

Lung cancer is the leading cause of cancer deaths in the U.S. However, the five-year survival rate is four times higher for cases that are caught early, before the tumor spreads and when it is easier to treat. Nationally, only 16% of eligible individuals are being screened for lung cancer. This document provides an overview of ways to elevate lung cancer screening that advocates and stakeholders can work from and incorporate into their state comprehensive cancer control plans and other activities.

Topic	Background	Examples
Identifying Current Lung Cancer Screening Guidelines	<p>The United States Preventive Services Task Force (USPSTF) recommends that adults ages 50–80 with a 20 pack-year history who currently smoke or have quit in the last 15 years receive annual screening for lung cancer with low-dose computed tomography (LDCT). These guidelines have a Grade B and were updated in 2021.</p>	<p>Texas’ plan clearly identifies the updated screening guidelines as recommended by USPSTF:</p> <p><i>The United States Preventive Services Task Force recommends annual LDCT screening for lung cancer in adults aged 50 to 80 years who have a 20 pack/year smoking history and currently smoke or quit within the past 15 years.</i></p>
Setting State Lung Cancer Screening or Early Detection Goals	<p>Goals should focus on raising the screening rate or raising the early detection rate. Current lung cancer screening and early detection rates can be found in the State of Lung Cancer Report as a baseline for measuring goals.</p>	<p>Illinois’ plan establishes the state’s screening goals to raise screening rates with a timeline:</p> <p><i>Objective 1: Increase lung cancer screening among adults 50–80 years of age from 6.3% to 6.9% by 2027 (American Lung Association 2019).</i></p> <p>Florida’s plan establishes the state’s goal to raise the early detection rate:</p> <p><i>By 2025, within the population of Floridians newly diagnosed with lung cancer, increase the percentage of those with limited stage disease (Stage 1 and 2) from 34.5% (Baseline, 2016 FCDS) to 40% or higher.</i></p>
Reducing Structural Barriers to Lung Cancer Screening	<p>Structural barriers such as lack of transportation, distance to screening, lack of childcare, work schedules, availability of screening, language barriers, and prior authorizations have all been shown to impede access to cancer screening.¹</p>	<p>Ohio’s plan includes strategies to address barriers to screening among underserved populations:</p> <p><i>Increase the number of lung cancer screening sites; increase mobile access via mobile CT (computerized tomography) units, especially in southern Ohio Appalachian regions and underserved locations, and among populations with limited access to screening sites; and streamline the screening process from approval by insurers and providers to completion.</i></p>

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Reducing Out-Of-Pocket Costs	<p>Research consistently shows that higher cost-sharing, even small copays, is associated with decreased use of preventive services,² and patients who incur high out-of-pocket costs for lung cancer screening and follow-up are less likely to return for annual screening.³</p>	<p>California’s plan outlines strategies to reduce out-of-pocket costs for patients:</p> <p><i>Decrease or eliminate copays for visits for initial lung cancer screening or follow-up procedures or tests...Eliminate out-of-pocket costs for both screening LDCTs and follow-up LDCTs for all Medi-Cal insurance plans.</i></p>
Addressing Differences in Prevalence Among Communities	<p>Lung cancer screening reflects ongoing differences in prevalence among communities. Individuals of color are less likely to be diagnosed early, and health coverage status can impact access to screening.⁴ Interventions are needed to improve access to screening for people in underserved communities.</p>	<p>Washington D.C.’s plan outlines goals for closing gaps in lung cancer diagnosis to address differences of prevalence among communities:</p> <p><i>Decrease the disparity (difference in time/# of days) from diagnosis to treatment between Blacks/African Americans and Whites. Lung Baseline (2018): 11. Lung Target (2026): 9.9</i></p>
Raising Awareness of Screening	<p>Other methods of improving lung cancer screening rates include building awareness and increasing education on screening within communities and health systems through a multi-faceted approach to include cross-promotion and integration.</p>	<p>In Texas’ plan, strategies to raise awareness of screening are divided into areas of implementation:</p> <p><i>For Schools...Work with families through parent-teacher organizations to raise awareness of the dangers of smoking and the importance of early screening for at-risk family members.</i></p> <p><i>For Community Organizations...Educate the public on the eligibility, risks, benefits and unknowns of lung cancer screening and that screening is not a substitute for tobacco treatment.</i></p> <p><i>For Insurers...Engage high-risk populations through outreach campaigns that inform policyholders about their eligibility for lung cancer screenings and cessation support.</i></p> <p><i>For Hospitals and Health Systems...Promote and train health care professionals on lung cancer screening utilizing a patient/healthcare professional shared decision-making model and the USPSTF recommendations.</i></p>

References

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- ² Artiga, Samantha at al. The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings. KFF. June 1, 2017. Available at: <https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/>
- ³ Repeat Annual Lung Cancer Screening After Baseline Screening Among Screen-Negative Individuals: No-Cost Coverage Is Not Enough. Tailor, Tina D. et al. Journal of the American College of Radiology, Volume 20, Issue 1, 29 - 36
- ⁴ Racial and Ethnic Disparities, State of Lung Cancer. American Lung Association. November 13, 2024. Available at: <https://www.lung.org/research/state-of-lung-cancer/racial-and-ethnic-disparities>