

112TH CONGRESS
1ST SESSION

H. R. 1394

To establish a comprehensive interagency response to reduce lung cancer mortality in a timely manner.

IN THE HOUSE OF REPRESENTATIVES

APRIL 6, 2011

Mrs. CHRISTENSEN (for herself and Mr. LOBIONDO) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Armed Services and Veterans' Affairs, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To establish a comprehensive interagency response to reduce lung cancer mortality in a timely manner.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Lung Cancer Mortality
5 Reduction Act of 2011".

6 **SEC. 2. FINDINGS.**

7 Congress makes the following findings:

1 (1) Lung cancer is the leading cause of cancer
2 death for both men and women, accounting for 28
3 percent of all cancer deaths.

4 (2) The National Cancer Institute estimates
5 that in 2010, there were 222,520 new diagnoses of
6 lung cancer and 157,300 deaths attributed to the
7 disease.

8 (3) According to projections published in the
9 Journal of Clinical Oncology in 2009, between 2010
10 and 2030, the incidence of lung cancer will increase
11 by 46 percent for women and by 58 percent for men.
12 The increase in the incidence of lung cancer among
13 minority communities during that time period will
14 range from 74 percent to 191 percent.

15 (4) Lung cancer causes more deaths annually
16 than the next 4 leading causes of cancer deaths,
17 colon cancer, breast cancer, prostate cancer, and
18 pancreatic cancer, combined.

19 (5) The 5-year survival rate for lung cancer is
20 only 15 percent, while the 5-year survival rate for
21 breast cancer is 89 percent, for prostate cancer 99
22 percent, and for colon cancer 65 percent. Yet in re-
23 search dollars per death, lung cancer is the least
24 funded of the major cancers.

1 (6) In 2001, the Lung Cancer Progress Review
2 Group of the National Cancer Institute stated that
3 funding for lung cancer research was “far below the
4 levels characterized for other common malignancies
5 and far out of proportion to its massive health im-
6 pact” and it gave the “highest priority” to the cre-
7 ation of an integrated multidisciplinary, multi-insti-
8 tutional research program. No comprehensive plan
9 has been developed.

10 (7) While smoking is the leading risk factor for
11 lung cancer, the President’s National Cancer Advi-
12 sory Board Report of 2010 identified radon as the
13 second leading cause of lung cancer and listed 15
14 other environmental contaminants strongly associa-
15 tion with lung cancer, and there is accumulating evi-
16 dence that hormonal and genetic factors may influ-
17 ence the onset.

18 (8) Lung cancer is the most stigmatized of all
19 the cancers and the only cancer blamed on patients,
20 whether they smoked or not.

21 (9) Nearly 20 percent of lung cancer patients
22 have never smoked. Sixty percent of individuals di-
23 agnosed with lung cancer are former smokers who
24 quit, often decades ago.

1 (10) Lung cancer in men and women who never
2 smoked is the sixth leading cause of cancer death.
3 Of individuals diagnosed with lung cancer who have
4 never smoked, $\frac{2}{3}$ of are women.

5 (11) Lung cancer is the leading cause of cancer
6 death in the overall population and in every major
7 ethnic grouping, including White, African-American,
8 Hispanic, Asian and Pacific Islander, American In-
9 dian, and Alaskan Native, with an even dispropor-
10 tionately higher impact on African-American males
11 that has not been addressed.

12 (12) Military personnel, veterans, and muni-
13 tions workers exposed to carcinogens such as Agent
14 Orange, crystalline forms of silica, arsenic, uranium,
15 beryllium, and battlefield fuel emissions have in-
16 creased risk for lung cancer.

17 (13) Only 16 percent of lung cancer is being di-
18 agnosed at an early stage and there were no targets
19 for the early detection or treatment of lung cancer
20 included in the Department of Health and Human
21 Services's "Healthy People 2010" or "Healthy Peo-
22 ple 2020".

23 (14) An actuarial analysis carried out by
24 Milliman Inc. and published in Population Health
25 Management Journal in 2009 indicated that early

1 detection of lung cancer could save more than
2 70,000 lives a year in the United States.

3 (15) A National Cancer Institute study in 2009
4 indicated that while the value of life lost to lung can-
5 cer will exceed \$433,000,000,000 a year by 2020, a
6 4-percent annual decline in lung cancer mortality
7 would reduce that amount by more than half.

8 (16) In 2010, the National Cancer Institute re-
9 leased initial results from the National Lung Screen-
10 ing Trial, a large-scale randomized national trial
11 that compared the effect of low-dose helical com-
12 puted tomography (“CT”) and a standard chest x-
13 ray on lung cancer mortality. The study found 20
14 percent fewer lung cancer deaths among study par-
15 ticipants screened with the CT scan.

16 **SEC. 3. SENSE OF THE CONGRESS CONCERNING INVEST-**
17 **MENT IN LUNG CANCER RESEARCH.**

18 It is the sense of the Congress that—

19 (1) lung cancer mortality reduction should be
20 made a national public health priority; and

21 (2) a comprehensive mortality reduction pro-
22 gram coordinated by the Secretary of Health and
23 Human Services is justified and necessary to ade-
24 quately address all aspects of lung cancer and re-

1 “(1) With respect to the National Institutes of
2 Health—

3 “(A) a strategic review and prioritization
4 by the National Cancer Institute of research
5 grants to achieve the goal of the lung cancer
6 mortality reduction program in reducing lung
7 cancer mortality;

8 “(B) the provision of funds to enable the
9 Airway Biology and Disease Branch of the Na-
10 tional Heart, Lung, and Blood Institute to ex-
11 pand its research programs to include pre-
12 dispositions to lung cancer, the interrelationship
13 between lung cancer and other pulmonary and
14 cardiac disease, and the diagnosis and treat-
15 ment of these interrelationships;

16 “(C) the provision of funds to enable the
17 National Institute of Biomedical Imaging and
18 Bioengineering to expedite the development of
19 screening, diagnostic, surgical, treatment, and
20 drug testing innovations to facilitate the poten-
21 tial of imaging as a biomarker and reduce lung
22 cancer mortality, such as through expansion of
23 the Quantum Grant Program and Image-Guid-
24 ed Interventions programs of the National In-

1 stitute of Biomedical Imaging and Bio-
2 engineering;

3 “(D) the provision of funds to enable the
4 National Institute of Environmental Health
5 Sciences to implement research programs rel-
6 ative to lung cancer incidence; and

7 “(E) the provision of funds to enable the
8 National Institute on Minority Health and
9 Health Disparities to collaborate on prevention,
10 early detection, and disease management re-
11 search, and to conduct outreach programs in
12 order to address the impact of lung cancer on
13 minority populations.

14 “(2) With respect to the Food and Drug Ad-
15 ministration, the provision of funds to enable the
16 Center for Devices and Radiologic Health to—

17 “(A) establish quality standards and guide-
18 lines for hospitals, outpatient departments, clin-
19 ics, radiology practices, mobile units, physician
20 offices, or other facilities that conduct com-
21 puted tomography screening for lung cancer;

22 “(B) provide for the expedited revision of
23 standards and guidelines, as required to accom-
24 modate technological advances in imaging; and

1 “(C) conduct an annual random sample
2 survey to review compliance and evaluate dose
3 and accuracy performance.

4 “(3) With respect to the Centers for Disease
5 Control and Prevention—

6 “(A) the provision of funds to establish a
7 Lung Cancer Early Detection Program that
8 provides low-income, uninsured, and under-
9 served populations that are at high risk for
10 lung cancer access to early detection services;

11 “(B) the provision of funds to enable the
12 National Institute for Occupational Safety and
13 Health to conduct research on environmental
14 contaminants strongly associated with lung can-
15 cer in the workplace and implement measures
16 to reduce lung cancer risk and provide for an
17 early detection program; and

18 “(C) a requirement that State, tribal, and
19 territorial plans developed under the National
20 Comprehensive Cancer Control Program include
21 lung cancer mortality reduction measures com-
22 mensurate with the public health impact of lung
23 cancer.

24 “(4) With respect to the Agency for Healthcare
25 Research and Quality, the annual review of lung

1 cancer early detection methods, diagnostic and treat-
2 ment protocols, and the issuance of updated guide-
3 lines.

4 “(5) The cooperation and coordination of all
5 programs for women, minorities, and health dispari-
6 ties within the Department of Health and Human
7 Services to ensure that all aspects of the Lung Can-
8 cer Mortality Reduction Program adequately address
9 the burden of lung cancer on women and minority,
10 rural, and underserved populations.

11 “(6) The cooperation and coordination of all to-
12 bacco control and cessation programs within agen-
13 cies of the Department of Health and Human Serv-
14 ices to achieve the goals of the Lung Cancer Mor-
15 tality Reduction Program with particular emphasis
16 on the coordination of drug and other cessation
17 treatments with early detection protocols.”.

18 **SEC. 5. DEPARTMENT OF DEFENSE AND THE DEPARTMENT**
19 **OF VETERANS AFFAIRS.**

20 The Secretary of Defense and the Secretary of Vet-
21 erans Affairs shall coordinate with the Secretary of Health
22 and Human Services—

23 (1) in developing the Lung Cancer Mortality
24 Reduction Program under section 399V–6 of the
25 Public Health Service Act, as added by section 4;

1 rector of the Centers for Disease Control and Prevention,
2 the Commissioner of Food and Drugs, the Administrator
3 of the Centers for Medicare & Medicaid Services, and the
4 other members of the Lung Cancer Advisory Board estab-
5 lished under section 7 of the Lung Cancer Mortality Re-
6 duction Act of 2011, shall establish a demonstration
7 project, to be known as the Lung Cancer Computed To-
8 mography Screening and Treatment Demonstration
9 Project (referred to in this section as the “demonstration
10 project”).

11 (c) PROGRAM REQUIREMENTS.—The Secretary shall
12 ensure that the demonstration project—

13 (1) identifies the optimal risk populations that
14 would benefit from screening;

15 (2) develops the most effective, safe, equitable
16 and cost-efficient process for screening and early
17 disease management;

18 (3) allows for continuous improvements in qual-
19 ity controls for the process; and

20 (4) serves as a model for the integration of
21 health information technology and the concept of a
22 rapid learning into the health care system.

23 (d) PARTICIPATION.—The Secretary shall select not
24 less than 5 National Cancer Institute Centers, 5 Depart-
25 ment of Defense Medical Treatment Centers, 5 sites with-

1 in the Veterans Affairs Healthcare Network, 5 Inter-
2 national Early Lung Cancer Action Program sites, 10
3 community health centers for minority and underserved
4 populations, and additional sites as the Secretary deter-
5 mines appropriate, as sites to carry out the demonstration
6 project described under this section.

7 (e) QUALITY STANDARDS AND GUIDELINES FOR LI-
8 CENSING OF TOMOGRAPHY SCREENING FACILITIES.—The
9 Secretary shall establish quality standards and guidelines
10 for the licensing of hospitals, outpatient departments, clin-
11 ics, radiology practices, mobile units, physician offices, or
12 other facilities that conduct computed tomography screen-
13 ing for lung cancer through the demonstration project,
14 that will require the establishment and maintenance of a
15 quality assurance and quality control program at each
16 such facility that is adequate and appropriate to ensure
17 the reliability, clarity, and accuracy of the equipment and
18 interpretation of the screening scan and set appropriate
19 standards to control the levels of radiation dose.

20 (f) TIMEFRAME.—The Secretary shall conduct the
21 demonstration project under this section for a 5-year pe-
22 riod.

23 (g) REPORT.—Not later than 180 days after the date
24 of enactment of this Act, the Secretary shall submit a re-
25 port to Congress on the projected cost of the demonstra-

1 tion project, and shall submit annual reports to Congress
2 thereafter on the progress of the demonstration project
3 and preliminary findings.

4 **SEC. 7. LUNG CANCER ADVISORY BOARD.**

5 (a) IN GENERAL.—The Secretary of Health and
6 Human Services shall establish a Lung Cancer Advisory
7 Board (referred to in this section as the “Board”) to mon-
8 itor the programs established under this Act (and the
9 amendments made by this Act), and provide annual re-
10 ports to Congress concerning benchmarks, expenditures,
11 lung cancer statistics, and the public health impact of such
12 programs.

13 (b) COMPOSITION.—The Board shall be composed
14 of—

15 (1) the Secretary of Health and Human Serv-
16 ices;

17 (2) the Secretary of Defense;

18 (3) the Secretary of Veterans Affairs;

19 (4) the Director of the Occupational Safety and
20 Health Administration;

21 (5) the Director of the National Institute of
22 Standards and Technology; and

23 (6) one representative each from the fields of
24 clinical medicine focused on lung cancer, lung cancer
25 research, radiology, imaging research, drug develop-

1 ment, minority health advocacy, veterans service or-
2 ganizations, lung cancer advocacy, and occupational
3 medicine to be appointed by the Secretary of Health
4 and Human Services.

5 **SEC. 8. AUTHORIZATION OF APPROPRIATIONS.**

6 To carry out this Act (and the amendments made by
7 this Act), there are authorized to be appropriated such
8 sums as may be necessary for each of fiscal years 2012
9 through 2016.

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