The federal government health insurance health and social care essay

Medicare Part Adisabilities, people over the age of 65, or persons receiving social security or railroadretirement benefits. To be eligible for Medicare a person must meet one of the requirements(Medicare. gov/plans, 2012). To enroll in Medicare, before retirement or the recipient of socialsecurity the person may well have to pay a premium based on income. If over 65, andreceiving social security, the person is automatically enrolled, approximately three monthsbefore the 65th birthday (Medicare. gov/parts a and b, 2012). When enrolled in Medicare, a person will have the option of parts A and B(Medicare. gov/plans, 2012). Medicare part A is a hospital coverage that for most costs little ornothing. The premium for part A has been paid by the social security taxes pain while working, by the person and their employer (Medicare. gov/parts a and b, 2012). If not contacted by thesocial security department a few months prior to the 65th birthday the person should makecontact with their local social security office, a delay will prevent coverage from beginning. Theaverage costs of part A is around $441. 00 per month (medicare. gov/part a costs, 2012). Thepremiums are generally paid for by social security taxes. If, however, the person has not paidinto social security and wish to enroll they may have to pay the premiums. There are specialcircumstances; a disabled widow or widower, the person or a dependent have permanentkidney failure, or a disabled government worker, all under the age of retirement (Medicare. gov/parts a and b, 2012). Medicare part A pays for in hospital care, lab tests, surgery, doctor visits, medicalequipment deemed necessary, hospice care, skilled nursing facilities (Medicare approvedKOT2- part 1only), and some home health care services (Medicare. gov/coverage part a, 2012). Thiscoverage pays for 90 days per benefit period; this is the period from admission to a

hospital to60 days, in a row, of no inpatient or skilled nursing care (Medicare. gov/coverage part a, 2012). The hospital coverage is the first 60 days after the first $1068. 00, then for the next 30 days, allcovered charges beyond $267. 00 per day. After an inpatient hospital stay of at least three days, the costs of a certified skilled nursing facility are covered 100% for the first 20 days and thenext 80 days everything except the daily co-insurance payment (medicare. gov/part a costs, 2012). Medicare A will not pay for routine eye exams, glasses, routine dental examine ordentures, routine foot care, custodial care, acupuncture, or medication outside of a medicalfacility. Medicare will not pay for hospital acquired infections, such as a urinary tract infection. The cost of hospital acquired infection must be absorbed by the hospital or patient (Economicsofpreventing hospital infections; vol. 10, no4, 2004). Medicare Part BMedicare part B is an optional benefit; the person may opt out of the coverage if desired (Medicare. gov/plans, 2012). Medicare B covers some services not covered by part A, such as medical supplies anddoctor visits. The average cost of part B is $104. 90 in premiums and $147. 00 indeductible per year (Medicare. gov/cost part b, 2012). If the person does not obtain part B whenenrolled there could be an additional penalty for services later. The average income for fees of$104. 90 is for a single person with income based around $85, 000. 00, or joint income of lessKOT2-part1than $170, 000. 00 annually (Medicare. gov/cost part b, 2012). This coverage is to help coversome of the additional costs not covered by part A and include preventative treatment, such asflu shots; treatments or diagnosis of medical conditions unmet by part A; medical supplies andequipment; outpatient doctor visits; ambulance services to the hospital or nursing facility, when deemed medically necessary; and a second

opinion before surgery (Medicare. gov/part b coverage, 2012). Medicare part B pays 80% after the annual deductible, the deductible changes yearly(Medicare. gov/cost part b, 2012). Part B will also cover the cost of a social worker for medicalmanagement, screenings for cancer and diabetes, outpatient physical and occupationaltherapy and mental health services (Medicare. gov/part b coverage, 2012). If the person isunsure why they may require specific services, ask the physician and ask if the services arecovered with Medicare (Medicare. gov/parts a and b, 2012). Medicare Part DMedicare parts A and B, will not cover prescription medications outside of a medicalfacility such as a hospital or skilled nursing facility (Medicare. gov/parts a and b, 2012). MedicareD is the section for medication coverage (Medicare. gov/part-d, 2012). As with parts A and B, A person may enroll three months before the 65th birthday (Medicare. gov/plans, 2012). If, themedication plan is not enrolled at the same time as parts A and B; there could be an additionalfee or late penalty applied. Typically the drug plans have two periods per year that allows forenrollment (Medicare. gov/part b coverage, 2012). The coverage is through an insuranceKOT2-part1company approved by Medicare, and there is a variety of plans with different prices. Whenenrolling in a prescription drug plan the person will need their Medicare A and B number andthe date started. Depending upon the plan chosen, there could be co-pays and deductiblebased on suchas the medications they use, and the use of generic verses brand namemedications (Medicare. gov/part-d, 2012). There is typically a monthly premium and an annualdeductible. The choice will depend on which best " fits" the person’s needs. No drug plan mayinclude a deductible more than $320. 00 annually (Medicare. gov/plans, 2012). Some plans witha co-insurance charge a percentage of the

medication costs, a co-pay is a set amount formedications on a tier plan and will differ based on brand verses generic. Again, delay inenrollment may create an additional fee or penalty to the plan (Medicare. gov/part-d, 2012). ReimbursementIn February 2006 the President signed the Deficit Reduction Act (DRA). In this, it wasstated that a hospital could not be paid for services that increased the cost of patient carerelated to a hospital acquired condition. The Center for Medicare and Medicaid defined theseas conditions that could have been prevented through using evidence-based guidelines. Thiswas to include urinary tract infections not present upon admission. (Center for Medicare and Medicaid Services, 2008). The hospitals are not legally allowed to charge for a secondary diagnosis that add topayments to the hospital without approval. The hospital will have to absorb the additional costfor treatment in such cases (O'Reilly, 2007). The idea is for hospitals to become more awareKOT2-part 1of incidents of nosocomial infections and to strengthen infection control policies. When theprice for hospital acquired infections are removed from the expenditures of Medicare thehealthcare premiums are more controlled (Sanders, 2008). Controlling medical costs assist incontrolling the overall U. S. deficit, due to Medicare being a federal insurance program. TheMedicare system and the patient both benefit from controlling the additional cost of hospitalacquired infections and the lack of pay for such conditions (Sanders, 2008). The additional costto the patient, for a hospital acquired infection will most likely come from out-of-pocket pay. Ifnoted just after being discharged from the hospital, the patient may be able to pass the cost tothe hospital by appeal to Medicare (Center for Medicare and Medicaid Services, 2008). Ethical ImplicationsWhen considering the ethical implications of the additional cost to the patient, due to ahospital

acquired infection; the hospital is responsible for reporting the incident and informingthe patient and family. Failure to protect patients from nosocomial infections is a reflection onthe organization, and perhaps a systems failure. If the facility adheres to the infection controlguidelines, as directed by the CDC and Center for Medicare and Medicaid, there must be asystems failure in evidence. Ethically the organization would report this and outline a plan tocorrect the failure and prevent future incidents from happening. The facility is responsible forpossible compensation to the patient, reimbursement for medical cost related to the infectionand an apology and reassurance that the organization is working on a plan to improve andprevent future occurrences. It is an ethical imperative for reporting and financially sound movefor the organization to correct issues involved.

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