Lung Cancer Screening With Low-Dose Computed Tomography for Medicare Beneficiaries

Robert Steinbrook, MD

Lung cancer, the vast majority of cases of which are caused by smoking, is the leading cause of cancer deaths in both men and women in the United States. In 2014, about 160,000 people are expected to die from lung cancer, accounting for about 27% of all cancer deaths.1

Although the prevention of deaths from lung cancer is a public health priority, the role of screening has been unclear. In 2011, the National Lung Screening Trial found that screening with low-dose computed tomography (CT) reduced mortality.2 In 2013, the US Preventive Services Task Force issued a B recommendation for screening with low-dose CT for high-risk current and former smokers, concluding that the screening was likely to offer moderate to substantial net benefit.3

In February 2014, the Centers for Medicare & Medicaid Services (CMS) initiated a “national coverage analysis” for lung cancer screening with low-dose CT for Medicare beneficiaries. In April 2014, CMS convened a meeting of the Medicare Evidence Development & Coverage Advisory Committee (MEDCAC) to review the available evidence. The committee voted that it had low to intermediate confidence that “there is adequate evidence to determine if the benefits outweigh the harms”4 in the Medicare population. MEDCAC does not make coverage recommendations; it reviews the evidence and answers the voting questions posed by CMS.

In this issue of JAMA Internal Medicine, we publish 2 Special Communications about lung cancer screening with low-dose CT. Wood argues for coverage of low-dose CT screening for Medicare beneficiaries because it “can lead to early diagnosis and cure for thousands of patients each year in the United States.”5 Woolf et al make the case against such coverage because “[i]t is unclear if routine screening would result in net good or net harm,” noting the potential for “false-positive results, patient anxiety, radiation exposure, numerous diagnostic workups, and the complications of these workups.”6 These articles should help inform readers about the quality of the available evidence and the issues that CMS should take into account before it issues a final decision, which is expected in 2015.

The decision about low-dose CT is one of the most consequential and closely watched coverage determinations that CMS has had to make in many years. At issue is not only whether low-dose CT will be covered but, if it is covered, the specifics, such as the number and frequency of scans, the beneficiaries who would be eligible, and the procedures to assure that scans are of high quality and that false-positive results are minimized. As CMS deliberates, an intensive lobbying effort is under way to influence the decision, with support from industry and various professional and advocacy organizations. In June 2014, 45 US Senators and 134 House Representatives, from both political parties, separately wrote to CMS to advocate for low-dose CT scans.

The CMS owes it to Medicare beneficiaries to reach a timely decision about the coverage of lung cancer screening with low-dose CT based on medical evidence, not lobbying or politics. I hope that it does.

Conflict of Interest Disclosures: Dr Steinbrook was a member of MEDCAC from 2010 to 2012. Rita F. Redberg, MD, MSc, the editor of JAMA Internal Medicine, is the chair of MEDCAC; as chair, Dr Redberg does not vote on voting questions before the committee. No other disclosures are reported.