August 26, 2013

RE: Finalization of USPSTF’s Recommendations for Lung Cancer Screening

Dear Chairman Moyer:

The National Congress of American Indians, National Indian Health Board, and National Council of Urban Indian Health write in support of the draft recommendations issued on July 29, 2013 by United States Preventative Services Task Force (USPSTF) which gave low dose CT screening for the early detection of lung cancer in certain high risk populations a “B” rating. This “B” rating is the second highest rating, and if finalized in a timely manner, will be a crucial first step in ensuring that lung cancer screening is equitably and responsibly deployed.

Lung cancer is the leading cause of all cancer deaths, taking nearly as many lives each year as breast, prostate, colon and pancreatic cancers combined. This is a growing concern for tribal communities, because American Indians and Alaska Natives have the third highest incidence rate of lung cancer after African Americans (74.7 per 100,000) and Caucasians (64.4 per 100,000). Our population also has the third highest age-adjusted mortality rate due to lung cancer. Approximately 35.2 per 100,000 American Indian and Alaska Native deaths can be attributed to lung cancer, compared with 54.7 per 100,000 Caucasians, and 57.9 per 100,000 African Americans.

In 2006, the age-adjusted incidence rate of lung cancer for the American Indians and Alaska Natives was 44.9 per 100,000. In addition, lung cancer cases among American Indians and Alaska Natives are diagnosed before 65 years of age 39.6 percent more often (41.6%) than among Caucasians (29.8%).

Generally, lung cancer is the leading cancer killer of women, taking more lives than breast and all gynecological cancers combined. For veterans, conservative estimates show a 25% higher incidence and mortality rate from lung cancer, compared to the general population.

In November 2010, the National Lung Cancer Screening Trial (NLST) – one of the largest and most expensive randomized controlled cancer trials ever conducted by the National Cancer Institute (NCI) -- provided conclusive evidence that CT screening can diagnose lung cancer at an earlier, more treatable stage and significantly reduce deaths. Such early detection is a key component in winning the battle against lung cancer. Lung cancer’s 5-year survival rate is 15% and this survival rate has changed little in the past forty years. The reason for this stagnation in survival rates is because lung cancer is generally asymptomatic until late stage when it has spread to other organs and treatment options are limited and sadly, futile in almost all cases. However, recommendations put forward by the USPSTF can significantly change the current trajectory. When lung cancer is caught at an early stage, it is highly treatable, in many cases using minimally invasive surgery and without requiring chemotherapy or radiation.
Given its proven lifesaving benefit, we are gratified that USPSTF has awarded lung cancer screening such a high recommendation. To the extent we have concerns with these recommendations, they relate to access to screening. Too often, the communities we represent are among the last to receive the full benefit of newly available screenings or treatments. We are still seeing access disparities with regard to mammography and colorectal cancer screening in some of our communities. Despite these challenges, we are committed to ensuring that this same pattern is not repeated with lung cancer screening.

In addition to maintaining the recommendation for a "B" rating, timing of the final recommendations will impact access in our communities. Responsible and effective lung cancer screening has long been available to those who can afford to pay for it out of pocket. However, the only way to ensure equitable access to everyone at risk, including American Indians and Alaska Natives, is to ensure that lung cancer screening is covered as an Essential Health Benefit in the qualified health plans offered in the health insurance marketplaces.

As described in the Affordable Care Act (ACA), the qualified health plans offered in the health insurance marketplaces are only required to cover new A or B rated preventive services “within one year of the plan’s anniversary date.” Presuming the draft recommendation stands and the timeline is extended too long, this provision could mean that nearly two years could pass before some plans are required to cover lung cancer screening. For example, if the final recommendations are released on January 26, 2014, those plans that are part of the health exchanges with an anniversary date of January 1, 2014 would not be required to cover screening until one year from the 2015 anniversary date of the plan. That would mean issuers would not have to provide coverage until January 1, 2016 – nearly two years later.

With so many lives lost to lung cancer each day, every day matters in the battle against this deadly disease. We urge the USPSTF to move expeditiously in finalizing its recommendations on lung cancer screening so that this life saving benefit can be moved into the public health infrastructure without unnecessary delay.

Thank you for considering our views.

Respectfully submitted,

Jefferson Keel  
President  
NCAI

Cathy Abramson  
Chairwoman  
NIHB

Moke Eaglefeathers  
President  
NCUIH
Organizational Information:

**National Congress of American Indians**
Formed in 1944, the National Congress of American Indians (NCAI) is the oldest, largest, and most representative Native organization in the country. It is a membership organization that represents the broad interests of tribal governments in the U.S. Its mission is to protect and enhance tribal sovereignty. NCAI’s members – and leadership – are elected tribal officials who have the opportunity to implement innovative policy that can change the discourse on a range of key policy issues. Since its inception, NCAI has been working to inform the public and Congress about the governmental rights of American Indians and Alaska Natives and the ability of tribes to self-govern and engage in their own governmental policymaking. NCAI also serves as a forum for tribal nations – tribal nations seek out NCAI for unity, a common vision, and progressive policy and advocacy.

**National Indian Health Board**
Established over 40 years ago, the National Indian Health Board (NIHB) is a not for profit, charitable organization serving all 566 federally recognized Tribal governments. NIHB’s vision is creating one voice affirming and empowering American Indian and Alaska Native Peoples to protect and improve health and reduce health disparities. Whether Tribes operate their own health care delivery systems through contracting and compacting or receive health care directly from the Indian Health Services (IHS), NIHB is their national advocate. NIHB also conducts research; provides policy analysis; assists with program development, management and assessment; supports national and regional meeting planning; and provides training and technical assistance in a variety of Tribal health areas.

**National Council of Urban Indian Health**
The National Council of Urban Indian Health is a 501(c)(3), membership-based organization devoted to supporting its membership in the development of quality, accessible, and culturally competent healthcare programs for American Indians and Alaska Natives living in urban communities by serving as a resource center providing advocacy, education, technical assistance, training, and leadership.