EDITOR'S CHOICE

The Effect of Insurance Type on Patient Access to Carpal Tunnel Release Under the Affordable Care Act

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Purpose To assess the effect of insurance type (Medicaid, Medicare, and private insurance) on access to hand surgeons for carpal tunnel syndrome (CTS).

Methods The research team called 240 hand surgeons in 8 states (California, Massachusetts, Ohio, New York, Florida, Georgia, Texas, and North Carolina). The caller requested an appointment for her fictitious mother to be evaluated for CTS and possible surgical management through carpal tunnel release (CTR). Each office was called 3 times to assess the responses for Medicaid, Medicare, or Blue Cross Blue Shield. From each call, we recorded whether an appointment was given and whether there were barriers to an appointment, such as the need for a referral.

Results Twenty percent of offices scheduled an appointment for a patient with Medicaid, compared with 89% for Medicare and 97% for Blue Cross Blue Shield. Patients with Medicaid had an easier time scheduling appointments (28% vs 13%) and experienced fewer requests for referrals (25% vs 67%) in states with expanded Medicaid eligibility. Neither Medicaid nor Medicare reimbursement for CTR was significantly correlated with the incidence of successful appointments. Although the difference in Medicaid and Medicare reimbursements for CTR was small, the appointment success incidence for Medicare was approximately 5 times higher.

Conclusions Despite the passage of the Affordable Care Act, patients with Medicaid have reduced access to surgical care for CTS and more complex barriers to receiving an appointment. Although Medicaid was accepted at a higher rate in states with expanded Medicaid eligibility, a more robust strategy for increasing access to care may be helpful for patients with Medicaid. *(J Hand Surg Am. 2016;41(4):503–509.*

Type of study/level of evidence Prognostic II.

Key words Medicaid, Affordable Care Act, access to care, carpal tunnel surgery, hand specialty care.

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In 2010, Congress passed the Patient Protection and Affordable Care Act (PPACA) to expand health care to uninsured Americans. Medicaid eligibility expanded markedly from covering only individuals with low incomes (61% of the federal poverty level) who fell into specific categories (children, parents, pregnant women, people with disabilities, and those >65 years of age) to anyone with incomes up to 138% of the poverty level.[1] However, the Supreme Court left

the decision to expand Medicaid eligibility to each state,[1] and currently 31 states and the District of Columbia have done so. The disparity in policy between states with expanded Medicaid eligibility and those without has created a marked coverage gap.[2]

Analysts have estimated that all states will eventually accept the expansion of Medicaid eligibility owing to financial incentives. Upon full implementation of the PPACA, the national uninsured rate is expected to decline by 50%.[1,3] However, increased health insurance coverage is not necessarily synonymous with increased health care access.[4] The number of health care practitioners willing to accept Medicaid compared with other types of insurance is decreasing,[5] partially owing to lower levels of reimbursement compared with other types of insurance.[5–7] Although the PPACA has established provisions to increase Medicaid reimbursements for primary care physicians (PCP), no such provisions exist to incentivize specialists such as orthopedic surgeons to accept Medicaid patients.[7]

Kim et al[8] analyzed the effect of insurance type on access to joint replacement procedures in states with and without Medicaid expansion. Recent data indicate that the difficulty faced by Medicaid patients seeking joint replacement mirrors the difficulty of obtaining hand procedures.[9,10] In particular, there is concern about patient access to carpal tunnel release (CTR), one of the most common elective hand surgeries performed today.[11]

Our study focused on the effect of the different types of insurance (Medicaid, Medicare, or private insurance) on the ability of patients to request surgical care for carpal tunnel syndrome (CTS). The purpose of this study was to evaluate, in the setting of the PPACA, patient access to hand surgeons for elective CTS based on insurance type. We hypothesized that patients with Medicaid would face more obstacles when seeking an appointment for CTS.

MATERIALS AND METHODS

We received institutional review board approval for this study. The study population included board-certified orthopedic and hand surgeons who belonged to the American Society for Surgery of the Hand from 8 states: California, Massachusetts, Ohio, New York, Florida, Georgia, Texas, and North Carolina. We selected these states because they represent diverse geographic areas and health marketplaces. Using the American Society for Surgery of the Hand Web site's "Find a Hand Surgeon" search tool to identify hand surgeons,[12] we generated an alphabetized list of surgeons and paired each surgeon with a number. After randomizing these numbers, we called the corresponding surgeons. We excluded disconnected or inaccurate numbers from the calling list. If the surgeon did not manage patients with CTS, we removed his or her response from the data set and called the next number. We contacted approximately 30 hand surgeons per state in this manner. We also collected data about the characteristics of each office we called. These included office location (suburban vs urban), practice size (solo vs group), physician ownership of office, and office affiliation (academic vs private).

We called each office to make an appointment for the caller's fictitious mother. We specifically asked every surgeon's office whether the surgeon manages CTS and performs CTR. The caller had a standardized protocol to limit intra-office and inter-office variation (Appendix A, available on the *Journal's* Web site at www.jhandsurg.org). The scenario was a request to be evaluated for CTS and possible surgical management through CTR, with the patient having Medicaid, Medicare, or Blue Cross Blue Shield. Some states such as Florida allow third-party payers (eg, United Healthcare and Blue Cross Blue Shield) to offer Medicaid and Medicare products. A few offices in these states inquired about the caller's specific Medicaid or Medicare plan. In these scenarios, the caller responded, "I have traditional Medicaid or Medicare," which always clarified the issue for the office. The scenario required separate calls to the same surgeon for each of the 3 insurance types. We separated the calls by at least 1 week so that the receptionist would be unlikely to recognize the caller during repeat calls.

The health literary and self-advocacy of the caller (an author of the study) may have differed from those of actual Medicaid beneficiaries. However, most of the calls did not require extensive conversation with the surgeon's office. Once the caller read the prewritten scenario and described the type of insurance she had, the remainder of the call was straightforward.

We recorded the following data from each attempt to make an appointment: date of the phone call, date of the appointment if given, and the training background of the hand surgeon (orthopedic surgery or plastic surgery). If the office did not give an appointment, we asked why. If a denial occurred for a patient with Medicaid, we asked for a referral to another office that accepted Medicaid. We considered barriers to obtaining an initial appointment, such as requiring a referral from a PCP, as an unsuccessful attempt to make an appointment. We obtained the waiting period for an appointment by calculating the time between the date of the call and the date of the appointment. We did not schedule actual appointments for any of the calls, to