Doctors list overused medical treatments

A coalition of healthcare provider associations says many common practices are costly, often unnecessary and sometimes even harmful.


WASHINGTON — Nearly 100 medical procedures, tests and therapies are overused and often unnecessary, a coalition of leading medical societies says in a new report aimed at improving healthcare and controlling runaway costs.

The medical interventions — including early caesarean deliveries, CT scans for head injuries in children and annual Pap tests for middle-aged women — may be necessary in some cases, the physician groups said. But often they are not beneficial and may even cause harm.

"We are very concerned about the rapidly escalating cost of healthcare," said Dr. Bruce Sigsbee, president of the American Academy of Neurology, which was among the 17 medical groups contributing to the list of procedures. "This is not healthy for the country, and something has to be done."

Development of the list, which was organized by the American Board of Internal Medicine's ABIM Foundation, is a minor milestone in efforts to enlist physicians to rein in unnecessary services, a leading cause of the skyrocketing healthcare tab.

In 2011, the ABIM Foundation published a similar list of procedures submitted by nine other medical societies as part of its Choosing Wisely campaign.
The United States spends more than $2.5 trillion a year on healthcare, or more than $8,000 per person. That is 2 1/2 times as much as the average spent by other industrialized nations, according to data collected by the Organization for Economic Cooperation and Development, whose members include the richest nations.

Studies show that the high cost of U.S. healthcare is driven in large part by prices. American hospitals and doctors charge much more than their international counterparts.

But U.S. physicians also perform many more tests and elective procedures. For example, American doctors order nearly twice as many CT and MRI exams as doctors in other industrialized countries do. They perform more knee replacements and deliver more babies by caesarean section.

Some of this extra care may result in better outcomes. The U.S. has some of the highest cancer survival rates in the world, for instance.

But America lags far behind other industrialized countries in caring for children with asthma and adults with chronic bronchitis and emphysema, among other illnesses.

A growing number of experts have concluded that much medical care in the U.S. is wasteful and even dangerous for patients. A 2012 report from the independent Institute of Medicine estimated total waste in the system at 30%, or $750 billion a year.

"Millions of Americans are increasingly realizing that when it comes to healthcare, more is not necessarily better," said Dr. Christine K. Cassel, president of the ABIM Foundation.

For example, despite the popularity of early caesareans, there is growing evidence that babies born before 39 weeks' gestation have higher risks of learning disabilities and even death.

Whether, or how quickly, the initiative to curb unnecessary procedures will yield results remains unclear.

Persuading doctors to be more conservative can be difficult, said Dr. Lowell E. Schnipper, an oncologist at Boston's Beth Israel Deaconess Medical Center and chairman of a national task force on controlling the cost of cancer care. "These diseases can be fatal," Schnipper said. "The stakes are high. And families very often push the doctor, who wants to take care of the patient as best he or she can."

Recent warnings from the U.S. Preventive Services Task Force that screenings for breast and prostate cancers often do more harm than good drew huge backlashes from patient advocates. Similarly, the Obama administration's efforts to raise awareness about unnecessary medical care and to improve data on best medical practices as part of the 2010 healthcare law prompted many Republicans to characterize the ideas as rationing.

But Dr. Manoj Jain, a leading health quality advocate in Memphis, Tenn., said more aggressive efforts may be needed to reduce wasteful and dangerous medical practices.

Like many experts, Jain advocates more evaluation of physicians and new ways to pay for healthcare that reward better outcomes and higher efficiency instead of the current fee-for-service system, which pays doctors for every procedure they do.

"If we really are going to bend the cost curve, we have to get really serious," Jain said.
Among the medical societies that identified overused procedures prescribed by their members were the American Academy of Pediatrics, the American Academy of Ophthalmology, the American College of Obstetricians and Gynecologists, and the Society of Thoracic Surgeons.

The ABIM Foundation effort also drew support from leading consumer and business groups, including Consumer Reports, the AARP and the National Business Group on Health.
Empowered by ACA, old fraud law puts new scrutiny on doctors

Creating a culture of transparency in a practice and developing strong billing standards are key to complying with a strengthened, civil False Claims Act.


With the Affordable Care Act giving the government more power and dedicating more money to improving federal efforts against health care fraud, waste and abuse, physicians’ business practices are under the microscope like never before.

While only a small fraction of physicians are engaged in fraudulent activity, all doctors face the new reality of increased scrutiny over billing, referral and coding activity, legal experts said.

But recognizing federal False Claims Act risks and enacting a strong compliance program can help doctors come through such reviews unscathed and thwart violations before they occur, said attorney Julie E. Kass, a principal in the Ober|Kaler Health Law Group based in Maryland. She spoke about the FCA and compliance steps for physicians at the American Health Lawyers Assn.’s Physicians and Physician Organizations Law Institute meeting February in Phoenix.

“You’ve got this hammer that’s going against all these physicians when only a small segment are doing what they’re not supposed to,” Kass said. “Not all doctors are bad, but [the government has] found some bad doctors, so they’ve created broad rules, and all doctors must follow those rules.”

Physicians can face treble damages and civil fines for violating the False Claims Act.

Physicians already have become a larger target for federal health fraud investigations, including those brought under the FCA. The statute, enacted in 1863 during the Civil War, protects against the submission of fraudulent claims by government contractors and enforces strict penalties for such violations. The 2010 health system reform law expanded the reach of the law and made it easier for federal investigators to launch FCA cases against alleged violators.

More physicians face charges

Of 2,309 civil and criminal cases — including FCA cases — opened in 2012 by the Dept. of Health and Human Services Office of Inspector General, 21% involved physicians, compared with about 15% in 2010, according to OIG data. Some physicians recently have made headlines for allegations of major FCA violations and other fraud:

- In February, a Florida dermatologist agreed to pay $26.1 million to settle allegations that he had violated the FCA, the largest settlement ever with an individual under the act. Steven J. Wasserman, MD, was accused of accepting illegal kickbacks and providing medically unnecessary services that he billed to Medicare. He did not admit any wrongdoing.

- In July 2012, South Carolina family physician James Vest, MD, and his clinics settled FCA allegations for $320,000. The government contended that Dr. Vest and his practices submitted claims to Medicare for physician services that were provided by midlevel practitioners, not by Dr. Vest. He admitted no wrongdoing.

- In May 2012, Wichita, Kan., cardiologist Roger W. Evans, MD, agreed to pay the government $1.5 million to settle allegations that he and his practice submitted false claims to Medicare. The government said Dr. Evans issued bills for services for which he was not present and did not provide direct supervision. Dr. Evans did not admit any wrongdoing.

Heightened federal focus on individual doctors and physician practices is likely to continue, said George B. Breen, a Washington-based attorney with Epstein Becker Green and part of the firm’s health care practice. “Probably the biggest misconception [among doctors] is, ‘The government is looking at the hospital and not me individually, or it’s looking at another deeper pocket,’ ” said Breen, who also
presented on the subject of FCA and compliance issues at the AHLA conference.

If the government comes knocking, physicians must be able to show how they are complying with FCA regulations and how they address problem claims, he said. “The only way you are able to defend yourself is to be proactive in engaging in activities where you are compliant.”

**Violations can carry significant cost**

Under the FCA, a violation occurs when a person knowingly presents a false or fraudulent claim for payment; knowingly makes, uses or causes a false record; or conspires with others to issue such a record or claim.

For doctors, a broad range of scenarios can constitute running afoul of the FCA, including filing false codes for payment, making improper referrals and participating in Medicare kickback schemes. Physicians can face treble damages and civil fines for violating the FCA, a percentage of which might go to compensate whistle-blowers who first alerted the government to the alleged fraud. Violations also can bring increased monitoring going forward or exclusion from government programs.

**21% of federal cases of health care fraud involved physicians in 2012, up from about 15% in 2010.**

The consequences don’t stop there, said Kim Harvey Looney, who co-presented with Kass at the AHLA conference. She is a Nashville, Tenn.-based attorney at the Waller law firm.

“It’s not just that you might have to pay money back,” she said. “If your operations have been disrupted, you might lose patients.” Doctors’ reputations also can be harmed just by allegations of health care fraud, she said.

While criminal health fraud enforcement has targeted hot spots such as California, Florida, New York and Texas, FCA investigations have not been as geographically focused, Breen said. “Many of the investigations nationwide are largely driven [by] the subject matter.”

For instance, billing for cardiac procedures has been prominent on the government’s radar, he said. Back surgeries and the implantation of cardiac defibrillators also are procedures that have gained significant attention from federal investigators, Kass added.

She said hospital-based services are commonly examined. “But of course those services are ordered by physicians. After they look at the hospitals, they can find out who are the larger referring physicians, and then they look at those doctors.”

Kass said that when enforcement officers become knowledgeable about a certain medical service or treatment that is involved in potential fraud, they generally start scrutinizing similar procedures ordered by other physicians.

**Enabling a strong compliance program**

The first step to complying with FCA requirements is knowing what the rules are and how they apply to individual physician practices, Kass said. The OIG provides general compliance guidance to all health professionals, but particular risk areas vary depending on industry circumstances.

“You’re not going to have the same compliance plan if you’re a three-physician practice compared to a 300-faculty practice,” she said.

Doctors should implement written policies, procedures and standards of conduct related to compliance expectations, Looney said. Such documentation should identify how compliance issues are investigated and resolved, and it should include policies of non-intimidation and non-retaliation for employees who report potential violations, she said.

Promoting overall transparency and a culture of compliance also is important. Physicians should maintain detailed records and report any potential violations to authorities immediately, Kass and Looney
said. All levels of employees, from senior management to entry-level workers, should receive regular compliance training.

Breen added that doctors should be aware of the accepted, defined and used markers for demonstration of medical necessity. Developing a process to know proactively when medically necessary care might be diverging from payers’ coverage guidelines is essential, he said.

“You can have problems, and you can make mistakes. Everyone does,” he said. “But there’s a difference between making a mistake and, in effect, ignoring what the obligations are and submitting a bill despite that.”

Creating a compliance program now, instead of reacting to problems later, will save physicians significant time, money and investigative burden, Breen added.

“Doctors are in the business of trying to protect their patients and trying to provide patients the best possible care, and that’s where their focus is, but now it’s become a double-edged sword,” he said. “You have to protect yourself and your practice also.”
AHIP study: Medicare Advantage cuts will drive up premiums

By Sam Baker - 02/26/13

Seniors would likely see significant premium hikes and benefit cuts under proposed cuts to Medicare Advantage plans, according to a study commissioned by the insurance industry.

The industry has launched an all-out assault on the Obama administration’s recent proposal to cut Medicare Advantage payments next year. The industry’s top lobbyist said Tuesday that the cuts would be a “crushing blow.”

In a study released by America’s Health Insurance Plans (AHIP), the consulting firm Oliver Wyman said Medicare Advantage plans are facing a total cut next year of roughly 7 or 8 percent.

That would translate into benefit cuts or premium increases worth $50 to $90 per month for each senior who uses Medicare Advantage, according to Oliver Wyman.

“The impact of these cuts is real; it’s not speculative,” AHIP President and CEO Karen Ignagni told reporters Tuesday.

The federal Medicare agency recently said it plans to cut Medicare Advantage payments by 2.3 percent next year — on top of significant cuts included in President Obama’s healthcare law.

All told, Medicare Advantage plans would be absorbing a total cut of 6.9 to 7.8 percent, according to Oliver Wyman’s report, and those cuts would translate into benefit cuts or premium increases for seniors.

It’s hard to predict how plans would balance those options, but they would have to cut benefits or raise seniors’ costs by $50 to $90 per month to make up the difference.

Ignagni said previous rounds of payment cuts have driven seniors out of the Medicare Advantage program. Allowing the 2.3 percent cut to go through would have serious effects on seniors, potentially including lower enrollment, she said.

“We’ll see it in benefits, we’ll see it in costs that beneficiaries have to pay, and we’re very concerned … that we’ll see it in disruption,” she said.
IRS moves to collect billions in fees from healthcare law

By Ben Goad - 03/01/13

The Internal Revenue Service on Friday unveiled its proposal to raise tens of billions of dollars through annual fees on health insurers, prompting fierce criticism from industry groups who warn the costs will be passed along to consumers.

The proposed rule from President Obama’s healthcare law will be published for public consideration in Monday’s Federal Register.

The rule would assess annual fees on most insurers that would total $8 billion next year and rise thereafter, eclipsing $14 billion in 2018, according to the IRS. The fees would vary in size, depending on a firm’s net premiums, and would come due by Sept. 30 every year.

Insurers that don’t pay on time would face penalties of $10,000, plus $1,000 for every day they miss deadline.

The IRS acknowledged concerns from outside groups who suggest “that covered entities may attempt to recover a large portion of the fee from policyholders.” The agency will accept comments for 90 days, beginning Monday.

America’s Health Insurance Plans (AHIP), the leading trade group for the insurance industry, blasted the fees as a tax that would exceed $100 billion in the next decade and hit average families still struggling to rebound from the economic recession.

“This is a new $100 billion tax on health insurance,” AHIP spokesman Robert Zirkelbach said in an interview Friday. “Taxing health insurance is only going to make it more expensive.

The group estimates that an average family’s health insurance would rise by more than $300 next year, with that total surpassing $500 in subsequent years.

During consideration of the Affordable Care Act, congressional Republicans fought unsuccessfully to scrap the fees. Another attempt to do away with them is now under way in the House, where Reps. Charles Boustany Jr. (R-La.) and Jim Matheson (D-Utah) are pressing a bill to repeal the provision.

Later Friday, the Treasury Department defended the rule, noting that it is merely one part of a law that contains many provisions. On balance, a Treasury Department spokesperson said, the law will increase competition and drive down costs. The ACA would also bring the industry millions of new customers, allowing them to keep costs down, the agency argued.

The spokesperson pointed to estimates from the Congressional Budget Office suggesting that the law could reduce premiums for insurance plans in the small group and individual markets, while having a negligible effect on plans in the large group market.
Health care pricing transparency for all: Our view

The Editorial Board March 5, 2013

Disconnect between consumers and providers drives up prices and insurance premiums.

Hip replacement surgery.(Photo: Matt Ford, AP)

Story Highlights

- Transparency will expose gougers, like the hospital that put a 10,000% markup on a generic Tylenol.
- A study found hip replacement costs range from $11,100 to almost $126,000.
- Though 40 states require or encourage price disclosure, most of those laws are toothless.

Cars are one of the most expensive things most people ever buy, so today's auto-buyers have easy access to information on quality, reliability and price. Empowered consumers help keep the prices of cars down and the quality up.

On the other hand, shopping for another one of the most expensive things most people ever buy — health care procedures such as colonoscopies or hip replacements — just doesn't work. Prices are shrouded in secrecy.

People with typical employer insurance have little incentive to look for a good deal. Insurers negotiate prices with providers. The uninsured, meanwhile, can face outlandish prices no matter where they turn, and they have almost no leverage.

This dysfunctional system works fine for providers and insurers, but the disconnect between consumers and providers creates a situation that is driving up health care costs — and insurance premiums — at a rapid and unsustainable pace.

As that trend drives people to opt for plans with higher out-of-pocket deductibles, or ones that give customers a fixed amount of money and essentially wish them luck, the lack of transparent pricing will pose an escalating problem. Greater transparency would help them, and it would have another benefit:
exposing and shaming institutions charging absurd prices — such as the hospital that journalist Steven Brill, writing in *Time*, found putting a 10,000% markup on a generic Tylenol pill.

As it is, prices are all over the place. Hospitals and doctors typically have numerous charges for the same procedure, depending on who's buying. Someone without insurance gets the list price, which can literally be high enough to bankrupt a typical person within days.

Comparison shopping, while not a complete solution, could contribute to one. But shopping around isn't easy.

Recently, for example, a student researcher set out to find the price of a hip replacement by calling more than 100 hospitals and asking what it would cost her (fictitious) grandmother, who supposedly had no insurance but could afford to pay out of pocket. As detailed in the *Journal of the American Medical Association*, many hospitals wouldn't answer, and those that did quoted prices from $11,100 to almost $126,000.

As both parties in Washington seek ways to control health costs, they are trying to address the market disconnect. Republicans are promoting voucher plans that would expose older Americans to market forces. Democrats are seeking to discourage "gold plated" employer-provided and Medigap plans that leave patients with no deductibles and co-pays. But if individuals are going to have more skin in the game, they will have more need to know how much things cost.

Health insurance is largely regulated by states, and their attempts to force price disclosure have been disappointing. Though 40 states have laws that require or encourage price disclosure, transparency advocates such as Suzanne Delbanco of Catalyst for Payment Reform consider most of those laws toothless.

Some change in transparency is happening anyway, thanks to innovative websites such as Fairhealth.org and Clearhealthcosts.com, which have begun to uncover comparative prices. Some insurers are moving to help customers price shop, and an effort in New Hampshire helps state employees compare costs.

Big hospitals and insurers worry that divulging prices could erode their competitive edge. But the money they make from hiding charges and discouraging comparison shopping comes from the pockets of patients, taxpayers and employers. That's not the way markets are supposed to work.
EXERCISE, LESS SITTING TIME LINKED TO BETTER SLEEP
By Patricia Reaney Reuters March 3, 2013

NEW YORK (Reuters) - Insomniacs looking for a good night's sleep may want to hit the treadmill, take a walk or play a game of golf or tennis because a new report released on Monday shows exercise promotes good sleep and the more vigorous the workout the better.

Just 10 minutes of exercise a day could make a difference in the duration and quality of sleep, the survey by the non-profit National Sleep Foundation showed.

"We found that exercise and great sleep go together, hand in hand," Max Hirshkowitz, a sleep researcher and the chair of the poll task force, said in an interview.

"We also found a step-wise increase in how vigorous the quality is, in terms of how much you exercise. So if you say you exercise a lot, we found better sleep quality. For people who don't exercise at all we found more sleep problems."

Earlier research studies have shown the impact of exercise on sleep, but Hirshkowitz, who is a professor at Baylor College of Medicine in Houston, said the survey is the first to detail the benefits of exercise in a nationally representative poll of this size.

People who described themselves as exercisers reported better sleep than their more sedentary counterparts, although the amount of sleep, an average of just under seven hours on weeknight, was the same.

More than 75 percent of the 1,000 people questioned in the Internet and telephone poll who described themselves as exercisers said they slept well, compared to just over half of people who did no exercise.

Very active people reported fewer sleep problems, dozed off quicker and needed less shut eye a night to function at their best during the day.
Sitting, more than eight hours daily also had a negative impact on sleep, according to the poll.

NAPS, STRUGGLING TO STAY AWAKE

Nearly half of Americans report experiencing insomnia occasionally, and 22 percent suffer from the condition, which can be caused by stress, anxiety, pain and medication, every or almost every night, according to the foundation.

In addition to poorer sleep, non-exercisers also were less likely to report good or excellent health compared to active people and had more trouble staying awake while driving and eating.

Nearly three times as many sedentary people said they have trouble keeping awake during the day than exercisers. They also took more naps and had more symptoms of sleep apnea, a disorder that causes shallow breaths or pauses in breathing during sleep, than exercisers,

More than 44 percent of non-exercisers were at a moderate risk for sleep apnea, a higher percentage than active people questioned in the poll.

The survey also seemed to debunk the idea that exercising early or late in the day would adversely impact sleep because it showed that being active at any time of the day was better than being sedentary.

"Exercise is beneficial to sleep," Dr. Barbara Phillips, a member of the poll task force, said in a statement. "It's time to revise global recommendations for improving sleep and put exercise - any time - at the top of our list for healthy sleep habits."
States balk at $15B Obama healthcare 'tax'

By Ben Goad - 03/08/13

A newly unveiled component of President Obama’s healthcare law forcing insurers to pay annual fees is sowing angst in state capitols, where officials view the provision as a $15 billion tax that could disrupt Medicaid programs and other services.

The health insurance providers fee, included in the healthcare reform law over the objections of congressional Republicans, is designed to raise tens of billions of dollars in the coming years.

In Wisconsin alone, the fee would hit the state’s coffers to the tune of $23 million in 2014, and will likely total more than that in subsequent years, said J.P. Wieske, legislative liaison and public information officer for the state’s Commissioner of Insurance.

The blow to Wisconsin’s private insurance market would be far higher – $3 billion over the next 10 years, Wieske said.

The proposed regulation’s details were published this week, and prompted harsh criticism from the health insurance industry, which warns that the fees would ultimately raise the price of healthcare. The Obama administration has countered that the insurer fee is just one of many provisions, which, taken together, would drive costs down.

But in states that participate in Medicaid managed care plans, the fee would be painful. One study commissioned by the Medicaid Health Plans of America found that states would be on the hook for $15 billion over the next ten years.

“That’s dangerous,” said Bruce Greenstein, Louisiana’s health secretary. “I have deep concerns.”

Greenstein said the fee is tantamount to discrimination, since some plans – including those offered by certain nonprofit healthcare providers – are exempt from the fee.

Administration officials did not imemditaeley respond to requests for comment on the concern from states.

Nationwide, fees assessed on non-exempt insurers would total $8 billion next year and rise thereafter, eclipsing $14 billion in 2018, according to the Internal Revenue Service, which drafted the proposed rule. The fees would vary in size, depending on a firm’s net premiums, and would come due by Sept. 30 every year.

In Wisconsin, some smaller private insurers were considering changing their business model to nonprofit status because of the added costs, Wieske said.

For states offering Medicaid managed care, however, that is not an option.

Ultimately, the fee will raise the costs of Medicaid programs, which are funded by a combination of federal and state money, said Joe Moser, executive director for Medicaid Health Plans of America (MHPA).

The trade group opposes the fee in general and is pressing for its repeal. Short of that, Moser said, MHPA would support changes that exempt Medicaid. from the provision.
During consideration of the Affordable Care Act, congressional Republicans fought unsuccessfully to scrap the fees. Another attempt to do away with them is now under way in the House, where Reps. Charles Boustany Jr. (R-La.) and Jim Matheson (D-Utah) are pressing a bill to repeal the provision.

Even if the House were to pass the bill, it would have a tough road forward in the Senate and would likely face a veto from Obama.

Opponents, meanwhile, are trying to build their case against the fee. Already, the fee is a top issue for health insurers who contract with states, said Jonathan Dinesman, vice president of government relations for Centene Corporation, a managed care company based in St. Louis.

“This fee will discourage states from enrolling more people,” he said. “It contradicts the objectives of the ACA.”

Dinesman said Centene was still analyzing the language of the proposed rule. Beyond legislation to block or repeal the fee, opponents can submit public comments on the proposal for the next three months and otherwise seek to influence its language during the rulemaking process.

“Everything’s on the table,” he said.
FOODS THAT HELP YOU SLEEP

6 Surprising Foods That Put You to Sleep

By Bill Phillips and the Editors of Men's Health Mar 18, 2013

There's an easier way to fall asleep fast and sleep straight through the night than popping a sleeping pill or downing a glass of vino: Just eat something.

Well, okay, not just anything—chow down on the wrong stuff and you'll be up all night. For example, a University of Cambridge study found that eating protein-rich foods fires up the cells in your brain (called orexin cells) that make you alert and energetic. And if you drink before bed, 4 hours into sleep the alcohol wears off, leaving you in a more activated state, says Men's Health advisor Christopher Winter, M.D., medical director of the sleep medicine center of Martha Jefferson Hospital.

But the right bedtime snacks can put you in prime position for a stress-free evening—one with hours and hours of sleep ahead.

So where do you start? Here are six surprising sleep-inducing foods to add to your grocery list today.

**Bananas**

A little sugar counters the effects of your orexin cells, says Dr. Winter. Try a banana before bed—it will give you just enough sugar to calm your orexin cells, plus magnesium and potassium to help to relax your muscles.

**Passionfruit Tea**

An Australian study found that when people drank a cup of either passionfruit or parsley tea, the passionfruit drinkers slept more soundly. Researchers believe chemicals called harman alkaloids—
high levels of which are unique to the passionfruit flower—act on your nervous system to make you sleepy. (From white to green and everything in between, discover the 9 Healthiest Teas.)

**DID YOU KNOW? Red wine contains some of the world’s best medicine—and you don’t have to go broke to reap the benefits! Try one of these 10 Best Wines Under $15.**

**Hummus**

While L-tryptophan—the amino acid that supposedly makes you crash after Thanksgiving dinner—does make you sleepy, there are better sources than turkey. Consider elk instead, says Christine J. Jones, sleep researcher at Charlottesville Neurology and Sleep Medicine. At 746 milligrams (mg) a portion, it far surpasses turkey (333 mg). Game meats not your thing? Sesame seeds (120 mg) and hummus (usually about 600 mg) are packed with L-tryptophan too.

**FIX IT WITH FOOD: Check out our list of the 40 Foods with Superpowers—foods that, even in moderation, can strengthen your heart, fortify your bones, and boost your metabolism.**

![Dates](image)

L-tryprophan works best when combined with carbs. Carbs trigger your body to secrete insulin, which uses up other amino acids in your bloodstream first, leaving more L-tryptophan to sedate, says Dr. Winter. The best foods for the job? Carbs that raise your blood sugar levels fast, since slow-acting carbs don’t produce the same kind of insulin response. Go for a healthy handful of dates—they’re high in carbs and have a fair amount of L-tryptophan. Fruit and air-popped popcorn are other healthy fast-acting carbohydrates.

**Which snacks are actually good for you? We read the labels so you don’t have to! Find out the 125 Best Foods for Men.**
Chinese Food

GABA (gamma-Aminobutyric acid) is an inhibitory neurotransmitter in your body—in other words, it’s your brain’s brakes to calm the party down. It plays a role in regulating the excitability of neurons throughout your nervous system. The only problem: “It’s not found in food, so you can’t really eat GABA-rich products,” says Dr. Winter. Instead, you can eat foods high in glutamic acid—a precursor to GABA that turns into the neurotransmitter in your body. Monosodium glutamate (MSG) is the salt of glutamic acid, and it’s usually added to Chinese food.

While MSG sometimes gets a bad reputation because it makes food “addictively” good tasting, the FDA has declared it a safe food additive. MSG can be made simply enough by putting salt on a tomato, Dr. Winter says. Other natural options: raw seaweed/spirulina (6,648 mg glutamic acid), Chinese cabbage (6,232 mg), or low-fat cottage cheese (7,455 mg). Still, if you experience the symptoms often associated with MSG, you should avoid it.

Cherries

Recent research in the *European Journal of Nutrition* found that drinking an ounce of cherry juice twice a day—once in the morning and once at night—for a week helped people sleep an extra 25 minutes. Why? It’s laced with L-tryptophan, which can convert into serotonin, and eventually melatonin—the compound that influences your sleep cycle, says Jason Ellis, Ph.D., the director of the Northumbria Centre for Sleep Research. Increase the melatonin circulating in your body, and you’ll increase the chances of a good night’s sleep, too. Try an ounce of juice or a cup of cherries before bed. Since there are no foods high in melatonin, you want to look for foods that can produce it, says Dr. Winter. A few to keep in mind: milk, yogurt, oats, eggs, and peanuts.
Kathleen Sebelius: Obamacare Implementation May Cause Some Health Care Costs To Rise

Reuters | Posted: 03/26/2013 | Updated: 03/27/2013

* Sebelius says expects some shifting in the insurance markets

* Independent study sees 32 percent average rise in premium costs

* Key changes from Obama's signature healthcare law coming next year

By Jeff Mason and David Morgan

WASHINGTON, March 26 (Reuters) - President Barack Obama's top healthcare adviser acknowledged on Tuesday that costs could rise in the individual health insurance market, particularly for men and younger people, because of the landmark 2010 healthcare restructuring due to take effect next year.

U.S. Health and Human Services Secretary Kathleen Sebelius said definitive data on costs will not be available until later this year when private health plans become authorized to sell federally subsidized coverage on new state-based online marketplaces, known as exchanges.

"Everything is speculation. I think there's likely to be some shifting in the markets," she told reporters at the White House.

The law, also known as "Obamacare," eliminates discriminatory market practices that have imposed higher rates on women and people with medical conditions.

It also limits how much insurers can charge older people. But while the changes are expected to lower costs for women, older beneficiaries and the sick, men and younger, healthier people will likely see higher rates as insurers try to hedge against continued risks.

"Women are going to see some lower costs, some men are going to see some higher costs. It's sort of a one to one shift ... some of the older customers may see a slight decline, and some of the younger ones are going to see a slight increase."

Insurance premiums could rise for some with individual plans, she said, as Obama's Patient Protection and Affordable Care Act enhances the level of coverage and either eliminates or reduces the rate of price discrimination against people who are older, female or have preexisting medical conditions.

"These folks will be moving into a really fully insured product for the first time, so there may be a higher cost associated with getting into that market," Sebelius said.

But those who qualify for federal subsidies through state healthcare exchanges would still get a better deal, she said.

Her remarks coincide with growing uneasiness about possible cost increases among lawmakers and executives in the $2.8 trillion U.S. healthcare industry.
A new study released on Tuesday by the nonpartisan Society of Actuaries estimates that individual premiums will rise 32 percent on average nationwide within three years, partly as a result of higher risk pools. Changes would vary by state, from an 80 percent hike in Wisconsin to a 14 percent reduction in New York.

Obama's healthcare restructuring, the signature domestic policy achievement of his first term, is expected to provide coverage to more than 30 million people beginning on Jan. 1, 2014, both through the state exchanges and a planned expansion of the government-run Medicaid program for the poor.

Subsidies in the form of premium tax credits, available on a sliding scale according to income, are expected to mitigate higher costs for many new beneficiaries.

But the insurance industry, which is set to gain millions of new customers under the law, is warning of soaring premium costs next year because of new regulations that include the need to offer a broader scale of health benefits than some insurers do now.

That has raised concerns about people with individual policies not subject to subsidies and the potential for cost spillovers into the market for employer-sponsored plans, which according to U.S. Census data, cover about half of U.S. workers.

'LITTLE IMPACT'

Sebelius dismissed the idea of significant change for employer plans, saying that market segment was "likely to see very little impact."

Separately, a Democratic U.S. senator on Tuesday said the federal government has limited scope to help millions of people likely to remain without affordable health insurance under the new law.

Senator Ron Wyden of Oregon, a member of the Senate Finance Committee, released a report submitted to the panel by the administration that outlines an "employee choice" policy that would allow some employers to offer a wider range of coverage choices to their workers at reduced rates for 2014.

But Wyden said the approach would not help many of the nearly 4 million worker dependents who may have to forego subsidized private health coverage as a result of an IRS ruling.

"Even in the states that allow for employee choice, it will be limited to a small number of workers," Wyden said.

The law would have most people with employer insurance remain under their current plans. Workers can opt for subsidized coverage if their employer plan is unaffordable, but only according to a narrow definition of what is affordable.

The IRS ruled in January that the cost of insuring a worker's family will be considered unaffordable if the employee's contribution to an individual coverage plan exceeded 9.5 percent of that person's income. That rule ignores the fact that family coverage is far more expensive than individual coverage.

As a result, the nonpartisan Kaiser Family Foundation estimates that 3.9 million family dependents could be left unable either to afford employer-sponsored family coverage or to obtain federally subsidized insurance through an exchange.

In its report to the Senate committee, Sebelius' department said some employers could claim a tax
credit in 2014 to make coverage more affordable and offer workers a range of coverage plans through state-based exchanges. (Writing by David Morgan; Editing by Fred Barbash and Paul Simao)
Small businesses confused about ACA, will need help moving into 2014

By IFAnews Staff Posted: March 28, 2013

A new survey of small business owners finds that a majority incorrectly believe health care reform requires them to provide health insurance for employees in 2014, or that they’ll be taxed if they don’t offer health insurance next year.

The survey of small business owners with fewer than 50 employees was conducted by eHealth, Inc., the parent company of eHealthInsurance.com, an online health insurance marketplace. The survey asked about aspects of the Affordable Care Act (ACA), including online health insurance exchanges that will operate in the states.

Uncertainty about exchanges

The survey reveals that only 18% of small employers believe they can confidently define or explain health insurance exchanges. Nearly two-thirds, 62%, admit to not understanding exchanges at all, while 20% say they have only a vague understanding of the role exchanges are expected to play.

To the best of your knowledge, does health care reform require you to offer your employees health insurance next year?

- Yes: 32%
- No: 44%
- No, but I’ll pay a tax if I don’t: 24%

- Almost a third (32%) of respondents incorrectly believe that they will be required by the health reform law to provide group health insurance in 2014.
- Nearly a quarter (24%) incorrectly believe that they will be required to pay a penalty if they fail to provide group coverage in 2014.

Government-run exchanges, which are slated to come online Oct. 1, would make subsidized health insurance available for lower-income people who don’t get health insurance from their employer, starting in 2014. Fewer than half the states have agreed to create their own exchanges; the remainders will rely on a federal program.

The survey shows that the number of small employers who misunderstand the employer mandate has shrunk from 69% last year to a slim majority of 56%.

Beginning next January, ACA requires businesses with 50 or more full-time employees to offer their employees health insurance or pay additional taxes. ACA does not require this of businesses with fewer than 50 workers.

ACA calls for the creation of a Small Business Health Options Program (SHOP) for small businesses in each exchange.

Resistant to forced purchase
The survey also reveals that the overwhelming majority of small business owners do not want to be forced to buy health insurance through any single source, whether through a government or private online exchange. A significant 71% say they want the option to buy their health insurance coverage from the source of their choice. Only 24% said they would prefer to work exclusively with a private company to find health insurance, and 5% say they would prefer to work exclusively with a government exchange.

**Dropping employer-based insurance**

Even with these new rules in place in 2014, two-thirds (67%) of small business owners say they would not stop offering their employees health insurance. According to the survey, only 6% say they’ll definitely stop offering health insurance to employees, while another 27% say they may stop offering health insurance under certain circumstances.

A whopping 91% of the small employers who are considering dropping insurance for employees say that the cost of providing health insurance impacts their decision. The survey shows that employers offer health insurance to employees, first and foremost, because they feel morally obligated to do so (44%). However, in 2014 that sense of obligation could go away for some employers as access to individual insurance becomes guaranteed, regardless of an applicant’s medical history and access to subsidies for individuals. In the past, access to employer-based insurance was guaranteed but applicants for individual coverage could be declined due to their medical histories, in most states.

Because health insurance is a big part of compensation (31% of employers surveyed offer it to attract talented workers), dropping it is a big consideration. At least 70% of the employers surveyed say that it is possible workers would look for work elsewhere if they stopped providing health insurance.

**Assistance from brokers crucial in 2014**

Most employers believe they’ll need help understanding and securing health insurance next year when the new rules kick in, with 70% expecting their choices to be complex enough to require outside assistance.

Employers admit to being confused by and say they’re most likely to turn to their agent or broker when they have questions.

Employers were asked to list the information sources they trust the most:

- 72% trust their health insurance agent or broker
- 30% would turn to a small business association or group
- 28% would work directly with their insurance company
- 24% would choose to reach out to a government agency for help.

When asked to list their motivations for working with a licensed agent or broker, employers say:

- they want to know all of their options (82%)
- they are looking for the best prices (81%)
- they seek the highest quality insurance for employees (68%)

**Hiring in 2014 with ACA**

Among those employers who correctly interpret the employer mandate, 18% say that ACA will have an impact on their hiring plans for 2014. Among all employers surveyed, a third (33%) say ACA will have an impact on their plans to hire and grow their business in 2014 and beyond.

**Health insurance costs in 2014**
When asked to predict what they think will happen to health insurance costs next year, 59% of small employers say they expect costs to go up. Only 11% say they think costs would go down and 21% admit they don’t know what will happen to costs. Only eight percent 8% do not expect the ACA to impact costs at all.

The online survey of small employers was conducted Feb. 12-15, 2013, and gathered a total of 259 responses. Of these, 95% had between 2 and 10 employees. All of the employers work with eHealthInsurance.com, a licensed health insurance marketplace.

To contact us: go to www.healthcareil.com or Call (800) 739-4700