Health & Retirement Services Of Illinois

December 2009 Newsletter

OUR NEWS LETTER

HRSI

Fact...

On the 11/8th@ 11:15 p.m., the House of Representatives voted to pass their health insurance reform bill. Despite countless attempts over nearly a century, no chamber of Congress has ever before passed comprehensive health reform. This is history.

But you and millions of your fellow Organizing for America supporters didn't just witness history tonight -- you helped make it. Each "yes" vote was a brave stand, backed up by countless hours of knocking on doors, outreach in town halls and town squares, millions of signatures, and hundreds of thousands of calls. You stood up. You spoke up. And you were heard.

So this is a night to celebrate -- but not to rest. Those who voted for reform deserve our thanks, and the next phase of this fight has already begun.

The final Senate bill hasn't even been released yet, but the insurance companies are already pressing hard for a filibuster to bury it. OFA has built a massive neighborhood-by-neighborhood operation to bring people's voices to Congress, and tonight we saw the results. But the coming days will put our efforts to the ultimate test. Winning will require each of us to give everything we can.

In Our Newsletter

This Week in Health Reform.

November 11, 2009

Federal Legislative Overview

Senate
Health care reform remains behind closed doors in the Senate this week as Leadership continues to develop a single bill and the Congressional Budget Office (CBO) continues to analyze the work product to date. It is uncertain if a bill will be ready to begin floor debate in the Senate before Thanksgiving. Majority Leader Harry Reid (D-NV) now says that Senate action might not come until early next year.

House
The House of Representatives passed its health care reform legislation, the **Affordable Health Care for America Act** (H.R. 3962), on November 7 by a vote of 220 to 215. Thirty-nine Democrats voted against the bill and one Republican voted for it – Joseph Cao (R-LA). Representatives Dan Boren (D-OK), Harry Teague (D-NM) and Chet Edwards (D-TX) voted against the legislation. A main issue that

proved to be a lightning rod for the bill's passage was an amendment by Rep. Bart Stupak (D-MI), who included an amendment on abortion that stipulated insurers selling plans through the Exchange

could not offer policies covering elective abortion procedures to people who receive federal subsidies for premiums.

Earlier in the week, House Republican Leadership released its alternative solution to current health care reform legislation. The 230-page Republican health reform amendment was introduced by Minority Leader John Boehner (R-OH), but did not get adopted into the final legislation.

Key elements of the amendment:

- Lower health care premiums.
- Establish Universal Access Programs to guarantee access to affordable care for those with pre-existing conditions.
- End junk lawsuits
- Prevent insurers from unjustly cancelling a policy or instituting annual or lifetime spending caps
- Encourage small business health plans
- Encourage innovative state programs
- Allow Americans to buy insurance across state lines
- Codify the Hyde Amendment
- Promote healthier lifestyles
- Enhance Health Savings Accounts (HSAs)
- Allow dependents to remain on their parents' policies

The Republican amendment can be can be accessed at:
http://www.kaiserhealthnews.org/Stories/2009/November/03/republican-health-bill.aspx

The full House legislation, related summaries and section-by-section analyses can be read on the House Ways and Means Committee Web site at: http://waysandmeans.house.gov/MoreInfo.asp?section=52

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Source Blue Cross Blue Shield Of Illinois

Cuts to Medicare Advantage, Fewer Doctors, Fewer Choices

Millions of Seniors with Medicare Advantage [MA] Will Lose Their Coverage

"Over 9.9 million seniors would be restricted from choosing the plan that best suits their needs, with an estimated 8.5 million losing Medicare Advantage coverage entirely. According to the Congressional Budget Office (CBO), MA payments would be cut by $117 billion in the Senate Finance Committee bill and by $156 billion in the House bill from 2010 to 2019."

—James C. Capretta and Robert A. Book, Ph.D., Senior Research Fellow in Health Economics, The Heritage Foundation, October 30, 2009.

According to Capretta and Book, the consequences of modifying Medicare Advantage are five-fold: A reduction in benefits, worse options, more financial risk, higher state and federal Medicaid costs, and higher prescription drug spending.

Fewer Doctors will accept Medicare

"Senior citizens will find it harder to find a doctor who accepts Medicare if Congress does not stop a 21.5 percent cut in payment rates, say physicians and hospitals. 'We might as well start building bigger emergency rooms, because that's where people will be if they don't have access to a regular physician,' said Micki Benz, vice president of development for Saint Mary's Health Care. 'In the end, people's care will suffer, and we will all end up paying more.'"

—Monica Scott, The Grand Rapids Press, October 24, 2009

"'It leaves the physician community in a very difficult spot,' says Dr. James Rohack, president of the American Medical Association. If that cut goes into effect, it's basically telling doctors, 'OK, we want you

to limit access to Medicare patients,' he says."

—"Medicare Costs Key to Health Care Reform," Kent Garber, US News and World Report, October 26, 2009

Fewer Doctors to Choose From

"Medicare recipients have been promised that reform will not negatively impact their current health care. The scenario described above will translate to a type of rationing of health care to seniors, as there will be waits to see fewer physicians, a lack of qualified physicians, and an increasing need for Medicare patients living in smaller communities like Vero Beach to travel elsewhere to receive quality care."

—Dr. Charles Fischman, "Medicare Reimbursement Cut Posts Health Care Armageddon for Floridians," TC Palm, October 25, 2009

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Launch of the report on Women and health: today's evidence, tomorrow's agenda

Dr Margaret Chan
Director-General of the World Health Organization

Excellencies, colleagues in the UN system, colleagues in public health, representatives of civil society, ladies and gentlemen,

What gets measured gets done.

I commissioned this report on women and health to gather a baseline of data about the health of women and girls throughout the life-course, in different parts of the world, and in different groups within countries.

I did so based on my conviction that the health of women has been neglected, that this neglect is a major impediment to development, and that the situation needs to improve. I did so based on my conviction that women matter in ways far beyond their role as mothers.

My conviction is backed by commitment. When I took office in early 2007, I made the health of women and of the people of Africa my top priorities. Because so many factors shape health outcomes in these two groups, improvements are a good measure of the overall performance of WHO.

From this report, we clearly see that the health status of girls and women in sub-Saharan Africa is, by nearly every measure, the lowest in the world. Let me give just one example. For women aged 20 to 60 years in affluent countries, the risk of premature death is only 6%. In sub-Saharan Africa, the risk is 42%, or seven times higher.

Before taking action on any health problem, we must first take stock. Efficient policies for change must deliberately address areas where progress is inadequate, specific needs are not being met, deaths and illness can be prevented, or trends over time give cause for alarm.

When we compare the health of women and men, what differences do we see, and what does this tell us? When we compare women across geographical regions, cultures, and income groups, where are the gaps in health outcomes and what are the trends? Where gaps exist, can we pinpoint the reasons why?

Through its epidemiological analysis of existing data, this report on women and health deepens my conviction that many health needs of women are not being met. It deepens my commitment to call for action and guide a targeted response. But let me be very clear at the start. As this report reveals, the obstacles that stand in the way of better health for women are not primarily technical or medical in

nature. They are social and political, and the two go together.

We will not see significant progress as long as women are regarded as second-class citizens in so many parts of the world. We will not see significant progress as long as women are excluded from educational and employment opportunities, are paid less or not paid at all, are denied the right to own property, are victims of violence, have no control over household income, and have no freedom to spend money on health care, even if it means saving their own lives.

We will not see significant progress when so many women accept their inferior status, acquiesce, suffer, and endure. In so many societies, men exercise political, social, and economic control. The health sector has to be concerned. These unequal power relations translate into unequal access to health care and unequal control over health resources.

In fact, an assessment of health outcomes in girls and women is a reliable way to quantify what the low social status of women really means. And this must be our starting point.

What gets measured gets done. And what this report has measured is the profound impact that social status has on the health of women and girls.

Now that we know what we are up against, how do we move forward? I can assure you: this is not an easy task. In public health, it is arguably easier to deliver medicines, bednets, and other interventions, even on a massive scale, than it is to change attitudes and behaviours, including sexual behaviours, fight discrimination, and raise the status of women.

But societies create unequal relationships and policies sustain them. These things can change.

Ladies and gentlemen,

Let us look at some of the evidence.

Thanks to this report, we are beginning to see some patterns and beginning to get some answers. But if we want to base action on evidence and answers, we are only at the start. The neglect of women's health extends to the research community and statistical services.

One of the striking findings of the report is the paucity of statistics on key health issues that affect girls and women, especially in developing countries. In some areas, we are still in the dark. In others, the picture is becoming clear.

Girls begin life with a biological advantage. In general, women live six to eight years longer than men. As the report shows, female babies and young girls do not die with greater frequency than boys. Childhood immunization programmes show no gender inequality in coverage. Girls are protected just as well as boys.

But as we look at data along the life-course, this early situation changes and the impact of women's lower social status becomes apparent. Where this situation prevails, females will continue to be taken for granted, and taken advantage of.

From the report, we know that up to 80% of all health care and 90% of care for HIV/AIDS-related illness is provided in the home, almost always by women. Most of this work is unsupported, unrecognized, and unremunerated. Women are less likely than men to be in formal employment. They work most of their waking hours but are not paid. Because they are less likely to be part of the formal work force, women lack access to job security and the benefits of social protection, including access to health care.

Worldwide, more than 580 million women are illiterate, which is more than twice the number of illiterate men. The impact of educational status on the health of women and their families is very well documented. How can we tolerate such a huge difference in such a hugely important opportunity?

A full 38% of girls in developing countries, notably in Asia, marry before the age of 18, and 14% do so before the age of 15. If these young ladies are lucky, health services will be able to manage at least some of the well-know health risks associated with early childbearing. But public health cannot prevent early marriage.

These are social and political problems. They extend beyond the borders of public health and are too

big, too tangled up in social and cultural norms to be solved by technical or medical interventions alone, or even by much-needed reforms in health systems.

Societies and the political leaders who govern them must first decide that the health of women matters. Public health can do some things, of course. We can promote better access to sexual and reproductive health services. We can do something about cervical cancer or risks for the many chronic diseases that plague women later in life. We can map out clear technical strategies for reducing deaths associated with pregnancy and childbirth.

But such efforts will ultimately have a patchy and limited impact because they do not address the root causes of unmet health needs in girls and women. The root causes reside in social attitudes, norms, and behaviours and the policies that perpetuate them.

When the health status of women in high- and low-income countries is compared, the results are predictable and telling. In all regions and age groups, girls and women in higher income countries have lower levels of mortality and burden of disease than those who live in low-income countries.

It is tempting to conclude that poverty is the single most important determinant of health problems in females, and that, as economies grow, countries modernize, and incomes rise, the problems will gradually, automatically go away all by themselves. Poverty is important, but the evidence points to many other factors.

Women have some biological vulnerabilities, related to their reproductive functions, that make them susceptible to certain special health risks. We have known this for ages. But is biology destiny throughout the life course, before and after the reproductive years? Better health outcomes in high income groups tell us that the answer is no.

Biology certainly cannot explain why 99% of maternal mortality is concentrated in the developing world. Biology cannot explain why the health problems and the leading causes of mortality and disability differ so dramatically between women in high- and low-income groups.

In high-income countries, chronic diseases such as heart disease, stroke, dementias and cancers predominate in the 10 leading causes of death, accounting for more than 4 in every 10 female deaths.

In low-income countries, maternal and perinatal conditions, lower respiratory tract infections, diarrhoeal diseases, and HIV/AIDS account for nearly four in every 10 female deaths. On the positive side, tools are available to prevent or readily treat all of these conditions.

This points to another problem: the failure of health services to meet women's needs. Cervical cancer provides a vivid example of what lack of equitable access to health services means. Globally, cervical cancer is the second most common type of cancer among women. Around 80% of cervical cancers and an even higher proportion of deaths occur in low-income countries. This is a cancer that can be prevented by a vaccine, detected early by screening, and treated early with good results. These deaths should not be happening.

In developing countries, complications of pregnancy and childbirth are the leading cause of death and disability among 15-19 year old women. Unsafe abortion contributes substantially to these deaths. This points to an urgent need to improve access to sexual and reproductive health services.

As noted, women generally live longer than men, but their lives are not necessarily healthy or happy. As the report shows, women are more susceptible to depression and anxiety than men. An estimated 73 million adult women worldwide suffer a major episode of depression each year. While the causes of mental ill health vary from one individual to another, women's low status in society, their burden of work, and the violence they experience are contributing factors.

Trends are ominous and strongly influenced by the globalization of unhealthy lifestyles. The female advantage in life expectancy is being lost in some parts of the world. Malnutrition as a risk factor for poor pregnancy outcome is now joined by high blood pressure, high cholesterol levels, tobacco use, obesity and violence. Cardiovascular disease, long considered a male disease in rich societies, is now the main killer of older women nearly everywhere.

Ladies and gentlemen,

We have known for ages that, as standards of living improve, health gets better. But this is usually a gradual process stretched out over a considerable time.

Recent decades have seen some striking progress for women. Life expectancy for women has increased from just 51 years in the early 1950s to 70 years in 2007, compared with 65 years for men. The use of

contraception in developing countries has risen from 8% in the 1960s to 62% in 2007. Women are generally marrying later, having their first babies later, and living longer.

This is striking progress, but it has taken place over a strikingly long time. This is my big question to you. Do we want to wait for the health of women to gradually improve, or are we compelled to take deliberate action now? What is at stake?

Around 85% of the world's population of 3.3 billion females lives in low- and middle-income countries. Poverty is important, but the report also found a direct link between discrimination against women and lower health status.

If women are denied a chance to develop their full human potential, including their potential to lead healthy and at least somewhat happier lives, is society as a whole really healthy? What does this say about the state of social progress in the 21st century?

A call for action must reach beyond the health sector into areas such as education, transport, employment, and legal and judicial frameworks. Essentially, this is a call for women-centred policy-making and programming in all sectors, in a whole-of-government approach.

Above all, primary health care, with its focus on equity, social justice, and giving people a voice, offers an opportunity to make a difference through policy change. And we need the voice and clout of civil society to bring political leaders to account.

With the launch of this report, WHO intends to start a broad policy dialogue to work out an agenda for change both within and well beyond the health sector.

Finally, there is no global prescription for change. Agendas for action must be context-specific. As the report reveals, health problems in women vary considerably across countries and regions. For example, adolescent pregnancy is a major concern in many countries. In others, suicides in women who ingest pesticides need to be addressed. This is a horrific way to die and a clear signal of utter, unbearable misery.

We must be alert to these signals and respond with the compassion and care that are hallmark traits of what it means to be a woman, anywhere, everywhere.

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Helping parents in developing countries improve adolescents' health

In 2005, CAH and the Department of Population and Family Health of Johns Hopkins University undertook a literature review to capture recent research on parenting of adolescents in developing countries and in particular to examine the evidence for specific parenting roles that programmes could aim to promote and improve. Given the importance of parents in adolescents' worlds, what are the specific ways that they influence adolescent health? In addition, how can we translate that knowledge into actions?

WHO convened a meeting in October with researchers and representatives from some projects currently under way in developing countries. A summary of the discussions in the meeting is available in a document entitled Helping parents in developing countries improve adolescents' health which highlights the importance of parents in preventing adolescent health risk behaviours, the ways in which parents influence these behaviours, and their implications for programmes aiming to improve adolescent health.

Parents' roles are organized into five dimensions, each of which has specific influences on adolescent health outcomes:

1. connection – *love*
2. behaviour control – *limit*
3. respect for individuality –*respect*
4. modelling of appropriate behaviour – *model*
5. provision and protection – *provide.*

These parenting roles are played out in the daily interactions with adolescents. Parents are usually unconscious of the individual roles and of their potential consequences on health and development.

Each of the five roles is described including its contribution to adolescent health and the corresponding evidence base. Also outlined, where available knowledge exists, are its implications for programmes, including activities that can be delivered to parents to enhance each role and examples of projects currently engaged in activities that address that role.

Authors: World Health Organization

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Women and health

Despite considerable progress in the past decades, societies continue to fail to meet the health care needs of women at key moments of their lives, particularly in their adolescent years and in older age. These are the key findings of the WHO report *Women and health: today's evidence tomorrow's agenda.*

WHO calls for urgent action both within the health sector and beyond to improve the health and lives of girls and women around the world, from birth to older age.

The report provides the latest and most comprehensive evidence available to date on women's specific needs and health challenges over their entire life-course. The report includes the latest global and regional figures on the health and leading causes of death in women from birth, through childhood, adolescence and adulthood, to older age.

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Source WHO

USA Statistics:

Total population: 302,841,000

Gross national income per capita (PPP international $): 44,070

Life expectancy at birth m/f (years): 75/80

Healthy life expectancy at birth m/f (years, 2003): 67/71

Probability of dying under five (per 1 000 live births): 8

Probability of dying between 15 and 60 years m/f (per 1 000 population): 137/80

Total expenditure on health per capita (Intl $, 2006): 6,714

Total expenditure on health as % of GDP (2006): 15.3

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Figures are for 2006 unless indicated. Source: World Health Statistics 2008

The Difference Between a CD & a Fixed Annuity

What is a CD?

1. CDs are issued by banks and offer investors a safe place to invest their money. CDs grow based on a stated interest rate by the issuing bank over a predetermined time frame, such as three months, six months or one year. CDs are not based on the stock market or any other volatile index. Once the CD reaches the end of its period, the bank will automatically roll the CD over into a new period at a rate the bank is paying currently. The interest rate is only guaranteed for the duration of the CD period and can and will change. The periods can also range up to five years depending on the bank issuing the CD. Typically, the longer the duration of the CD period, the higher the interest rate the bank will pay.

What is a Fixed Annuity?

2. Fixed annuities earn interest much like a CD does, but usually only on an annual basis on the policy anniversary. Fixed annuities are issued by insurance companies, and they earn an interest rate stated each year by the insurance company. Like a CD, fixed annuities are safe investments and not based on the stock market or any other volatile index. Insurance companies also offer multiyear guarantees on an interest rate. For example, an insurance company may offer a guaranteed 5 percent interest rate for the first five years. When this time period is up, the insurance company then has a right to drop the rate down to a minimum guarantee allowed by the state it is operating in, such as 1 percent or 1.5 percent.

What are the Differences?

3. There are many similarities when it comes to CDs and fixed annuities, but there are also differences. One of the main differences is the fact that fixed annuities offer tax-deferred growth of your money. With a CD, the bank will send the owner a 1099 form at the end of the year listing the amount of interest earned. This amount must be included on the owner's tax return and is subject to ordinary income tax. A fixed annuity, however, grows tax deferred, meaning there is no tax reporting of interest year by year. The tax is paid by the owner when he or she withdraws from the annuity, so the owner is capitalizing on triple compounding--interest on principal, interest on interest and interest on money that would've been paid in taxes. Fixed annuities also may carry a declining surrender charge schedule and have some different liquidity features than CDs. Typically, the insurance company will allow the owner to withdraw up to 10 percent of the value of the annuity each year without having to pay any surrender charges. If the owner withdraws more than 10 percent, the insurance company may impose a surrender charge. This amount decreases each year until it reaches zero. Annuities also are considered retirement accounts and are subject to a 10 percent penalty if the owner withdraws any amount prior to the age of 59 1/2.

What are the Real Guarantees?

4. CDs and fixed annuities both have guarantees backed up by the government. CDs fall under Federal Deposit Insurance Corporation (FDIC) insurance. In the past, the amount that was insured in banks was $100,000, but that recently was changed by the federal government to $250,000 until December 31, 2013, in light of the recent economic turmoil experienced in this country. Annuities are not backed up by the FDIC but instead by each state's guarantee funds that help pay claims for financially impaired insurance companies. This amount varies by state.

Which One is Best for Me?

5. Choosing between CDs and fixed annuities depends on a number of factors: your age, your tax situation and your investment objectives. Consult a financial professional who can help you assess your situation and make recommendations based on your objectives, risk tolerance and tax status. Read all prospectuses and make sure you completely understand what financial product you are buying before investing any money. Following these guidelines should help you eliminate any surprises or financial mistakes.

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Five Truths about Long-term Care

Five Truths about Long-term Care

Most people don't understand long-term care. Another survey (this one from Prudential) tells us that we aren't prepared financially for a long illness if it strikes.

It's not a surprise since long-term care isn't something we really want to think about…until it happens to a family member or someone close to us. Then, the choices and the costs can be overwhelming.

This is Long-term care awareness month. So build your knowledge about long-term care with these five things to know about the risks and reality of long-term care.

1. **Long-term care is not just about aging.**

   Nearly 40% of people currently needing long-term care are working age adults. Accidents can happen at any age and that leads to the need for extended care. And it is true, that as you age there is a greater likelihood that you will need some form of long-term care (about 60% of people age 65 and older).

2. **Medicare is not the solution for paying for long-term care services.**

   Generally, Medicare doesn't pay for long-term care. Medicare pays only for medically necessary skilled nursing facility or home health care. However, you must meet certain conditions for Medicare to pay for these types of care. Most long-term care is to assist people with support services such as activities of daily living like dressing, bathing, and using the bathroom. Medicare doesn't pay for this type of care called "custodial care". Custodial care (non-skilled care) is care that helps you with activities of daily living.

3. **Most long-term care is provided outside nursing homes.**

   While we used to equate nursing homes with long-term care, that's not the case anymore. Care is provided in a number of different settings including home care, assisted living, and adult day care. More and more people say they want to stay at home as long as they can. That is why there has been such growth in home care service agencies. But don't think that home care is necessarily less expensive. It depends on the services you need, the frequency and whether there are family and friends who can help out as well.

4. **There are limits on accessing government long-term care programs.**

   For people who have no assets and little income, the Medicaid program will probably cover their long-term care costs. But first you must prove that you virtually have no assets and then your choice of care is generally limited to a nursing home. Medicaid programs differ by states, but most states do not provide long-term care services at home. A nursing home is the solution.

5. **Long-term care can be expensive.**

   With the national average for a year in a nursing home now approaching $80,000 (and it is much higher in some states), long-term care can wipe out retirement savings in no time. Your health insurance or Medicare covers medical care. Disability insurance replaces lost income to cover necessities such as mortgage, food etc. Long-term care insurance is designed specifically to cover long-term care services.

   If you think long-term care insurance might be right for you, the younger and healthier you are the more likely it is that you can qualify for a policy. Long-term care insurance may be offered through your employer, usually as a voluntary benefit which means you pay the full costs. You can also purchase an individual policy based upon your health conditions and your age.

   With more than 40 million caregivers in the country, the odds are great that you or a family member will face long-term care issues. The more you learn now and prepare the better off you'll be.

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Call (800) 739-4700