



The Bleeding Edge of Rationing: Obama's Health Plan and the New Power of the United States Preventive Services Task Force

By Scott Gottlieb, MD

Under the Patient Protection and Affordable Care Act (PPACA), a previously obscure government advisory body has acquired vast authority to decide which health care services Americans will have access to. The United States Preventive Services Task Force (USPSTF) was created in 1984 as a government advisor with the mission of assessing the clinical utility of preventive health measures such as screening tests and issuing nonbinding recommendations about which measures doctors should incorporate into routine medical care. PPACA gives the USPSTF's recommendations the force of law, making them de facto mandates on which preventive services private health plans and public programs such as Medicare must pay for. Services that do not make the USPSTF grade are unlikely to be covered at all. The USPSTF was not designed to wield this kind of sweeping and binding authority. It does not maintain the transparency, deliberative process, appeal process, or requirements for public notice and comment that are hallmarks of sound regulatory policymaking. Moreover, because the USPSTF has few guidelines governing its function, it has great flexibility to adapt its criteria and grow its mandate in ways that may conflict with political goals and public sentiment and lead to unintended consequences.

In November 2009, the United States Preventive Services Task Force (USPSTF) said women age forty to forty-nine should not get routine mammograms. Almost instantly, a little known and largely marginalized government health agency was thrust onto the front pages of America's newspapers. What proved the most controversial aspects of the mammography proposal were some of the criteria the task force had considered in reaching its decision. Among other things, the USPSTF was weighing the benefit of breast cancer screening against the burden of letting some additional cancers go undetected.

To health professionals who had championed earlier, more widespread screening and to women who had heeded that advice, the new analysis

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Key points in this Outlook:

- Under President Obama's health care plan, the United States Preventive Services Task Force now wields great power to decide which health services (like mammograms) doctors should provide, yet it has few checks on its sweeping authority.
- Its mandates are likely to raise health insurance costs and premiums, while reducing the number of covered preventive services.
- To improve accountability for an agency that is both out of date with the medical community and out of touch with the public, Congress should closely monitor the impact new mandates have on patient care.

seemed callous and poorly conceived. Embedded in its analysis, the USPSTF also considered the cost of some of the newer screening modalities, such as digital mammography.¹ Critics of President Obama's new health care law quickly cited this verdict as emblematic of the rationing that the legislation would soon usher.

Of all the criticisms of PPACA, this critique was most firmly grounded in the plain language of the new statute. That is because, under PPACA, the USPSTF has acquired an expansive new mandate. Going forward, how the USPSTF grades preventive medical technologies will shape which preventive health services are covered by private health plans and public programs like Medicare.² In short, the USPSTF's decisions will bind much of the American health care market.

The USPSTF decision around breast cancer screening was widely rejected because it was so out of sync with other federal policy priorities. But this is not unusual, as the USPSTF has issued plenty of recommendations that have diverged with conventional clinical dogma. Many have even conflicted with advice offered by other federal agencies like the Centers for Disease Control (CDC). Previously, many of these USPSTF recommendations were simply ignored by practicing doctors. But with the passage of PPACA, the group's rulings cannot be disregarded any longer.

Now, the USPSTF is back in the news again, having recently issued another set of controversial decisions. In the first, it recommended against routine screening for prostate cancer with a simple, cheap, and widely used blood test for PSA (an enzyme released by the prostate when the gland's tissue becomes disrupted).³ In a separate decision, the task force recommended against screening for cervical cancer with a simple test for a virus that predisposes women to the cancer.⁴ In a recently released report to Congress, the USPSTF identified some of its additional "policy areas that deserve further examination." These include screening for colon cancer and heart disease and counseling for obesity. "Evidence gaps" that it says warrant further research include "screening and treatment for depression in children, screening and counseling for alcohol misuse in adolescents, [and] aspirin use to prevent heart attacks and stroke in adults ages 80 years and older."⁵

With all of these decisions, the task force is quickly becoming a household name. The Obama administration is touting the availability of free preventive services under PPACA as one of legislation's benefits, and the USPSTF is the body charged with designating which

services will be covered.⁶ But there are plenty of reasons to believe that the current construction of the USPSTF and the way it operates leave it unsuited to discharging its new authority.

A large problem is the lack of formal regulatory guardrails governing the USPSTF's operations. The task force started life as an advisory body and has now become a de facto regulatory agency. But there has been too little reflection along the way on how the body is organized and discharges its mission. Whether by accident or by political design, the USPSTF has evolved into a powerful health regulatory agency, but one with few of the requirements for transparency and due process that Americans have come to demand from their regulatory bodies.

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Many of these problems were on display in the USPSTF's recent recommendations on breast cancer screening. In reaching its decision, the task force said "the harms resulting from screening for breast cancer include psychological harms, unnecessary imaging tests and biopsies in women without cancer, and inconvenience due to false-positive screening results." When evaluating breast cancer screening, "one must also consider the harms associated with treatment of cancer that would not become clinically apparent during a woman's lifetime . . . as well as the harms of unnecessary earlier treatment of breast cancer that would have become clinically apparent but would not have shortened a woman's life," the task force wrote.⁷

In criticizing the decision, the American Cancer Society responded that the USPSTF had arbitrarily decided that screening 1,300 women to save a life was an acceptable cost but screening 1,900 to save a life was not.⁸ The USPSTF has no formal rules or guidance on how it arrives at this kind of analysis. As a result, not just clinicians are now questioning how the USPSTF reaches its decisions and the merit in investing its assessments with so much political clout.⁹ Even the political architects of the USPSTF's new authorities are expressing doubts.

In October 2010, when the USPSTF canceled a meeting at which it was due to recommend against prostate cancer screening for men of all ages, many figured that the Obama administration's political leadership had intervened to avoid another round of negative headlines about the USPSTF and its new mandates on access to health care.¹⁰ In the post-PPACA age, the USPSTF is the bleeding edge of the unaccountable and largely unpredictable Washington institutions that will start intruding themselves into public's available medical choices.

A Brief History of the USPSTF

The USPSTF was created twenty-five years ago as an independent advisory panel. It is composed of sixteen individuals with expertise in health prevention and primary care, most of whom are clinicians and academic experts. The USPSTF members are volunteers who are appointed to four-year terms by the director of the Agency for Healthcare Research and Quality (AHRQ). The USPSTF serves as an advice-giving body to that agency.

In recent years, prior to the passage of PPACA, the task force has had three main objectives. Its first mandate was to evaluate the benefits and risks of individual medical screening and diagnostic services based on age, gender, and risk factors for disease. Second, it was tasked with issuing recommendations about which preventive services should be incorporated routinely into primary medical care and for which populations. Third, it was supposed to identify a research agenda for clinical preventive care.

Initially, the group's work was mostly advisory. Its original mission was, simply stated, to "develop recommendations for primary care clinicians on the appropriate content of periodic health examinations."¹¹ It was left to doctors and patients to evaluate the recommendations and decide how to best incorporate them into clinical practice.

In its individual screening recommendations, the USPSTF gives a letter grade of A (strongly recommends) through D (recommends against). These grades are based on the task force's interpretation of the strength of medical evidence supporting a screening tool and its benefits versus clinical and (sometimes) economic costs. When the task force does not believe there is enough evidence to render a verdict, it will give a grade of I (insufficient evidence).

The USPSTF typically favors large prospective, randomized trials to validate a preventive service. But such

research is generally hard to conduct for screening tests. It would require, for example, patients at risk for a particular disease to be randomly selected to either receive a screening test for the ailment or forgo the diagnostic measure. The patients would then need to be followed, sometimes for many years, to see if the tool enabled screened patients to recognize better health outcomes (and lower overall utilization of medical services) than patients who were randomly selected to forgo the screening test.

Because of the high burden of evidence that the USPSTF requires to complete its evaluation of a preventive service, it ends up issuing a majority of I recommendations.¹² The fact that most preventive services have ended up with an I has had few direct implications in the past. But that is about to change as a result of PPACA and the importance the law ascribes to USPSTF ratings.

An Expanding Mission

The USPSTF's new authority began to take shape with the Medicare Improvements for Patients and Providers Act (MIPPA), signed into law in July 2008. MIPPA shifted decisions about Medicare's coverage of individual preventive services away from Congress to a "national coverage determination" process that is run by Medicare but heavily influenced by the USPSTF.¹³ Previously, Medicare did not have the legal authority to routinely add coverage for medical services aimed at prevention. So the Centers for Medicare and Medicaid Services (CMS) often had to get explicit authority from Congress to pay for new services like screening tests or wellness physicals. In some cases, it would use creative interpretations of its existing authorities to originate ways to cover some preventive services. Needless to say, regardless of the path the CMS chose, the process was long and cumbersome.

The idea of MIPPA was to make it easier for the CMS to add coverage of additional preventive services without requiring a separate act of legislation in each instance.¹⁴ Under the new process, Medicare was able to independently assume coverage of new preventive services, subject to a USPSTF determination. Starting in January 2009, the CMS was given authority to add coverage of preventive services on its own. For the CMS to add coverage, a service had to be deemed "reasonable and necessary" for the prevention or detection of an illness or disability and appropriate for Medicare beneficiaries.¹⁵ The preventive service also had to earn a grade of

A or B from the USPSTF. The latter requirement gave the USPSTF a prominent role in determining what preventive service Medicare could pay for. Like other well-intentioned legislation, this measure had unintended consequences.

PPACA has extended this construct and substantially increased the USPSTF's role by turning the discretionary arrangement into a de facto mandate. PPACA requires that health plans and insurers offering group or individual health insurance provide coverage for preventive health services with a grade of A or B and that they not impose cost-sharing requirements with respect to such services. The requirement that preventive services with a letter grade of A or B be fully covered is likely to prove costly to private insurance plans.¹⁶ Insurers previously were not covering all of these services, and when they did cover them, they often shared the costs with consumers. Now health plans will be required to cover them with no co-pays.

Ample evidence shows that mandates like these end up raising health insurance costs and premiums. In 2000, the Congressional Budget Office estimated that the marginal cost of state benefit mandates was 5–10 percent of total claims between 1990 and 1998. A 2003 Government Accountability Office study put the aggregated cost at 3–5 percent of premiums. Other estimates have put the impact of mandates as high as 20–50 percent of premiums.¹⁷

Whatever the merits of mandated benefits and first-dollar coverage of preventive services, the bottom line is that mandates will siphon premium revenue away from competing priorities. Although preventive services are an important part of comprehensive medical care, they are also costly. Dozens of separate studies have shown that prevention usually adds to medical costs instead of reducing them. Generally, about 80 percent of preventive services add more to medical costs than they save.¹⁸ Private plans forced to take on the full costs of these services will compensate by not covering services that do not get an A or B grade.¹⁹

Though the A- and B-rated services will get full coverage under PPACA, a lot of other services that do not make those grades but are currently covered (often with co-pays) may be nixed by health plans entirely. Likewise, if the USPSTF has not formally reviewed a particular preventive service, then Medicare will not need to cover it. The USPSTF chooses to review only a relatively small fraction of the preventive services available to patients, putting it fully in control of what preventive services are likely to get paid for. Far from increasing the

number of preventive tests and treatments that health plans pay for, the new mandate may have the reverse effect of reducing the number of covered services.

Widespread Procedural Shortcomings

The significant and unexpected new authority conferred on the USPSTF is all the more troubling because of shortcomings in the way it operates and its limited number of expert staff. These features leave it ill equipped to discharge an increasingly complex mission. Though the task force was created as an advisory body, its new mandates require it to exercise many of the same procedures and coverage authorities as an agency like Medicare. Yet it has put in place few of the procedures routine in similar regulatory agencies to ensure transparency in its deliberations, due process for stakeholders, and mechanisms to solicit and consider input from the broader community.

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For one thing, the task force maintains a largely insular process in comparison to similar regulatory functions that exist in sister public health agencies. Moreover, the deliberations and meetings of the USPSTF are not subject to the provisions of the Federal Advisory Committee Act (FACA), which means, among other things, that its proceedings are not required to be made public. The USPSTF is also not subject to the Administrative Procedures Act (APA), which governs the way in which administrative agencies of the federal government may propose and establish regulations. The act imposes requirements for transparency, interagency review, and ample opportunity for notice and comment. The APA also sets up a process for federal court review of agency actions.

The USPSTF was long able to operate without meeting these customary expectations because the body was largely advisory and often ignored. The task force would often say that it was just an advisory council with non-binding recommendations. That argument clearly does not hold true anymore. There is a credible case that the

USPSTF is now acting as an agency and its recommendations constitute final agency actions. The USPSTF is convened by AHRQ but functions as an independent, external advisory body. Until recently, AHRQ did not even publish the basis for USPSTF findings or its evidence review as a draft for public comment before it completed its recommendations. While the task force now voluntarily issues its draft recommendations for a brief period of public comment, it has no formal requirement to do so. The organization has taken admirable steps to improve its transparency and outreach in recent years, but these efforts are voluntary and still fall short of the expectations that bind other regulatory agencies.

Moreover, the task force has little capacity to vet and incorporate public comments made during this process, nor are there clear ways for people to appeal decisions. The only mechanism is for an affected party to seek a political waiver from the Secretary of Health and Human Services. The provision for this last-ditch waiver process was slipped into PPACA as compromise to address the backlash created by the USPSTF breast cancer screening decision.

The procedural shortcomings in how the USPSTF operates are amplified by the fact that it could become the first federal authority to explicitly make cost effectiveness a part of its criteria for covering health care services. Cost-effectiveness analysis is not a central part of the USPSTF's mandate. Indeed, the members of the task force do not have expertise in this discipline, but it has been gradually worked into some of its analyses. Since the way the USPSTF goes about its work is not governed by many explicit regulations or instructions from Congress, the task force is able to unilaterally adapt its approach to meet political trends.

In 2001, the USPSTF announced it would start conducting systematic reviews of cost-effectiveness analysis to inform its recommendations. To this end, the USPSTF "initiated a process for systematically reviewing cost-effectiveness analyses as an aid in making recommendations about clinical preventive services."²⁰ The USPSTF stated on its website that one of its goals in using this analysis in its recommendations is to "provide substrata for policy discussions and public debate over the role of cost-effectiveness in allocating health care resources."²¹

However, there are some unique problems with using cost as a basis to vet screening tests. One is that many of the economic benefits of screening tests cannot be easily measured by tabulating the direct savings from these technologies. For example, cost-benefit analyses cannot

easily measure the value afforded by intangible benefits such as greater assuredness that patients gain from a negative test result. Embedding cost in the evaluation of coverage for screening tests can also create long delays in deploying new tools or adapting medical care to new discoveries. Moreover, uncovering illness early will sometimes prove more costly than letting it fester, even if early detection makes a particular disease more curable.

The least we can expect is that the USPSTF be required to operate in a way that is rigorous, transparent, and inclusive.

All of these shortcomings are complicated still more by the byzantine manner in which the USPSTF gathers the evidence to support its coverage decisions. The task force members review evidence that is independently collected for them by AHRQ staff. But that evidence collection process is largely subcontracted by the AHRQ to outside groups (mostly academic research teams). The AHRQ takes charge of compiling resulting information and passing it on the task force, but typically has little hand in generating the data. (A recent exception was the breast cancer screening decision, for which AHRQ went to great lengths to consider emerging data.) This process means that the USPSTF often has limited proximity to the origin of the data and reduced ability to actively solicit new information.

The sixteen advisors appointed to serve on the USPSTF are mostly primary care physicians, generally experts in preventive and public health. However, as clinical generalists, they rarely have deep expertise in the discrete medical disciplines in which they are asked to pass judgment, such as oncology or infectious diseases. While the USPSTF is obligated to solicit input from other clinical experts when evaluating a particular preventive service, they have no process to formally engage these experts.

The USPSTF also has nothing similar to the advisory committee process maintained by the Food and Drug Administration (FDA) or even the less formal practices used by the CMS. Proponents celebrate this insular approach, arguing that it leads to more objective decisions free from intrusion. But as we have seen in the last year with the Obama administration's efforts to obviate controversial USPSTF decisions, the political process easily pushes around the task force. All that the insular

process guarantees is that USPSTF recommendations can be out of sync with conventional medical practice and even sister health agencies.

Another problem is that the USPSTF's criteria consistently undervalue the benefits of tests and treatments aimed at prevention, especially services aimed at secondary prevention. The USPSTF has generally failed to recognize the benefits of services used to prevent complications in older patients with established diseases (for example, coronary artery disease).²² Additionally, it has an institutional preference for issuing I ratings.

Many of the preventive services subsequently rejected by the USPSTF are officially recognized as beneficial by competing public health authorities.²³ At times, this means that the USPSTF finds its negative recommendations opposed by decisions made by sister public health agencies both in the United States and abroad. In addition to the previously mentioned breast cancer screening decision, some of these conflicts have involved screening tests for HIV, prostate cancer, and hepatitis C.²⁴

An additional problem is that the task force has been slow to incorporate new science into its recommendations. For example, in 2010, the USPSTF finally recommended aspirin for the prevention of stroke and heart attack for those at risk, decades after this practice was demonstrated to save lives and had become standard practice.²⁵ This is going to have broad implications once the USPSTF is established as the standard for coverage decisions made by the private health plans under PPACA.

Finally, the way that the USPSTF evaluates preventive services does not adequately account for innovations in technology and medical care delivery. The delay between the establishment of new science and its incorporation into USPSTF guidelines is a function of not just the agency's deliberative process, but its institutional design. It can take a few years for the USPSTF to issue a recommendation after it commits to a particular review and even longer for it to reconsider its prior decisions in the face of new evidence that leaves its recommendations obsolete. Therefore, the USPSTF's authority over setting the standards for coverage of preventive services is likely to delay the incorporation of new treatment approaches into reimbursement policies.

This is compounded by the fact that evidence that the USPSTF considers is collected only periodically. There is no continual data collection or regular monitoring of evolving evidence and clinical practice trends. This sort of monitoring of current clinical standards is required at agencies like the FDA and CMS. In some cases, the

USPSTF will take as many as five years to reconsider its prior recommendations. As a result of these shortcomings, the USPSTF's recommendations can significantly lag behind the state of practice. This tortuous process disconnects the USPSTF's findings from the current scientific evidence and the state of medical practice.

Righting a Wrong

In an optimal world, the USPSTF would not set decisions that bind much of the public and private market for health coverage, but PPACA has already set these steps in motion. Short of opening up that legislation, the least we can expect is that the USPSTF be required to operate in a way that is rigorous, transparent, and inclusive. Congress should take the following steps to bring greater accountability and precision to this process.

First, Congress should closely monitor how the new mandates that the USPSTF imposes on health plans begin to impact coverage, access, and medical practice. There is good reason to believe that once plans are forced to cover all of the costs of the USPSTF's A- and B-rated recommendations, these same health plans will offset those new costs by curtailing coverage for many other preventive services, even those that might be more highly valued by patients and clinicians.

Health plans will not be able to both comply with all of the USPSTF mandates (which will require first-dollar coverage for many services that presently require co-pays) and continue to offer coverage for those services that do not meet the USPSTF's grade. Doing both will be too expensive. So the USPSTF A- and B-graded services will become both a floor and ceiling on what gets covered.

Congress also should make sure that recommendations issued by the USPSTF are in sync with sister public health agencies that have far more expertise in the domains in which they operate. These include the CDC, the National Institutes of Health, and the FDA. The USPSTF lacks the capacity of these other agencies, and as such, its analysis should not supersede their expert opinions. Congress invested these bodies with far more resources and expertise to make these judgments, and the USPSTF should not be able to displace their work.

Moreover, at the very least, the USPSTF should be subject to the Administrative Procedures Act. It is no longer functioning as an academic advisory body but instead is a full-fledged federal health agency making cost-based decisions on access to medical care that will bind the entire private marketplace. Therefore, it should

be subject to all the rules that are attached to agencies that exercise these sorts of sweeping authorities.

Finally, Congress should bar the USPSTF from using cost as one criterion in establishing recommendations on preventive services. By its own admission, it does not have the requisite expertise, capacities, or regulatory traditions to exercise this authority. Its approach to making coverage decisions is opaque and insular. The decision to balance considerations of cost against clinical benefit must be made with great care. The USPSTF should not be wielding this kind of questionable authority.

Conclusion

The USPSTF has evolved from an expert commission to an advisory body to an independent body with all of the authority of a regulatory agency. Along the way, it has developed few of the characteristics shared by regulatory bodies. While the USPSTF has taken steps to bring more structure and transparency to its process in recent years, it still does not meet the expectations placed on sister agencies that discharge similar regulatory power. Historically, the USPSTF saw its purpose as providing users with information about the extent to which its recommendations are supported by evidence, allowing them to make more informed decisions about implementation. Now its recommendations will have regulatory force that will effectively bind clinicians by determining what their patients can be reimbursed for.

At the very least (given its expansive new authority) Congress should view the USPSTF as the regulatory authority that it has become and, in turn, subject the body to the APA. Or less appropriately, Congress could view USPSTF as an advisory committee to the government and subject the body to FACA. But given its expanding mandate, how can the USPSTF continue to be treated as a body that is neither advisory or regulatory, and exempted from all of the customary rules that govern other federal entities?

Under PPACA, a body that was once empowered only to make preventive health recommendations now has been delegated authority to create coverage requirements for private health plans. To those who feared that considerations of cost and the determinations of centralized processes could drive decision making under PPACA, the USPSTF may become a visible manifestation of these concerns. Proponents of this sort of centralized decision making may have done their policy prerogatives significant harm by allowing a group with so little

procedural rigor to represent the leading edge of these kinds of prescriptions.

Notes

1. For the complete summary of the USPSTF's decision on breast cancer screening, see US Preventive Services Task Force, "Screening for Breast Cancer: Recommendation Statement," November 2009, www.uspreventiveservicestaskforce.org/uspstf09/breastcancer/brcanrs.htm (accessed October 27, 2011).

2. PPACA also mandates coverage for other preventive recommendations, including those issued by the Advisory Committee on Immunization Practices that have been adopted by the director of the Centers for Disease Control and Prevention, the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA), and HRSA's list of recommended women's preventive services. Note that the requirement applies only to plans created after March 23, 2010. However, plans created before that date that lose their grandfathered status will be required to cover these preventive services. See Amanda Cassidy, "Health Policy Brief: Preventive Services without Cost Sharing," *Health Affairs*, December 28, 2010, www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=37 (accessed October 27, 2011).

3. Zosia Chustecka, "Recommendation against Routine PSA Screening in US," *Medscape News*, October 7, 2011, www.medscape.com/viewarticle/751159 (accessed October 31, 2011).

4. Alina Selyukh, "US Health Panel Cautious on HPV Screening vs Pap," *Reuters*, October 19, 2011.

5. US Preventive Services Task Force, *First Annual Report to Congress on High-Priority Evidence Gaps for Clinical Preventive Services* (Washington, DC: US Preventive Services Task Force, October 2011).

6. Centers for Medicare and Medicaid Services, "More People with Medicare Receiving Free Preventive Care," news release, June 20, 2011, www.cms.gov/apps/media/press/release.asp?Counter=3987 (accessed October 28, 2011). For details on the mandated preventive services, see US Department of Health and Human Services, "Preventive Care," n.d., www.healthcare.gov/law/features/rights/preventive-care/index.html (accessed October 28, 2011); see also Alina Selyukh, "U.S. Says Insurers Must Fully Cover Birth Control," *Reuters*, August 1, 2011.

7. US Preventive Services Task Force, "Screening for Breast Cancer: US Preventive Services Task Force Recommendation Statement," *Annals of Internal Medicine* 151, no. 10 (2009): 716–26.

8. Joseph Brownstein and Dan Childs, "Doctors Sound Off on New Mammogram Recommendations," *ABC News*, November 18, 2009; Mark A. Helvie et al., "USPSTF Erroneously Understated Life-Years-Gained Benefit of Mammographic

Screening of Women in Their 40s,” *Radiology* 258, no. 3 (2011): 958–59.

9. R. Edward Hendrick and Mark A. Helvie, “United States Preventive Services Task Force Screening Mammography Recommendations: Science Ignored,” *American Journal of Roentgenology*, 196 (2011): W112–16. In their analysis, the two researchers found that having annual mammograms from age forty saved 64,889 more lives, with the current 65 percent compliance rate.

10. See, among other entries, this blog post by a former USPSTF member entitled “Mammograms and Death Panels: Why the Preventive Services Task Force Keeps Pulling Its Punches,” DrPullen.com: A Medical Blog for the Informed Patient, August 22, 2011, <http://drpullen.com/uspstf> (accessed October 28, 2011).

11. Office of Disease Prevention and Health Promotion, “US Preventive Services Task Force,” n.d., www.odphp.osophs.dhhs.gov/pubs/guidecps/uspstf.htm (accessed October 28, 2011).

12. Diana B. Petitti et al., “Update on the Methods of the U.S. Preventive Services Task Force: Insufficient Evidence,” *Annals of Internal Medicine* 150, no. 3 (2009): 199–205.

13. *The Medicare Improvements for Patients and Providers Act of 2008*, Public Law No: 110-275, 110th Congress, July 15, 2008. Full text of the legislation available at www.govtrack.us/congress/bill.xpd?bill=h110-6331.

14. Under its new authority, the CMS has added services such as HIV screenings as a Medicare-covered benefit.

15. *Social Security Act*, 42 U.S.C. §1862, 1965. Full text of the legislation available at www.ssa.gov/OP_Home/ssact/title18/1862.htm.

16. For a complete list of recommended preventive services by the USPSTF, see US Department of Health and Human Services, “Preventive Service Recommendations,” n.d., www.ahrq.gov/clinic/uspstfix.htm (accessed October 28, 2011).

17. Jonathan Gruber, “State-Mandated Benefits and Employer-Provided Health Insurance,” *Journal of Public Economics* 55, no. 3 (November 1994): 433–64; Lawrence H. Summers,

“Some Simple Economics of Mandated Benefits,” *American Economic Review* 79, no. 2 (May 1989): 177–83; John R. Graham, *From Heart Transplants to Hairpieces: The Questionable Benefits of State Benefit Mandates for Health Insurance* (San Francisco: Pacific Research Institute, July 2008), www.pacificresearch.org/docLib/20080630_Heart_to_Hair.pdf (accessed October 28, 2011).

18. Louise Russell, “Preventing Chronic Disease: An Important Investment, but Don’t Count on Cost Savings,” *Health Affairs* 28, no. 1 (January 2009): 42–45.

19. On July 19, 2010, the Departments of Health and Human Services, Labor, and Treasury jointly released “Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services under the Patient Protection and Affordable Care Act,” *Federal Register* 75, no. 137 (July 19, 2010). Among other things, the rule requires group health plans and health insurers to cover certain preventive health services and to eliminate cost-sharing requirements for such services. The rule does not apply to grandfathered plans.

20. Somnath Saha et al., “The Art and Science of Incorporating Cost Effectiveness into Evidence-Based Recommendations for Clinical Preventive Services,” *American Journal of Preventive Medicine* 20, no. 3, supp. 1 (April 2001): 36–43.

21. Ibid.

22. Russell P. Harris et al., “Current Methods of the U.S. Preventive Services Task Force: A Review of the Process,” *American Journal of Preventive Medicine* 20, no. 3S (2001): 21–35.

23. S. J. Zyzanski et al., “Family Physicians’ Disagreements with the US Preventive Services Task Force Recommendations,” *Journal of Family Practice* 39, no. 2 (1994): 140–47.

24. Jonathan E. Rodnick, “The CDC and USPSTF Recommendations for HIV Testing,” *American Family Physician* 76, no. 10 (2007): 1456, 1459.

25. Doug Campos-Outcalt, “USPSTF Recommendations You May Have Missed amid the Breast Cancer Controversy,” *Journal of Family Practice* 59, no. 5 (2010): 276–80.