Emergency Department Use for Eye Care Services and Future Directions in Care

In this issue of the Archives, Witmer et al describe the changing nature of payer distributions for emergency department (ED) provision of eye care in the state of Florida between 2005 and 2009, both for outpatient ED visits and visits that result in an admission.1 By providing detailed information in their article and tables, Witmer et al illuminate several key points. First, in their Table 3, the more than 25% increase in reimbursement by Medicaid for ED visits (from 20.8% to 26.3%) between 2005 and 2009 occurred essentially in 2008 and especially in 2009. This 5.5 percentage point increase corresponded to a 5.9 percentage point decrease in commercial insurance visits (from 33.3% to 27.4%) and a 2.1 percentage point decrease in worker's compensation visits (from 4.9% to 2.8%). At the same time, the proportion of self-pay visits, used as a proxy for uninsured status in their article,1 was essentially unchanged during this time (at around 26%). Thus, the deep recession precipitated by the collapse of the housing bubble and the associated financial consequences, which were felt particularly hard in Florida, did not appear to increase the number of uninsured seeking eye care in EDs across the state. Instead, the proportion of care paid for by Medicaid increased, suggesting that this safety net (and 2-income households) mitigated the effect of financial distress during this time. This illustrates the importance of assessing the role of the uninsured and potentially underinsured in understanding health care use, because those with Medicaid often have greater difficulty in finding providers for office-based care.

Second, the effect of the financial crisis in Florida can be seen in the rates of ED use. In Table 2 of Witmer et al,1 the total rate of ED use decreased from 698.5 adults and children per 100 000 population in 2005 to 593.8 adults and children per 100 000 population in 2008 and 619.6 adults and children per 100 000 population in 2009. As reported in the Health Insurance Experiment by the RAND Corporation more than 2 decades ago, when cost sharing by the patient increases (in this case, from loss of insurance or a change to a different form of insurance with more out-of-pocket costs), the use of care decreases.2 What is somewhat reassuring, however (as seen in their Table 2), is that the absolute rates of ED admissions per 100 000 population did not decrease during this time; they actually increased from 12.6 to 14.1 ED admissions per 100 000 population.3 In this case, ED admissions can be used as a proxy for the more severe cases that appropriately presented to the ED. Collectively, this suggests that the decrease in ED use may have occurred more frequently among those conditions that are more likely to be self-limited or to not be “true” emergencies. Such a finding would be consistent with reports from EDs providing eye care from around the world.4,5 However, it could also signal some delay in seeking and receiving care for conditions that would benefit from earlier treatment, resulting in a higher rate of admissions in 2009.

The literature regarding ED use for access to care suggests that placing limitations on access to the ED for services would presumably result in barriers to needed care and harm to patients' health.

As such, additional details on whether there have been shifts in the content of ED use in eye care services (particularly the nature and complexity of conditions seen), especially from Florida given the richness of the data set used in the study by Witmer et al,1 are needed to better understand the potentially changing role of the ED as an access point in eye care services. Recently, during an internal review of patterns in access to eye care in our ED (Duke University Hospital), we discovered that, similar to the findings of Witmer et al,2 patients who received eye care in the ED (as opposed to Duke’s many outpatient clinics) were most likely to be covered by Medicaid (J.D., unpublished data, 2011).

Witmer et al1 note an important implication of their study in the ongoing discussions and current difficulties faced by many EDs in obtaining emergency coverage of eye conditions. To the extent that ED payments are linked to an increasing proportion of Medicaid patients, traditionally among the lowest paying of all payors for adult care, the economic incentive for ophthalmologists not employed by hospitals to provide coverage will decrease, further exacerbating challenges in obtaining call coverage of eye conditions. In such a situation, alternative coverage models may arise to supplement the current practice of some EDs paying for call coverage, such as the use of telemedicine services for ED services6 or the use of nonphysician providers.6,7 Once these models are used in emergency services, their expansion to other areas of eye care would likely occur, which could have larger implications for the eye care delivery system.

The long-term growth in Medicaid, Medicare, and other public payor sources will only accelerate over the next 10 years, creating additional pressures and constraints on how we deliver eye care. The Office of the Actuary of the Centers for Medicare and Medicaid estimated that 60.4 million residents in the United States were covered by

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Medicaid or the Children’s Health Insurance Program in September 2010. Under the Patient Protection and Affordable Care Act enacted last year, this number is expected to increase to more than 85 million residents in 2014 and stabilize at approximately 82 million residents by 2018 and 2019, while the total number of residents covered by public means (Medicare, Medicaid/Children’s Health Insurance Program, and other public insurance) will total nearly 158 million. Meanwhile, the number of residents covered by employer-sponsored private health insurance is estimated to increase only slightly from 162 million residents in 2010 to 165 million residents in 2019, the number of residents covered by other types of private insurance will decrease from 27.1 to 11.4 million residents, and insurance purchased through the state-level “exchanges” will enroll 30.6 million individuals by 2019 following initiation in 2014. These projections are based on assumptions of employer decision making regarding continuation of private employer–provided health care insurance; however, these assumptions may underestimate the likelihood that employers will make an economic decision to discontinue their health insurance in favor of paying a penalty and having their employees covered by the health insurance exchanges. In such a context, the numbers of residents with private employer–based insurance will decrease in absolute terms, and those enrolled in Medicaid and through state-level exchanges will increase beyond current projections.

The study by Witmer et al provides important baseline information for Florida and the United States and presages the form of analyses that will drive our health care system, both from an analytical and a political perspective. From an analytical perspective, rates can be scrutinized to reduce variation across sites and to better direct care to more appropriate settings (ie, efficiency) while also monitoring outcomes. From a political perspective, analyses of payor burdens and the underlying factors behind their rates (such as promotion of access to non-ED sources of care) will help shape future policy and influence the allocation of resources. For example, possible solutions could include the expansion of existing community resources, taking advantage of preexisting infrastructures such as community health clinics, to provide new points of access to eye care. Additionally, a review of ED billing documents could be used to profile and strategically map out residential zip codes of patients using the ED for access to eye care and determine the demand for site-specific locations within the community to provide access to eye care. Finally, technologies such as telemedicine could be used to triage eye-related problems possibly through use of strategically placed teleconferencing or videoconferencing equipment, or through the establishment of partnerships between off-site ophthalmologists with local primary care physicians serving as primary point of care liaisons. If “necessity is the mother of invention,” the findings described in the study by Witmer et al may be a harbinger of fundamental changes in the financing of ED provision of eye care and in the resulting care delivery models in Florida as well as the United States.

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Financial Disclosure: None reported.

REFERENCES