Health & Retirement Services Of Illinois

Newsletter September 2013

OUR NEWS LETTER HRSI

The cheapest-and most expensive-cars to drive

CNBC.com *By Philip LeBeau | CNBC*

MORE AT CNBC.COM

With gasoline prices on the rise again, many Americans are probably curious to know: What's the cheapest car to drive?

Well, gas-price comparison site GasBuddy.com crunched the numbers and the winner is ... the Toyota Prius!

The hybrid vehicle clocked in at just 7 cents per mile, beating out more than 700 cars for the title of cheapest ride.

Not surprisingly, hybrids across the board topped the least expensive list.

Lowest fuel-cost-per-mile

Toyota Prius c (7.2 cents/mile)
Ford Fusion Hybrid (7.6 cents/mile)
Ford C-MAX Hybrid (7.6 cents/mile)
Volkswagen Jetta Hybrid (8.0 cents/mile)
Lincoln MKZ Hybrid (8.0 cents per mile)

GasBuddy.com calculated the fuel-cost-per-mile by taking the combined EPA fuel economy ratings for each vehicle and divided that by the national average for a gallon of unleaded gas.

By comparison, the Bugatti Veyron, a 16-cylinder supercar that sells for $2.25 million dollars, is the most expensive car to fuel, coming in at 36 cents per mile.

"I suppose you could argue that someone driving a 16-cylinder car like the Veyron isn't worried about spending

In Our Newsletter

36 cents per mile to drive their car!" said Tom Kloza with GasBuddy.com. "But for most people, this is a good gauge of how fuel efficient their car is out on the road," he said.

GasBuddy.com says the cars that cost the most to fuel uptend to be the most expensive cars, including ultra luxury sports cars and bigger, heavier trucks and vans.

Highest fuel-cost-per-mile

Bugatti Veyron (35.9 cents/mile)
Ford E350 Wagon (32.6 cents/mile)
Chevrolet 2500 Suburban (29.9 cents/mile)
GMC 2500 Yukon XL (29.9 cents/mile)
Lamborghini Aventador (29.9 cents/mile)

GasBuddy.com also broke the list down by automaker and individual brands that carry the lowest cost to fuel up. Topping the list - Smart, maker of the Smart car.

Lowest average fuel-cost-per-mile

Smart (10 cents/mile)
Fiat (12 cents/mile)
Scion (12.5 cents/mile)
Mini (12.6 cents/mile)
Honda (12.8 cents/mile)

Overall, most people spent less per mile on fuel in July of this year compared to July of 2012. That's a reflection of the moderate gas prices we've seen this summer.

What's a fair price to pay per mile?

According to GasBuddy.com, almost 500 vehicles cost less than 20 cents per mile to drive. What's a reasonable expectation? Kloza says anything under 19 or 20 cents per mile. "19 or 20 cents per mile is a fair expectation," says Kloza. "You can get a great car for that price and a lot lower without having to give up much."

Share of young adults living with their parents hits four-decade high

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The Christian Science Monitor

Chelsea B. Sheasley Pew Research Center Generation Y

More than a third of young adults lived at their parents' home in 2012, the highest rate in at least four decades, according to a new study by the Pew Research Center.

Thirty-six percent of America's so-called Millennial generation – young adults aged 18 to 31 – lived at home last year, compared with 32 percent in 2007, prior to the Great Recession. In 2009, the year the recession officially ended, 34 percent of Millennials lived at home.

"The steady rise in the share of young adults who live in their parents' home appears to be driven by a combination of economic, educational and cultural factors," the Pew report states.

Key among those factors are declining employment, rising college enrollment, and declining marriage rates, according to the report.

"I think part of this trend is indeed a reflection of the weak labor market and difficult job prospects, says Richard Fry, the report's author. "More young adults are living with their mom or dad, but nationally, jobholding hasn't really increased much."

In 2012, 63 percent of 18-to-31-year-olds had jobs, compared with 70 percent in 2007. Millennials without jobs were much more likely to live at home than their employed counterparts: 45 percent to 29 percent, according to the report.

Over the past five years, the percentage of 18-to-24-year-olds enrolled in college rose from 35 percent in March 2007 to 39 percent in March 2012. Overall, at least a third and perhaps as many as half of the Millennials living at home are college students, and this includes those who live in college dormitories during the academic year, according to the report.

The percentage of married Millennials, aged 18 to 31, declined from 30 percent in 2007 to 25 percent in 2012.

ConsumerWatch: Big Push Ahead to Sell Obamacare to …Play video."

Lauren Rikleen, executive in residence at the Boston College Center for Work & Family who is writing a book about Millennials in the workforce, says she meets Millennials living at home “all the time.”

“I don’t see any stigma at all anymore. The stigma would be a sense of wistfulness that they wished they were independent. I see more often a sense of real appreciation for the safety net,” she says.

“By and large, it’s really interesting to watch because in many respects, it’s become normative because the options are so limited," she says. "Home is the place where they take you in."

A separate Pew study last year found that Millennials are largely happy with their situation, with 78 percent satisfied with their living arrangements.

Less research has been published about how parents are feeling. A guide published last year by AARP offered eight tips for parents when their adult kids move back home. Among them: No hot meals all the time, set a deadline, and don’t be an ATM machine.

Armed With Bigger Fines, Medicare To Punish 2,225 Hospitals For Excess Readmissions

By JORDAN RAU KHN Staff Writer AUG 02, 2013

Medicare will levy $227 million in fines against hospitals in every state but one for the second round of the government's campaign to reduce the number of patients readmitted within a month, according to federal records released Friday.

Medicare identified 2,225 hospitals that will have payments reduced for a year starting on Oct. 1. Eighteen hospitals will lose 2 percent, the maximum possible and double the current top penalty. Another 154 will lose 1 percent or more of every payment for a patient stay, the records show. Hospitals that treated large number of low income patients were more likely to be penalized than those treating the fewest impoverished people.

The penalty program, which began in October 2012, is among the toughest of Medicare's efforts to pay hospitals for the quality of their performances rather than merely the number of patients they treat. Unlike other new programs created by the federal health law, the readmissions program offers hospitals no rewards for improvements or the opportunity to opt out.

While the overall number of penalized hospitals stayed about the same -- with Medicare penalizing two-thirds of eligible hospitals -- there have been considerable shifts among facilities. A Kaiser Health News analysis found that 1,371 hospitals are receiving a lower fine. Alegent Creighton Health Midlands Hospital in Papillion, Neb., will see the biggest penalty decrease, going from the maximum 1 percent fine in the current year to no fine for the second year. Nationwide, the average hospital fine will be slightly smaller, and the national total will be $53 million less than this year's fines.

Medicare is increasing penalties for 1,074 hospitals. A total of 283 hospitals not fined in the current year, including Stanford Hospital in California and Johns Hopkins' Sibley Memorial Hospital in Washington, D.C., will be penalized in the new round.

The October penalties will be applied on at least four out of five hospitals in Alabama, Arkansas, Florida, Kentucky, Illinois, Massachusetts, New York, New Jersey, Tennessee, West Virginia and the District of Columbia, the KHN analysis found. Maryland, which Medicare exempted from the program because it has a unique reimbursement system designed under a federal waiver, is the only state without a hospital getting a fine.

"The recognition of just how complex and difficult of a problem this is is growing as people are starting to grapple with it on the ground," said Dr. Karen Joynt, a Boston cardiologist and Harvard researcher. "It's going to take creativity and innovation and most importantly reaching outside the hospital walls."

Fighting Incentives To Do More

Medicare has credited the penalty program for combatting a perverse financial incentive: hospitals earn more money if their patients' health deteriorates after they are discharged, because they can be paid for two stays instead

of one. The Medicare Payment Advisory Commission (MedPAC), which reports to Congress, has estimated that 12 percent of Medicare patients may be readmitted for potentially avoidable reasons. Averting one out of every 10 of those returns could save Medicare $1 billion, MedPAC says.

The penalties are based on readmissions of Medicare patients who originally went into the hospital with at least one of three conditions—heart attack, heart failure and pneumonia—and were discharged between July 2009 and June 2012. Those that ended up in any hospital within 30 days were counted unless that readmission had been planned when the patients left the hospital after their original stay. Hospitals that had more readmissions than Medicare predicted after taking the severity of their patients' illness into account received fines.

Readmissions Penalty Data

- **Medicare To Punish 2,225 Hospitals For Excess Readmissions**
- **Penalties By Hospital (Printable PDF)**
- **Penalties By Hospital (Downloadable CSV)**
- **State Averages**
- **Methodology**

Nationally, the average fine decreased from 0.42 percent in the first year of the program to 0.38 percent.

In addition, 141 hospitals that in the first year were given the maximum penalty will get a lower punishment starting in October. Medicare determined that 1,154 hospitals kept their readmissions numbers low enough to escape fines.

Some of the changes in the new penalties may be due to refinements Medicare made in the way it calculated readmissions. This time, it excluded from its analyses cases where doctors had planned for a second admission. A lung cancer patient, for instance, might be admitted for pneumonia and then return for previously planned chemotherapy. Or doctors might unblock one of a heart attack patient's arteries and have him come back for a heart pump or previously planned transplant. Medicare estimates that readmissions are planned in 12 percent of heart attack cases, 6 percent of heart failure cases and 4 percent of pneumonia cases.

Nationally, the rate of all readmissions dropped somewhat last winter, according to Medicare, but those changes are too recent to be reflected in this year’s penalties.

As they did last year, the Medicare penalties appeared to land harder on hospitals that treat large numbers of poor people, according to calculations Medicare made and included in a regulation published Friday.

Among the safety net hospitals with the most poor patients, 77 percent were penalized, while only 36 percent of the hospitals with the fewest poor patients were penalized. Denver Health Medical Center, which has historically had low readmission rates and thus has been cited as proof that safety net hospitals can avoid readmissions for their patients, will get a 0.04 percent penalty after avoiding any punishment last year.

However, Medicare stated that it did not see a need to take the socio-economic populations of hospitals into account in the penalties, since it already factored in the differing health of those populations. "We routinely monitor the impact of socioeconomic status on hospitals’ results and have consistently found that hospitals that care for large proportions of patients of low socioeconomic status are capable of performing well on our measures," the agency wrote in its rule.

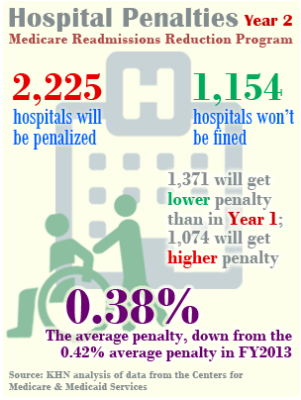
Dr. Eric Coleman, a director of care transitions program at University of Colorado, said more hospitals are taking readmissions seriously, in part because of the penalties. "People are starting to recognize that renaming discharge planning does not actually improve your readmissions rate," said Coleman, who designed a widely adopted method to reduce readmissions by coaching patients on what they need to do to stay healthy after leaving the hospital. "Hospitals have moved past 'is this for real' or 'should we do something.'"

Because Medicare applies the penalties to every payment for a patient stay, hospitals can only estimate what the dollar amount of the fines will turn out to be. Some large hospitals may end up losing more than $1 million from the penalties if last year is any guide.

But hospitals that succeed in reducing readmissions may end up with even less revenue by forgoing those second patient admissions, said Erik Johnson, a senior vice president at Avalere Health, a Washington consultant group that advises hospitals and other providers. "The economics of it still do not make a tremendous amount of sense, honestly," he said. "I think hospitals are being good actors in trying to bring these numbers down."

Hospitals Raise Concerns

The uneven impact of the penalties has been a major concern for hospitals. Low-income patients often have a harder time adhering to their post-hospital instructions, researchers say. Buying medicines can be prohibitively expensive for them, discharge instructions harder to follow, and a low-salt diet required to avoid continued congestive heart failure can be expensive. Some hospitals have noted that they have low mortality rates and said that may in part be due to their aggressiveness in recalling patients who seem to not be healing.



The hospital industry has been vocal in its dislike of the penalties, complaining that it should not be punished for patients' health beyond the confines of the hospitals, especially since they get no extra payments for that care. The architects of the health law believed that hospitals have abdicated too much responsibility for their patients and included the penalties to force medical providers to do a better job of working together as patients move to different sites of care.

Even before the penalties kicked in last October, many hospitals started searching for better ways to ensure their patients did not relapse. Some began sending nurses to check in on patients at their homes, while others gave low-income patients free medications on their way out. Medicare does not pay hospitals for those efforts.

"In the past, hospitals haven't been in engaged because frankly that was the responsibility of the physician or the post-acute providers," said Chip Kahn, president of the Federation of American Hospitals, an association of for-profit institutions. "That wasn't perceived to be part of the hospital role. Now there's a provider who is looking over everyone's shoulder post hospitalization to encourage compliance and appropriate service."

Joynt and Dr. AshishJha, a fellow researcher at the Harvard School of Public Health, have questioned whether some safety net hospitals with limited finances can lower their readmission rates as aggressively as well-heeled hospitals can. In June, MedPAC recommended that the readmission penalties take the socio-economic status of patients into account when calculating penalties.

Academic medical centers were more likely to get penalized than were community hospitals. The KHN analysis found 87 percent of major teaching hospitals were penalized, while 63 percent of hospitals that do not train medical residents were penalized. The penalties for major teaching hospitals, however, were not noticeably higher than other hospitals, and hospitals that are not major teaching centers but maintain smaller numbers of residents received slightly lower fines on average than other hospitals.

Hospitals Receiving The Full 2 Percent Penalty	
Bertrand Chaffee Hospital	**Springville, N.Y.**
Dimmit County Memorial Hospital	**Carrizo Springs, Texas**
ETMC Henderson	**Henderson, Texas**
Falls Community Hospital And Clinic	**Marlin, Texas**
Five Rivers Medical Center	**Pocahontas, Ark.**
Franklin Medical Center	**Winnsboro, La.**
Harlan Appalachian Regional Healthcare Hospital	**Harlan, Ky.**
Jennings American Legion Hospital	**Jennings, La.**
LibertyHealth-Jersey City Medical Center Campus	**Jersey City, N.J.**
Livingston Regional Hospital	**Livingston, Tenn.**
Medical Center of Southeastern Oklahoma	**Durant, Okla.**
Medical Park Hospital	**Hope, Ark.**
Monroe County Medical Center	**Tompkinsville, Ky.**
Morton County Hospital	**Elkhart, Kan.**
Perry Community Hospital	**Linden, Tenn.**
Pineville Community Hospital	**Pineville, Ky.**
Russell County Medical Center	**Lebanon, Va.**
Westlake Regional Hospital	**Columbia, Ky.**

Many of the most prominent academic medical centers stung in the first round of penalties did better this year. In Boston, Beth Israel Deaconess Medical Center—which has a $4.9 million grant from the government to reduce readmissions—will see its penalty fall from 1 percent to 0.69 percent. Massachusetts General Hospital's fine will drop from 0.51 percent to 0.25 percent. In Connecticut, Yale-New Haven Hospital's fine will go down from 0.90 to 0.51 percent. The Cleveland Clinic's fine will drop from 0.74 percent to 0.33 percent.

In Saint Louis, Barnes-Jewish Hospital's fine will fall from 0.98 to 0.60, and the system's hospital in Saint Peters will see its fine decreased from 0.63 percent to 0.01 percent.

For other major academic medical centers, the fines will be steeper. University of Missouri Health Care in Columbia will start losing money with a 0.11 percent decrease. In New Jersey, Liberty Health-Jersey City Medical Center's fine doubled to the maximum of 2 percent.

In the third round of the program, starting in October 2014, Medicare is increasing the final maximum penalty to a 3 percent payment reduction for all patient stays. Also that year, Medicare plans to consider readmissions for more conditions, including chronic lung disease and elective hip and knee replacements. Health experts have also designed a way to measure all of a hospital's readmissions, and that may ultimately be used for the penalties. In

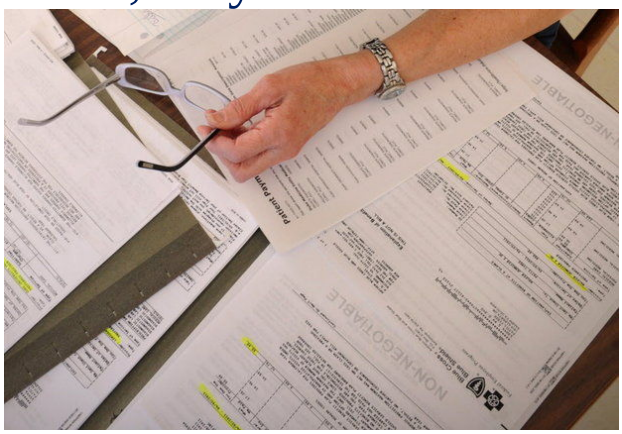
addition, several of Medicare's other experiments in alternative payment plans, including accountable care organizations and bundled payments, aim to give hospitals full financial responsibility for patients.

"Many of the hospitals we work with are scrambling to put measures in place to reduce their rate of readmissions, to the extent they can," said Chas Roades, chief research officer for The Advisory Board Company, a consulting group based in Washington. "The financial penalties aren't huge right now, but hospital leaders recognize that the penalties will get bigger, and that scrutiny over readmissions rates will continue to grow."

Data for individual hospitals are available as a printable PDF file or a downloadable CSV spreadsheet. State Averages of readmission rates and our methodology are also available.

This article was produced by Kaiser Health News with support from The SCAN Foundation.

Instant help figuring out health care reform is now available on a new, easy-to-understand AARP website: The Frugal Patient



Want to instantly understand how health care reform will affect you? Check out the new AARP website HealthLawAnswers.org. *(AP photo)*

Print  By Diane Suchetka,

CLEVELAND, Ohio -- Want to know exactly what health care reform means for you and how it affects decisions about your health insurance?

You can find out in a minute – no exaggeration – using AARP's new website, HealthLawAnswers.org.

A few clicks – on your state, your age, your family size and income range – and you end up with exactly what you need to know about the law's effects on you.

In the time it takes to read that information, you'll know whether you need to shop on your state's insurance exchange, apply for Medicaid or do nothing.

And if you do have to buy your own insurance, the site tells you if you qualify for financial aid from the government to help pay for it.

HealthLawAnswers.org isn't just fast, it's easy to understand and links you instantly to websites providing all the additional information you need.

If you want to know more about new benefits provided under the health care law, how the insurance exchanges work or what health care reform means to small business, it's all available on a separate AARP site, HealthLawFacts.org.

Both sites are also available in Spanish: MiLeyDeSalud.org and LeyDeSalud.org.

KIDS CHRONIC STOMACH PAIN TIED TO ANXIETY DISORDERS

GenevraPittmanReuters *August 12, 2013*

NEW YORK (Reuters Health) - Children with chronic or recurring stomach pain without a clear medical explanation were also more likely to have an anxiety disorder than those without stomach problems, in a new study.

By the time kids with stomach pain reached age 20, just over half had had symptoms of an anxiety disorder at some point, most often social anxiety, researchers found.

Anxiety tended to start in early childhood, around the same time as the chronic stomach problems.

Past studies suggest between eight and 25 percent of all youth have chronic stomach pain, researchers noted. When there's no clear medical cause for the pain - such as inflammatory bowel disease or celiac disease - it's known as functional abdominal pain.

"It's very prevalent, and it's one of the most common reasons that children and adolescents end up in their pediatrician's office. It's one of the most common reasons kids are missing school," said Dr. Eva Szigethy, head of the Medical Coping Clinic at the Children's Hospital of Pittsburgh Inflammatory Bowel Disease Center.

One small study of children with that type of pain found they were at a higher than average risk of anxiety disorders as young adults.

To build on those findings, Lynn Walker from the Vanderbilt University School of Medicine in Nashville, Tennessee, and her colleagues followed 332 children who visited a doctor for unexplained stomach pain between age eight and 17.

For comparison, they also tracked 147 youth from the same area schools without stomach problems.

When participants were 20 years old, on average, the researchers interviewed them in person or over the phone about symptoms of anxiety and depression. At that point, four in 10 of those with a history of stomach pain still had a gastrointestinal disorder.

Based on the interviews, Walker's team found 51 percent of people with stomach pain as children had ever had an anxiety disorder and 30 percent currently met the criteria for a diagnosis.

In comparison, 20 percent of people in the no-stomach pain group had ever had an anxiety disorder and 12 percent currently had one.

"What was striking was the extent to which anxiety disorders were still present at follow-up," Walker told Reuters Health.

Anxiety was more common among people who continued having stomach pain compared to those whose childhood symptoms went away, she and her colleagues wrote Monday in Pediatrics.

Although the researchers couldn't tell from their analysis which came first - the pain or the anxiety - most anxiety disorders traced back to early childhood.

Szigethy, who wasn't involved in the new research, said that in her experience it's "extremely common" to find functional abdominal pain and anxiety occurring together.

"We've noticed clinically that often the anxiety does predate the onset of pain," she told Reuters Health.

She said children with anxiety may be more sensitive to pain, and may constantly worry about any pain they do feel.

Walker agreed.

"People who are anxious tend to be very vigilant to threat, scanning their environment or their body for something that might be wrong," she said. Those children are more likely to get into a "vicious cycle" of staying home from school due to a stomachache, getting behind on schoolwork and becoming more anxious, Walker added.

The researchers both said doctors treating kids with unexplained stomach pain should be asking about anxiety as well.

The interviews also showed 40 percent of participants with childhood stomach pain had been depressed at some point, versus 16 percent of those in the comparison group.

Szigethy noted that the study didn't track how kids were treated for anxiety or stomach pain and whether that affected their symptoms as young adults. That, she said, is "a next step to be looking at in this type of work."

IRS moves to share taxpayer information under ObamaCare

By Julian Hattem - 08/13/13

The IRS has finalized its rule for disclosing taxpayer information under provisions of ObamaCare.

The agency will share personal information such as income and tax filing status with states and other agencies to confirm whether or not people are eligible for tax credits to buy health insurance in new state-based marketplaces.

Republicans and critics of the healthcare reform law have questioned the tax agency's ability to effectively safeguard Americans' personal information when it is shared with outside officials. They have worried that people could have their identities stolen or have sensitive details made public.

Critics have also pointed to recent revelations that the agency had subjected conservative groups and others to extra scrutiny.

As part of the Affordable Care Act, the IRS is required to confirm whether people are eligible to receive tax credits or other special assistance to buy health insurance. Government officials will use tax return data to check household income and make sure it matches what applicants have declared.

In a letter on Monday, Senate Minority Leader Mitch McConnell (R-Ky.) asked the Department of Health and Human Services (HHS) to delay the law because of concerns that Americans' personal and financial data could be at risk.

He cited delays in assuring that "data thieves" will not be able to access an HHS-run data hub that will be used to process applications for insurance and subsidies to cover the cost. The department's current schedule calls for a final security authorization to be issued just a day before the Oct. 1 opening of the insurance exchanges.

Earlier this month, House Ways and Means Committee Chairman Dave Camp (R-Mich.) said that Americans would be at "even greater risk" of having their identities stolen thanks to the law.

Supporters of the administration have countered that the charge is just the latest in a long-running Republican attempt to discredit the healthcare law.

The IRS already shares taxpayer information with other federal agencies to determine whether Americans are eligible for programs like Medicaid. Additionally, there are legal penalties already on the books for the improper use or release of tax return information.

That should be enough to satisfy concerns about privacy, supporters have said.

Earlier this month, acting head of the IRS Danny Werfel told a House panel that the agency has "all kinds of safeguards and procedures" whenever it shares taxpayer information outside the IRS.

Before leaving town for the August recess, the House voted to prevent the IRS from implementing any part the law. The legislation stands little chance in the Democratic-controlled Senate and President Obama has threatened to veto the bill, should it ever reach his desk.

METFORMIN TIED TO LONGER PROSTATE CANCER SURVIVAL

Veronica Hackethal, MD Reuters *August 15, 2013*

NEW YORK (Reuters Health) - In older men with diabetes and prostate cancer, taking the diabetes drug metformin was linked to a lower risk of death, according to a new study.

Researchers found metformin's apparent benefits accumulated over time. Among men with diabetes in Ontario, Canada, who were over age 66, the study found a 24 percent reduction in prostate-cancer mortality for every six months of metformin use, and a similarly lower risk of death from any cause for the first six months.

"Among diabetic men with prostate cancer metformin should be considered the drug of choice, not only for diabetes control but possibly to improve prostate cancer outcomes," Dr. David Margel, a urologist at Rabin Medical Center, Petah Tikva, Israel, and lead author of the study, told Reuters Health in an email.

The World Health Organization estimates that prostate cancer is among the top five leading causes of cancer death worldwide.

Approximately 1 in 7 men in the U.S. will be diagnosed with prostate cancer at some point in their lives, with roughly two-thirds of these cases found between the ages of 55-74. According to the National Cancer Institute, more than 29,000 American men will die from prostate cancer in 2013.

Likewise, the World Health Organization estimates that 347 million people worldwide have diabetes, and that it will be the seventh leading cause of death by 2030.

According to the U.S. Centers for Disease Control and Prevention, more than 25 million Americans are affected by diabetes and over one-quarter of people older than age 65 have the disease.

How metformin would work in someone with prostate cancer but without diabetes is unknown, however. Margel's research team is planning a randomized controlled trial to see if metformin also improves prostate cancer outcomes for non-diabetic men.

"Metformin is cheap, safe and has minimal side effects among patients without diabetes and therefore may be an ideal drug for secondary prevention." Margel added.

Metformin is a first-line medication for the treatment of noninsulin dependent diabetes. It is one of the oldest and cheapest oral diabetes medications, with prices ranging from 16 to 83 cents per pill for the generic form. The most common side effects include digestive problems and headache.

Using the Ontario Diabetes Database and the Ontario Cancer Registry, the researchers identified 3,847 men who had already been diagnosed with diabetes before their prostate cancer was discovered between March 1, 1997 and March 31, 2008.

The researchers also looked at the Ontario Drug Benefit Database to determine length of men's metformin use, as well as other diabetes medications and statins, which are used to control high blood cholesterol. Then they looked at deaths from prostate cancer and other causes.

The men were followed for about four and a half years, during which time 35 percent of them died. Of these, 7 percent died from prostate cancer.

The researchers, who published their findings in the Journal of Clinical Oncology, found that men who took metformin over time had significantly longer survival than men who didn't take the drug, in terms of deaths from prostate cancer as well as other causes.

Metformin's role seemed to be unique, since other diabetes medications did not have the same effect.

Statin use was also tied to decreased mortality, but the researchers were not able to examine what was going on with their use more closely.

"This is a scientifically rigorous and well-done study, and provides some of the best evidence we have up to this point that metformin may be helpful in preventing the progression of prostate cancer," said Dr. Scott Eggener, associate professor of surgery and co-director of the prostate cancer program at University of Chicago Medicine.

He cautioned, though, that this study was based on observation of events after they happened, so it cannot provide the level of evidence needed to say whether everyone with prostate cancer should go on metformin.

Metformin's role in preventing prostate cancer is also still unclear. Eggener told Reuters Health that most studies so far suggest metformin doesn't play a role in preventing diabetic men from developing prostate cancer.

"Once you have prostate cancer, what the present study suggests is that metformin may prevent progression or minimize the rate of progression," Eggener, emphasized, "This could turn out to be a real legitimate advance in prostate cancer management."

Old-fashioned Cheerios still a healthy cereal pick

By Bill Bradley | GQ

Not everyone has the time to stir steel-cut oats for 25 minutes before work. But as your mother insisted before she shoved you off to school every morning, you have to eat breakfast. And that doesn't mean pouring a heaping bowl of your favorite neon-colored marshmallow cereal. Have you ever *looked* at the nutrition facts on a cereal box?

Lucky Charms has 10 grams of sugar. Frosted Mini-Wheats has 11. Post Raisin Bran contains a staggering 20 grams! Even Bear Naked fruit and nut granola—a seemingly healthy choice—clocks in at six, the same as Honey Bunches of Oats. Most cereal, even granola, is a shockingly not-so-great way to start the day. But it's also super-fast and convenient when you're rushing out the door. So we at the GQ Institute For Not Getting Fatter Than We Have To sought professional expertise to ask: What's the least bad cereal out there?

The answer: Old-fashioned Cheerios. With a heaping scoop of fresh fruit.

"A cup of Cheerios is 100 calories and the first ingredient is whole-grain oats," says registered dietitian Kim Kirchherr. A serving from that big yellow box (which debuted in 1941 as Cheerioats) has only one gram of sugar. It's low in calories—less than half the caloric load of a bowl of Grape Nuts, which weigh in at 210 calories per serving—and, as the original name suggests, the primary ingredient is whole-grain oats, which help reduce the risk of type-two diabetes and heart disease. Men need 38 grams of fiber daily, and Kirchherr recommends looking for a cereal with at least three grams per serving, which is exactly what Cheerios offer. You can add even more with fresh fruit.

"Cereal is a vessel for a lot of other good stuff," adds Jim White, a registered dietitian and spokesperson for the Academy of Nutrition and Dietetics. "Fruit is a great way to increase fiber. It'll keep you full longer. It can really get men jump-started for the day." And if you're wondering what to pour on top of it, White likes organic skim milk. "It has protein to build muscles, calcium to help support strong bones, electrolytes to help replace after a hard workout, and water to help hydrate the body. It's one of the perfect foods for men."

One thing you'll notice once you start poring over the nutrition labels in the cereal aisle is the miniscule serving size. It's generally one cup, which feels like half of what you feed your dog for breakfast. "Most guys grab a bowl and put as much as they can. They don't realize it could be three to five times the serving," White says. "You have to watch that portion size."

This is where the fruit comes into play. It makes a small bowl of Cheerios—that one measly cup—seem a hell of a lot bigger. Throw in a half-cup of sliced strawberries or bananas, and you won't even think about pouring a second bowl.

Health-care taxes are complicated calculation

By Russ Wiles The Republic | azcentral.com Sat Aug 17, 2013

The Affordable Care Act is a complex piece of legislation. How complicated? The Internal Revenue Service has just launched a separate website, irs.gov/aca, to help explain it.

The site is worth perusing, especially if you make a lot of money or run a business. Otherwise, if you can remember three key numbers about the new law, also known as "Obamacare," that should go a long way toward simplifying things. Those numbers are $125,000, $200,000 and $250,000.

These are the income-eligibility thresholds above which the two key individual tax provisions kick in. The health-insurance marketplaces or exchanges created by the legislation haven't opened their doors, but these key taxes, which provide funding for the program, got started in January.

If you don't earn more than the dollar-threshold amounts relevant to your situation, you won't have to pay the taxes, though there are some devils in the details — no surprise there!
The two key fundraising levies for the program are the Additional Medicare Tax and the tax on Net Investment Income. A person could be subject to one of the taxes, both or neither.

Only those married taxpayers earning more than $250,000 are affected, as are single filers making in excess of $200,000. The $200,000 figure also applies to people in other filing categories such as heads of household and qualifying widows and widowers with a dependent child. The third number, $125,000, is for married couples filing separate returns.

The $125,000/$200,000/$250,000 thresholds apply to both the Additional Medicare Tax and the levy on Net Investment Income. But here's a warning: Those thresholds are based on different measures of income.
The threshold amounts are actually the simple part of the law — simple in the sense that if your income falls below these levels, you don't pay. Most people in Arizona won't. Only 2.5 percent of federal returns filed by Arizonans reported income above $200,000, according to the IRS.

But if your income is high enough, your taxes will rise and your life gets more complicated.
The Additional Medicare Tax is the more straightforward of the two. All wages and self-employment income that already were subject to regular Medicare taxes also are subject to this one. The tax itself is a flat 0.9 percent, a rather odd number. The tax also applies to tip income, but you'd have to wait on a lot of tables to get into the relevant income range.

If you make more than $125,000/$200,000/$250,000, you probably noticed that your withholding amount rose and take-home pay dropped at the start of the year. Note a possible problem here: If neither you nor your spouse exceeds the limits individually but together you do, then your employers might not be withholding any additional taxes, setting you up for a stinger of a penalty next year. The same caveat also applies if you have multiple jobs that put you over the earnings target, yet your employers, acting independently, don't know this.

Solutions: Start making estimated tax payments or boost your withholding.

The tax on Net Investment Income is more confusing. Those same $125,000/$200,000/$250,000 income numbers are the triggers. If you're above, then you must calculate investment earnings on which the 3.8 percent tax (another strange number) would apply.

If susceptible to this tax, you need to calculate your investment income and gains. Tax-exempt interest from municipal bonds isn't subject to this tax. Nor are capital gains on primary, owner-occupied homes up to the normal exclusion amounts — $250,000 for singles, $500,000 for married couples (subject to other eligibility requirements). But a lot of other things are, including rental income and gains from rental real estate and second homes, capital gains from the sale of stocks, bonds and mutual funds and interest from bonds, bank accounts and stock dividends.

The 3.8 percent tax applies on one of two numbers, either your regular wage income above the $125,000/$200,000/$250,000 amounts or your Net Investment Income, whichever is less.
Here's a simplified example from the IRS. Consider a married couple earning $300,000 who sell their home for $1.3 million, realizing a gain of $600,000 after subtracting their non-taxed basis in the property. Because Since they can exclude $500,000 in capital gains from the $600,000, that lowers their net investment income to $100,000. But assume they also have $125,000 in other investment income and gains. This increases their Net Investment Income to $225,000.

Do they pay 3.8 percent on that amount? No. The tax applies on the lesser of the $225,000 in net investment income or the amount by which their wage earnings ($300,000) exceed their eligibility threshold ($250,000), which equals $50,000. That's the taxable figure, because since it's the lower of the two calculations. The couple's Net Investment Income tax thus is 3.8 percent of $50,000, or $1,900.

The health-care legislation contains several other key provisions, but that's enough tax math for now.

Ignorance of Obamacare exchanges threatens plan's success

Published: Friday, 23 Aug 2013  By: Dan Mangan | Health Care Reporter

Miguel S. Salmeron | Stockbyte | Getty Images

With just 38 days to go before the opening of Obamacare insurance exchanges, public ignorance about those marketplaces remains sky-high, threatening the very goal of offering affordable health care to the uninsured, several studies show.

And according to a troubling conclusion in at least one study earlier this year, awareness about the new health-care law had declined among some groups more than three years after Obamacare was signed.

But whether knowledge is slipping or stagnantly low, health-care advocates are now in crunch mode as they work to spread the word about exchanges, whose success is dependent on large consumer participation.

Just 22 percent of adults ages 18 to 64 had heard "a lot" or "some" about the insurance exchanges, according to a Kaiser Family Foundation study in June. But 45 percent said they knew "nothing at all about them," according to the study.

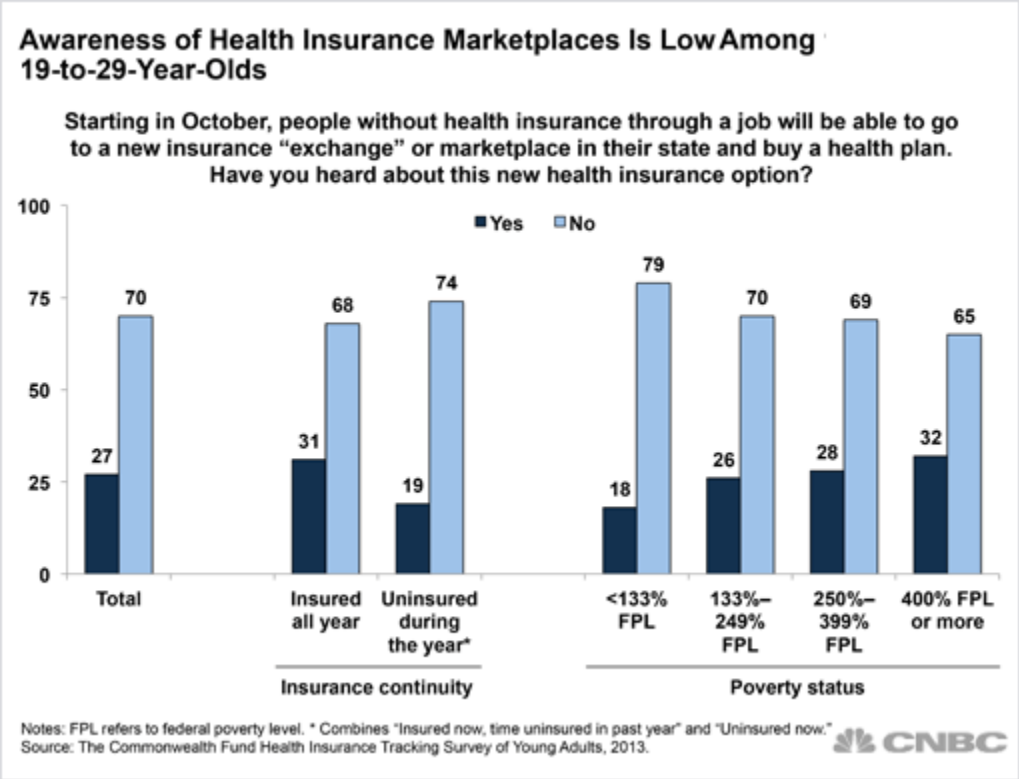
Perhaps most alarming is the number of young adults who appear particularly clueless about the Affordable Care Act exchanges that are due to open Oct. 1 and begin coverage on Jan. 1. A whopping 73 percent of adults between the ages of 19 and 29 are unaware of the marketplaces, a separate Commonwealth Fund study this week found.

"If you continue to see that very low level of awareness even as you get toward October, that's a sign that we may not be getting the enrollment, and the exchanges are going to be at a bit of risk from that," said Commonwealth Fund report co- author Sara Collins.

"You want a broad, healthy diverse risk pool in the marketplaces. It's really important that young, healthy people come into the market," said Collins, noting the danger of premium hikes from having a disproportionate number of older, sicker people in insurance plans.

Even if they know about the exchanges, a surprising 68 percent of people with pre-existing health conditions—who potentially have the most to benefit because the law now will bar denial of insurance in such cases—say they are unsure if they will buy the plans there, according to a separate report this month from InsuranceQuotes.com. That same report found that 14 percent of such people with health conditions said they actually would not buy insurance.

(*Read more*: **Health-care changes on the horizon**)



Confusion about health insurance

Liz Hamel, an associate director for surveys at the Kaiser Family Foundation, said, "We certainly haven't seen an increase in public knowledge since the law passed" in 2010.

In fact, a Kaiser survey in March found that "awareness had decreased" among some groups about Obamacare, Hamel said.

Since then, there have been news headlines about Obamacare that have left some people with the mistaken impression that the exchanges are either going to be delayed for a year or have been overturned altogether, neither of which is true. Contributing to that confusion are repeated votes by the Republican-controlled House of Representatives to either repeal or defund the law.

(*Read more*: **Another Obamacare delay**)

One in Five Have Heard About the Health Insurance Marketplaces

How much have you heard of health insurance exchanges in your state?	Total public	Insured	Uninsured	Less than $40,000	$40,000-$89,999	$90,000 or more
A lot	8%	10%	4%	7%	7%	11%
Some	14	15	8	13	14	16
Only a little	34	33	32	31	35	35
Nothing at all	45	42	55	49	43	38

Source: kff.org

'Knowledge gap'

"I think it shows that people are really confused. I think it just shows a basic misunderstanding," said Laura Adams, senior analyst at InsuranceQuotes.com. "If these people don't know this law is around the corner and designed to benefit them, then I think that shows a real knowledge gap that I don't think we're going to close before Oct. 1."

"Next year, we're probably going to see a lot of people who could be getting benefits not signing up," Adams said.

The wide knowledge gap has sparked a scramble to educate the uninsured about the exchanges and to push them to sign up during the six-month open enrollment.

"We've definitely got our work cut out for us," said Jessica Barba Brown, national communications director of Enroll America, a nonprofit group that's spending tens of millions of dollars and deploying more than 3,000 volunteers to spread the word about the exchanges.

"This is going to be a huge, unprecedented option for millions and millions of Americans that never had it before," said Barba Brown. "So yeah, it's a big deal, and it's definitely not going to be easy."

What's an insurance exchange?

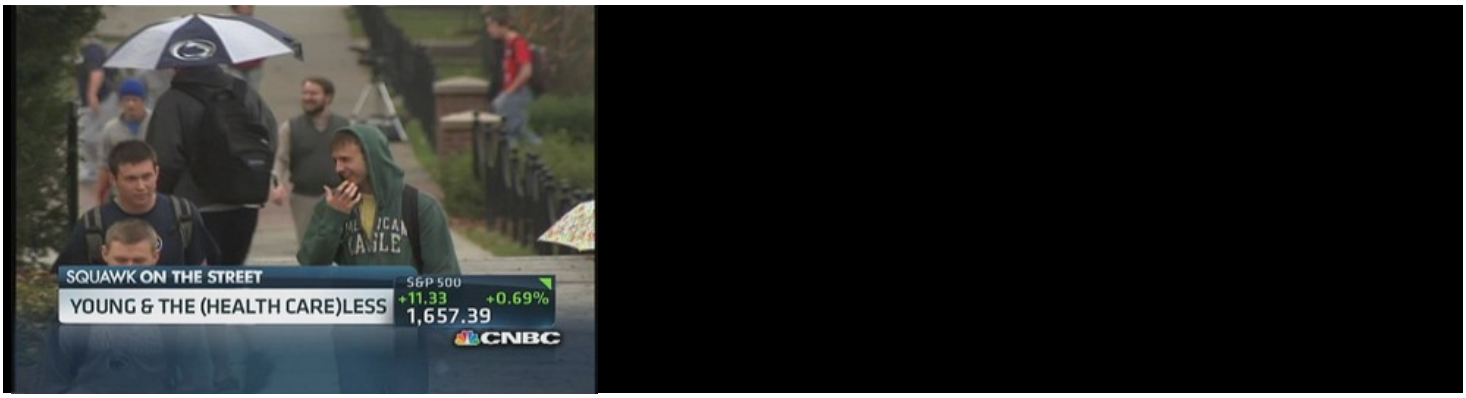
The government-run exchanges being set up in all 50 states and the District of Columbia will offer a menu of health insurance plans that all must have certain minimum benefits and be affordable. The plans will be offered at different levels of premiums—ranging from bronze plans up to platinum plans—and subsidies will be available to many people to help them pay for the coverage.

Most Americans, about 80 percent, already have insurance through their employers. But for 50 million or so other people, the exchanges will be their primary way of obtaining insurance, which is required by the Affordable Care Act.

Making the job of selling the brand-new exchanges even more difficult is the public's general ignorance about health insurance. A recent *Journal of Health Economics* study found that just 14 percent of people were able to correctly define all of four insurance terms that could affect plan-buying decisions: deductibles, copays, coinsurance and maximum out of pocket costs.

But the persistent ignorance about the Obamacare exchanges is striking given extensive news coverage of the health-reform law upheld by the Supreme Court last year as well as a presidential election, which was seen as a referendum on President **Barack Obama**'s championing of the legislation.

(*Read more*: **Obamacare penalty**)



Health-care law's success depends on youth

It's crunch time for Obamacare, and the success of the law depends on young people signing up, reports CNBC's Bertha Coombs.

The risk of ignorance about the exchanges isn't limited to potential premium hikes stemming from lower-than-projected enrollment.

There are also "some dramatic consequences" for the health of the people who don't obtain insurance, said Jeffrey Levi, executive director of the Trust for America's Health, a health advocacy group.

"For example, there are estimates that as much as a quarter of people that are HIV-positive do not know they are infected," said Levi, noting that if those people had insurance coverage they would be getting "routine screening" that could detect the virus.

"This is not just preventing the people with HIV from developing AIDS, but we also know that people in treatment are much less likely to transmit the disease."

New York State of Health

Like other states, New York is launching a multifront effort to overcome lack of awareness about exchanges and get people to enroll.

Donna Frescatore, director of New York's exchange, said this week's roll out of its official name, "New York State of Health," a tax credit calculator on the marketplace's website and the release of information about the insurance plans being offered in each county were "a big step" in raising awareness.

New York, which has received nearly $41 million in federal funds to market the exchange over two years, also launched a social media campaign on Wednesday, targeting potential exchange users on **Facebook**, Twitter and **Google**, popular platforms for younger people, Frescatore noted.

New York State of Health in late September will begin TV, print and radio advertising promoting the exchanges. It's also partnering with about 150 organizations and subcontractors including YMCAs and faith-based groups to bolster enrollment and spread the word.

Frescatore said the average 53-percent reductions in the exchange's plans premium rates over current rates that were announced last month "are largely built" on assumptions that 1.1 million people will enroll in the next three years.

"We're optimistic that will happen," Frescatore said. "That's what makes this outreach so critical."

FINAL RULES RELEASED ON ACA INDIVIDUAL MANDATE

- August 27, 2013, 5:46 PM

Final Rules Released on Obamacare's Individual Mandate By Jennifer Corbett Dooren

The Obama administration released final rules Tuesday involving the controversial so-called individual mandate that requires most individuals to carry health insurance starting in 2014 or pay fines.

The rules from the Treasury Department codify the amount of penalties called for under the 2010 Affordable Care Act as well who might be exempt from the penalties.

Last month several Republicans called for the administration to delay the individual mandate to 2015 along with an employer mandate. On July 2, the administration announced it was delaying reporting requirements and penalties for employers by a year but stood firm on calls to also delay health-law requirements involving individuals.

More In Obamacare

- White House Enlists Bill Clinton to Sell Obamacare
- Consumers Remain Baffled By Health Law, Poll Shows
- Obama Asks African-American Churches for Help With Health Law
- Waxman: GOP Stalking Great White Whale on Obamacare
- Maryland Touts Low Premiums in Health Exchange

Most Americans will be required to have health insurance starting in 2014 and will have to report whether they had coverage on their 2015 tax returns. An individual who opts against carrying insurance will be subject to a fine of $95 next year or 1% of income above a certain threshold, which is ever greater. The penalty increases to $695 per person in 2016 and beyond – or 2.5% of taxable annual income – with the amount rising by inflation.

There are exceptions in the law for people with incomes below the threshold that's required to file an income tax return, which is about $10,000 for an individual in 2013. People with certain religious exemptions and those who are members of Indian tribes are exempt from requirements under the health law. People who lack insurance coverage for less than three months in a given year also won't be penalized.

People who obtain health insurance through an employer, or are on Medicare, the federal health insurance program for people age 65 and older, qualify as having insurance and won't be subject to any penalties. The federal government and states are setting up online exchanges or marketplaces where people can purchase health insurance starting Oct. 1. Many people are expected to qualify for tax credits to offset the cost of monthly insurance premiums.

In a statement posted on Treasury Department's website, the agency said the requirement for individuals to carry health insurance is "integral to delivering the Affordable Care Act's consumer protections at an affordable cost."

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