

**Research Report**

# **Observation Status: Financial Implications for Medicare Beneficiaries**

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## Executive Summary

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Doctors who cannot quickly diagnose patients in the emergency room sometimes place them “under observation”—a status that can create significant financial hardships for many Medicare beneficiaries. Medicare considers those under observation to be outpatients and requires them to pay some of the cost for each hospital service delivered with no limit on the total they may owe. In contrast, inpatients typically pay only the hospital deductible (\$1,260 in 2015).

Recipients of observation services can also be disadvantaged if they need care in a skilled nursing facility after leaving the hospital. Medicare requires that people spend at least 3 consecutive days as hospital inpatients to cover skilled nursing facility costs. As a result, observation beneficiaries may end up with unexpectedly large hospital bills and later owe thousands of dollars more for skilled nursing facility care.

This report, which uses data from a sample of 2009 Medicare claims, reveals that rules for observation status are having a notable impact on the cost of health care for many Medicare beneficiaries, and perhaps also on their decisions about whether or not to seek additional recommended follow-up care.

For example, our findings show that 1 in 10 observation patients (about 167,000) spent more for hospital services than they would have

spent if they were admitted as inpatients. We found that nearly a third of all those referred to a skilled nursing facility after receiving observation services (50,000) forewent that care, perhaps because of the anticipated costs. Furthermore, among observation beneficiaries who were subsequently admitted to a skilled nursing facility, Medicare did not pay claims for a small number who owed, on average, about five times more (over \$12,000) than those whose care was covered by Medicare (\$2,520).

These findings have important policy implications, particularly since the use of observation status in the Medicare population has increased substantially over the past decade and a half. Limiting the amount owed for hospital outpatient services to the inpatient hospital deductible would protect observation patients from disproportionate out-of-pocket spending.

In addition, counting time spent in observation toward Medicare’s 3-day inpatient stay requirement for skilled nursing facility coverage would both protect those who get observation services from the high cost of care in a skilled nursing facility and improve access to needed care, while only marginally increasing Medicare spending (\$5.2 million in 2009). Ultimately, Medicare should base skilled nursing facility coverage on patients’ clinical need, rather than on an arbitrary number of inpatient days.

# Introduction

Emergency room patients cannot always be quickly or easily diagnosed: Someone’s chest pain, for example, may be the result of a heart attack or indigestion. As a result, doctors who need time to monitor patients sometimes place them “under observation”—a decision that can have serious financial repercussions for Medicare beneficiaries.<sup>i,ii</sup>

In fee-for-service Medicare, those placed under observation are considered to be outpatients, even though they may be hospitalized for several days—perhaps even occupying inpatient beds.<sup>iii</sup> Once observation patients have been diagnosed and stabilized, they may be discharged, transferred to another hospital, or formally admitted as inpatients (“*postobservation inpatients*” throughout this report; see also box 1).

Despite a dramatic increase in the use of observation status in the Medicare population over the past decade and a half,<sup>iv,v</sup> policy makers have had little information about patients’ out-of-pocket costs for health care.<sup>vi,vii,viii</sup> This report, which uses data from a sample of 2009

Medicare claims (see box 2 for details), shows that Medicare’s rules for observation status are having a substantial impact on spending for hospital services by beneficiaries. The report also examines whether those who required care in a skilled nursing facility after getting observation services actually received it, and how much they personally owed for that care. Finally, we outline recommendations to protect Medicare beneficiaries who are placed under observation from disproportionate expenses and to improve their access to skilled nursing facility care.

## Box 1. Definition

Throughout this report, “observation patients” refers exclusively to Medicare beneficiaries who were placed under observation and remained as outpatients, receiving only outpatient hospital services.



## Observation Outpatient versus Inpatient: Who Pays More for Hospital Services?

Observation patients who receive multiple or costly services may end up owing more than they would have if the doctor had later admitted them as inpatients. Under Medicare, Part A requires post-observation inpatients to pay a deductible (\$1,068 in 2009) for services received while hospitalized.<sup>1</sup>

Under Part B, however, observation beneficiaries pay both an outpatient deductible (\$135 in 2009) and a percentage<sup>2</sup> of the Medicare allowed charge (coinsurance) for *each* outpatient service they receive.<sup>3</sup> Although those under observation cannot be charged more than the inpatient deductible (\$1,068 in 2009) for a single outpatient service,

there is no limit on how much they may owe for multiple outpatient services.

Because Medicare beneficiaries may not understand the consequences of being kept as observation patients, recent media reports portray some as being stunned by their large hospital bills.<sup>x</sup> Furthermore, the apparent inequities in observation status policies have spawned a nationwide class action lawsuit.<sup>x</sup> As a result, some advocates are urging those placed under observation to request admission as inpatients as a way to limit their spending for hospital services to the inpatient deductible and become eligible for Medicare coverage of skilled nursing facility care.

- 
- 1 Medicare Part A pays for hospital inpatient stays, including prescription drugs. Physician fees are paid separately under Part B. The deductible covers all inpatient services and related outpatient services for 72 hours before admission obtained during the first 60 days of each benefit period (a benefit period begins on the day of hospital inpatient or skilled nursing facility admission and ends when the beneficiary has not received any inpatient hospital or skilled nursing facility care for 60 consecutive days). Beneficiaries must pay an inpatient deductible for each benefit period and there's no limit to the number of benefit periods. In addition to the inpatient deductible, beneficiaries owe a daily copayment between their 61st and 90th day in the hospital (\$267 in 2009) and between their 91st and 150th day in the hospital (\$534 in 2009).
  - 2 Observation beneficiaries can owe the hospital more than 20 percent of Medicare-allowed charges for a given hospital outpatient service. In 2011, the average coinsurance rate for outpatient services was 23 percent of the Medicare-approved cost (Medicare Payment Advisory Commission, *Data Book* [Washington, DC: 2012], chart 7-14). In some situations, the coinsurance rate for outpatient services may even reach 40 percent of the Medicare-approved cost (CCH Editorial Staff (CCH), *Medicare Explained 2013*, Wolters Kluwer, para. 874 [Chicago, IL: 2013]).
  - 3 In addition, observation beneficiaries pay a coinsurance for physicians' fees. Unless they are covered through Medicare Part D, they also pay for the entire cost of self-administered prescription pills and over-the-counter drugs.

## Without a 3-day Inpatient Stay, Skilled Nursing Facility Care Can Prove Costly

Medicare covers a portion of a skilled nursing facility bill for beneficiaries who were previously admitted to the hospital<sup>4</sup> and kept as inpatients for at least 3 consecutive days.<sup>5,6</sup> In contrast, Medicare considers those under observation to be outpatients, making them ineligible for such benefits no matter how long they stay in the hospital.

Even post-observation inpatients with an extended hospital stay may not accumulate the requisite 3 days for skilled nursing facility coverage.<sup>7</sup> For example, someone placed under observation for 2 days and then admitted as an inpatient for 2 more would not satisfy the 3-day requirement.

A lack of Medicare coverage may not preclude observation patients and post-observation

inpatients from getting skilled nursing facility care; however, they face the risk of having to pay for it entirely out of pocket, which may total thousands of dollars.<sup>8,9</sup>

In fact, like those observation patients blindsided by their steep hospital bills, some Medicare beneficiaries have been surprised to learn that they owe the skilled nursing facility the entire cost of their stay.<sup>x1,xii,xiii</sup> That confusion may be partly attributable to the fact that Medicare does not require hospitals to tell consumers that the outpatient observation services they're receiving do not later qualify them for skilled nursing facility coverage.<sup>10</sup> Nevertheless, Medicare has mistakenly paid for almost all stays in skilled nursing facilities by patients with fewer than 3 prior inpatient days.<sup>11</sup>

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- 4 Generally, the qualifying hospital stay must take place within 30 days of the skilled nursing facility admission.
  - 5 Medicare introduced the 3 inpatient days rule in 1965 (Social Security Act § 1861(i); PL 89-97 [July 30, 1965]). The 3-day prior stay rule was repealed by the Medicare Catastrophic Coverage Act of 1988, which itself was repealed in 1989.
  - 6 The day a patient is admitted to the hospital is counted toward the 3-day inpatient requirement for Medicare skilled nursing facility coverage, but the day a patient leaves the hospital is not. Op. cit., CCH, para. 230. Medicare has started to waive the 3-day rule for a small number of providers who participate in alternative payment models, such as accountable care organizations and bundled payment demonstration ("CMS Tests Waiving 3-Day Hospital Stay as SNF Coverage Precursor in Bundles, Pioneer ACOs," M. Stein. Inside CMS [May 28, 2014]).
  - 7 Medicare beneficiaries' average number of inpatient hospital days declined from 13 in 1965 to 5.4 in 2010 (M. R. Chassin), "Variations in Hospital Length of Stay: Their Relationship to Health Outcomes" [Congressional Office of Technology Assessment, Aug. 1983]). As a result, more than one-third of beneficiaries who were hospitalized in 2010 had an inpatient stay of less than 3 days, which excluded them from Medicare coverage of skilled nursing facility care (CMS, Data Compendium, "Medicare Short-Stay Hospital Utilization," Tables V.1 and V.2 [Dec. 2011]. Accessed at [http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/DataCompendium/2011\\_Data\\_Compendium.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/DataCompendium/2011_Data_Compendium.html)).
  - 8 In 2009, beneficiaries who received care for 100 days in a skilled nursing facility owed \$10,680 in copayments. Because beneficiaries with stays longer than 100 days pay for all the costs without limit to the amount they owe, their skilled nursing facility bill can amount to tens of thousands of dollars.
  - 9 Medicaid may cover skilled nursing facility costs for low-income beneficiaries who do not qualify for Medicare skilled nursing facility coverage. However, Medigap is unlikely to do so because supplemental insurances do not generally pay for services that Medicare does not cover.
  - 10 At least three states, Connecticut, New York, and Maryland, require hospitals to notify their patients under observation of their status.
  - 11 In 2012, many Medicare beneficiaries (under observation, long-stay outpatients, and short-stay inpatients) who were in the hospital for at least 3 nights did not qualify for Medicare skilled nursing facility coverage. According to the Inspector General, Medicare mistakenly paid for 92 percent of these patients' skilled nursing facility claims. The remaining 8 percent who owed all costs for their skilled nursing facility stay paid about \$10,000 out of pocket (Office of Inspector General, OIG, "Hospitals' Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries," Memorandum Report OEI-02-12-00040 [Washington, DC: U.S. Department of Health and Human Services, July 29, 2013]. Accessed at <http://oig.hhs.gov/oei/reports/oei-02-12-00040.pdf>).

## Box 2. Methods

### Data

This study uses a random 5 percent sample of 2009 Medicare hospital and skilled nursing facility claims representing 2,156,680<sup>12</sup> beneficiaries. In addition to being enrolled in Medicare Parts A and B, beneficiaries had to be placed under observation during that year. This was determined by locating claims with any of the Medicare codes for observation services.<sup>13</sup> We identified post-observation inpatients as people with an inpatient hospital claim dated on the day of or the day after their last observation service. Subscribers to Medicare Advantage plans were excluded, and we had no data on the severity of beneficiaries' medical conditions.

### Sub-samples

To study how much those who received observation services paid for needed care in a skilled nursing facility, we examined the claims of those referred by a hospital to such a facility (159,960 claims). We also looked at the records of those who filed a Medicare claim for reimbursement of their skilled nursing facility stay (109,960 claims).

### Measuring how much observation patients pay for hospital services

We added the amounts owed by observation patients in deductibles and coinsurances for all the observation services as well as for other outpatient services they received. Although some of what people owed could have been covered by supplemental insurances (such as Medicaid, Medigap, or retiree health coverage),<sup>14</sup> we had almost no information on these payers' contributions.<sup>15</sup>

### Measuring how much recipients of observation services who later get skilled nursing facility care pay for such care

Medicare pays 100 percent of the cost for the first 20 days of care in a skilled nursing facility. Those who remain there longer owe a daily copayment (\$133.50 in 2009) up to their 100th day and then pay all the costs. When Medicare reimbursed a skilled nursing facility stay, we counted these initial copayments as out-of-pocket spending toward skilled nursing facility care; after 100 days, we counted the facility charges not covered by Medicare as out-of-pocket costs. When Medicare did not pay any portion of a beneficiary's skilled nursing facility claims, we counted the average Medicare allowable charges as out-of-pocket costs—that is, the amount Medicare would have paid—plus the copayment that patient would have owed.<sup>16</sup>

### Exclusions

We did not include amounts beneficiaries paid for physician fees, other health professional fees, or for Part D prescription drugs. These costs would be added to the amount owed by Medicare patients for both hospital and skilled nursing facility care.

Further information on the methodology can be found in appendix C.

12 To get the total number of beneficiaries represented by our data, we multiplied our 5 percent Medicare sample by 20.

13 We excluded people who may have similar conditions as those placed under observation, but who instead stayed in the emergency room for a long time or were admitted to the hospital as inpatients for short stays (J. L. Wiler, M. A. Ross, and A. A. Ginde, "National Study of Emergency Department Observation Services," *Academic Emergency Medicine* 2011, vol. 18, pp. 959–65).

14 In 2009, approximately half of Medicare beneficiaries had Medigap or retiree supplemental coverage, 14 percent were "dually eligible" with Medicaid coverage, and 12 percent had no supplemental coverage (Kaiser Family Foundation, *Medigap: Spotlight on Enrollment, Premiums, and Recent Trends* [April 2013]).

15 We found that only 5 percent of our sample included a contribution from a supplemental insurance. It's possible that these reimbursements weren't reported even though they took place. However, we believe that our estimates of how much observation patients spent out of pocket are only somewhat greater than the true numbers.

16 In the vast majority of cases, Medicare paid for the skilled nursing facility stays of those who received observation services, even though they should not have been covered (see Results section).

# Results

## A) One in ten observation patients spent more for hospital services than they would have as inpatients.

In 2009, approximately 2.2 million fee-for-service Medicare beneficiaries were placed under observation. More than three-quarters (77.6 percent) of these patients received only outpatient services. About one-quarter of them were later admitted to the hospital as post-observation inpatients (figure 1).

**FIGURE 1**  
**The Vast Majority of Those Placed Under Observation Received Only Outpatient Services, 2009**

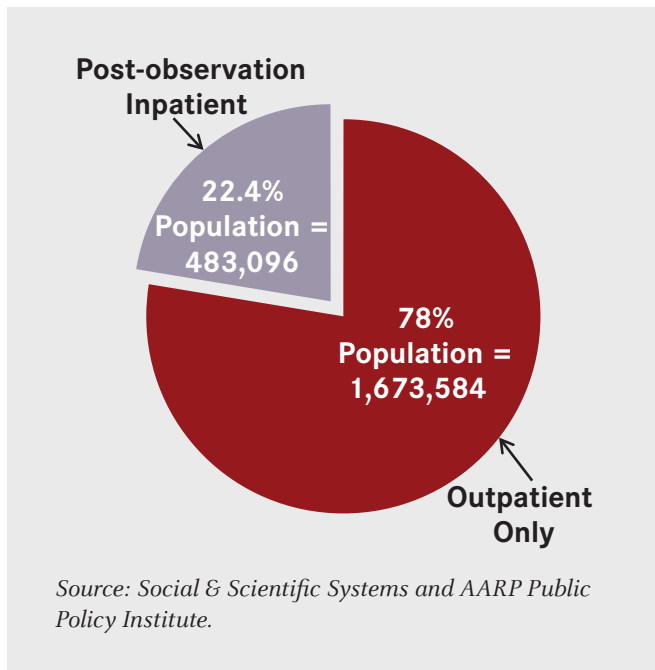


Table 1 reveals that 1 in 10 observation patients (167,358) paid more for hospital services than the deductible owed by post-observation inpatients (\$1,068 in 2009).<sup>17</sup> The 1 percent of observation patients who spent the most (16,736) paid at least \$2,283—more than twice what they would have owed had they later been admitted.<sup>18</sup>

Table 1 also shows that most of those placed under observation who remained as outpatients paid less than the inpatient deductible.<sup>19</sup> The average observation patient spent less than half of what he or she would have paid as a post-observation inpatient (\$504 versus \$1,068). Half of all those who received only outpatient services spent less than \$310 and three-quarters spent less than \$535. What’s more, for 90 percent of observation patients (1.5 million), subsequent inpatient admission would have resulted in higher spending than if they had simply remained under observation.

**TABLE 1<sup>20</sup>**  
**About 10 Percent of Observation Patients Owed More for Hospital Services than If They Had Been Admitted, 2009**

	Personal Spending
<b>Average</b>	\$504
<b>Median</b>	\$310
<b>75th Percentile</b>	\$535
<b>90th Percentile</b>	\$1,068
<b>99th Percentile</b>	\$2,283
<b>Population</b>	1,673,584

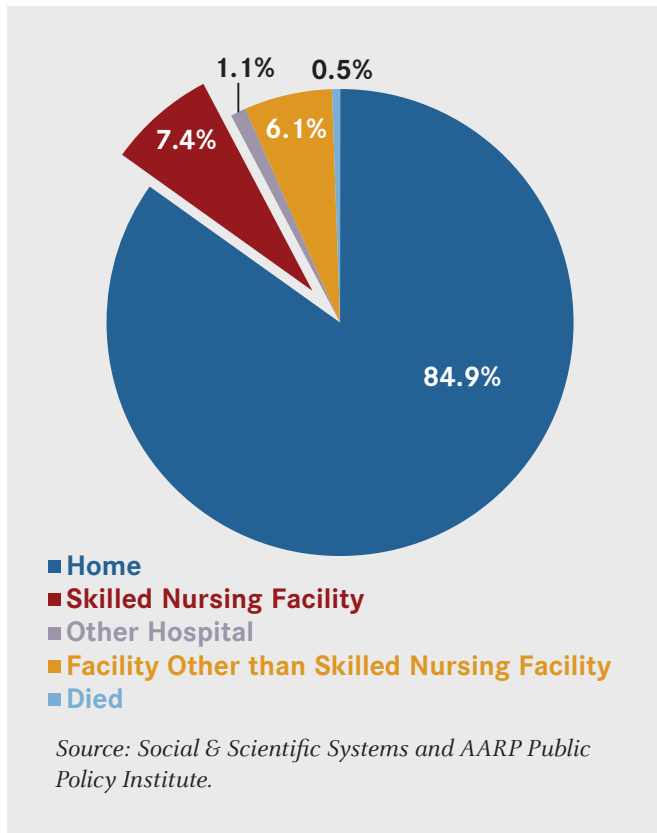
Source: Social & Scientific Systems and AARP Public Policy Institute.

17 Many of those who owe more than the inpatient deductible have undergone a coronary stent insertion (Op. cit., OIG).  
 18 These observation patients also owed over \$2,500 for prescription drugs and almost \$40,000 for skilled nursing facility care covered by Medicare (data available on request).  
 19 Our data did not include amounts beneficiaries paid for professional fees, Part D prescription drugs, or skilled nursing facility care not covered by Medicare. These costs would have added to the amount owed by Medicare patients for both hospital and skilled nursing facility care.  
 20 The figures in this table show the amounts owed by observation patients in deductibles and coinsurances for all observation services as well as for other outpatient services they received. We did not count what observation patients paid for physician fees, other health professional fees, or for Part D prescription drugs.

**B) Only a small fraction of those placed under observation were referred to a skilled nursing facility.**

Only 7.4 percent (159,960) of those placed under observation were referred to a skilled nursing facility (figure 2).<sup>21</sup> By far, the most common situation was for those who received observation services to return home<sup>22</sup> (84.9 percent) after their hospital stay. Slightly more than 6 percent were transferred somewhere other than a skilled nursing facility.<sup>23</sup> Finally, 1.1 percent of those who got observation services were later transferred to another hospital, and 0.5 percent died.

**FIGURE 2**  
**About 7 Percent of Those Placed under Observation Were Referred to a Skilled Nursing Facility**



**C) Most of those who received observation services and needed follow-up care in a skilled nursing facility did not qualify for Medicare coverage for such services.**

Almost two-thirds (62.1 percent) of all those who needed care in a skilled nursing facility after getting observation services did not meet the 3-day inpatient requirement for Medicare to cover such care (table 2).

**TABLE 2**  
**Most Observation Patients Were Not Eligible for Skilled Nursing Facility Coverage, 2009**

	Total Referred to a SNF	Without Coverage for SNF Care*	With Coverage for SNF Care
<b>Population</b>	159,960	99,280	60,680
<b>Percent</b>	100.0%	62.1%	37.9%

Source: Social & Scientific Systems and AARP Public Policy Institute.

SNF=skilled nursing facility

\* Beneficiaries receiving observation services who were referred to a skilled nursing facility but did not have a prior 3-day inpatient stay.

21 Some of those referred to a skilled nursing facility were not admitted to one.

22 Either without (78.4 percent) or with (6.5 percent) services from Medicare home health care. Under Medicare rules, “home” can also refer to a nursing home or an assisted living facility.

23 Such as an intermediate care facility or nursing home, a hospice, an inpatient rehab facility, or a long-term care hospital.

More than three-quarters (77.3 percent) of those without Medicare coverage for skilled nursing facility care had remained in the hospital fewer than 3 days. The remainder (22.7 percent) had spent at least 3 days in a hospital but did not have 3 consecutive inpatient days (table 3).

**TABLE 3**  
**Why Did Those Who Needed Care in a Skilled Nursing Facility after Getting Observation Services Not Have Medicare Coverage for It?**

	Total Referred to a SNF without Coverage for SNF Care	Fewer than 3 Hospital Days	3 Hospital Days but Fewer than 3 Inpatient Days
<b>Population</b>	99,280	76,760	22,520
<b>Percent</b>	100.0%	77.3%	22.7%

Source: Social & Scientific Systems and AARP Public Policy Institute.

SNF=skilled nursing facility

**D) Many beneficiaries who received observation services and needed follow-up care in a skilled nursing facility did not receive it.**

Almost one-third (31.3 percent) of those who received observation services and were referred to a skilled nursing facility (50,000 beneficiaries) did not file a Medicare claim for reimbursement of a stay in such a facility (figure 3). In other words, they did not receive needed skilled nursing facility care.<sup>24</sup>

**FIGURE 3**  
**Beneficiaries Who Were Referred to a Skilled Nursing Facility after Receiving Observation Services and Filed a Claim for Reimbursement of a Stay in Such a Facility, 2009**

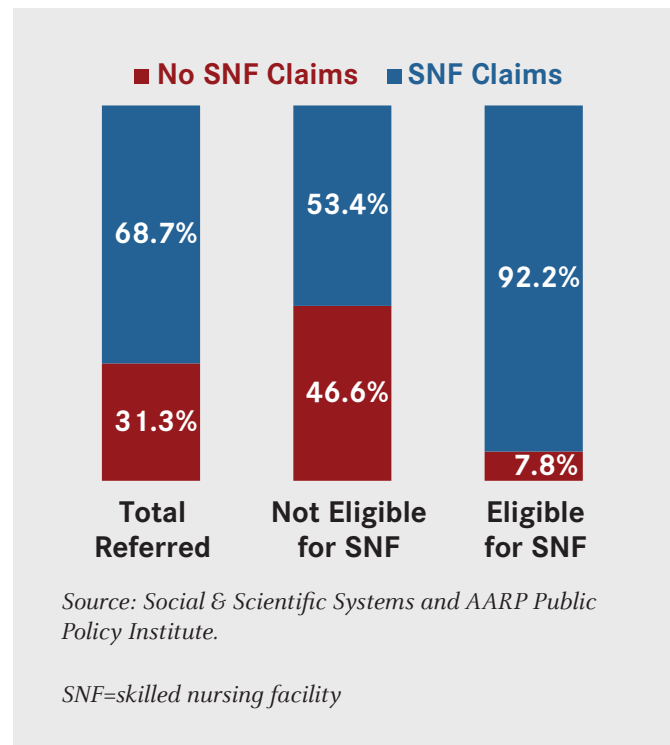


Figure 3 also reveals that those who needed care in a skilled nursing facility, but did not qualify for Medicare coverage for such services, were considerably less likely to receive this follow-up care (53.4 percent) than those with coverage (92.2 percent).

Those who receive observation services but do not have coverage for skilled nursing facility care may be reluctant to obtain such care when they think they will have to pay for it entirely out of pocket.<sup>25</sup>

24 We expect that it was rare for patients to pay for skilled nursing facility care out of pocket without filing a Medicare claim because skilled nursing facilities must give beneficiaries the option of submitting a claim even when Medicare is not expected to pay it. Our data included about 6,200 such claims that were not paid by Medicare. These “demand bills” are designed to generate a Medicare denial letter, which triggers appeal rights (*Medicare Claims Processing Manual*, Chapter 1 §60.3. Accessed at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Liability-Notices-Beneficiary-Appeal-Rights-Review.pdf>).

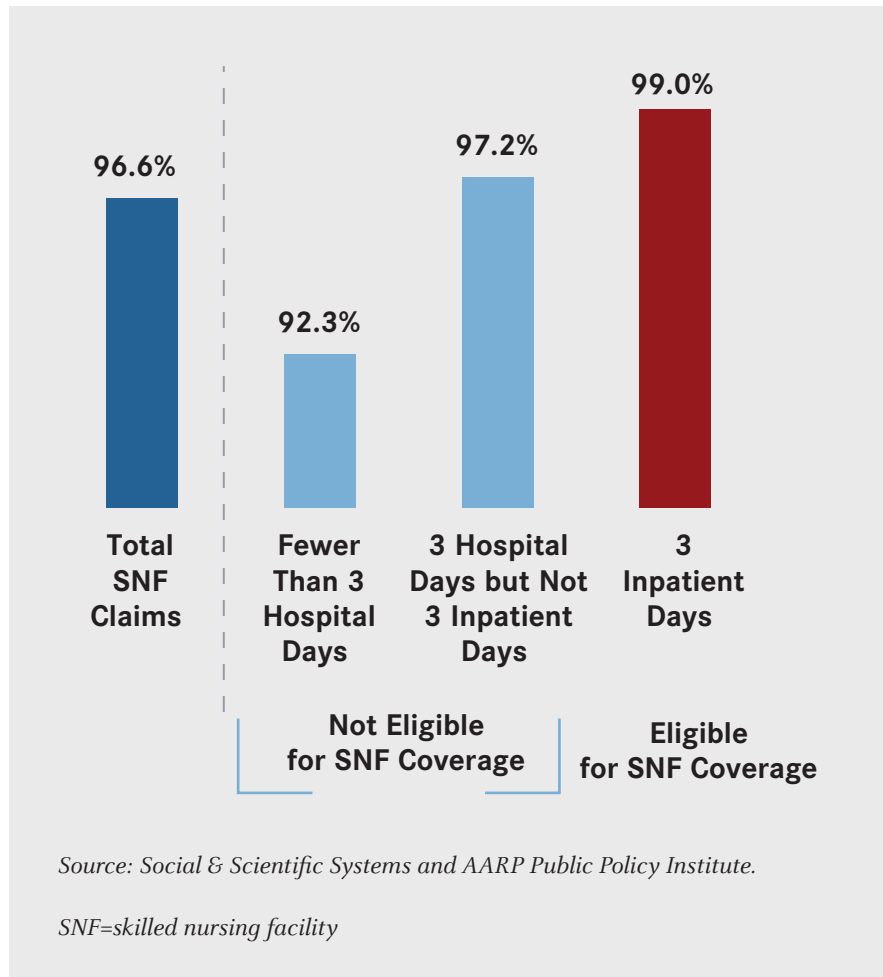
25 Those with a 3-day inpatient stay qualifying them for Medicare coverage of skilled nursing facility care may also have been sicker and needed more follow-up care than those without coverage.

**E) Medicare paid for almost all skilled nursing facility stays—even when beneficiaries who received observation services did not qualify for such coverage.**

As expected, when those who had received observation services were admitted to a skilled nursing facility after qualifying for Medicare coverage, Medicare paid for 99 percent of their claims (figure 4). Furthermore, despite current coverage rules, Medicare paid the skilled nursing facility claims for almost all those under observation without a prior 3-day inpatient stay (figure 4). This represents over 50,000 mistakenly reimbursed claims.

For example, Medicare paid 97.2 percent of skilled nursing facility claims for those 18,380 individuals who did not qualify for such coverage despite having previously spent 3 days in the hospital.<sup>26</sup> Only 2.8 percent of claims for skilled nursing facility care (about 520<sup>27</sup>) provided to this group were denied by Medicare as prescribed by current law.

**FIGURE 4**  
**Proportion of Skilled Nursing Facility Claims Paid by Medicare, 2009**



26 This is consistent with a recent finding by the Inspector General that, in 2012, Medicare mistakenly paid 92 percent of skilled nursing facility claims (25,245) for beneficiaries who were in the hospital at least 3 days, but did not have 3 inpatient days. The estimated cost to Medicare was \$255 million, and officials called for Medicare to recover these payments (Op. cit., OIG).

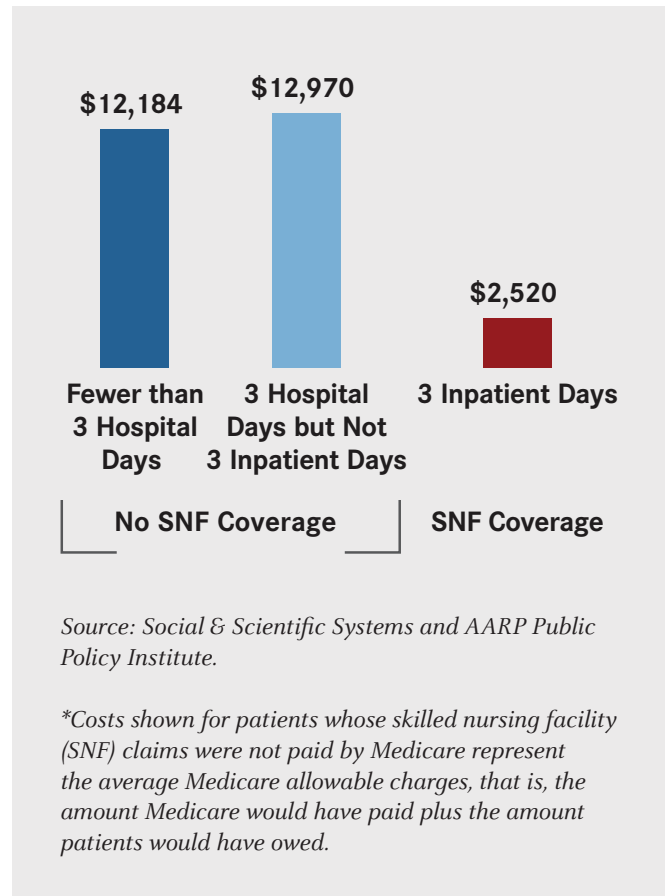
27 2.83 percent of 18,380.

**F) Recipients of observation services without Medicare coverage for skilled nursing facility care could end up paying five times more for such care than those with coverage.**

Beneficiaries under observation who later received care in a skilled nursing facility without Medicare coverage for such care owed the facility \$3,409, on average. That is only \$889 more than those who had Medicare coverage (\$2,520). The difference in personal spending between those with and without coverage is relatively small because Medicare mistakenly reimbursed almost all the skilled nursing facility claims of those lacking coverage (see above).

If Medicare had denied reimbursement for ineligible skilled nursing facility claims, beneficiaries needing such follow-up care would have faced thousands of dollars in facility bills. A small group of beneficiaries (3,761 in 2009) who got skilled nursing facility care without coverage, in fact, faced such large bills.<sup>28</sup> We estimated that those who spent less than 3 days in the hospital and subsequently paid for the entire cost of their follow-up care out of pocket would spend upwards of \$12,000 (figure 5). Beneficiaries who spent at least 3 days under observation and later received uncovered skilled nursing facility care owed the most (\$12,970). This is over five times the amount paid by those who had Medicare covered skilled nursing facility care after being placed under observation.

**FIGURE 5**  
**Estimated Average Out-of-Pocket Spending\* for Skilled Facility Care under Current Medicare Coverage Rules, 2009**



28 In 2012, about 2,100 beneficiaries who got skilled nursing facility care without coverage for it after being in the hospital at least 3 days were required to pay an average of \$10,503 to the facility, for a total out-of-pocket cost of approximately \$22 million (Op. cit., OIG).



## Policy Recommendations

Consumers and their advocates are concerned that Medicare observation patients may owe more for hospital services than they would have if they had been admitted as inpatients. Our findings support this worry for the top 10 percent of spenders among observation patients. The other 90 percent of observation patients owed less than the inpatient deductible.

There is also escalating concern that those who were placed under observation but did not have a 3-day inpatient stay may later face substantial costs for skilled nursing facility care. Our data reveal that a small but vulnerable group of observation beneficiaries without Medicare coverage faced this reality. If Medicare were to strictly enforce its rules, many more beneficiaries could end up paying five times more than those with coverage or entirely skipping needed skilled nursing facility care.

To address these concerns, policy makers should consider the following recommendations:

### **A) Protect Medicare observation patients from disproportionate out-of-pocket spending for hospital services.**

- Cap total beneficiary out-of-pocket costs for observation services and other outpatient care at the Medicare inpatient (Part A) deductible. This would limit the financial burden for observation services to the amount

beneficiaries would incur for an inpatient admission (\$1,260 in 2015).

### **B) Protect Medicare beneficiaries who get observation services from disproportionate out-of-pocket spending for skilled nursing facility care.**

- In the short term, credit time spent in observation, as well as time spent continuously in other hospital settings (such as the emergency department), toward the 3-day inpatient stay required to qualify for Medicare skilled nursing facility coverage. This would reduce the disproportionate financial burden faced by observation beneficiaries who spend at least 3 days in a hospital setting but lack a 3-day inpatient stay. (See appendices A and B for estimated cost of crediting time spent in observation toward Medicare's 3-day stay rule.)
- In the longer term, replace the 3-day inpatient stay requirement with more appropriate clinical criteria. These could include beneficiary characteristics and clinical factors relevant to the appropriateness of skilled nursing facility care.<sup>xix</sup> Eliminating the 3-day inpatient stay rule would level the playing field with other postacute care services (e.g., home health agencies, inpatient rehabilitation facilities, long-term care hospitals) that do not require prior inpatient admission for coverage.

## Conclusion

The use of observation services can have disproportionate financial implications for some fee-for-service Medicare beneficiaries. While not all who are placed under observation are negatively affected, a small but vulnerable share of them can face substantial out-of-pocket expenses for hospital services or for follow-up skilled nursing facility care.

Our findings indicate that some Medicare observation patients' out-of-pocket spending for hospital services can be strongly affected by Medicare rules governing beneficiary cost-sharing. For example, the top 10 percent of spenders among those receiving only observation services paid more out of pocket than they would have as post-observation inpatients. To date, there is no indication that such greater personal spending reflects higher quality or safer hospital services. Limiting the total amount owed by observation patients to the inpatient deductible would protect them from disproportionate personal spending.

Our findings also demonstrate that a small portion of Medicare beneficiaries who get observation services face very large out-of-pocket expenses for skilled nursing facility care after leaving the hospital. In addition, almost one-third of Medicare patients for whom skilled nursing facility care was recommended may not have sought such treatment because they failed to qualify for it under Medicare's rule requiring an inpatient stay of 3 consecutive days.

Finally, our research suggests that Medicare patients placed under observation face a notable dilemma. On one hand, they may press to be admitted as inpatients—as some advocates have urged—if they expect to spend 3 days in the hospital, since Medicare will then cover their care in a skilled nursing facility. On the other hand, beneficiaries who do not require skilled nursing facility care after getting observation services will likely face lower out-of-pocket costs for hospital services as outpatients rather than as inpatients. Although the vast majority of patients will be in the latter group, few Medicare patients will be able to anticipate into which group they will fall. If they guess wrong, they are likely to face higher out-of-pocket costs.

Bipartisan legislation pending in Congress would credit time spent in observation status toward the 3-day inpatient stay requirement.<sup>xv</sup> This could both reduce the financial burden on those who receive skilled nursing facility care after getting observation services and allow more of them to obtain such needed services. Adopting such a policy change is particularly important in light of the long-term decline in Medicare beneficiaries' inpatient length-of-stay,<sup>29</sup> and given the increased use of observation services as a substitute for inpatient admission.<sup>xvi</sup> In this context, requiring a 3-day prior inpatient stay as the primary criterion for Medicare skilled nursing facility coverage may no longer be appropriate.

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29 Medicare introduced the 3 inpatient days rule in 1965 when the average inpatient hospital stay for beneficiaries over 65 was about 13 days (Op. cit., M. R. Chassin). By 2010, the average inpatient stay by Medicare beneficiaries had dropped to 5.4 days, with over a third of those stays lasting fewer than 3 days (Op. cit., CMS).

## Appendix A. Estimated Cost of Crediting Time Spent under Observation toward Medicare’s 3-Day Stay Requirement for Skilled Nursing Facility Coverage

Bipartisan legislation pending in Congress would require that Medicare count outpatient time spent under observation toward the 3-day inpatient stay requirement for skilled nursing facility coverage.<sup>xvii,xviii</sup> Beneficiaries of observation services affected by this new rule would be those who get care in a skilled nursing facility after at least 3 days total in the hospital, but without 3 consecutive inpatient days (18,380 in 2009).

To estimate the cost to Medicare of implementing this rule change, we first determined how many beneficiaries within this potentially affected group saw their skilled nursing facility claims denied by Medicare (520 beneficiaries; see Results

section for details). We multiplied this figure by the average amounts<sup>30</sup> reimbursed by Medicare—despite its own rules—for skilled nursing facility stays for observation patients who were in the hospital 3 or more days but did not meet the 3-day inpatient stay threshold.

The daily rates Medicare pays to skilled nursing facilities depend on the patient’s skilled care needs and on the intensity of the care provided.<sup>xix</sup> Unfortunately, we did not have information on type or intensity of care. As a proxy, we calculated average Medicare payments to a skilled nursing facility according to the length of beneficiaries’ stays in such a facility (table 4).<sup>31</sup> For beneficiaries

**TABLE 4**  
**Medicare Payments for Skilled Nursing Facility Claims Varied by Length of Stay (LOS), 2009**

SNF Claim Period	Without Coverage for SNF Care*		3 Hospital Days but Fewer than 3 Inpatient Days		With Coverage for SNF Care	
	Average Payment	Population	Average Payment	Population	Average Payment	Population
<b>1-20 Days LOS</b>	\$3,887	14,880	\$4,643	8,560	\$4,553	27,780
<b>21-100 Days LOS</b>	\$12,390	18,040	\$14,934	9,300	\$14,730	27,640

Source: Social & Scientific Systems and AARP Public Policy Institute.

SNF=skilled nursing facility

\*Some who were placed under observation did not earn Medicare SNF coverage despite having been admitted as inpatients. All those who did not qualify for Medicare SNF coverage remained as inpatients fewer than 3 consecutive days.

30 We accounted for differences in average Medicare reimbursements according to how long individuals remained in the skilled nursing facility.

31 For this analysis, we limited our sample to beneficiaries of observation services whose skilled nursing facility claims were covered by Medicare (i.e., 96.6 percent of those who filed such a claim, or 106,199 individuals). This group of observation beneficiaries is smaller by 3,761 than the total number of observation beneficiaries filing a skilled nursing facility claim.

who received observation services and had remained in the hospital at least 3 days but fewer than 3 inpatient days, Medicare paid an average of \$4,643 for stays of up to 20 days and \$14,934 for stays lasting 21–100 days.

In addition, Table 4 reveals that 47.9<sup>32</sup> percent of all covered skilled nursing facility stays by this group of observation beneficiaries lasted 1–20 days and 52.1<sup>33</sup> percent lasted 21–100 days. We applied this distribution of lengths of stay to the total number of skilled nursing facility claims denied by Medicare (520).

In total, we estimate that crediting time spent in observation toward the 3-day stay rule would have increased Medicare spending by approximately \$5.2 million<sup>34</sup> in 2009.<sup>35</sup> We believe that this figure represents a realistic approximation of the cost to Medicare of crediting time spent under observation toward the current 3-day stay requirement for skilled nursing facility coverage.<sup>36</sup> However, estimates that assume Medicare’s current rules are fully enforced for those who lack a 3-day prior inpatient stay would be higher than ours (see appendix B).

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32  $(8,560/[8,560+9,300])*100=47.93\%$

33  $(9,300/[8,560+9,300])*100=52.07\%$

34  $\$1,157,162 + \$4,043,719=\$5,200,881$

35 We estimate that Medicare spending would have increased by \$1,157,162 for 249 observation beneficiaries staying in a skilled nursing facility 1–20 days plus an additional \$4,043,719 for 271 individuals using observation services and then staying 21–100 days in a skilled nursing facility.

36 Our estimate does not consider potential savings from fewer hospital readmissions attributable to better access to skilled nursing facility care.

## Appendix B. Alternative Cost Estimate Based on Current Medicare Rules

An alternate estimate of the Medicare cost of counting observation time toward the 3-day inpatient stay rule might assume that—as prescribed by current law—Medicare would deny all claims for skilled nursing facility stays that are not preceded by at least 3 consecutive days as a hospital inpatient. Based on this premise, the cost of crediting time spent under observation toward Medicare’s requirement for skilled nursing facility coverage would have been about \$273 million in 2009, compared with the \$5.2 million estimated in this report.

Additional assumptions used to derive this figure are:

- A) No additional people are placed under observation merely because such time is counted toward the 3-day inpatient stay requirement for skilled nursing facility coverage.
- B) Because time spent under observation is counted toward that 3-day stay, more beneficiaries of observation services file a skilled nursing facility claim after spending at least 3 days in a hospital setting but fewer than 3 inpatient days (“woodwork effect”). We estimated an additional 27,352 claims from this group by using the following logic:

**Step 1:** We determined that 25.9 percent of all those with coverage for skilled nursing facility care after being placed under observation were referred to such a facility.

**Step 2:** In comparison, we determined that only 17.4 percent (22,520) of those who spent at least 3 days in the hospital, but fewer than 3 inpatient days,<sup>37</sup> were referred to a skilled nursing facility.

**Step 3:** We assumed that if time spent under observation counted toward the 3-day inpatient stay, the proportion of those *without* coverage for skilled nursing facility care—despite at least a 3-day hospital stay—then referred to a skilled nursing facility would match the proportion of beneficiaries *with* coverage, increasing to 25.9 percent from 17.4 percent, or to 33,520<sup>38</sup> individuals from 22,520.

**Step 4:** In 2009, 81.6 percent of those under observation who were in the hospital at least 3 days and were later referred to a skilled nursing facility despite not having coverage were actually admitted to such a facility.<sup>39</sup> We assumed that this proportion would remain constant if time spent under observation were counted toward the 3-day inpatient stay<sup>40</sup>—resulting in 27,352<sup>41</sup> new skilled nursing facility claims. Since current law prescribes that ineligible skilled nursing facility stays not be reimbursed, all of these 27,352 claims would contribute to additional Medicare spending.

37 129,420 individuals spent at least 3 days in the hospital, but fewer than 3 inpatient days.

38 25.9% of 129,420=33,520.

39 If current rules were fully observed, all skilled nursing facility claims for this group would have been denied by Medicare.

40 We assumed that beneficiaries of observation services in this group were not as sick as those who remained in the hospital at least 3 days as inpatients and that their need for skilled nursing facility care would not increase.

41 81.6% of 33,520=27,352.

C) Counting time spent under observation toward the 3-day inpatient stay requirement would have no effect on how long beneficiaries stay in a skilled nursing facility.

**Step 1:** We assumed that counting time spent under observation toward the 3-day inpatient requirement would not change beneficiaries' length of stay in a skilled nursing facility.

**Step 2:** We assumed that counting time spent under observation toward that 3-day requirement would not change the

distribution of lengths of stay in a skilled nursing facility.<sup>42</sup> We calculated an increase in Medicare spending of \$60,832,586<sup>43</sup> for 13,102<sup>44</sup> additional skilled nursing facility stays lasting up to 20 days, and \$212,809,500<sup>45</sup> more for 14,250<sup>46</sup> such stays lasting 21–100 days.

In total, assuming current law, we estimate that counting time spent under observation toward the 3-day inpatient stay requirement would have cost Medicare an additional \$273.6 million<sup>47</sup> in 2009.

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42 47.9 percent of all covered skilled nursing facility stays by beneficiaries receiving observation services who had remained in the hospital at least 3 days but fewer than 3 inpatient days lasted 1–20 days and 52.1 percent lasted 21–100 days. For this group of beneficiaries, Medicare paid an average of \$4,643 for stays of up to 20 days and \$14,934 for stays lasting 21–100 days (see section on the cost of crediting time spent under observation toward Medicare's requirement for skilled nursing facility coverage).

43 These claims would be paid at an average of \$4,643:  $13,102 * \$4,643 = \$60,832,586$ .

44 47.9% of 27,352 new claims=13,102 claims.

45 These claims would be paid at an average of \$14,934:  $14,250 * \$14,934 = \$212,809,500$ .

46 52.1% of 27,352 new claims=14,250 claims.

47  $\$212,809,500 + \$60,832,586 = \$273,642,086$ .

## Appendix C. Additional Methods

**Measuring time spent in the hospital under observation**—We identified the arrival dates of patients receiving hospital observation services. When they spent time in the hospital (usually in the emergency room) before being placed under observation, we counted those days in their total length of stay under observation. By compiling consecutive or overlapping outpatient and inpatient claims, we counted days up to when observation patients were discharged or post-observation inpatients were admitted.

**Measuring time spent in the hospital as an inpatient**—For post-observation inpatients, we followed Medicare’s method of counting partial inpatient days as full days if a patient was present at midnight. We included the day of inpatient admission but did not count the day a patient was discharged. We also excluded inpatient days preceding an observation stay.

**Measuring total time spent in the hospital**—For observation patients, total time in the hospital was equal to time spent under observation. For post-observation inpatients, we added time spent under observation and time spent as an inpatient.

**Determining who has Medicare coverage for skilled nursing facility care**—Post-observation inpatients who were admitted at least 3 consecutive days were eligible for coverage of care in a skilled nursing facility. We did not identify recipients of observation services who could have gotten such coverage from a separate inpatient stay before or after being placed under observation.<sup>48</sup>

**Classifying beneficiaries of observation services without coverage for skilled nursing facility care**—We identified two groups of patients

without skilled nursing facility coverage: (1) those who were in the hospital for a total of fewer than 3 days; and (2) those who stayed in the hospital for at least 3 days but did not have 3 or more consecutive inpatient days.

**Identifying beneficiaries of observation services who need care in a skilled nursing facility**—Those who needed care in a skilled nursing facility after getting observation services had a hospital claim with a discharge code for a referral to such a facility. Being referred to a skilled nursing facility does not necessarily mean that these patients were actually admitted to one.

**Identifying beneficiaries of observation services who receive care in a skilled nursing facility**—Recipients of observation services who later received care in a skilled nursing facility had a claim from such a facility dated immediately after their departure from the hospital. Some who got skilled nursing facility care after receiving observation services may not have filed a Medicare claim for reimbursement,<sup>49</sup> instead paying all costs out of pocket.<sup>50</sup> We estimate this situation to be rare, because skilled nursing facilities must give beneficiaries the option of submitting a claim even when Medicare is not expected to pay it. Some who were referred to a skilled nursing facility but not admitted may also have gotten postacute care in a different type of facility or at home. But this also appears unlikely, because only 6 percent of those who received observation services were later referred to a facility other than a skilled nursing one. Overall, counting claims for reimbursement of stays in a skilled nursing facility by beneficiaries of observation services provides a reliable estimate of the number actually receiving care in such a facility.

48 Very few beneficiaries who receive observation services (about 440 in 2009) are (re)admitted as inpatients within 30 days of having been released from the hospital. It is therefore unlikely that observation beneficiaries obtain coverage for skilled nursing facility care based on a separate and subsequent 3-day inpatient stay.

49 We were not able to identify observation beneficiaries who were admitted to a skilled nursing facility but did not file a Medicare claim for their stay.

50 Some beneficiaries without Medicare coverage for care in a skilled nursing facility owe the entire cost of their stay in such a facility.

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