

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       duce lung cancer mortality among current smokers,  
2       former smokers, and non-smokers.

3   **SEC. 4. LUNG CANCER MORTALITY REDUCTION PROGRAM.**

4       Part P of title III of the Public Health Service Act  
5   (42 U.S.C. 280g et seq.) is amended by adding at the end  
6   the following:

7   **“SEC. 399V-6. LUNG CANCER MORTALITY REDUCTION PRO-**  
8                   **GRAM.**

9       “(a) IN GENERAL.—Not later than 180 days after  
10   the date of enactment of the Lung Cancer Mortality Re-  
11   duction Act of 2011, the Secretary, in consultation with  
12   the Secretary of Defense, the Secretary of Veterans Af-  
13   fairs, the Director of the National Institutes of Health,  
14   the Director of the Centers for Disease Control and Pre-  
15   vention, the Commissioner of Food and Drugs, the Admin-  
16   istrator of the Centers for Medicare & Medicaid Services,  
17   the Director of the National Center on Minority Health  
18   and Health Disparities, and other members of the Lung  
19   Cancer Advisory Board established under section 7 of the  
20   Lung Cancer Mortality Reduction Act of 2011, shall im-  
21   plement a comprehensive program to achieve a 50-percent  
22   reduction in the mortality rate of lung cancer by 2020.

23       “(b) REQUIREMENTS.—The program implemented  
24   under subsection (a) shall include at least the following:

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-

stitute of Biomedical Imaging and Bio-engineering;

“(D) the provision of funds to enable the National Institute of Environmental Health Sciences to implement research programs relative to lung cancer incidence; and

“(E) the provision of funds to enable the National Institute on Minority Health and Health Disparities to collaborate on prevention, early detection, and disease management research, and to conduct outreach programs in order to address the impact of lung cancer on minority populations.

“(2) With respect to the Food and Drug Administration, the provision of funds to enable the Center for Devices and Radiologic Health to—

“(A) establish quality standards and guidelines for hospitals, outpatient departments, clinics, radiology practices, mobile units, physician offices, or other facilities that conduct computed tomography screening for lung cancer;

“(B) provide for the expedited revision of standards and guidelines, as required to accommodate 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           (2) in implementing the demonstration project  
2           under section 6 within the Department of Defense  
3           and the Department of Veterans Affairs with respect  
4           to military personnel and veterans whose smoking  
5           history and exposure to carcinogens during active  
6           duty service has increased their risk for lung cancer;  
7           and

8           (3) in implementing coordinated care programs  
9           for military personnel and veterans diagnosed with  
10          lung cancer.

11 **SEC. 6. LUNG CANCER SCREENING DEMONSTRATION**  
12 **PROJECT.**

13          (a) SENSE OF THE CONGRESS.—It is the sense of the  
14 Congress that a national computed tomography lung can-  
15 cer screening demonstration project should be carried out  
16 expeditiously in order to assess the public health infra-  
17 structure needs and to develop the most effective, safe,  
18 equitable, and efficient process that will maximize the pub-  
19 lic health benefits of screening.

20          (b) DEMONSTRATION PROJECT IN GENERAL.—Not  
21 later than 1 year after the date of enactment of this Act,  
22 the Secretary of Health and Human Services (referred to  
23 in this Act as the “Secretary”), in consultation with the  
24 Secretary of Defense, the Secretary of Veterans Affairs,  
25 the Director of the National Institutes of Health, the Di-

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-

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

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

(a) IN GENERAL.—The Secretary of Health and Human Services shall establish a Lung Cancer Advisory Board (referred to in this section as the “Board”) to monitor the programs established under this Act (and the amendments made by this Act), and provide annual reports to Congress concerning benchmarks, expenditures, lung cancer statistics, and the public health impact of such programs.

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

(1) the Secretary of Health and Human Services;

(2) the Secretary of Defense;

(3) the Secretary of Veterans Affairs;

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

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

(6) one representative each from the fields of clinical medicine focused on lung cancer, lung cancer 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.

○