

112TH CONGRESS  
1ST SESSION

# S. 752

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

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## IN THE SENATE OF THE UNITED STATES

APRIL 6 (legislative day, APRIL 5), 2011

Mrs. FEINSTEIN (for herself, Mr. ISAKSON, and Mr. KERRY) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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## 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:

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

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

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

12          (4) Lung cancer causes more deaths annually  
13          than the next 4 leading causes of cancer deaths,  
14          colon cancer, breast cancer, prostate cancer, and  
15          pancreatic cancer, combined.

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

22          (6) In 2001, the Lung Cancer Progress Review  
23          Group of the National Cancer Institute stated that  
24          funding for lung cancer research was “far below the  
25          levels characterized for other common malignancies

1 and far out of proportion to its massive health im-  
2 pact” and it gave the “highest priority” to the cre-  
3 ation of an integrated multidisciplinary, multi-insti-  
4 tutional research program. No comprehensive plan  
5 has been developed.

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

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

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

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

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

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

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

19           (14) An actuarial analysis carried out by  
20 Milliman Inc. and published in Population Health  
21 Management Journal in 2009 indicated that early  
22 detection of lung cancer could save more than  
23 70,000 lives a year in the United States.

24           (15) A National Cancer Institute study in 2009  
25 indicated that while the value of life lost to lung can-

1 cer will exceed \$433,000,000,000 a year by 2020, a  
2 4 percent annual decline in lung cancer mortality  
3 would reduce that amount by more than half.

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

12 **SEC. 3. SENSE OF THE SENATE CONCERNING INVESTMENT**  
13 **IN LUNG CANCER RESEARCH.**

14 It is the sense of the Senate that—

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

17 (2) a comprehensive mortality reduction pro-  
18 gram coordinated by the Secretary of Health and  
19 Human Services is justified and necessary to ade-  
20 quately address all aspects of lung cancer and re-  
21 duce lung cancer mortality among current smokers,  
22 former smokers, and non-smokers.

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

2 Part P of title III of the Public Health Service Act  
3 (42 U.S.C. 280g et seq.) is amended by adding at the end  
4 the following:

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

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

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

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

25 “(A) a strategic review and prioritization  
26 by the National Cancer Institute of research

1 grants to achieve the goal of the lung cancer  
2 mortality reduction program in reducing lung  
3 cancer mortality;

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

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

23 “(D) the provision of funds to enable the  
24 National Institute of Environmental Health

1 Sciences to implement research programs rel-  
2 ative to lung cancer incidence; and

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

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

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

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

21 “(C) conduct an annual random sample  
22 survey to review compliance and evaluate dose  
23 and accuracy performance.

24 “(3) With respect to the Centers for Disease  
25 Control and Prevention—



1           “(A) the provision of funds to establish a  
2 Lung Cancer Early Detection Program that  
3 provides low-income, uninsured, and under-  
4 served populations that are at high risk for  
5 lung cancer access to early detection services;

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

13           “(C) a requirement that State, tribal, and  
14 territorial plans developed under the National  
15 Comprehensive Cancer Control Program include  
16 lung cancer mortality reduction measures com-  
17 mensurate with the public health impact of lung  
18 cancer.

19           “(4) With respect to the Agency for Healthcare  
20 Research and Quality, the annual review of lung  
21 cancer early detection methods, diagnostic and treat-  
22 ment protocols, and the issuance of updated guide-  
23 lines.

24           “(5) The cooperation and coordination of all  
25 programs for women, minorities, and health dispari-

1 ties within the Department of Health and Human  
2 Services to ensure that all aspects of the Lung Can-  
3 cer Mortality Reduction Program adequately address  
4 the burden of lung cancer on women and minority,  
5 rural, and underserved populations.

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

13 **SEC. 5. DEPARTMENT OF DEFENSE AND THE DEPARTMENT**  
14 **OF VETERANS AFFAIRS.**

15 The Secretary of Defense and the Secretary of Vet-  
16 erans Affairs shall coordinate with the Secretary of Health  
17 and Human Services—

18 (1) in developing the Lung Cancer Mortality  
19 Reduction Program under section 399V-6 of the  
20 Public Health Service Act, as added by section 4;

21 (2) in implementing the demonstration project  
22 under section 6 within the Department of Defense  
23 and the Department of Veterans Affairs with respect  
24 to military personnel and veterans whose smoking  
25 history and exposure to carcinogens during active

1 duty service has increased their risk for lung cancer;  
2 and

3 (3) in implementing coordinated care programs  
4 for military personnel and veterans diagnosed with  
5 lung cancer.

6 **SEC. 6. LUNG CANCER SCREENING DEMONSTRATION**  
7 **PROJECT.**

8 (a) SENSE OF THE SENATE.—It is the sense of the  
9 Senate that a national computed tomography lung cancer  
10 screening demonstration project should be carried out ex-  
11 peditiously in order to assess the public health infrastruc-  
12 ture needs and to develop the most effective, safe, equi-  
13 table, and efficient process that will maximize the public  
14 health benefits of screening.

15 (b) DEMONSTRATION PROJECT IN GENERAL.—Not  
16 later than 1 year after the date of enactment of this Act,  
17 the Secretary of Health and Human Services (referred to  
18 in this Act as the “Secretary”), in consultation with the  
19 Secretary of Defense, the Secretary of Veterans Affairs,  
20 the Director of the National Institutes of Health, the Di-  
21 rector of the Centers for Disease Control and Prevention,  
22 the Commissioner of Food and Drugs, the Administrator  
23 of the Centers for Medicare & Medicaid Services, and the  
24 other members of the Lung Cancer Advisory Board estab-  
25 lished under section 7 of the Lung Cancer Mortality Re-

1 duction Act of 2011, shall establish a demonstration  
2 project, to be known as the Lung Cancer Computed To-  
3 mography Screening and Treatment Demonstration  
4 Project (referred to in this section as the “demonstration  
5 project”).

6 (c) PROGRAM REQUIREMENTS.—The Secretary shall  
7 ensure that the demonstration project—

8 (1) identifies the optimal risk populations that  
9 would benefit from screening;

10 (2) develops the most effective, safe, equitable  
11 and cost-efficient process for screening and early  
12 disease management;

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

15 (4) serves as a model for the integration of  
16 health information technology and the concept of a  
17 rapid learning into the health care system.

18 (d) PARTICIPATION.—The Secretary shall select not  
19 less than 5 National Cancer Institute Centers, 5 Depart-  
20 ment of Defense Medical Treatment Centers, 5 sites with-  
21 in the Veterans Affairs Healthcare Network, 5 Inter-  
22 national Early Lung Cancer Action Program sites, 10  
23 community health centers for minority and underserved  
24 populations, and additional sites as the Secretary deter-

1 mines appropriate, as sites to carry out the demonstration  
2 project described under this section.

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

16 (f) TIMEFRAME.—The Secretary shall conduct the  
17 demonstration project under this section for a 5-year pe-  
18 riod.

19 (g) REPORT.—Not later than 180 days after the date  
20 of enactment of this Act, the Secretary shall submit a re-  
21 port to Congress on the projected cost of the demonstra-  
22 tion project, and shall submit annual reports to Congress  
23 thereafter on the progress of the demonstration project  
24 and preliminary findings.

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

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

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

12 (1) the Secretary of Health and Human Serv-  
13 ices;

14 (2) the Secretary of Defense;

15 (3) the Secretary of Veterans Affairs;

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

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

20 (6) one representative each from the fields of  
21 clinical medicine focused on lung cancer, lung cancer  
22 research, radiology, imaging research, drug develop-  
23 ment, minority health advocacy, veterans service or-  
24 ganizations, lung cancer advocacy, and occupational  
25 medicine to be appointed by the Secretary of Health  
26 and Human Services.

1 **SEC. 8. AUTHORIZATION OF APPROPRIATIONS.**

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

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