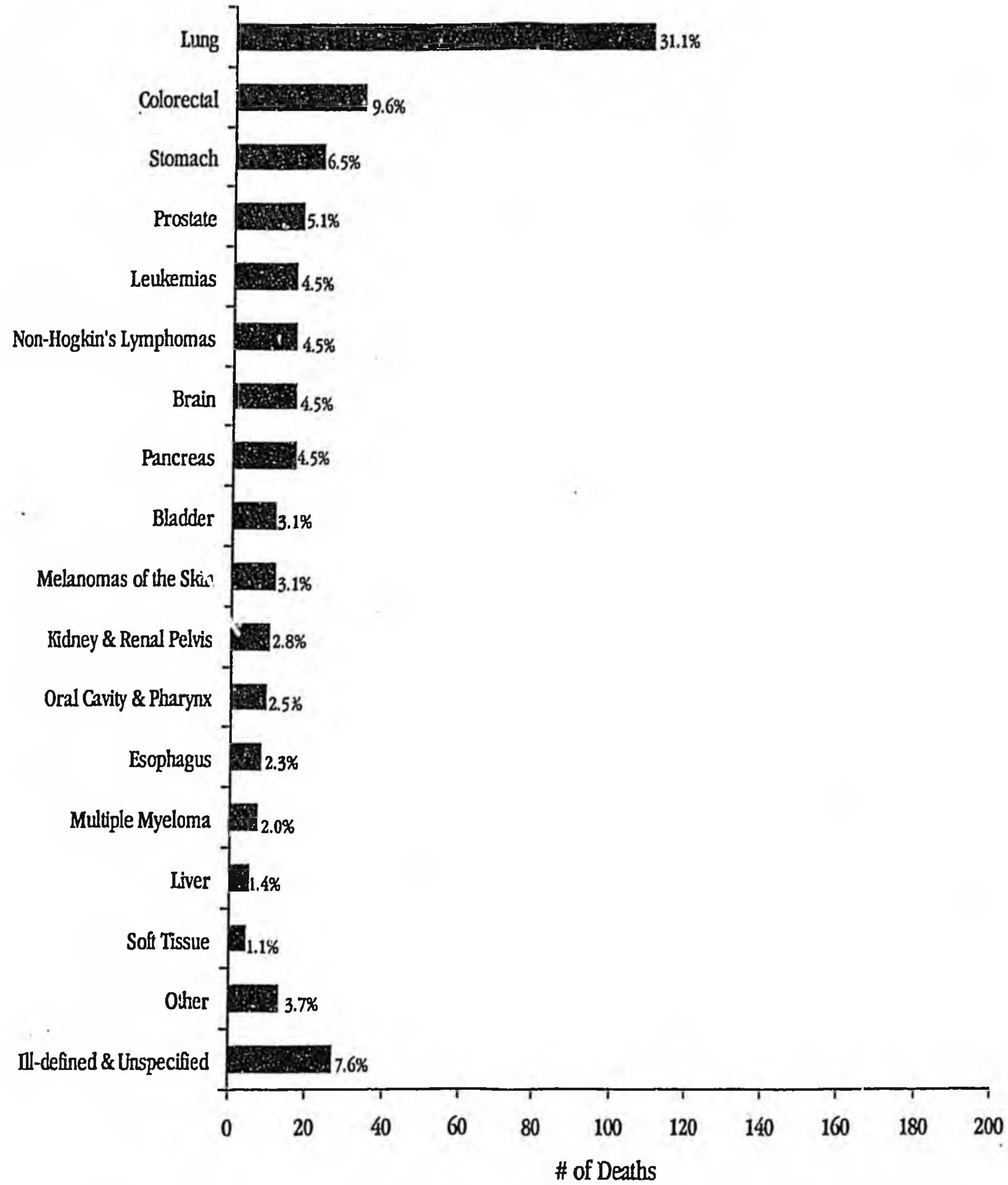
Percent of Cancer Cases by Site

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



Percent of Cancer Deaths by Site

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



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 occur 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	Brai[illegible] 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.

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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, electrodessication (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

	White			African American			All Races		
	Relative 5-Year Survival Rate (%)			Relative 5-Year Survival Rate (%)			Relative 5-Year Survival Rate (%)		
Site	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 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.

NEWS LETTER

Prostate Forum

Solving the Puzzle

Updates on Screening, Diet, and PC-SPES

Volume 4 Number 2 February 1999

Introduction

During the last few months, a number of important papers on prostate cancer were published. This issue will be devoted to a discussion of these studies.

Screening for Prostate Cancer

One of the major controversies surrounding prostate cancer is whether it is worthwhile to screen for this disease. No major health care organization in the United States advocates mass screening of men for prostate cancer. The American Cancer Society promoted prostate cancer screening, but they have recently lessened their support. Now their position is to promote patient choice and access to screening. Despite :he current lack of support for .t, I think that prostate cancer icreening saves lives and essens suffering and that clini- :al trials now in progress will rove this beyond any reason- ble doubt.

One objection to screen- ng is that once the cancer has een detected, there is no evi- ence that currently available reatments improve survival. n fact there are no randomized ontrolled clinical trials that emonstrate an advantage of irgery or radiation therapy ver watching and waiting.

A second objection is that :reening for prostate cancer

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 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.

HOUSE CS FOR CS FOR SENATE BILL NO. 253(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINETEENTH LEGISLATURE - SECOND SESSION

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered: 4/26/96
Referred: Labor and Commerce, State Affairs

Sponsor(s): SENATORS DUNCAN, Ellis, Salo, Zharoff, Lincoln, Kelly

REPRESENTATIVES Robinson, Kubina, Navarre, Rokeberg, Nicholia

A BILL

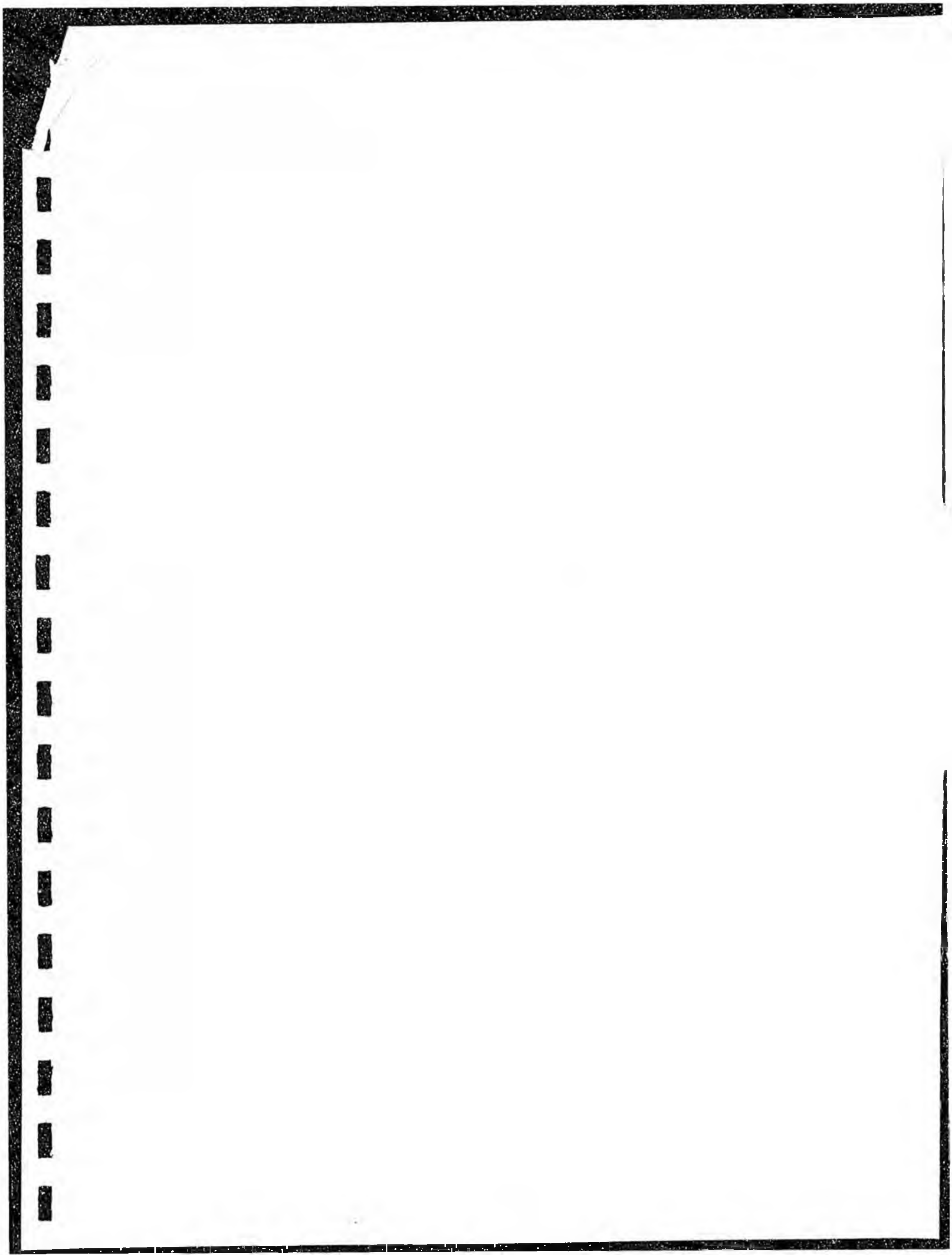
FOR AN ACT ENTITLED

1 **"An Act relating to insurance coverage for costs of prostate cancer or cervical**
2 **cancer detection."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 * **Section 1.** AS 21.42 is amended by adding a new section to read:
5 Sec. 21.42.395. COVERAGE FOR PROSTATE AND CERVICAL CANCER
6 DETECTION. (a) An insurer authorized under AS 21.09 to offer, issue for delivery,
7 deliver, or renew an individual or group disability insurance policy for medical
8 coverage on an expense incurred basis in the state, a hospital or medical service
9 corporation authorized under AS 21.87 to offer or renew a subscriber's contract for
10 medical coverage in the state, or a health maintenance organization authorized under
11 AS 21.86 to offer an enrollee contract to provide health care services on a prepaid
12 basis shall offer coverage for the costs of prostate cancer screening tests as required
13 under the schedule described under (b) of this section, and shall offer coverage for the
14 costs of cervical cancer screening tests as required under (c) of this section. The

1 coverage required to be offered by this section is subject to standard policy provisions
2 applicable to other benefits including deductible or copayment provisions. If a
3 physician recommends that an insured, subscriber, or enrollee undergo prostate cancer
4 screening by taking a prostate antigen blood test, coverage may not be denied because
5 the insured, subscriber, or enrollee has already had a digital rectal exam and the exam
6 results were negative.
7 (b) The minimum coverage required to be offered under (a) of this section
8 includes an annual prostate cancer screening test for a person who is
9 (1) at least 40 years of age but less than 50 years of age and the person
10 is in a high risk group; in this paragraph, "high risk" means a person who is an
11 African American or who has a family history of prostate cancer; or
12 (2) 50 or more years of age.
13 (c) The minimum coverage required to be offered under (a) of this section for
14 cervical cancer screening is an annual pap smear cancer screening test for a person
15 who is 18 or more years of age.
16 (d) This section does not apply to a supplemental insurance contract covering
17 a specified disease or offering limited benefits.
18 (e) In this section, "prostate cancer screening tests" includes a prostate antigen
19 blood test or another test that is equivalent or better in cancer detection.
20 * **Sec. 2.** This Act applies to a policy of insurance entered into or renewed on or after the
21 effective date of this Act.



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 the1997 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

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, 1,500 Alaskans, or four a day, will contract cancer this year, 200 more people on an annual basis than three years ago. Seven hundred Alaskans will die of cancer this year. Prostate cancer accounts for 29% of all the male-related cancers and 11% of cancer-related deaths in men.

This year, 715 men in Alaska will be diagnosed with cancer, nearly one quarter with prostate cancer. Of the 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 a 1 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 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, are 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 just under $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.

MEDICARE NORTHWEST NEWS

Volume 3 Issue 1 Winter 2000

DEDUCTIBLE & CO-INSURANCE RATES

Effective January 1, 2000

PART A HOSPITAL INSURANCE

Includes inpatient hospital care, inpatient care in a skilled nursing facility after a hospital stay, home health care and hospice care.

Inpatient	
Deductible *per benefit period*	$ 776.00
61st – 90th day (co-pay per day)	$ 194.00
91st – 150th day (co-pay per day)	$ 388.00

Skilled Nursing Facility	
21st – 100th day (co-pay per day)	$97.00

PART B MEDICAL INSURANCE

Helps pay for doctors' services, *outpatient hospital care*, diagnostic tests, durable medical equipment, ambulance services and other health services and supplies not covered by Part A.

Outpatient	
Monthly premium (unchanged)	$ 45.50
Annual deductible (unchanged)	$ 100.00
Co-insurance (unchanged)	20%

WE NEED YOUR OPINION

Have you called one of our Medicare Northwest offices recently? If so, you may receive a survey from us asking how well we served you when you called. This is part of our ongoing effort to provide you with the best possible customer service. Please take a few moments to answer the questions on the survey form. Then simply place the form in the postage-paid envelope we provide and drop it in the nearest mailbox.

When we receive your response, we will record the results and adapt our service accordingly. Your comments about how we serve you helps us to design the approach which will best meet your needs. We strive to provide you with the highest possible level of customer service. Thank you, in advance, for your participation.

SCREENING PSA TESTS

Effective January 1, 2000 Medicare will cover prostate cancer screening tests for men aged 50 and older. Coverage includes a digital rectal exam and Prostate Specific Antigen (PSA) test once every twelve months.

GENERAL ENROLLMENT PERIOD

If you do not currently have Medicare Part B benefits but would like to have them, you may sign up during the general enrollment period. This time frame is from January 1st through March 31st of each year. Your Part B coverage will then begin on July 1st. Contact the Social Security Administration at 1-800-772-1213 for more information.

WHAT'S NOT COVERED BY MEDICARE?

- **Most outpatient prescription drugs**
- **Routine or yearly physical exams**
- **Vaccinations** (except flu and pneumonia shots and Hepatitis B shots for those at risk)
- **Orthopedic shoes** (with few exceptions)
- **Custodial care in a home or nursing home** (This includes help with bathing, dressing, toileting, and eating)
- **Dental care services**
- **Dentures**
- **Routine foot care**
- **Hearing aids**
- **Eyewear (glasses or contact lenses)** except after cataract surgery
- **Cosmetic surgery**
- **Health care provided in a foreign country**
- **Health care provided on a cruise ship**

LOST YOUR MEDICARE CARD ?

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I want to bring to the HESS committee's attention the American Cancer Society indicates 1.2 million Americans will contract cancer and 552,000 Americans will die of cancer in the year 2000. Every 25 seconds someone is diagnosed with cancer and every 56 seconds someone dies of cancer. Every day over 1,500 people will die which is equivalent to three jumbo jetliners crashing. People get very excited about airline crashes and the tragedy it involves for everyone. Of these cancer deaths 171,000 are related to tobacco use and about 19,000 are related to excessive use of alcohol, which accounts for 52.5% of the cancer-related deaths. Children under the age of 20 comprise 30% of the US population and while rare at these ages 12,400 will contract cancer. The average age of these individuals will be 6 years old. Children between the ages of 13-20 have a 1 in 300 possibility of contracting cancer. The lifetime risk, birth to death in United States is 1 in 2 men and 1 in 3 women will develop cancer.

In Alaska, 1,500 Alaskan (4 per day) will contract cancer in 2000 and is 200 more people on annual basis than three years ago per the information provided by the American Cancer Society. Seven Hundred Alaskans will die in 2000, which are almost 2 Alaskans per day and 58 per month. The presented information thus far brings me to the statistics that prostate cancer accounts for 29% of all the male related cancers and 11% of the cancer related deaths. In Alaska, 715 men will contract cancer, which prostate cancer accounts for 24.5% (ranks #1) and 354 men will die of cancer, which prostate cancer accounts for 5.1% (ranks #4). The average of prostate cancer is 72 for African American men who have a 32 per cent higher risk and the average age of white male population is 70 years old. Please note other races are not ignored, but these are the two highest male race related populations that contract prostate cancer. In 2000 180,400 men in United States will contract prostate cancer which is equivalent to approximately 494 per day and 31,900 which is equivalent to 87 men per day and approximately 12 to 13 minutes a man dies of prostate cancer. In 1976, Dr. Gerald Murphy, MD/PHD oncology/urologist residing (died at the age of 65 on January 21, 2000) in Seattle developed the Prostate Specific Blood Antigen (PSA) Test in 1979, which eventually became available to all physicians in 1990. A decade old this development and tool for physicians to help detect prostate cancer has lead a decrease in mortality rate. In 1976, 73,500 men were diagnosed and 22,100 men died for a 30.0% mortality rate. In 2000, 180,400 men will be diagnosed and 31,900 men will die for a 17.7% mortality rate. Granted that along with the PSA test, men's educational forums, and prostate cancer awareness events over the last 4 years has helped reduce these statistics.

CORRECTION

THE FOLLOWING DOCUMENT(S)
HAVE BEEN REFILMED TO
ASSURE LEGIBILITY OR PAGINATION

Central Microfilm Services
Departement of Education & Early Development
State of Alaska

Rev. 6/98

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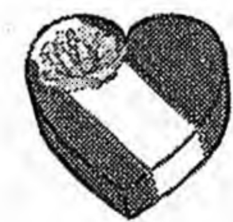
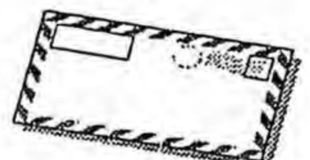


DID WE MISS YOU?

Medicare and You 2000, the current Medicare handbook, was mailed to households in September and October 1999. If you were missed, it's not too late to order a copy. Just call 1-800-MEDICARE (1-800-633-4227) and ask for publication number 10050. You will need to have your name, address and phone number handy when you make the call.

HANDBOOK CORRECTION

We have recently learned that the toll-free phone number for the Medicare Part B carrier in Idaho is a misprint. This error appears on page 23 of your *Medicare and You 2000* handbook that you recently received by mail. Idaho's Part B claims are processed by CIGNA Medicare in Tennessee. Idaho residents may call the CIGNA office toll-free by using this **correct number: 1-800-627-2782**. If you receive medical services from Idaho providers, please make this correction in your handbook.



SAVE THAT STAMP !

Are you moving soon? Here's a time and money saving tip. Instead of mailing us an address change, call the Social Security Administration. When you notify them at 1-800-772-1213, the changes they make will also update the address in our Medicare Northwest files. Their phones are open weekdays from 7 AM to 7 PM PST.

If you are on Railroad Medicare, you will want to notify your local Railroad Retirement Board of your address change

Notifying Medicare of your address change by telephone will be just one less thing you have to do when you move.

DOOR-TO-DOOR SURVEY ALERT

During our beneficiary outreach seminars we conducted across Oregon this past fall, we educated our audience about how to prevent fraud. One example we used was not to share your Medicare number with anyone who is not a medical provider.

We cited a scam from the recent past where people would conduct a door-to-door survey asking questions about Medicare. The surveyor would then ask for the resident's Medicare number. Later, it would become clear that the number had fallen into the wrong hands. Medicare claims bearing that Medicare number would appear in other parts of the country. The services were never rendered to the patient, but Medicare paid the charges. We urged you to treat your Medicare card as privately as you would a credit card. Doing so would help us prevent such fraudulent activity.

We have received news of a survey being conducted in Oregon by the Research Triangle Institute (RTI). Beneficiaries are receiving letters addressed to "Resident". The letter states that an RTI representative will be in their neighborhood conducting surveys for the Department of Health and Human Services. Since several callers were wary of this survey, we researched the issue for you with the Health Care Financing Administration (HCFA).

HCFA has told us that the RTI survey is a valid one. It is a household survey and is designed to gather information about drug abuse. It is not designed for Medicare beneficiaries. You do not have to participate in it.

HCFA added, "Beneficiaries should not give their Medicare number to anyone but their medical providers."

Mr. Chairman and members of the committee on Health, Education & Social Services, my name is Michael H. Miller, 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 the diagnosis I was given 17-35 months, but with an aggressive clinical (experimental) trial program I am sitting before you today.

I want to bring to the HESS committee's attention the American Cancer Society indicates 1.2 million Americans will contract cancer and 552,000 Americans will die of cancer in the year 2000. Every 25 seconds someone is diagnosed with cancer and every 56 seconds someone dies of cancer. Every day over 1,500 people will die which is equivalent to three jumbo jetliners crashing. People get very excited about airline crashes and the tragedy it involves for everyone. Of these cancer deaths 171,000 are related to tobacco use and about 19,000 are related to excessive use of alcohol, which accounts for 52.5% of the cancer-related deaths. Children under the age of 20 comprise 30% of the US population and while rare at these ages 12,400 will contract cancer. The average age of these individuals will be 6 years old. Children between the ages of 13-20 have a 1 in 300 possibility of contracting cancer. The lifetime risk, birth to death in United States is 1 in 2 men and 1 in 3 women will develop cancer.

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Today, there are more and more young men being diagnosed with these factors mentioned. In 1998, the American Cancer Society put out information in regards to the number of men in United States who will contract prostate in age groupings. The number of diagnosis from 1997 was 209,900 and 41,800 men died from prostate cancer. These figures accounted for 47,600 under age 65 and 162,300 for men over 65 diagnosed with prostate cancer, and 2,700 men under age 65, 39,100 over 65 who died of prostate cancer. This trend still continues today, but the statistical information is not yet available.

My concern as a patient who was diagnosed at the age of 43 years is that, as time marches on more and more young men will be diagnosed. The younger a man is the more aggressive in nature the prostate cancer will be for the individual. I have a vested interest the fact that my two sons have double to up to four to six times higher risk of contracting prostate cancer. 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 risk by age groupings. Please note the vast difference from the Birth to 39 and the 40-59 age groupings. In 1999, the statistical information in the 40-59-age grouping shows 1 in 57 (1992 – 1994 data) and in 2000 these same stats show 1 in 53 (1994-1996) men will contract prostate cancer. Four years ago the statistics in the 40-59 age group show 1 in 59. Over the last 4 years the incidence rate increased by 6 men and 4 men within one year's worth of statistical information. At this rate by the year 2008 men in the 40-59-age grouping will have a 1 in 35, or 1 in 32 chance of contracting prostate cancer.

This brings me to the point of why HB 416 should be of grave concern to all Alaskans, especially men. With an aging baby boomer society more and more men will eventually be diagnosed, but the men under age 65 should be given the opportunity to have access and availability. Why? The odds of men who are diagnosed late enough will be put on hormonal treatment with many men like myself have been forced to retire. Today, cancer in the United States accounts for a 107 billion-dollar debt, which 37 billion is attributed to direct medical cost, 11 billion is through job loss productivity (early retirement), and 59 billion is due to pre-mature deaths related to cancer. Since 1996, prostate cancer has contributed 190, 400,000.00 dollars, which over a 4-year time equals nearly 762 million dollars. Personally, I am currently on Social Security Disability Income and State Disability Retirement. That is why I feel the Alaska Legislature should respond to this concern of unnecessary incurred costs through prostate cancer. In a time of budget short falls we certainly do not need to increase costs in other areas I have just mentioned. The average cost for a prostate cancer patient is $6,000.00 to $10,000.00 annually. The annual cost in keeping me alive, not counting the doctor's office visits is $12,000.00 to $15,000.00. It would be ever so prudent for the State of Alaska and the insurance companies to make an investment for preventative health care maintenance for men starting at the age of 35 for men high at risk and men 40 and over with amending the current

insurance contract to read as such. Why? It is cost effective vs. the long-term cost which is approximately $48,690.00 (refer to the Pay Now...Pay Later page – second column from left).

In the research from SB 253 introduced by then Senator Jim Duncan stated there should not be any fiscal note, nor appreciable increased cost. Please refer to the Age Distribution of Invasive Cancer – 1996 from the 1999 Cancer Alaska Registry report. Forty to Forty Four age group shows two men in 1996 were diagnosed. I was one of those 2 men with advanced prostate cancer. If this test were made available to me prior to age 50. I would have probably been diagnosed with early stage of prostate cancer. The 45 – 49 groups show 10 men. I cannot see where 12 men will make a difference with the current insurance program in place. This is based on the fact there was not any appreciable associated cost when SB 253 was passed in 1996. Please refer to the Medicare Northwest Newsletter that shows effective January 1, 2000 Medicare will cover prostate cancer tests for men aged 50 and older. Coverage includes a Prostate Specific Antigen (PSA) and digital exam once every twelve months. If the federal government is being very prudent about starting these tests for men age 50 when Medicare does not normally begin until age 65, then in Alaska we should be ever so diligent and vigilant for men living in Alaska. Part of the reason why Medicare starts this at age 50 is for men who have been forced to retire need to obtain PSA/digital exams.

Men are dying of prostate cancer leaving behind spouses, children and many family members and friends associated with each of these men. While we have made great strides in the United States too many men are still being lost at too young of an age. I myself, would like to leave my two sons the best possible gift and that is to give them an opportunity to be screened at an earlier age, because the odds will be they will contract prostate cancer at a younger age than me. If prostate cancer is a currently affecting fathers son, then this number will still be increasing way beyond the number imagined. Over the last 4 years approximately 800 Alaskan men have been diagnosed. Certainly there will continue to be sons of fathers who will contract this disease. Let us give these men falling in the appropriate age groupings an opportunity to at least be diagnosed in the early stage category, placing them in the 5-year relative survival rate of 100 per cent they will die of another cause. Finally, I want to have you refer to the page listed as Cancer Basic Facts provided by the American Cancer Society which is highlighted presents the current 5 year relative survival rate of 80%, and if all Americans participated in a regular cancer screenings, this rate would increase to 95%. Let's have Alaska be a leader within the United States and be in the 95% or more percentile when it comes to screenings, such as prostate cancer for men. Please support HB 416 for the future health and wealthfare for all Alaskan families. Thank you for passing legislation in 1998 with HJR 29 stating Alaska wants increased federal funding for prostate cancer research. In FY '99 we saw a 50% increase in federal funding. Also, thank you for your time and energy spent representing the citizens of Alaska.

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.

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 the1997 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 26 years to his lovely wife, Judy. They have three children, Todd, 22, Chris, 19, and Jena, 15.

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

TRANSMISSION RESULT REPORT (MAR 21 '00 10:27AM)

MERRILL LYNCH JUNEAU

(AUTO)

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D)DETAIL $)TRANSFER
F)FINE P)POLLING

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HOUSE BILL NO. 416

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - SECOND SESSION

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Introduced: 2/16/00
Referred: Labor and Commerce, Health, Education and Social Services

A BILL

FOR AN ACT ENTITLED

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

2 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

3 * Section 1. AS 21.42.395(b) is amended to read:

4 (b) The minimum coverage required under (a) of this section includes an

5 annual prostate cancer screening test for a person who is

6 (1) at least 35 [40] years of age but less than 40 [50] years of age and

7 the person is in a high risk group; in this paragraph, "high risk" means a person who

8 is an African-American or who has a family history of prostate cancer; or

9 (2) 40 [50] or more years of age.

HB
420

Alaska State Legislature

HOUSE OF REPRESENTATIVES

Committee on Finance

Official Business

State Capitol
Juneau, Alaska 99801-1182

House Bill 420 "An Act relating to Tourism Markteting contracts."

SPONSOR: House Finance Committee

SPONSOR STATEMENT:

House Bill 420 makes a change to legislation enacted last year that implements the New Millenium Plan to consolidate tourism marketing performed by the State of Alaska. The date that the Department of Community and Economic Development must enter into a contract with a single qualified trade association for planning and executing a destination tourism marketing campaign has been moved up the calendar to May 1 from August 1.

This change is necessary to facilitate the decision-making process regarding production expense and fund raising activities taken on by the travel industry. These decisions need to take place six to eight months prior to the initiation of an effective advertising campaign. In addition, the new date falls prior to the last day of session, enabling the Legislature to see the final product before appropriating significant resources to the effort.

Alaska Tourism Marketing Timeline

In order to implement a marketing program for FY01 a number of major commitments need to be made and sub-contractors hired. For example, Visitors planning a trip to Alaska require information approximately one year prior to their intended travel date. Starting distribution of the 2001 Vacation Planner in October 2000 is critical to visitor industry businesses. Research has shown that the peak planning period for an Alaska vacation is 6 to 9 months prior to the intended date of travel.

Production – December through May

- The decision is made to print a Vacation Planner for the following year.
- Send requests for proposals to Advertising Agencies to enter into a contract for design, layout, advertising, marketing, and production supervision of the Vacation Planner.
- Select contractors, Advertising Agency and others as needed to implement all components of the marketing plan.
- Send requests for proposals to printing companies for cost of printing the 96 page planner and availability of print dates in September.
- Determine Vacation Planner advertising rates and deadlines.
- Identify pay-to-play components of the marketing program in conjunction with the Vacation Planner.

Distribution of Advertising Sales Information to Visitor Industry Businesses – March through May

- Determine Vacation Planner sales staff.
- Design and produce the advertising solicitation packet.
- Mail advertising materials to approximately 4,000 visitor industry businesses.

Selling Vacation Planner Ads – March through May

- Process, data enter and fulfill orders from advertisers.
- Available to answer questions and guide industry businesses through the marketing process.

Research and Planning – February through April

- Develop the marketing and advertising program for distribution of the Vacation Planner.
- Secure advertising space for magazine ads, TV image, and newspapers nationwide.

Printing the Vacation Planner – August and September

- All materials that make up the printed Vacation Planner are sent to a color house in August for printing in September.
- September the Vacation Planner is printed.
- Printed planners are delivered to a mail-house.

Distribution of 2001 Vacation Planner – October through September 2001

- Vacation planners are sent out.

Visitor Industry Reservation for 2001 – November through April

- The majority of reservations for travel during 2001 will be made during this time.

REPRESENTATIVE
GENE THERRIAULT
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Alaska State Legislature

House Of Representatives

While in session
State Capitol
Juneau, Alaska
99801-1182
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Fax: (907) 465-3884

House District 33

MEMORANDUM

TO: Dave Gray, committee aide
Senate Labor & Commerce Committee

FROM: Joe Balash, staff
Representative Gene Therriault

DATE: April 11, 2000April 11, 2000

SUBJECT: HB 420 changes

Attached are the suggested changes to House Bill 420. The Department testified in House Finance that there were too many problems with moving the contract date up to May 1 for them to support the bill. However, they did express support for moving the date up in future years. These changes address those concerns while addressing the need for statutory guidance during current negotiations on the Fiscal Year 2001 marketing contract.

Sections 1 and 2 amend language in Senate Bill 107 to require the Department to enter into a contract by April 1 each fiscal year instead of August 1. The contract is to be for the marketing campaign to be executed in the next fiscal year. Section 1 becomes effective July 1, 2000 and sets the industry match requirement at 30%. What this means is that SB 107 will no longer apply to Fiscal Year 2001. Section 2 becomes effective July 1, 2002 and raises the industry match requirement to 60%. These match rates remain unchanged from the original SB 107.

Section 3 sets out how the contract for Fiscal Year 2001 will be negotiated. The Department will issue its "essential components" to the Qualified Trade Association by May 1. The QTA will, in turn, draft its marketing campaign plan and provide it to the Department by June 15. The level of detail required of the QTA's marketing campaign plan is to be similar to that contained in the Division's own Action Plan for FY 2000, which I have attached. Finally, the Department and the QTA shall enter into a formal contract by July 1, 2000. Section 6 was added to make Section 3 effective immediately.

Please call me if you have any questions regarding these changes.

Email: Representative_Gene_Therriault@legis.state.ak.us

1-LS1499\H
Cook
4/10/00

SENATE CS FOR CS FOR HOUSE BILL NO. 420( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): **HOUSE FINANCE COMMITTEE**

A BILL

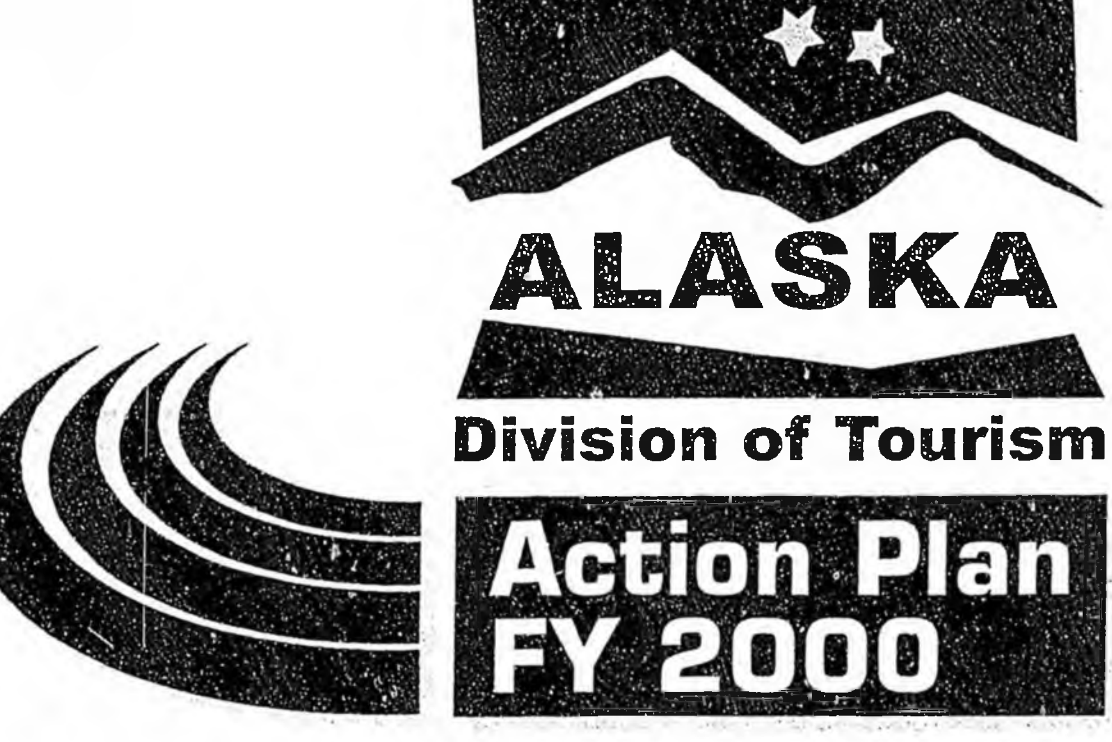
FOR AN ACT ENTITLED

1 **"An Act relating to tourism marketing contracts; and providing for an effective**
2 **date."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 * **Section 1.** AS 44.33.125(a), as enacted in sec. 7, ch. 29, SLA 1999, is amended to read:
5 (a) Subject to appropriations for the purpose, the Department of Community
6 and Economic Development shall, on or before **April** [AUGUST] 1 of each **fiscal**
7 year, contract with a single qualified trade association for the purpose of planning and
8 executing a destination tourism marketing campaign **during the next fiscal year**. The
9 contract may be awarded only if the qualified trade association provides matching
10 funds equal to at least 30 percent of the costs of the marketing campaign described in
11 the contract. The marketing campaign may promote distinct segments of tourism, such
12 as highway tourism, seasonal tourism, ecotourism, cultural tourism, regional tourism,
13 and rural tourism. Before the contract is executed, the marketing campaign plan must
14 be approved by the department.

1 * **Sec. 2.** AS 44.33.125(a), as amended in sec. 8, ch. 29, SLA 1999, is amended to read:
2 (a) Subject to appropriations for the purpose, the Department of Community
3 and Economic Development shall, on or before **April** [AUGUST] 1 of each **fiscal**
4 year, contract with a single qualified trade association for the purpose of planning and
5 executing a destination tourism marketing campaign **during the next fiscal year**. The
6 contract may be awarded only if the qualified trade association provides matching
7 funds equal to at least 60 percent of the costs of the marketing campaign described in
8 the contract. The marketing campaign may promote distinct segments of tourism, such
9 as highway tourism, seasonal tourism, ecotourism, cultural tourism, regional tourism,
10 and rural tourism. Before executing the contract, the marketing campaign plan must
11 be approved by the department.
12 * **Sec. 3.** The uncodified law of the State of Alaska is amended by adding a new section
13 to read:
14 TRANSITION. To carry out the purposes of ch. 29, SLA 1999, and subject to
15 appropriations for the purpose, the Department of Community and Economic Development
16 shall, on or before May 1, 2000, identify essential components for a destination tourism
17 marketing campaign for fiscal year 2001. A component may not be included in the campaign
18 that was not included in a campaign conducted during fiscal year 1998, 1999, or 2000. A
19 qualified trade association must respond by delivering its destination tourism marketing
20 campaign plan to the department by June 15, 2000. The plan must contain a similar level of
21 detail as is contained in the "Alaska Division of Tourism Action Plan for FY 2000, August
22 1999." By July 1, 2000, the department shall enter into a contract with a single qualified trade
23 association for the purpose of planning and executing a destination tourism marketing
24 campaign for fiscal year 2001.
25 * **Sec. 4.** Section 1 of this Act takes effect July 1, 2000.
26 * **Sec. 5.** Section 2 of this Act takes effect July 1, 2002.
27 * **Sec. 6.** Section 3 of this Act takes effect immediately under AS 01.10.070(c).



August 1999

Action Plan FY 2000

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To Contact the
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Website: www.dced.state.ak.us/tourism/

Action Plan FY 2000

Introduction

The Alaska Department of Community and Economic Development, Division of Tourism is responsible for initiating and contributing to the planning process for effective growth of the visitor industry, developing new markets, assisting in the development of Alaska tour product, and conducting tourism research. These activities enable the industry to grow, enhancing income and employment opportunities for Alaskans statewide.

One of the Division's responsibilities is to work with the travel trade and press/media worldwide, developing and enhancing Alaska tour programs. The Division of Tourism responds to trade, consumer, and press/media requests for information and assistance. The Division also compiles and distributes visitor research, responds to special initiatives such as increasing highway and adventure travel to and through Alaska, attends consumer and trade exhibitions, conferences and travel shows, and coordinates travel agent training, international workshops series, and other training/sales opportunities for Alaska's varied tourism industry.

Mission

The Alaska Division of Tourism endeavors to stimulate economic growth, diversification and job opportunities in Alaska by promoting Alaska as a visitor destination; providing technical assistance and planning for the development of infrastructure and visitor attractions; and assisting communities and small businesses in tourism and product development.

In order to fulfill its mission, the Division designs and manages programs both overseas and within North America. Some are of a broad, generic nature such as travel agent training or the international workshop series. Other programs are in direct response to statutory mandates such as, "to promote the development of tourism opportunities along the highway system of the state, including the Marine Highway, and in rural areas of the state."

A majority of the Division's programs are focused on tourism trade—the sales force of tour operators and travel agents that can efficiently and expertly deliver Alaska's tourism product into the hands of consumers around the world. Staff, along with their international contractors, works actively with the trade and press/media throughout North and South America, as well as in Asia, Australia/New Zealand, and Europe to increase awareness and ultimately travel to Alaska. The Division focuses on the development

North plans to continue its aggressive outreach to potential highway travelers, and will include the following elements:

- ***North! To Alaska*** publication: The cornerstone of the Tourism North program is the publication of a 104-page highway travel planner called ***North! To Alaska.*** The national award-winning guide is designed using an easy-to-read magazine-style format. It includes colorful hand-drawn maps, travel itineraries from each region or jurisdiction ranging from Alberta to Alaska, and travel information and facts about many of the towns and cities along the highways. The planner also includes the Official Alaska Marine Highway System's summer ferry schedule, the complete schedule for BC Ferries and a handy pullout map that details Alaska's most scenic drives.
- Direct Mail: The publication will be mailed throughout North America via niche mailing lists, responses received from the distribution of a newspaper insert to 1.2 million targeted residents throughout U.S. and Canada, co-promotional partner mailing lists, and the purchase of other labels or direct mail campaigns.
- Internet: This year, the internet site is being enhanced to include interactive itineraries, an expanded advertisers index to include a searchable database, overall website updating including graphic and copy including more Live Expeditions and co-promotions with other internet partners.
- Co-Promotions: May include but will not be limited to recreational vehicle shows around the country, joint venturing on programs with the recreational vehicle industry and other groups.
- Public Relations: To reach potential visitors, Tourism North has embarked on an aggressive public relations strategy to reach travel and automotive media, as well as the general and national news media. This effort includes developing a press kit for national distribution, placing editorial copy in major newspaper travel sections and travel magazines throughout the U.S., and working proactively to place travel news stories on television.
- Promotion of Alaska's nationally designated Scenic Byway, the Seward Highway, and promoting the 11 Alaska state designated Scenic Byways, as well.

CORRECTION

THE FOLLOWING DOCUMENT(S)
HAVE BEEN REFILMED TO
ASSURE LEGIBILITY OR PAGINATION

Central Microfilm Services
Departement of Education & Early Development
State of Alaska

Rev. 6/98

Action Plan FY 2000

Introduction

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One of the Division's responsibilities is to work with the travel trade and press/media worldwide, developing and enhancing Alaska tour programs. The Division of Tourism responds to trade, consumer, and press/media requests for information and assistance. The Division also compiles and distributes visitor research, responds to special initiatives such as increasing highway and adventure travel to and through Alaska, attends consumer and trade exhibitions, conferences and travel shows, and coordinates travel agent training, international workshops series, and other training/sales opportunities for Alaska's varied tourism industry.

Mission

The Alaska Division of Tourism endeavors to stimulate economic growth, diversification and job opportunities in Alaska by promoting Alaska as a visitor destination; providing technical assistance and planning for the development of infrastructure and visitor attractions; and assisting communities and small businesses in tourism and product development.

In order to fulfill its mission, the Division designs and manages programs both overseas and within North America. Some are of a broad, generic nature such as travel agent training or the international workshop series. Other programs are in direct response to statutory mandates such as, "to promote the development of tourism opportunities along the highway system of the state, including the Marine Highway, and in rural areas of the state."

A majority of the Division's programs are focused on tourism trade—the sales force of tour operators and travel agents that can efficiently and expertly deliver Alaska's tourism product into the hands of consumers around the world. Staff, along with their international contractors, works actively with the trade and press/media throughout North and South America, as well as in Asia, Australia/New Zealand, and Europe to increase awareness and ultimately travel to Alaska. The Division focuses on the development

and promotion of highway travel to and through the state through Tourism North, its partnership with Tourism Yukon, British Columbia, Alberta, and the city of Prince Rupert. A similar partnership with Alaska Village Initiatives provides a means of increasing rural tourism development.

Objectives

The Division of Tourism works with Alaska communities, organizations, government agencies and the visitor industry to accomplish the following objectives:

- increase the number of visitors coming from domestic and international markets;
- develop and maintain attractions and amenities for travelers throughout the state;
- extend the peak visitor season into April and late September;
- increase awareness of Alaska as a winter destination;
- increase the number of people traveling to and through Alaska by highway and ferry;
- improve access to Alaska and its attractions;
- increase employment and income opportunities for Alaskans in tourism; and
- extend the opportunity for benefits of tourism development throughout the state to communities that choose tourism.

Tourism North

Tourism North is a joint program between the State of Alaska, the Yukon. British Columbia. Alberta. and the city of Prince Rupert dedicated to influencing the travel decisions of independent highway travelers, including those traveling the Alaska Marine Highway System. This program has been an effective partnership for more than ten years.

Tourism North's research shows the average highway traveler is between 35-54 years old, is highly educated and earns an annual income of more than $71,000. In 1997, more than 120,600 visitors entered and/or left Alaska by highway and spent an average of 14.7 nights on each trip. These travelers comprise over 51 percent of the high potential audience for independent travel to Alaska. In its 1999-2000 program, Tourism

North plans to continue its aggressive outreach to potential highway travelers, and will include the following elements:

- ***North! To Alaska*** publication: The cornerstone of the Tourism North program is the publication of a 104-page highway travel planner called ***North! To Alaska.*** The national award-winning guide is designed using an easy-to-read magazine-style format. It includes colorful hand-drawn maps, travel itineraries from each region or jurisdiction ranging from Alberta to Alaska, and travel information and facts about many of the towns and cities along the highways. The planner also includes the Official Alaska Marine Highway System's summer ferry schedule, the complete schedule for BC Ferries and a handy pullout map that details Alaska's most scenic drives.
- Direct Mail: The publication will be mailed throughout North America via niche mailing lists, responses received from the distribution of a newspaper insert to 1.2 million targeted residents throughout U.S. and Canada, co-promotional partner mailing lists, and the purchase of other labels or direct mail campaigns.
- Internet: This year, the internet site is being enhanced to include interactive itineraries, an expanded advertisers index to include a searchable database, overall website updating including graphic and copy including more Live Expeditions and co-promotions with other internet partners.
- Co-Promotions: May include but will not be limited to recreational vehicle shows around the country, joint venturing on programs with the recreational vehicle industry and other groups.
- Public Relations: To reach potential visitors, Tourism North has embarked on an aggressive public relations strategy to reach travel and automotive media, as well as the general and national news media. This effort includes developing a press kit for national distribution, placing editorial copy in major newspaper travel sections and travel magazines throughout the U.S., and working proactively to place travel news stories on television.
- Promotion of Alaska's nationally designated Scenic Byway, the Seward Highway, and promoting the 11 Alaska state designated Scenic Byways, as well.

Trade/Consumer Shows

Throughout the year, the Division represents the state at trade shows. To promote the state and work with tour operators to develop or enhance existing Alaska programs. Most of these shows offer cooperative possibilities for Alaska businesses and destination marketing organizations (DMOs). Attendance at trade shows is always followed up with distribution of extensive lead lists, first to all cooperative participants, and then to all Alaska DMOs (CVBs, regional marketing organizations) for distribution to their members.

Trade shows planned for FY 2000 include the following (contact Division staff for cooperative opportunities):

Show	Location	Dates
► World Congress on Adventure Travel and Ecotourism	Tucson	September 20-22, 1999
► National Tour Association (must be a member to attend)	Nashville	November 5-11, 1999
► World Travel Market (WTM)	London	November 15-18, 1999
► American Bus Association (must be a member to attend)	Birmingham	December 4-10, 1999
► Japan Association of Travel Agents Congress and Trade Show (JATA)	Tokyo	November 30 - December 3, 1999
► Visit USA Seminars	Australia/ New Zealand	February 7-15, 2000
► Consumer shows in Germany attended by contract staff		
• T & C, Leipzig	Germany	November 17-21, 1999
• Reisemarkt Koln International	Cologne Germany	November 27-29, 1999
• Reisen Hamburg	Hamburg Germany	February 12-20, 2000
► Consumer shows in Japan attended by contract staff		
• JATA/Sendai	Sendai City Japan	September 24-26, 1999
• JATA/Nagoya	Nagoya City Japan	October 1-3, 1999
► ITB (International Travel Exchange)	Berlin	March 11-15, 2000
► National Tour Association Spring Meet	Pittsburgh	March, 2000
► Alaska Travel Workshops	Japan (four cities)	April 3-7, 2000
► Active America Travel Summit	Seattle	April 11-13, 2000
► TIA Pow Wow	Dallas	May 13-17, 2000

International Workshop Series

Many Alaska Suppliers and DMOs take advantage of the opportunity to promote their product (or members) in key, international markets by participating in the Division's international workshop series. While each market has developed a format that works best for its locale, participants are given the opportunity to educate travel trade and press during multi-city visits, as well as undertake sales calls to the travel trade (coordinated by the Division's international representatives). This fiscal year, the Division will again offer workshops in Japan (April, 2000). Information will be available soon. Space is limited!

Travel Agent Training

Preceding or following domestic trade show attendance, the Division has cooperative opportunities for Alaska suppliers and DMOs to participate in travel agent training as part of its "Top of the World" training program. The program is designed to increase general awareness and knowledge about the state as well as more in-depth information about its available tour product. Successful completion of the programs provides agents with a "Top of the World/Alaska Specialist" designation that includes a certificate and decal. Travel agent training workshops have been conducted in:

Phoenix	Las Vegas	Nashville
Chicago	St. Louis	Saginaw
Tampa	Ft. Lauderdale,	Orlando
Jacksonville	Miami	Throughout Canada

Plans for FY 2000 include San Antonio, Houston, Dallas, New York, and Pittsburgh.

Tour Operator And Wholesaler Product Development, Agent Educational And Press/Media Familiarization Trips

In addition to the product development trips held in conjunction with Alaska Travel Fair V, the Division coordinates tour operator and wholesaler product development, travel agent educational and press/media familiarization trips throughout the year. Every effort will be made to work with CVBs and regional marketing organizations (and their mem-

bers) to best showcase the state. Those interested in participating in this program should keep in mind that while goods and services are usually provided complimentarily (or heavily discounted), the investment provides an opportunity for showcasing their tour product. Ultimately, this should increase the number of visitors to Alaska (and purchasers of their product!).

Rural Tourism Center

The Rural Tourism Center (RTC) is a partnership between the Division of Tourism and Alaska Village Initiatives. The RTC serves as a resource to Alaskans in rural communities (all but Anchorage, Fairbanks, and Juneau) interested in starting a tourism business or enhancing or expanding an existing one. The RTC also serves as a liaison between rural entities and the Division to develop and plan for tourism development.

In partnership with the RTC, the Division of Tourism will coordinate at least three rural tourism workshops in FY 2000. Dates and locations are still under consideration. Anyone interested in hosting a workshop is encouraged to contact the Division of Tourism. Many topics on rural tourism development will be addressed, with the format and reference materials accessible on the Division's "Guidelines for Community Tourism Development" website at http://www.dced.state.ak.us/tourism/guideline.htm. Representatives of private sector tourism businesses, as well as community leaders, will take part in the workshops as presenters.

There is a growing recognition in the travel industry that tourism promoting an area's rich heritage, creativity and diversity is of increasing importance. Today's better educated and experienced leisure travelers have moved beyond travel as simple recreation and want to learn more about a particular interest, participate in an activity, or explore and understand a region or destination.

In response, the Division of Tourism will coordinate and co-host the Second Annual Governor's Conference on Cultural Tourism (dates and location to be announced). This conference will enable Alaska's art and cultural communities to participate in a dialogue with state tourism professionals and representatives from Alaska communities and allied fields.

Planning

Recognizing the need for tourism transportation planning and interagency coordination, the Division dedicates a professional staff position to tourism planning. Staff works closely with the Rural Tourism Center in assisting with new business and infrastructure development, and with land and transportation management agencies to develop plans to improve appropriate access, facility maintenance and ease permitting problems.

Up in the Air

and other access issues

The Division continues to look at airline relationships that will increase access to Alaska from around the globe. Balair and Condor, that provide weekly seasonal service from Europe, pioneered part of the current "direct flight mix" to Alaska. Through the combined efforts of the Division, the Anchorage CVB and others, Alaska now has twice weekly seasonal service from Japan to Anchorage. In additional, the Division continues to:

- advocate for the extension of the Visa Waiver Pilot Program for Korean travelers and modification of the Passenger Services Act;
- work with the Federal Aviation Administration regarding flight operations into rural Alaska;
- assist tour operators with motorcoach registrations or other governmentally driven issues as they arise;
- encourage carriers to provide year round service from Japan, to take advantage of the surge in the number of visitors for Northern Lights viewing; and
- encourage additional carriers from European markets to develop more service to Alaska.

Alaska Travel Fair

Begun in 1995 with approximately 20 tour operators from the United Kingdom and German-speaking Europe, the Alaska Travel Fair is a three-part buying experience for its tour operator participants that combines familiarization trips with a seminar series and trade show, the Alaska Travel Fair Marketplace. The Alaska Travel Fair and Marketplace enables the Division to bring the tourism marketplace to Alaska to better educate tour operators with a first hand experience of what Alaska has to offer. Additionally, the Marketplace provides operators with the opportunity to purchase tour product directly from Alaska suppliers. In turn, Alaska suppliers, many of whom would

not otherwise have the chance, are given the opportunity to work directly with tour operators from around the world. This year, ATF-V included eight statewide familiarization tours, a seminar series at Chena Hot Springs Resorts, and the Marketplace at the Westmark Fairbanks. In addition, a seminar was added to further educate DMOs and suppliers about working with tour operators.

In Print

As state marketing dollars continue to diminish, the Division continues to rely on cooperative collateral to get the word out about Alaska. Brochures, maps and pamphlets are used to fulfill both consumer and trade requests. Partnerships have produced publications specific to the German-speaking and Japanese markets. The inclusion of the ferry schedule in Tourism North's "*North to Alaska!*," further enhances that publication's efforts in promoting increased highway travel. Albeit in smaller quantities due to budget cutbacks, the Official State Map as well as other specific niche publications (sportfishing, wildlife viewing, and the student handbook) are distributed along with the Official State Vacation Planner and community and regional planners. The Gold Rush Centennial Celebration publication, the "Gold Rush Trails and Time Line," continues to find its way into the hands of the travel trade, press, and potential visitors.

Information Flow

The Division inquiry section regularly responds to calls and letters from future visitors. While some require mailed responses (such as maps or brochures), the greatest amount of time is spent responding to both trade and consumer questions from the simplest, to the more complex itinerary-related inquiries. Those already on their Alaska journey enjoy the hospitality and information provided by Division staff at the Alaska Public Lands Information Center (and reservation office for the Alaska Marine Highway System) in Tok.

Division staff also assist tour operators and travel agents in their efforts to sell Alaska, providing ideas for future Alaska programs or assisting a travel agent with understanding how to get a client from "here to there."

On the World Wide Web

The Division's extensive web site (www.dced.state.ak.us/tourism/) links communities, the travel trade, press, and consumers to research, publications, industry information, community development guidelines, business development resources, destination and activity information.

Alaska Division of Tourism Staff

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Notes

No: 1

FISCAL NOTE

Bill Version: CSHB 420(FIN)
(H) Publish Date: 3/6/00

STATE OF ALASKA
2000 LEGISLATIVE SESSION

Revision Date/Time (Note if correction)
Dept. Affected: Community & Econ Dev
Title: Tourism Marketing Contracts
BRU: Tourism
Component:
Sponsor: Finance
Requester: Finance
Component No.: 2278

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:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

General Concerns:
- It will be difficult to anticipate the amount available for a contract or to sign a binding contract without a specific amount appropriated.
- Difficult to engage in contract negotiations during the session.
- August was the date approved by the industry last year as a good time for the contract, since it is a relatively quiet time of year.

Section 3, Specific issues relating to this year's implementation:
- Marketing plan must be approved by Department which must include many components (see AS 44.33.125(b); no plan yet proposed, and ATIA marketing committee just appointed 2 weeks ago.
-ATIA must provide matching funds: fundraising March through May, thus will not be fully available by May 1.
- ATIA may not qualify as the QTA, at least until membership is set in late May. See 44.33.125 (j).

Prepared by: Jeff Bush | Phone: 465-2500
Division: Commissioner's Office | Date/Time: 3/3/00 4:55 PM
Approved by Commissioner Deborah Sedwick [signature] | Date: 3/3/00
Agency: Community & Economic Development

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COMMITTEE COPY

HB

422

FISCAL NOTE

STATE OF ALASKA
2000 LEGISLATIVE SESSION

BILL NO. HB 422

Revision Date/Time (Note if correction):
Title: Workers' Compensation: Drugs & Alcohol
Sponsor: House L&C
Requestor: House L&C

Department Affected: Labor & Workforce Development
BRU: Workers' Compensation
Component: Workers' Compensation
COMPONENT SERIAL NO. 344

EXPENDITURES/REVENUES: (Thousands of Dollars)

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

OPERATING	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						
CHANGE IN REVENUE FUND SOURCE #						

FUNDING: (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipt						
1006 GF/MHTIA						
Other (New Fund)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of current year (FY00) impact: $ 0.0

ANALYSIS: (Attach a separate page if necessary)

This bill bars an employee's workers' compensation claim if the injury is a result of the employee's willful consumption of an alcoholic beverage or the result of the employee's use of drugs unless the drugs were taken as prescribed by the employee's physician. The department does not anticipate an increase in operating costs as a result of this bill.

Prepared by: Paul Grossl, Director
Division: Workers' Compensation
Phone: 465-2790
Date/Time: 3/7/00 9:13 AM

Approved by Commissioner: Ed Flanagan, Commissioner
Agency: Department of Labor
Date: 3/7/00

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ALASKA STATE LEGISLATURE
HOUSE LABOR AND COMMERCE COMMITTEE

Representative Norman Rokeberg, Chairman
Representative Andrew Halcro, Vice-Chairman
Representative John Harris
Representative Lisa Murkowski
Representative Jerry Sanders
Representative Tom Brice
Representative Sharon Cissna

State Capitol
Juneau, AK 99801-1182
Telephone: (907) 465-4954
Fax: (907) 465-2040

HOUSE BILL 422
An Act relating to workers' compensation benefits for injuries resulting from consumption of alcohol or use of drugs; and providing for an effective date

House Bill 422 would strengthen workers' compensation laws concerning an employee's use of alcohol or drugs that might lead to an on-the-job accident.

Many Alaskan employers have adopted written policies concerning use of drugs and/or alcohol on the job or being under the influence of such items while at a job site. The State should support those employers who have a zero tolerance policy. Workers' compensation is a system to compensate workers for injuries sustained on the job; however, if that injury is caused by a violation of a state or federal law or employment policy concerning consumption or influence of drugs or alcohol, the employer should not bear the full brunt of the cost of the accident.

While Alaska law does currently cover intoxication and a person being under the influence of drugs, HB 422 would strengthen these sections of current law. It would be made clear that no compensation would be payable in incidents in which an injury was proximately caused by the consumption of an alcoholic beverage or employee's use of drugs. It should be noted that drugs prescribed by a physician would not cause worker's compensation to be loss.

HB 422 would only apply to injuries occurring on or after the effective date of the bill, which is July 1, 2000.

ED1:03/02/00

ALASKA STATE LEGISLATURE
HOUSE LABOR AND COMMERCE COMMITTEE

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State Capitol
Juneau, AK 99801-1182
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Fax: (907) 465-2040

HOUSE BILL 422

An Act relating to workers' compensation benefits for injuries resulting from consumption of alcohol or use of drugs; and providing for an effective date

Section 1: Amends 23.30.080 - Employer's failure to insure: Amends to replace "intoxication" with "consumption of an alcoholic beverage".

Section 2: Amends 23.30.120 - Presumptions: Amends presumption statute to reflect consumption of alcoholic beverage and employee's use of drugs.

Section 3: Amends 23.30.235 - Causes in which no compensation is paid: Amends to reflect consumption of alcoholic beverages or employee's use of drugs.

Section 4: Applicability: Act applies to injuries on or after effective date.

Section 5: Effective Date: July 1, 2000.

CHARR
STRENGTH THROUGH UNITY

Alaska Cabaret, Hotel,
Restaurant & Retailers Association

1111 East 80th Ave., Suite 3 • Anchorage, Alaska 99518
(907) 274-8133 • Fax: (907) 274-8640
Toll Free In Alaska: (800) 478-2427

March 24, 2000

Representative Rokeberg
Attention: Janet
716 W. 4th Ave
Anchorage, AK 99501-2133

Dear Janet,

I am writing regarding House Bill 422, an Act relating to workers' compensation benefits for injuries resulting from consumption of alcohol or use of drugs; and providing for an effective date.

Would you please define the parameter of deciding what "willful consumption of alcoholic beverages" is, and how this would be determined? Will we subject the injured party to compromise and incriminate themselves?

We are interested in hearing a scenario of this injury happening in an office, and how it would be handled.

Sincerely,

Kac'e McDowell

Kac'e McDowell
Executive Director, AK CHARR

RECE[illegible]D
MAR 24 2000

3/21/00

RECEIVED
MAR 2 3 2000

Alaska State Legislature
Representative Norman Rokeberg
State Capital MS 3100
Juneau, Alaska 99801-1182

Dear Representative Rokeberg:

I am writing in support of House Bill 422, an act relating to workers' compensation benefits for injuries resulting from consumption of alcohol or use of drugs. This legislation is sorely needed by employers in the Alaskan workplace where many job duties can be dangerous, even under the best conditions, but made more hazardous by the illegal use of drugs or misuse of alcohol.

WorkSafe provides drug and alcohol testing and program management services to over 2,500 for-profit businesses and governmental organizations. A number of WorkSafe's customers are oilfield service companies that employ workers whose jobs support or are located on the North Slope. These employers help drive the Alaskan economy but are sometimes hampered by workers' compensation claims from employees who have engaged in use of illegal drugs in general or unauthorized consumption of an alcoholic beverage during work hours, which has contributed to the occurrence of accidents and an unsafe work environment. House Bill 422 makes a change to current law, which would exempt employers from responsibility for workers' compensation benefits to injured employees who test positive for illegal drugs or an alcoholic beverage immediately after an accident in the workplace.

In order to deny workers' compensation benefits, the current law requires employers to prove an employee was "intoxicated" or "under the influence" at the time of the accident, which is difficult and, in some cases, impossible with current testing technology. As a result, employers are forced to pay