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Medicare and the Three-Day Rule

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To the Editor

Marion Landers, then 101 years old, went to a hospital in Connecticut on April 20, 2001 with pain in her back, left leg, and hip. In the emergency room, she underwent an MRI and received morphine. Doctors decided to admit her on April 21. On April 23, she was transferred to the rehabilitation wing at Avery Heights, a facility in Hartford. Medicare later denied coverage for her skilled nursing stay. She received a bill for \$11,610.

The trouble was the part of the Medicare statute commonly known as “the three-day rule.” This is the requirement, present since Lyndon Johnson signed the law in 1965, that “post-hospital extended care services” be paid for only “after transfer from a hospital in which [an individual] was an inpatient for not less than 3 consecutive days.”¹ Ms. Landers had not been admitted until many hours after arriving in the ER. Without that time counted toward the total, her stay had not been long enough to qualify for the SNF benefit. She filed a class-action lawsuit with two other plaintiffs. They argued that inpatient care included pre-admission emergency room services, as well as services provided to patients in the hospital under observation status. In 2006, the District Court of Connecticut disagreed, as did the Second Circuit, to whom the plaintiffs appealed in 2008. “Regardless of whether we think it sensible as a policy matter,” wrote Judge Livingston, there is “no *regulatory* inconsistency in [the] decision not to count pre-admission hospital time.”²

What was the rationale behind requiring an in patient hospital stay in the first place? And why three days? The rule appears to have been put in place to help identify persons entering nursing homes for “extended care,” *extending* a course of treatment begun in the hospital. Starting with the Forand Bill, in 1957, the idea had emerged that moving patients to these facilities would save money and free up beds for senior citizens with new hospital insurance. There was concern, however, that the government would end up inadvertently paying for long-term institutional care. When it took up the Medicare legislation in 1965, Congress was well aware of the cost of the Kerr-Mills program, the precursor to Medicaid, which had passed in 1960. Five years later, payments to nursing homes constituted a third of its budget, nearly \$500 million.³ Reading the House and Senate hearings, one is struck by how often lawmakers are reminding one another that the new insurance program will not pay for “merely custodial care.” The financial obligation, they feared, would be fathomless. Kenneth Williamson, from the American Hospital Association, worried that “any weakening ... which might tend to encourage the payment for custodial care for large numbers of aged persons will seriously jeopardize the financing of the program.”⁴

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Conflict of Interest

The editor in chief has reviewed the conflict of interest checklist provided by the author and has determined that the author has no financial or any other kind of personal conflicts with this paper.

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The hospitalization requirement was disputed repeatedly in testimony before Congress. Dr. Frank Furstenberg, of Sinai Hospital in Baltimore, wondered why an inpatient stay was necessary. Many patients, he said, could be referred to a nursing home directly from the clinic, without being “placed in high-cost inpatient facilities in order to obtain extended care facilities benefits.” Representatives from the AHA worried about “the incentive ... for people to go into the hospital for 1 day and pay their deductible and then get transferred to a nursing home.” J. Henry Smith, of the Equitable Life Assurance Society, testified that private insurance companies required a five-day hospital stay. He suggested the same restriction be written into the House bill, to “avoid abuse,” since “unwarranted confinements for 5 days, for the purpose of qualifying for extended care, are not likely to be arranged.” Admission for three days seems to have been settled upon as a way of splitting the difference.⁴

Delegates at the American Medical Association convention in December 1965 agreed to focus on repealing the three-day rule, which they saw as limiting physicians’ decisions about where patients could receive care.⁵ Their efforts failed. The requirement—“arbitrary, unnecessary, and burdensome”⁶—was eliminated by the Medicare Catastrophic Care Act of 1988. It was reinstated less than two years later, when that legislation was repealed. Except for managed Medicare plans, the rule remains in place, even as more services are provided outside the hospital, and admission under observation status has become increasingly common.⁷ A bill introduced to Congress in March would allow observation services to count toward the three-day total.⁸ Meanwhile, another lawsuit, involving seven plaintiffs who received bills totaling more than \$125,000, was heard in May.⁹

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