

## NEWS

## U.S. Preventive Services Task Force Confronts Critics

By Charlie Schmidt

In May, the U.S. Preventive Services Task Force recommended against screening for thyroid cancer. After reviewing the available evidence, the task force concluded that thyroid cancer screening leads to overdiagnosis and overtreatment of tumors that rarely spread and that the likely harms from screening outweigh the benefits. Making such decisions is part of the task force's mandate to provide independent recommendations on preventive services to primary-care clinicians and to people without obvious symptoms of the disease in question.

But that mandate increasingly pits the task force—whose membership is limited intentionally to primary-care experts who focus only on the strength of the evidence under their review—against specialists and companies with an economic stake in their deliberations. Disease screening flags enormous numbers of people who come for follow-up and treatments that they may not need. Under the Affordable Care Act (ACA), private insurance must fully cover screening tests that the task force approves. So drug companies, device makers, professional medical societies, and even investment firms that view screening as a major source of new patients have lobbied the task force, hoping to sway its recommendations.

Those vested parties have substantial political support. Rep. Marsha Blackburn (R-TN) introduced a bill earlier this year seeking to augment the task force with specialists and disease-specific patient advocacy groups. Skeptics of her bill worry that specialists and patient advocates are biased toward more screening. But in an e-mail from her spokesperson,

Blackburn said the proposed legislation, called the U.S. Preventive Services Task Force Transparency and Accountability Act of 2017, responds to “growing concerns that task force recommendations . . . are limiting patient access to preventive care.” Tom Price, M.D., now the Secretary of Health and Human Services, tried repeatedly to block task force recommendations against screening—and supported recommendations favoring it—as a Republican representative from Georgia. During a hearing on the Blackburn legislation, other Congressional officials also criticized the task force, claiming that implementing its recommendations against screening mammography for women younger than 50 years and against the prostate-specific antigen test for prostate cancer would jeopardize access to preventive services and lead to more cancer deaths.

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Speaking for the American Urological Association, John Lynch, M.D., a urologist



Gilbert Welch, M.D.  
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at MedStar Georgetown University Hospital in Washington, D.C., said putting disease specialists on the task force would “bring a different mindset, expertise, and a better understanding of all aspects of the disease in question.” The association supports the Blackburn bill.

However, Gilbert Welch, M.D., professor of medicine at the Dartmouth Institute for Health Policy and Clinical Practice in Lebanon, N.H., said that adding specialists to the task force would lead to what economists call regulatory capture, wherein a few parties with high-stakes interests in a regulatory agency's decisions work for the recommendations they prefer. “A mass screening test amounts to a huge market,” he said. “And while most people won’t develop the target disease, everyone gets exposed to the test and to the risk of false-positive results, overdiagnosis, and unnecessary interventions.”

The Department of Health and Human Services created the task force in 1984 to evaluate the scientific evidence used to determine whether medical screenings and other preventive services work for adults and children without symptoms. It's supported primarily by the Agency for Healthcare Research and Quality in the Department of Health and

Human Services, which funds the practice centers that review information on preventive services to guide the task force's recommendations. Task force members consist of 16 volunteer experts in primary care, drawn from pediatrics, family medicine, internal medicine, women's health, and nursing. They rate preventive services on a graded scale: A denotes a high certainty of net benefit; B, a moderate certainty of benefit; C, small potential benefits to select patients; D, no benefit and likely harms; and I, insufficient evidence to decide.

According to task force chair David Grossman, M.D., senior investigator at Kaiser Permanente Washington Health Research Institute in Seattle, benefits and harms are the only variables that go into a grade; costs never factor into the task force's decisions. Moreover, "it is critical that members have expertise in prevention and primary care alone," Grossman said. "We believe this is a specialty in and of itself." He added that the task force welcomes input from disease specialists and has procedures for involving them "at every stage of the recommendation development process."

But specialists can't vote on the task force's final recommendation. Being excluded from the final vote wasn't so

worrisome to specialty groups until the ACA required that commercial health plans cover preventive services with an A or B rating without copayments and deductibles. Since President Obama signed the ACA into law in 2010, the task force has become a "full-fledged policy authority" with a powerful influence on health care economics, according to David Johns, a Ph.D. candidate in the history of public health at Columbia University in New York, who cowrote an editorial on the task force's transformation under the ACA (*N. Engl. J. Med.* 2016;375:1710-2; doi.10.1056/NEJMp1607267). "Stock prices rise and fall with what the task force recommends," Johns said. "An A or B grade can affect a company's prospects in a way that wasn't always the case. There is more lobbying by industry, and the task force has consequently become more cautious about how it shares information. The politics are intense."

Some experts argue that because the task force has no experience factoring costs into its evidence-based reviews, the grades it assigns should never have been tied to insurers' coverage of preventive services. Blackburn's legislation calls for adding specialists in health economics (as well as specialty care

providers) to the task force, but others say the connection between its grading decisions and insurance coverage should be severed altogether, according to Johns.

Richard Wender, M.D., chief cancer control officer with the American Cancer Society, proposes yet another approach: to specifically delegate coverage decisions to a broader, nonpartisan group that "considers task force grading determinations but also takes input from other organizations that develop guidelines using evidence-based methodology."

He stressed that regardless of what future policy takes shape, preventive services with demonstrated benefits must be covered without cost-sharing (e.g., copayments and deductibles) because "even small out-of-pocket expenses can deter individuals from having a screening test." Wender was equally adamant that specialty organizations with professional or financial interests shouldn't be involved in making coverage decisions, "though their expertise should be gathered and considered."

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