Congressional Research Service
Informing the legislative debate since 1914

IN FOCUS

September 12, 2025

The United States Preventive Services Task Force

The United States Preventive Services Task Force (USPSTF, or Task Force) is an independent, volunteer panel of experts in preventive health services, evidence-based medicine, and primary care that makes recommendations for clinicians on preventive health care services. This In Focus provides an overview of the Task Force, including its legislative history, membership, and process for making recommendations.

The Task Force's current statutory mandate, as authorized by Public Health Service Act (PHSA) Section 915 (42 U.S.C. §299b-4), is to "review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services for the purpose of developing recommendations for the health care community, and updating previous clinical preventive recommendations." Clinical preventive services are health care services provided to individuals without any symptoms of a disease or condition.

History of USPSTF

The first Task Force was convened by the Department of Health and Human Services (HHS) in 1984 with the objective of reviewing evidence on the effectiveness of preventive services and publishing a guide to inform the standard of care for preventive services. Early convenings of the Task Force were iterative and focused on publishing a collection of recommendations. In 1998, the Task Force began issuing recommendations incrementally, and in 2001 its members began serving multiyear, rolling terms.

In 1995, the Agency for Health Care Policy and Research, the predecessor for the Agency for Healthcare Research and Quality (AHRQ), began providing programmatic support to the Task Force. The Healthcare Research and Quality Act of 1999 (P.L. 106-129) added PHSA Section 915, which codified the Task Force and directed AHRQ to convene the Task Force and provide it with administrative, research, and technical support. Section 915 was amended by the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), which further specified the Task Force's duties and operation.

Recommendation Process

While the Task Force's governing statute specifies its overall scope and duties, including to develop recommendations, review existing recommendations, and disseminate recommendations, much of its structure and recommendation processes have been further specified in its Procedure Manual, last updated in April 2023, as described below. The Task Force is not subject to requirements of the Federal Advisory Committee Act (P.L. 92-463, 5 U.S.C. Chapter 10).

Members

The Task Force is composed of 16 members who are appointed by the HHS Secretary and serve four-year terms. Membership is not specified in statute except that it is to be "composed of individuals with appropriate expertise." Additionally, the ACA amended Section 915 of the PHSA to direct members of the Task Force and their recommendations to "be independent and, to the extent practicable, not subject to political pressure" (42 U.S.C. §299b-4(a)(6)).

Preventive Services

While authorizing statute specifies that the Task Force focus on *clinical preventive services*, it does not define this term. *Preventive services* as health interventions can encompass a large range of activities with the goal of preventing the development or progression of infection, disease, or other adverse health outcome. Prevention interventions can be applied directly to individuals, such as immunizations and screenings for disease, as well as interventions applied at a community level, such as controlling lead in public drinking water.

The Task Force focuses on *clinical preventive services*, more specifically, services that can be administered or referred for in primary care settings to individuals without any symptoms of a disease or condition. This includes interventions to prevent the onset of a specific disease or condition; for example, prescribing preexposure prophylaxis (PrEP) medications to decrease the risk of acquiring HIV. This also includes services to identify or treat those without symptoms of a disease, but who have already developed risk factors or early stages of disease; for example, screening adults for high blood pressure.

The Task Force's recommendations span at least 12 categories of preventive care for men, women, and children, such as cancer, cardiovascular health, infectious diseases, and perinatal care. Within these categories, the Task Force's recommendations focus on three types of interventions: (1) preventive health screenings, (2) counseling, and (3) preventive medications.

Topic Consideration and Selection

When selecting a new topic for review, the Task Force first considers whether the topic is within the scope of the Task Force's work by assessing its relevance to clinical preventive services delivered in the primary care setting. In prioritizing topics for review, the Task Force then considers its importance to public health, the potential impact of the recommendation to change clinical practice, and the balance of the Task Force's portfolio (e.g., by population, disease). When deciding to revisit and potentially update an existing recommendation, the Task Force also considers

any new evidence that may change prior recommendations. Anyone, including the public and Members of Congress, can nominate a topic at any time for the Task Force's monthly review. The Task Force drafts an annual prioritized list of topics for review, including new topics and updates.

Evidence Review and Recommendations

For each topic the Task Force takes up, it develops a research plan that includes key questions, an analytic framework, and the research inclusion criteria it will use to inform its evidentiary review. The Task Force posts the research plan to its website for public comment and expert input, and it further revises the plan as needed before posting and conducting its final research plan.

With assistance from AHRQ, the Task Force reviews the available evidence pertaining to the intervention and evaluates the effectiveness of the intervention for the relevant population(s) depending on the specific service, for example, by age, sex, or other risk factors. When assessing the evidence, the Task Force weighs a preventive service's potential benefits against potential harms. Benefits can include improved health impacts, such as overall mortality reduction. Harms can include adverse health effects of an intervention or the impact of inaccurate tests.

Before publishing a final recommendation, the Task Force posts the draft recommendation for public comment. After considering public comments, the Task Force publishes a final recommendation on its website and in the *Journal of the American Medical Association*. The process of topic selection to publication of a final recommendation generally takes one to two years.

Recommendation Grading System

In making its recommendations, the Task Force grades the topic based on the certainty of evidence and magnitude of the preventive service's net benefit, as shown in **Table 1**. Recommendation grades for a specific service can vary by risk factor, such as age. For example, the Task Force grades colorectal cancer screening for adults between the ages of 45 and 49 with a B and for those between the ages of 50 and 75 with an A. For adults over age 75, the Task Force grades this screening with a C. The current meanings of the different grades are displayed in **Table 1**.

Table 1. USPSTF Grade Definitions

Grade	Definition and Suggestions for Practice
A	Recommended to offer or provide this service. There is a high certainty there is a substantial net benefit.
B	Recommended to offer or provide this service. There is a high certainty there is a moderate net benefit, or there is a moderate certainty there is a moderate to substantial net benefit.
C	Recommended to offer or provide selectively to patients depending on individual factors. There is moderate certainty the net benefit is small. Providers should use their professional judgement and consider patient preferences if offering or providing this service.
D	Not recommended, and providers are discouraged from offering or providing this service. There is a moderate to high certainty there is no net benefit or the harms of the service outweigh the benefits.
I	Insufficient evidence to issue a recommendation. The evidence is of poor quality, conflicting, or not available to determine the balance of benefits to harms.

Source: USPSTF, *Grade Definitions*, October 2018, https://www.uspreventiveservicestaskforce.org/uspstf/about-uspstf/methods-and-processes/grade-definitions.

Relevance in Health Care Coverage

The Task Force recommendations serve as clinical practice guidance to health care providers. Providers are not required to follow the recommendations of the Task Force, nor are consumers obligated to receive preventive services as recommended. Several federal laws link Task Force recommendations to health care coverage requirements or incentives, for example:

- **Private health insurance:** Section 1001 of the ACA added Section 2713 (42 U.S.C. §300gg-13) to the PHSA, which requires most private health insurance plans to cover (without cost-sharing) certain preventive services, as recommended. This includes the services and items with a Task Force grade of A or B.
- **Medicaid:** Coverage of preventive services varies state by state and by eligibility pathway within a given state. For example, Medicaid enrollees who receive Alternative Benefit Plan (ABP) coverage are entitled to PHSA Section 2713 preventive services coverage (without cost-sharing), as recommended by the Task Force by virtue of Medicaid ABP's required coverage of essential health benefits.
- **Medicare:** The Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275) provided the HHS Secretary with authority to add new clinical preventive services to be covered by Medicare that were not already required by statute. To qualify, a new service has to have a Task Force grade of A or B, among other criteria (Social Security Act [SSA] Section 1861(ddd)).

Although its recommendations are tied to health coverage, by its policy, the Task Force does not make recommendations for the purpose of creating coverage requirements. In addition, it is other relevant agencies, not the Task Force, that have oversight of the coverage requirements for the programs and plans above (e.g., the Centers for Medicare & Medicaid Services; the Employee Benefits Security Administration).

Kavya Sekar, Specialist in Health Policy

Alexa C. DeBoth, Analyst in Health Policy

IF13100

Disclaimer