National Business Group on Health

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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

December 10, 2012

Bruce N. Calonge, M.D.
Chair
U.S. Preventive Services Task Force (USPSTF)
Agency for Healthcare Research and Quality (AHRQ)
Office of Communications and Knowledge Transfer
540 Gaither Road, Suite 2000
Rockville, MD 20850

Re: ***Policy Implications of the Recent U.S. Preventive Services Task Force (USPSTF) Recommendations***

Dear Chairman Calonge:

The National Business Group on Health (NBGH) writes to state our ***deep and growing*** concern regarding the current direction of A and B recommendations from the U.S. Preventive Services Task Force (USPSTF) which is leading us down a path towards indiscriminate testing and exacerbating the problem of affordability in the US. As you know, the Patient Protection and Affordable Care Act requires that all plans, including employer-sponsored health plans, begin covering all A or B recommendations no later than the first plan year that occurs one year after the USPSTF finalizes them. After that point, they become mandated benefits covered at 100% with no cost-sharing by plan participants. The impact of your recommendations combined with the services being "free" to the users and profitable for those providing services are recipes for more hyperinflation of medical claims costs. Screening and tests that are not related to risk or clinical indications will also exacerbate an already serious problem of overuse in this country. ***Accordingly, we strongly recommend that USPSTF be much more rigorous in its review of scientific evidence, including defining such vague terms as "intensive behavioral screening", weighing affordability, and the potential for overscreening and unnecessary treatments that follow before making recommendations. Now is not the time to add unjustified costs when the country is struggling under the weight of expensive health care.***

The National Business Group on Health represents approximately 352, primarily large, employers (including 66 of the Fortune 100) who voluntarily provide health benefits and other health programs to over 55 million American employees, retirees, and their families. We believe that health plans, government, and employers should have policies that speed adoption of evidence-based medical practices and reduce the use of unproven

and/or ineffective treatments.

The most immediate cause for NBGH's and the employer community's concern are two of the USPSTF's recent recommendations that received an A or B rating despite the USPSTF's own misgivings regarding the evidence-base to make such recommendations:

- Intensive behavioral counseling for obesity in adults; and
- Screening for HIV infection.

First, while the USPSTF gave a recent "B" recommendation for intensive behavioral therapy for obesity in adults, it "could not determine" the effectiveness of the specific intervention components.[1]

- The USPSTF found inadequate evidence about the effectiveness of these interventions on long-term health outcomes.

- The USPSTF also specifically found that more "studies are needed that reassess the best methods for screening in adults (for example, waist circumference or waist–hip ratio), address weight management in elderly adults and other subpopulations, and examine the cost-effectiveness of behavioral and pharmacologic interventions" and, that "comparative effectiveness trials could provide more evidence about the components of an effective intervention."[2]

Accordingly, the USPSTF should not have given this recommendation for intensive behavioral therapy for obesity until research, based on additional properly designed, using uniformly specified, tested interventions have determined the long-term effects and recommended coverage limits of these intensive, multicomponent behavioral interventions. Plans and consumers also have no way to ensure that any of the visits will be of high quality and effective. Yet, by so designating them as recommended, the USPSTF has created an almost open-ended entitlement.

Second, the USPSTF recently issued a draft "A" recommendation changing its previous recommendation to screen adolescents and adults "at increased risk" for HIV infection to all individuals ages 15 to 65 years.

- The risk factors for HIV infection are very clear, arguing for risk-based rather than population screening. Screening individuals without known risk factors for HIV, including those "who are not sexually active, those who are sexually active in monogamous relationships with uninfected partners, and those who do not fall into any of [the defined risk] categories" will lead to unnecessary testing and wasted resources.[3] The average cost for a rapid HIV test and counseling was $48.07 for a negative test and $64.17 for a preliminary positive test.[4] Other

[1] U.S. Preventive Services Task Force. USPSTF Statement: Screening for and Management of Obesity in Adults. June. 2012, http://www.uspreventiveservicestaskforce.org/uspstf11/obeseadult/obesers.htm
[2] Ibid.
[3] USPSTF. Draft Recommendation Statement. Screening for HIV. November 2012, http://www.uspreventiveservicestaskforce.org/draftrec.htm
[4] Pinkerton SD, Bogart LM, Howerton D, Snyder S, Becker K, Asch SM. Cost of rapid HIV resting at 45 U.S. hospitals. *AIDS Patient Care STDS*. 2010; 24(7): 409–413.

sources estimate the average cost of a rapid test at $7 and a confirmatory test at $40.[5]

- It is worth noting that at least four States passed laws requiring a premarital HIV test, and later repealed them determining that a more effective use of resources included surveillance programs targeting high risk populations.[6]

- Again, the USPSTF found "insufficient evidence" to "determine the optimal time intervals for HIV screening" and called for research to quantify the benefits and harms of repeat HIV screening and identify ideal time intervals for rescreening in different populations.[7]

Consequently, the inability to provide guidance on appropriate screening intervals for HIV infection will lead to wide variation in the frequency of screening and unnecessary testing with an open-ended requirement for plan sponsors and ultimately increased costs for consumers. We think this is misguided and another driver of hyperinflation.

While we remain opposed to such a wide open proposal, at the very least, the Department of Health and Human Services (HHS) should provide an opt-out of HIV screening for individuals, which has been widely implemented and highly successful for prenatal screening[8], to promote shared-decision making, allowing clinicians and patients to decide if HIV screening is appropriate based on individuals' risk factors.

Thank you for considering our comments and recommendations. We believe that it is necessary for the financial future of our country as well as the quality and safety of care to move away from recommendations that will drive unnecessary screening, testing and overtreatments at the very time we need the most support for evidence-driven decisions. If you would like more information or wish to discuss this issue further, please contact Steven Wojcik, the National Business Group on Health's Vice President of Public Policy at (202) 558-3012.

Sincerely,

Helen Darling
President and CEO

cc: The Honorable Kathleen Sebelius, Secretary, HHS
Carolyn Clancy, M.D., Director, AHRQ

[5] Making HIV resting cost-effective.2006, http://aids-clinical-care.jwatch.org/cgi/content/full/2006/1211/1
[6] OLR Research Report. Accessed 2012, http://search.cga.state.ct.us/dtsearch.asp?cmd=getdoc&DocId=12813&Index=I%3A%5Czindex%5C1998&HitCount=0&hits=&hc=0&req=&Item=8250
[7] USPSTF. Draft Recommendation Statement. Screening for HIV. November 2012, http://www.uspreventiveservicestaskforce.org/draftrec.htm
[8] Qaseem A, Snow V, Shekelle P, Hopkins R Jr, Owens DK; Clinical Efficacy Assessment Subcommittee, American College of Physicians. Screening for HIV in Health Care Settings: A guidance statement from the American College of Physicians and HIV Medicine Association. *Ann Intern Me*d. 2009;150:125-131

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The Honorable Daniel K. Inouye, Chair, Senate Appropriations Committee
The Honorable Thad Cochran, Ranking Member, Vice-Chair, Senate Appropriations Committee
The Honorable Harold Rogers, Chair, U.S. House Appropriations Committee
The Honorable Nita Lowey, Incoming Ranking Member, U.S. House Appropriations Committee