In Brief

Observation Status: Financial Implications for Medicare Beneficiaries

During periods of medical uncertainty, doctors may place patients under “observation” pending a decision about whether to admit them or send them home. This can have unforeseen financial implications for several reasons, most notably:

- As outpatients, Medicare beneficiaries must pay part of the cost of each hospital service provided, with no limit on what they may owe. In contrast, the cost to those admitted as inpatients is typically limited to a single deductible amount.

- Those who spend fewer than 3 consecutive days as hospital inpatients are not eligible for Medicare coverage of subsequent care in a skilled nursing facility. Time spent in observation does not count toward the “3-day stay” requirement.

Because hospitals need not inform beneficiaries of their status, those placed in inpatient hospital beds may be unaware that they are technically considered outpatients under observation. As a result, Medicare patients under observation may not only end up with unexpectedly large hospital bills, but also later owe thousands of dollars for skilled nursing facility care.

Summary of Study Findings
Based on a sample of Medicare claims from 2009, this study found that:

- Ten percent of observation patients (about 167,000) paid more than if they had been admitted as inpatients.

This In Brief is a synopsis of the research report Observation Status: Financial Implications for Medicare Beneficiaries 2015-04. To view the full report, visit www.aarp.org//ppi.
admitted (i.e., their out-of-pocket costs exceeded the hospital inpatient deductible of $1,068 in 2009). The other 90 percent owed less than if they had been admitted.

- Only 7.4 percent of observation patients (about 160,000) were discharged to a skilled nursing facility. Almost one-third of these patients did not file claims and may not have been admitted to a skilled nursing facility, even though a hospital physician recommended such care.

- Surprisingly, we found that Medicare paid for the vast majority of skilled nursing facility claims, even for beneficiaries who spent 3 days in a hospital setting without a full 3-day inpatient stay (almost 18,000 claims).

— As a result, the average observation patient who received skilled nursing facility care while ineligible for Medicare coverage owed about $3,400, a relatively low amount.

— In contrast, a small group of observation patients whose skilled nursing facility claims were not paid by Medicare, on average, more than five times as much (over $12,000) as those whose care was eligible for and covered by Medicare ($2,520) (figure 1).

- These findings are consistent with a report by the HHS Inspector General that found that, in 2012, Medicare mistakenly paid about 92 percent of skilled nursing facility claims for more than 25,000 beneficiaries who did not have an inpatient stay of 3 days but spent at least 3 days in a hospital setting. The report characterized the $255 million in payments as “mistaken” and called for Medicare to recover them.

- These findings suggest that, if Medicare were not mistakenly paying skilled nursing facility claims, many more observation patients who need this care might forgo it. In addition, beneficiaries who did not qualify for skilled nursing facility coverage and chose to receive such care would face much higher out-of-pocket costs.

**Policy Recommendations**

To address the concerns raised by these findings, policy makers should consider the following:

- Cap total beneficiary out-of-pocket costs for observation services and other outpatient services at the Medicare inpatient (Part A) deductible.

  — This option would limit the maximum financial burden for hospital-related observation services to what beneficiaries incur for an inpatient admission ($1,260 in 2015), but would not affect beneficiary liability for skilled nursing facility costs.

- In the short term, credit time spent in observation, as well as time spent...

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**Figure 1**

*Observation Patients without Medicare Coverage for Skilled Nursing Facility Care Owed* Five Times More than Those with Coverage in 2009

- **$12,184** Fewer than 3 Hospital Days
- **$12,970** 3 Hospital Days but Not 3 Inpatient Days
- **$2,520** 3 Inpatient Days
- **SNF Coverage**
- **No SNF Coverage**

* Costs for patients whose skilled nursing facility (SNF) claims were not paid by Medicare represent the average Medicare allowable charges, that is the amount Medicare would have paid, plus the amount patients would have owed.

Source: Social & Scientific Systems and AARP Public Policy Institute.
continuously in other hospital settings (such as the emergency department), toward the 3-day stay required to qualify for Medicare skilled nursing facility coverage.

— This option would reduce the disproportionate financial burden faced by observation patients who spend at least 3 days in a hospital setting but lack a 3-day inpatient stay.

- Ultimately, replace the 3-day prior stay requirement with more appropriate clinical criteria, such as beneficiary characteristics and clinical factors related to the appropriateness of skilled nursing facility care.

— Eliminating the 3-day prior stay rule would level the playing field with other postacute care services (e.g., home health agencies, inpatient rehabilitation facilities, and long-term care hospitals) that do not require prior inpatient admission for coverage.

Impact of Crediting Time in Observation toward the 3-Day Stay Requirement

Legislation is pending in Congress that would credit time spent in observation toward the 3-day prior stay requirement.¹

- We estimated that the incremental cost of this change would have been about $5.2 million in 2009.

- Medicare had already paid more than 97.2 percent of skilled nursing facility claims for observation status beneficiaries who spent 3 days in a hospital setting without a qualifying 3-day inpatient stay. Thus, the legislation would impose additional costs only for the 2.8 percent of skilled nursing facility claims that Medicare did not pay in 2009.

- This estimate does not take into account potential savings that may arise from avoided hospital readmissions. These savings would reduce the overall cost of the legislation.
