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LETTER FROM THE EXECUTIVE EDITOR

Theme: Post-Pandemic Health Inequities: Sociological Perspectives on Recovery, Resilience, and Policy

Dear Readers,

Welcome to the Spring 2026 issue of the Journal of Medical Sociology and Public Health. This issue explores the lasting impact of the COVID-19 pandemic and the persistent health inequities it exposed across societies worldwide.

The contributions in this volume examine how social, economic, and structural factors continue to shape health outcomes in the post-pandemic era. Through diverse sociological and public health perspectives, our authors address critical issues of recovery, resilience, healthcare access, and policy reform, highlighting both the challenges that remain and the opportunities for creating more equitable health systems.

A common thread throughout this issue is the recognition that meaningful recovery extends beyond the management of disease. It requires sustained efforts to address the social determinants of health, reduce disparities, and strengthen the policies and institutions that support population well-being. The scholarship presented here offers valuable insights for researchers, practitioners, and policymakers committed to advancing health equity.

I extend my sincere appreciation to our authors, reviewers, and Editorial Board members for their dedication and scholarly contributions. We hope this issue fosters critical dialogue, inspires future research, and contributes to the development of more just and resilient public health systems.

Sincerely,
Kinjal Nayak
Executive Editor
Journal of Medical Sociology and Public Health

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Table of Contents

Page no. 9
Neuropsychological Consequences of Social Isolation in Older Adults After the *COVID-19* Pandemic: A Systematic Review

Page no. 27
Emergency Departments as Sites of Health Inequity Following the *COVID-19* Pandemic: Insurance Status, Delayed Care, Unequal Acute Care Outcomes.

Page no. 57
Post-Pandemic Barriers to Public Benefit Access Among People with Disabilities: A Sociological Perspective on Recovery and Health Inequities

Neuropsychological Consequences of Social Isolation in Older Adults After the COVID-19 Pandemic: A Systematic Review

Isha Patel

Abstract:

The COVID-19 pandemic introduced widespread social isolation, which disproportionally affected older adults, increasing concerns of both psychological well-being and potential cognitive decline. This systematic review aims to evaluate both the psychological and cognitive consequences of pandemic-related social isolation in older populations. A literature review was conducted using the PubMed search engine using predefined keywords, including "social isolation," "COVID-19," "cognitive decline," and "elderly." Studies were screened according to PRISMA guidelines and were included if they examined human participants, were published in English, and addressed isolation resulting from the COVID-19 pandemic specifically. Of the studies identified, 13 met inclusion criteria and were analyzed further.

Across the studies analyzed, social isolation resulting from the COVID-19 pandemic was consistently associated with increased levels of loneliness, depression, and anxiety among older adults. In contrast, findings related to isolation-induced cognitive decline were less consistent, with several studies reporting no short-term changes in cognition, while others reported worsening dementia severity or increased risk of developing a neurological condition among individuals with pre-existing impairment or risk factors. Factors such as social engagement and cohabitation, in addition to physical activity, indicated ways to mitigate negative outcomes of social isolation.

These findings suggest that while the psychological effects of pandemic-related isolation are evident and immediate, cognitive consequences may be more variable and influenced by external environmental and individual factors. Intervention targeting social connection and

mental health support are critical for reducing the long-term impact of social isolation in older populations.

Introduction

The COVID-19 pandemic was declared by the World Health Organization on March 11, 2020 (Nakamura et al., 2024) and affected countless individuals worldwide, whether via infection or through secondary effects of the pandemic, such as social isolation due to defined safety measures. The COVID-19 pandemic has been viewed as the greatest challenge to healthcare systems and society over the last century (Flatharta & Mulkerrin 2020).

Isolation caused by the COVID-19 pandemic's guidelines increased the risk of "social frailty" among older adults, which is known as the loss of social resources, activities, and abilities and other resources that are important for meeting the basic social needs over the course of an individual's lifetime (Terziotti et al., 2023). Loneliness is characterized by an individual's perceived deficits in meaningful social connections and companionship. Loneliness is associated with an increase in the risk of a variety of health issues, including risk of cardiovascular issues, neurological abnormalities, and can lead to deficits in immune function in older adults (Harb et al., 2025). Social isolation also affects the mental wellbeing of individuals with dementia, leading to issues including reduced sleep quality and increases in depression, anxiety, and loneliness, further affecting wellbeing as social connections decline due to a reduction in social interests and activities (Nakamura et al., 2024). Thus, maintaining social connections is a may be a key factor associated with reduced risks of cognitive decline in Alzheimer's disease and related diseases (ADRD).

Neurocognitive decline is a growing public health issue, with an estimated 55-57 million people worldwide currently living with cognitive impairment (Schrempft et al., 2024). The

pandemic's effect on psychological wellbeing among cognitively impaired older adults was more pronounced among patients with more severe impairment. Subjective cognitive decline (SCD) is one of the earliest noticeable symptoms of Alzheimer's disease and dementia. Because it is present before the onset of clinical impairment, SCD serves as a potential target for preventive and early intervention trials. While not everyone who experiences SCD develops risks for dementia, nearly half of older adults with SCD develop more severe cognitive decline. Even without more significant impairment, SCD can have a large impact on everyday life, including the ability to work and engage in social activities (Terziotti et al., 2023). Thus, understanding risk factors for SCD, such as social isolation, physical inactivity, smoking, poor sleep, and obesity, can serve as blueprints for finding ways to improve patients' quality of life and potentially prevent progression to more severe cognitive impairment.

Methods

In this study, a systematic literature review was conducted to identify studies evaluating the neural consequences of social isolation in older adults as a result of the COVID-19 pandemic. Articles that included information about the COVID-19 pandemic specifically and included individuals at risk for neurodegeneration due to older age were analyzed. Using the PubMed database in this search strategy, the usage or predefined keyword combinations such as "("social isolation" OR loneliness OR "social withdrawal") AND ("COVID-19" OR coronavirus) AND ("older adults" OR elderly OR aging) AND ("cognitive decline" OR dementia OR "mental health" OR depression OR anxiety) were used. These key words were selected based on prior research examining the patterns of increased neurodegeneration as a result of social isolation caused by the COVID-19 pandemic, adapting the key words used according to the specificity of this study.

Through further review, filters were used and studies were assessed for eligibility based on a few requirements, including articles published in English, discussion of human participants, and specificity of isolation caused by the COVID-19 pandemic. Articles that did not meet this specific criterion (i.e., systematic reviews and other secondary sources, non-English language studies, studies measuring isolation in rat participants, and lack of measurable outcomes) were excluding during the PRISMA (Preferred Reporting Items for Systematic Review and Meta-Analyses) screening. The population included in this study varied, including studies completed worldwide. All studies use were primary sources, including direct observations. No randomized controlled trials of social isolation were included, as exposure was not experimentally assigned. "Older adults" were defined as adults 55 years and older. Studies that examined older adults included adults considered cognitively healthy, subjective to cognitive decline, or experiencing mild to severe impairment were eligible.

Criteria	*Determinants*
Population	Older adults (ages 55 years of age and older) either considered cognitively healthy, subjective to cognitive decline, or experiencing mild to severe impairment.
Intervention	Social isolation due to the COVID-19 pandemic, including lockdowns, reduced social contact, or perceived social restrictions.
Comparison	Pre-pandemic vs post-pandemic measures or between-group comparisons where applicable.
Outcome	Psychological outcomes (loneliness, anxiety, depression, emotional distress) and/or cognitive outcomes (changes in cognition, dementia severity, subjective cognitive decline)

Results

A total of 6,045 studies were identified using the search terms described in the methods section. After one duplicate study was removed, each study underwent title and abstract screening. As a result of this screening process, 5,799 studies were excluded based on irrelevance, primarily because sources excluded information relating to the target population of older adults or neuropsychological impacts of social isolation caused by the COVID-19 pandemic. A total of 245 studies were assessed for eligibility, resulting in the analysis of 13 studies in this systematic review.

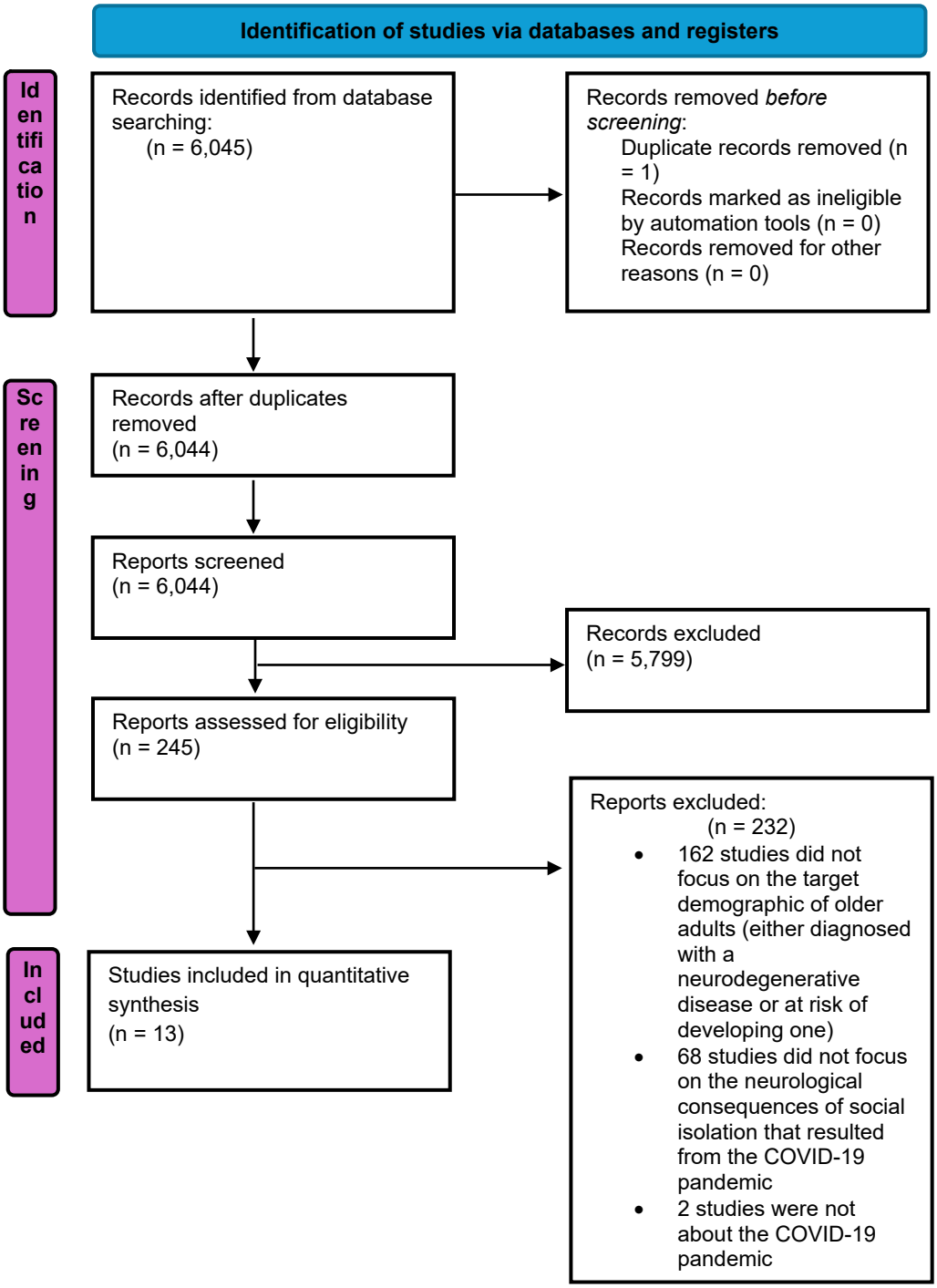

Figure 1: Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flowchart demonstrating the article selection process.

Study Characteristics

Thirteen studies met the inclusion criteria and were included in the final analysis. The studies were conducted across Japan, Sweden, France, the United States, India, the Netherlands, Argentina, Austria, Spain, Singapore, New Zealand, and Italy. Of these studies, sample sizes ranged from 51 to 8,970 participants. Most studies used longitudinal observational or cohort designs to examine older adults diagnosed with dementia, mild cognitive impairment, Alzheimer's disease, subjective cognitive decline, or individuals at elevated risk of neurodegenerative disease. Across studies, social isolation was assessed through pandemic-related reductions in social interactions, loneliness, living arrangements, or perceived social restrictions.

Study	*Sample*	*Study Design*	*Key Statistical Results*
Nakamura et al. (2024)	261 older Japanese adults who have not contracted COVID-19.	Longitudinal observational study	- The difference in the Alzheimer Disease Assessment Scale cognitive subscale scores indicated no statistical significance - results indicate that cognitive functions outcomes measured by ADAS-JCOG did not differ significantly between the groups during the analyzed period
Terziotti et al. (2023)	165 adults ages 70-91 diagnosed with mild cognitive impairment or mild-to-moderate dementia.	Prospective longitudinal cohort study	- Functional autonomy significantly declined (P<0.01) - Neuropsychiatric Inventory scores rose significantly, driven by increases in agitation, depression, and sleep disturbances During the lockdown, frail individuals experienced significantly higher emotional distress than other groups - Multivariable model revealed that frailty post-lockdown was independently associated with worsening social isolation and loss of instrumental independence
Schrempft et al. (2024)	Pandemic group consisting of 1,414 dementia-free Swedish adults ages 65 and over. Pre-pandemic group served as a comparison group and consisted of 1,181 Swedish adults.	Population-based cohort study	- The weighted prevalence of SCF in 2022 was statistically comparable to pre-pandemic baseline levels from 2014-2018 - SCD was more prevalent among older cohorts (75 years and older) - worsened mood, increased loneliness, less frequent social interactions, and self-reported post-COVID symptoms were associated with SCD risk - 3-fold higher risk of facing functional impairment - significantly lower standardized subjective wellbeing scores
El Haj et al. (2022)	62 residents of retirement homes in France who have been diagnosed with Alzheimer's disease.	Observational, longitudinal study.	- Mean depression measures increased from the first lockdown (13.65) to the second (15.69) - Mean anxiety measures increased from the first lockdown (13.26) to the second (15.02) - Mean loneliness measures increased from the first lockdown (2.40) to the second (2.85) - No significant correlation between the severity of cognitive impairment and the level of depression, anxiety, or loneliness.
Liu et al. (2024)	238 individuals aged 70 and older at high risk of cognitive decline.	Prospective, observational cohort study	- 16.4% of participants were classified as lonely - Anxiety and Vulnerability: RR* = 1.92 - Cognitive Function and Resilience: RR = 0.81 - Social network size and Resilience: RR = 0.92 - Engaging in social or physical activities significantly moderated the impact of loneliness on mental well-being (β = 0.65, p = 0.001) - Loneliness was associated with a significant drop in the SF-12 mental composite score (β = -5.91, p < 0.001)
Rajagopalan et al. (2022)	66 individuals diagnosed with dementia	Observational cohort study	- Significant increase in anxiety following the pandemic (mean difference = -0.552, p = 0.039) - Many patients who were asymptomatic for anxiety developed symptoms following the pandemic (24.53%) - Proportion of patients diagnosed with "severe dementia" doubled, raising from 19.7% (pre-pandemic) to 39.4% (post-pandemic)

Holwerda et al. (2023)	899 adults 55 years and older in the Netherlands	Observational, longitudinal study	- Increase in depressive symptoms (change in mean = 1.53, $p < 0.01$) - Increase in anxiety symptoms (change in mean = 0.44, $p < 0.01$) - Increase in loneliness (mean change = 2.04, $p < 0.01$) - Having a partner buffered against loneliness caused by the COVID-19 pandemic ($p = 0.09$)
Aragon et al. (2021)	51 older Argentinian adults who have been diagnosed with cognitive impairment.	Observational, descriptive, longitudinal study	- Depression measure significantly increased ($p = 0.049$) from March 2020 (mean = 11.25) to October 2020 (13.00) - No significant change in cognition (March mean = 45.67, October mean = 46.39, $p = 0.067$) - No significant change in memory delay (March mean = 3.10, October mean = 3.53, $p = 0.098$)
Mayerl et al. (2021)	557 Australian adults age 60 and older (wave 1) with 463 participants returning for Wave 2.	Longitudinal observational study	- More perceived social restrictions at Wave 1 predicted higher levels of loneliness at Wave 2 ($\beta = 0.23$) - Higher loneliness at Wave 1 predicted that participants would perceive more social restrictions by Wave 2 ($\beta = 0.22$) - No significant direct effect of social interactions at Wave 1 on mental distress at Wave 2 - Living alone was a major predictor of higher loneliness scores
Dura-Perez et al. (2022)	151 Spanish individuals ages 55 and older who scored 20-28 or 23-27 on the Mini Mental State Exam (MMSE) and have reported self-perception of memory problems for at least 6 months.	Retrospective cohort study	- No significant decline in cognition ($p = 0.43$) within the first month of the pandemic - No significant impact on depression ($p = 0.99$) within the first month of the pandemic - Living alone was associated with higher self-perceived fear ($p = 0.04$) and depression ($p = 0.04$) - Individuals who lived alone received significantly more ($p < 0.001$) home visits (82.9%) than those living with others (51.3%) - Changes in living arrangements due to lockdown were nominally associated with lower perceived stress ($p = 0.02$)
Yu and Mahendran (2021)	419 adults 60 years and older residing in Singapore	Longitudinal cohort study	As a result of the pandemic: - Depression increased (Cohen's $d = 0.52$) - Anxiety increased (Cohen's $d = 0.11$) - Social isolation increased (Cohen's $d = 0.25$)
Cheung et al. (2020)	8,111 vulnerable adults (65 years and older) in New Zealand being assessed during the 2020 lockdown period (Wave 1) and 8,970 individuals assessed in 2019	Observational, longitudinal study	- Baseline (2019): 17.9% reported feeling sad/depressed and 45.0% rated health as Fair/Poor - lockdown (2020): 13.5% reported feeling sad/depressed and 37.8% rated health Fair/Poor
Touron et al. (2025)	100 older adults with 53 adults in the DepS group (patients with pre-existing subclinical depressive symptoms) and 47 adults in the NoDepS group (participants	Longitudinal observational study	- Only the DepS group showed a further significant increase in anxiety during the second confinement ($p = 0.037$) while the NoDepS group remained stable between confinement 1 and 2 ($p = 0.997$) - The DepS group reported higher depressive symptoms than the NoDepS group at both confinement 1 ($p = 0.08$) and confinement 2 ($p = 0.002$)

without pre-existing subclinical depressive symptoms)

* Relative Risk for vulnerability factors, where 1.0 indicates no difference between groups, >1.0 indicates increased risk and <1.0 indicates decreased risk
** Several studies were conducted within cohorts originally enrolled in randomized trials. Because the exposure of interest in this review was pandemic-related social isolation rather than randomized intervention, these studies were classified according to the observational design use to assess the exposure-outcome relationship.

Psychological Outcomes

Psychological outcomes were among the most consistently reported findings across studies. Following periods of social isolation, increases in depression, anxiety, loneliness, and emotional distress were observed. El Haj et al. reported significant increases in depression, loneliness, and anxiety between the first and second COVID-19 lockdowns among individuals diagnosed with Alzheimer's disease. Similarly, Holwerda et al. observed significant increases in depression, anxiety, and loneliness in the Netherlands. Meanwhile, Rajagopalan et al. reported significantly higher anxiety levels among individuals diagnosed with dementia following the COVID-19 pandemic restrictions. Aragon et al. also observed worsening depressive symptoms among older adults diagnosed with cognitive impairment.

Frailty was associated with increased emotional distress and social isolation in the study by Terziotti et al., while Touron et al. found that participants with pre-existing depressive symptoms experienced greater increases in anxiety and depressive symptoms during confinement periods. These findings collectively indicate an association between social isolation during the COVID-19 pandemic and substantial psychological burden among older adults, especially those with existing cognitive vulnerabilities.

Cognitive Outcomes

Findings regarding cognitive outcomes were more heterogeneous. Several studies reported indications of worsening cognitive health. Rajagopalan et al. observed the proportion of patients classified as having severe dementia following the pandemic doubling. Schrempft et al. found that subjective cognitive decline was associated with reduced social interactions, poorer mood, loneliness, and lower subjective well-being.

Several other studies reported no significant changes in objective cognitive performance during the study period. For example, Nakamura et al. found no significant differences in Alzheimer's Disease Assessment Scale cognitive scores. Aragon et al. reported no significant changes in cognition or delayed memory performance. Similarly, Dura-Perez et al. found no significant decline in cognition during the early stages of the pandemic. These findings indicate that psychological symptoms may have been more immediately affected by social isolation resulting from the COVID-19 pandemic rather than measurable cognitive decline, although subjective perceptions of cognitive impairment frequently increased.

Risk of Bias Findings

Risk of Bias was evaluated using the Risk of Bias In Non-randomized Studies of Intervention (ROBINS-I) tool. The ROBINS-I tool assesses bias across seven domains, including (1) bias due to confounding, (2) bias in the selection of participants, (3) bias in the classification of intervention/exposures, (4) bias due to deviations from intended interventions, (5) bias due to missing data, (6) bias in the measurement of outcomes, and (7) bias in the selection of the reported result. Each domain was rated as low, moderate, serious, or critical risk of bias, and an overall risk-of bias judgement was assigned according to ROBINS-I guidance.

According to Figure 2 below, the most common source of bias was confounding and missing data, reflecting the observational nature of the studies included. Bias arising from participant selection and outcome measurement were low. No studies were judged to have critical risk of bias. These findings suggest that while methodological limitations were present, the overall quality of evidence was sufficient to support the interpretation of findings.

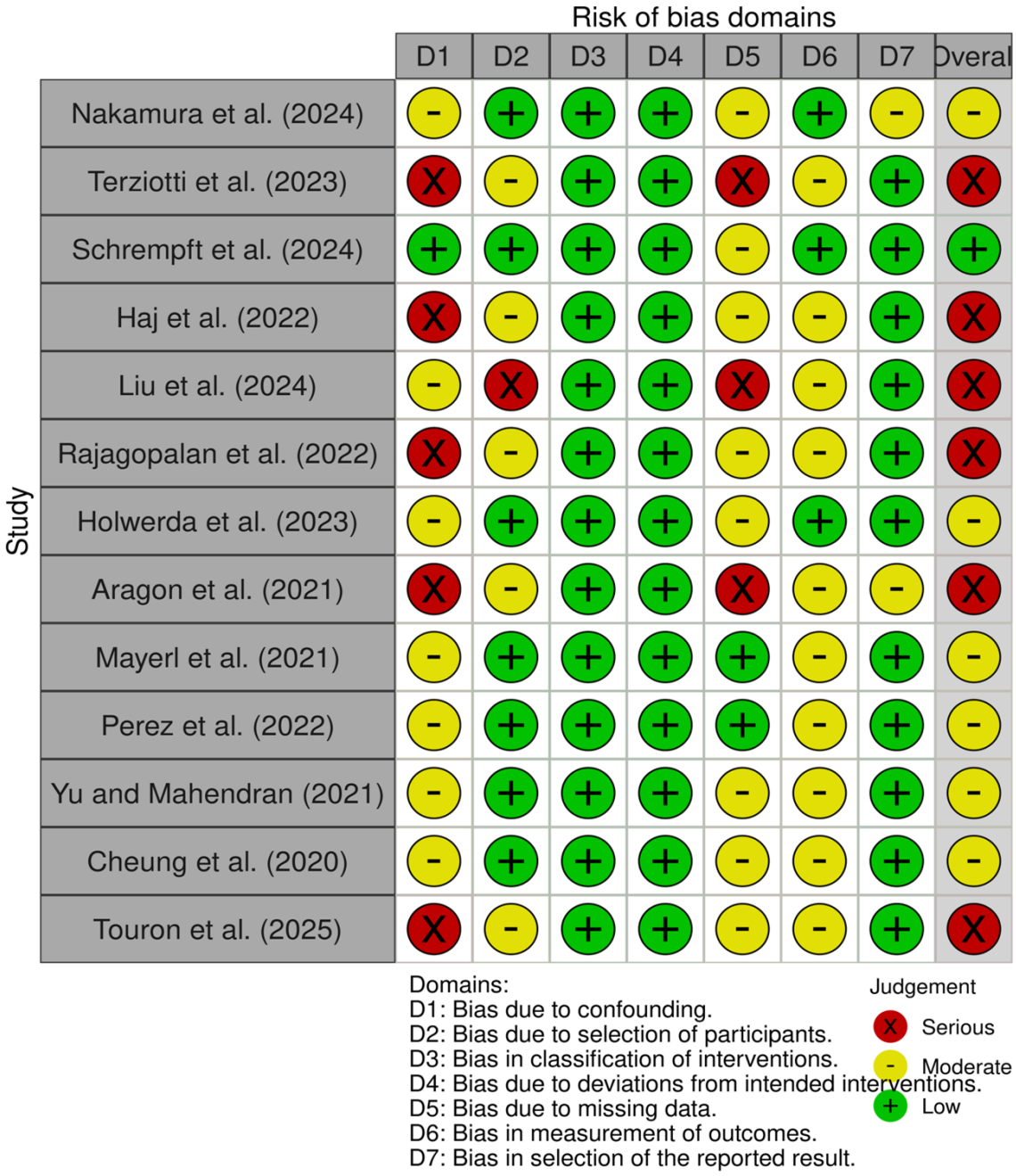

Figure 2. Assessment of risk of bias using ROBINS-I. Green (+) indicates a low risk, yellow indicates some concern, and red indicates a high risk of bias.

Discussion

The findings of this systematic review suggest an association between COVID-19-related social isolation and adverse psychological outcomes among older adults. Among the 13 studies analyzed, social isolation during the COVID-19 pandemic was consistently associated with increased loneliness, depression, and anxiety in older adults, as well as negative mental health outcomes. Multiple studies indicated an increase in depression (El Haj, Holwerda, Yu, and Mahendran), anxiety (Rajagopalan, Touron), and loneliness (Liu, Mayerl). These were the most consistent outcome of pandemic-induced social isolation among older adults. These findings align with prior research, which identifies loneliness and reduced social engagement as major contributors to declines in overall health and well-being.

A limitation of this study is that PubMed was the only search engine used in the methodology of this study. In future studies, additional data can be collected by searching other databases such as PsycINFO, Embase, and Web of Science, Scopus, CINAHL, or Cochrane Library.

While psychological outcomes were consistently affected, the evidence supporting cognitive decline was less consistent. For example. Some studies found no significant cognitive decline (Aragon, Dura-Perez) while others suggested worsening dementia severity (Rajagopalan), suggesting that the neurological effects of social isolation may be more gradual and influenced by other factors, such as baseline cognitive status, duration of isolation, and access to social stimulation.

Multiple studies highlighted moderating factors that influenced outcomes. Engagement in social or physical activities and the presence of a partner or cohabitation served as buffers against the negative psychological effects of isolation. Meanwhile, individuals living alone or having pre-existing depressive symptoms experienced more pronounced declines in mental health.

Despite these important insights, several limitations must be considered. Many of the studies included in this systematic review utilized observational or longitudinal designs, limiting the ability to establish casual relationships. Variability in measurement tools and sample populations also limit the ability to compare findings across studies. Furthermore, the short time frame of many studies analyzed may have prevented long-term cognitive consequences of prolonged social isolation from being captured, limiting the availability of research analyzing cognitive changes in older adults.

Overall, this review highlights the critical role of social connection in the maintenance of both mental and cognitive health among older adults. The results highlight the need for targeted interventions, including increased access to social support systems, community engagement, and mental health resources, especially during periods of prolonged widespread isolation, such as during a global pandemic. Future research should focus on the long-term neurological impacts of social isolation and explore strategies to prevent or delay cognitive decline in vulnerable populations through preventative measures.

Statements and Declarations

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Availability of Data and Materials
This study is based on data and literature obtained from primary research articles indexed in the PubMed database. All sources used in this systematic review are publicly available through the PubMed search engine and the respective publishers of the cited articles.

Author's Contribution
Isha Patel conceptualized and designed the study's topic, developed search strategies and inclusion criteria, conducted the systematic literature search, screened and selected eligible studies, extracted data from included studies, interpreted findings, and drafted and revised the manuscript critically for intellectual content.

Conflict of Interest
The author declares no conflicts of interest.

Consent for Publication
Not applicable. This study does not involve identifiable individual participant information.

Ethical Approval
Not applicable. This study is a literature-based analysis that utilized publicly available published research and did not involve human participants, animals, or direct collection of primary data by the author.

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Emergency Departments as Sites of Health Inequity Following the *COVID-19* Pandemic: Insurance Status, Delayed Care, Unequal Acute Care Outcomes.

Amith Challa, Rishabh Jain

Abstract

In a healthcare system where insurance status is consistently associated with access and utilization of care among individuals, emergency departments (EDs) can be consistently associated with areas of unequal outcomes and utilization patterns. Following global attitude changes, and relevant insurance policy amendments throughout the COVID-19 pre-pandemic (2010-2019), acute pandemic (2020-2022), and post-pandemic (2022-current) stages, these patterns have seen shifts. This study combined a narrative review with a secondary data analysis to examine these relationships. Twelve peer-reviewed, government, and policy sources were selected to synthesize evidence relating to insurance groups (Private, Medicare, Medicaid, Uninsured, and Other), ED utilization and policy implications. Secondary analysis applied one-way ANOVA and Tukey-HSD post-hoc tests to National Hospital Ambulatory Medical Care Survey (NHAMCS) data (2016-2022) across the insurance categories to further evaluate their relationship to ED utilization. Review indicated lower ED utilization rates among privately insured populations compared to all other insurance groups. During the pandemic, widespread care avoidance was observed, with disproportionate impacts among racial and ethnic minority groups and lower-income populations. Declining ED visit volumes co-occurred with higher admission rates, suggesting greater illness severity among care seeking individuals. Post-pandemic Medicaid unwinding was associated with notable increases in uninsured ED visits, particularly at rural and high-poverty hospitals. Statistical analysis revealed significant differences in ED visit patterns across all insurance categories, in population and rate based analysis. These findings are strictly descriptive, and do not establish that insurance instability directly determines ED reliance and population outcomes. However, observed patterns may warrant targeted insurance instability policy interventions.

Keywords: emergency department utilization, insurance status, health inequity, COVID-19 pandemic

Introduction

Health inequities in access to medical care remain a persistent issue in the United States healthcare system. Socioeconomic status, insurance coverage, and geographic access are among the many factors that shape how and when individuals obtain treatment. Disparities in this system were magnified by the COVID-19 pandemic across the United States, and the structural vulnerabilities and shortfalls of the US healthcare system were made apparent in the following

years. While the pandemic affected nearly every aspect of medical care, underlying weaknesses in the accessibility and equity of care were revealed in emergency departments (EDs).

Emergency departments became a critical point of access to care, especially for populations facing barriers to routine and preventative care. EDs provide care regardless of a patient's insurance status or ability to pay under the Emergency Medical Treatment and Labor Act (EMTALA, 42 U.S.C. § 1395dd). Even with this federal mandate, patterns of ED utilization are associated with structural inequalities in access to care. Prior research and public datasets have shown that uninsured and publicly insured populations are more likely to rely on EDs as primary sources of healthcare due to limited access to primary care providers, instability in insurance status, and/or financial barriers (Cairns et al., 2024; Geranios et al., 2022). This evidence is consistent with the possibility that underprivileged populations delay seeking care until conditions become acute enough to warrant emergency intervention.

The COVID-19 pandemic intensified these disparities. Early in the progression of the pandemic, healthcare systems experienced widespread disruptions, including reduced outpatient services, overwhelmed hospital systems, and wide-scale public hesitation to seek in-person medical care (Czeisler et al., 2020). Evidence suggests that many individuals delayed or avoided necessary medical treatment during this period, often presenting later with more advanced or severe illness. This pattern appears to have disproportionately affected individuals with unstable insurance or financial status, consistent with reinforcement of inequities in care.

Emergency care systems may serve as substitutes for inaccessible primary or preventative care among populations with limited or unstable insurance coverage, a pattern that puts a strain on ED systems while highlighting broader inequalities in the healthcare system. This study examines insurance status as a key socioeconomic determinant associated with access to emergency healthcare in the aftermath and recovery from the COVID-19 pandemic. Through a synthesis of national surveillance data, policy reports, and peer-reviewed literature, this paper

investigates discrepancies in utilization of emergency care, delay of care, and associated severity of illness across insurance groups.

This study aims to synthesize evidence on insurance-related inequities in emergency department utilization following the COVID-19 pandemic and to describe national ED visit patterns by insurance category from 2016 to 2022, with the goal of highlighting EDs as sites where broader healthcare inequities become visible and evaluating the potential of equitable healthcare policy in the post-pandemic landscape.

Methods

This study combines a narrative evidence synthesis with a descriptive secondary analysis of aggregate national emergency department visit data. A combination of these methods was selected to establish both general trends, and correlative relationships within national data. Neither component of this study involved qualitative data collection or formal qualitative-quantitative integration. This study is described as a narrative evidence synthesis with a secondary data analysis rather than a traditional mixed-methods study.

Methods: Narrative Review

A narrative evidence synthesis approach was used to identify, describe, and interpret evidence on emergency department utilization across insurance groups following the COVID-19 pandemic. This approach was selected because the relevant evidence spans multiple study designs, data types, and measurement frameworks that do not combine to a single general quantitative analysis. Rather than applying a formal systematic review protocol, the narrative synthesis aimed to provide an integrative, account of the available evidence, organized around three conceptually related topics: insurance status as associated with ED utilization, the

possibility of delayed care relating to severity at presentation, and how post-pandemic policy changes have affected ED payer composition.

A targeted literature and data search was conducted across two categories of sources. Peer-reviewed literature was identified through PubMed and Google Scholar using search terms including combinations of "emergency department utilization," "insurance status," "delayed medical care," "healthcare access," "COVID-19," and "health inequities." Government surveillance and policy sources including the Healthcare Cost and Utilization Project (HCUP), the National Hospital Ambulatory Medical Care Survey (NHAMCS), the Kaiser Family Foundation (KFF), the National Center for Health Statistics (NCHS), and CDC surveillance reports were searched directly for relevant data tables, statistical briefs, and policy reports. The search targeted material published between January 2010 and January 2025 to capture pre-pandemic (2010-2019), pandemic (2019-2022), and post-pandemic (2022-Current) trends, and was limited to sources analyzing emergency department access specifically in the United States. Sources were selected based on relevance to the three main topics, with preference given to studies reporting national or multi-site data. Because this study is a narrative synthesis rather than a systematic review, source selection involved the authors' judgment about relevance and evidence quality rather than a fully pre-specified and reproducible algorithm. This is acknowledged as a limitation in the following discussion.

Sources were selected based on the following criteria:

Inclusion Criteria	Exclusion Criteria
● Generalizability to US Population ● Focus on Emergency Department Utilization Patterns ● Focus on Acute Outcomes Relating to Reliance on emergency departments and Abnegation of Primary Care ● Published between 2010-2025 ● Peer-reviewed Study, National Dataset ● Pandemic Related Policy Changes ● All Age Groups Included	● Non-US population data ● No discussion of insurance status ● Focus on non-acute outpatient settings or limited access to primary care ● Focus on unrelated clinical outcomes ● Studies published before 2010 ● Editorial / commentary (non-empirical)

Figure 1. Source Selection Criteria for Narrative Evidence Synthesis

All selected findings were categorized into three thematic domains:

(1) Differences in ED utilization by insurance status,

(2) Patterns of delayed care and severity at presentation, and outcomes

(3) Post-pandemic policy changes and the persistence of insurance-based inequities.

Table 1. Summary of Sources Included in the Narrative Synthesis

Author / Source (Year)	Design / Report Type	Data Source	Population	Time Period	Exposure / Grouping Variable	Key Finding(s) Relevant to This Synthesis
Cairns et al. (2024)	Government data brief	NHAMCS (NCHS)	U.S. general population	2022	Primary payment source	Medicaid/CHIP visit rate highest (99/100 population); private insurance lowest (21/100)
Lowe et al. (2021)	Retrospective cohort	Two-ED health system, Northern California	All ED patients	Mar-Jun 2020	Insurance type; ZIP-code poverty level	Commercial-insurance visit share rose 11.6 pts; Medicaid share fell 9.5 pts after shelter-in-place
Geranios et al. (2022)	Cross-sectional analysis	National survey data	U.S. adults	Pandemic period	Insurance type (Medicaid, Marketplace, uninsured)	Medicaid/uninsured patients had more ED visits, fewer routine visits, than Marketplace-insured
Kaiser Family Foundation (2024)	Policy/data report	National survey & administrative data	Nonelderly (ages 0-64)	2010-2023	Insurance status	25.3 million uninsured in 2023; uninsured rate fell during continuous-enrollment period, rose after unwinding
National Center for Health Statistics (2024)	Government surveillance dataset	NHAMCS	U.S. ED patients, all ages	2016-2022	Insurance category	Source dataset for this study's secondary analysis of ED visit counts and rates
Czeisler et al. (2020)	Cross-sectional survey (MMWR)	National survey	U.S. adults	June 2020	Race/ethnicity; demographic group	40.9% of adults delayed/avoided care; Black and Hispanic adults had higher urgent-care avoidance (aPR 1.6, 1.5)
Gertz et al. (2022)	Cross-sectional study	National survey data	U.S. adults	2020-2021	Income; pre-existing condition status	40.5% of 2020 delayers had income <$50,000; comorbidity prevalence among delayers rose from 37.2% to 55.8%
Barrett et al. (2022)	HCUP statistical brief	HCUP, 29 states	All ED patients	Apr-Dec 2020 vs. 2019	Pre- vs. post-pandemic-onset period	Visits fell from 63.8M to 47.5M; ED admission rate increased
Hartnett et al. (2020)	Surveillance report (MMWR /NSSP)	CDC National Syndromic Surveillance Program	All ED patients	Jan 2019-May 2020	Time period; diagnosis category	Visits down 42% (late Mar-Apr 2020); AMI and chest-pain visits declined; cardiac-arrest visit share rose
Adjemian et al. (2021)	Surveillance update (MMWR /NSSP)	CDC NSSP	All ED patients	Dec 2020-Jan 2021	Time period; age; region	Visits remained ~25% below pre-pandemic baseline; steepest declines among children and hardest-hit regions

McIntyre et al. (2024)	Policy analysis	National Medicaid enrollment/claims data	Medicaid enrollees	April 2023 onward	Medicaid eligibility redetermination	>25 million disenrolled in first 18 months of unwinding; concentrated among young adults, pregnant adults, women
Giannouchos et al. (2025)	Retrospective interrupted time-series	California hospital ED claims (281 hospitals)	All ED patients	Medicaid unwinding period	Hospital rurality / poverty level	Uninsured visits rose ~10.2% relative to pre-unwinding average; largest increases at rural (46.7%) and high-poverty (7.7%) hospitals

Methods: Secondary Data Analysis

While the narrative review established general trends, it did not evaluate the statistical significance of the relationship between insurance coverage and ED utilization, nor did it examine the individual insurance subgroups that contribute to those trends. A secondary data analysis was therefore conducted to assess whether differences in ED utilization across individual insurance coverage groups were statistically significant. Testing the individual levels of insurance coverage - private, Medicare, Medicaid, uninsured, and other - allows assessment of whether each level of coverage differs in its emergency department visit patterns before, during, and after the COVID-19 pandemic.

Annual emergency department visit data for 2016-2022 were obtained from the National Center for Health Statistics (NCHS) National Hospital Ambulatory Medical Care Survey (NHAMCS) emergency department data tables (National Center for Health Statistics, 2024). For each year, two outcome measures were extracted for five insurance categories - private insurance, Medicare, Medicaid (including CHIP and other state-based programs), uninsured, and "other" (including worker's compensation and other payment sources):

- (1) total annual ED visit counts (in thousands), and
- (2) ED visit rates (visits per 1,000 population) within each insurance category.

The unit of analysis for both ANOVA models was the insurance-category-year (5 insurance

groups × 7 years), with visit counts and visit rates analyzed as separate outcomes in two independent one-way ANOVA models.

A one-way ANOVA test was used to evaluate whether there is a statistically significant association between insurance coverage category and (a) total ED visit counts and, separately, (b) ED visit rates. These tests were selected because the data is structured as a single categorical factor (insurance type) with a continuous outcome (visit count or visit rate), and one-way ANOVA is the standard approach for comparing means across more than two independent groups. A Tukey-HSD post-hoc test was then used to evaluate pairwise differences between each pair of insurance coverage groups for both outcomes.

Because the analysis is based on seven annual aggregate observations per insurance group rather than individual-level records, the sample size for each group is small (n = 7), and annual observations may not be fully independent of one another - for example, visit volumes in adjacent years are likely correlated due to shared underlying trends (e.g., the pandemic period). These constraints mean the ANOVA and Tukey-HSD results should be interpreted as descriptive evidence of group-level differences in this aggregate dataset rather than as inferential tests generalizable to the underlying patient population. The analysis cannot support patient-level conclusions, adjust for confounding variables, or establish causal relationships between insurance status and ED utilization.

Additionally, the effect of pre-existing factors such as delay of care and acute outcomes identified in the narrative synthesis were illustrated using graphical representations of the secondary analysis data to visualize empirical trends. Delayed care and clinical severity were not directly measured in the secondary dataset; discussion of these outcomes is based entirely on findings reported in the narrative synthesis, not on the NHAMCS data analyzed here. These limitations are further addressed in the discussion below.

Results

Narrative Review Findings

Differences in ED Utilization by Insurance Status

National data and estimates demonstrate that insurance status is associated with emergency department (ED) utilization rates. Note that rates from Cairns et al. (2024) are expressed per 100 persons, consistent with the source data brief, while NHAMCS-derived rates used in the secondary analysis (Figures 4 and 8) are expressed per 1,000 persons; these denominators reflect the conventions of their respective source publications and are not directly comparable.

In 2022, the ED visit rate for patients enrolled in state-based programs such as Medicaid or the Children's Health Insurance Program (CHIP) was 99 visits per 100 people - the highest of any payment category. The rate for patients with private insurance was the lowest, approximately 21 visits per 100 people (Cairns et al., 2024). This pattern is consistent with the interpretation that individuals with inconsistent or no regular health coverage rely more heavily on emergency departments relative to their population size.

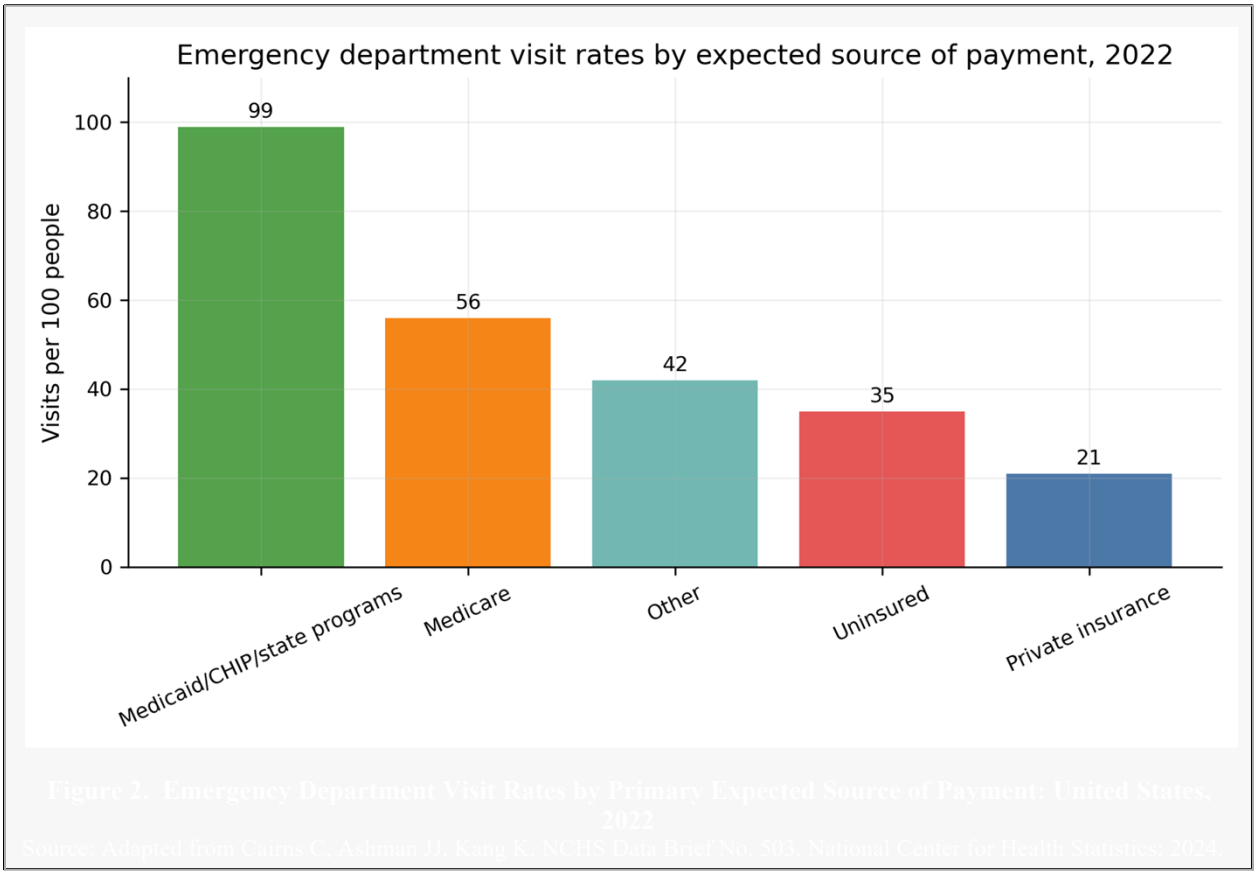

Figure 2. Emergency Department Visit Rates by Primary Expected Source of Payment: United States, 2022

Source: Adapted from Cairns C, Ashman JJ, Kang K. NCHS Data Brief No. 503. National Center for Health Statistics; 2024.

Research examining ED access during the COVID-19 pandemic is consistent with this structural relationship. A study of a two-ED healthcare system in Northern California found that even though overall volume of visits to the ED declined by 28% during the pandemic period, the proportion of patients with commercial insurance increased by 11.6 percentage points, while the share of Medicaid visits decreased by 9.5 percentage points at the initiation of shelter-in-place orders. For patients from neighborhoods below 300% of the federal poverty level, visits declined by 3.8 percentage points, compared to a 2.9 percentage point increase among patients from ZIP codes above 400% of the federal poverty level (Lowe et al., 2021). These patterns are consistent with the possibility that low-income and publicly insured populations faced compounded structural barriers during the pandemic that may have further restricted access to emergency care even when acutely ill.

Prior to the pandemic, research had already established that Medicaid beneficiaries and uninsured individuals on average seek less routine and preventive care, with healthcare utilization concentrated in acute settings. Compared to patients with Marketplace insurance, lower-income and publicly insured populations experienced greater barriers to routine healthcare and delayed care during the pandemic (Geranios et al., 2022). These findings are consistent with the interpretation that emergency departments may reflect, in part, the structural consequences of insurance-based gaps in access to the broader healthcare system.

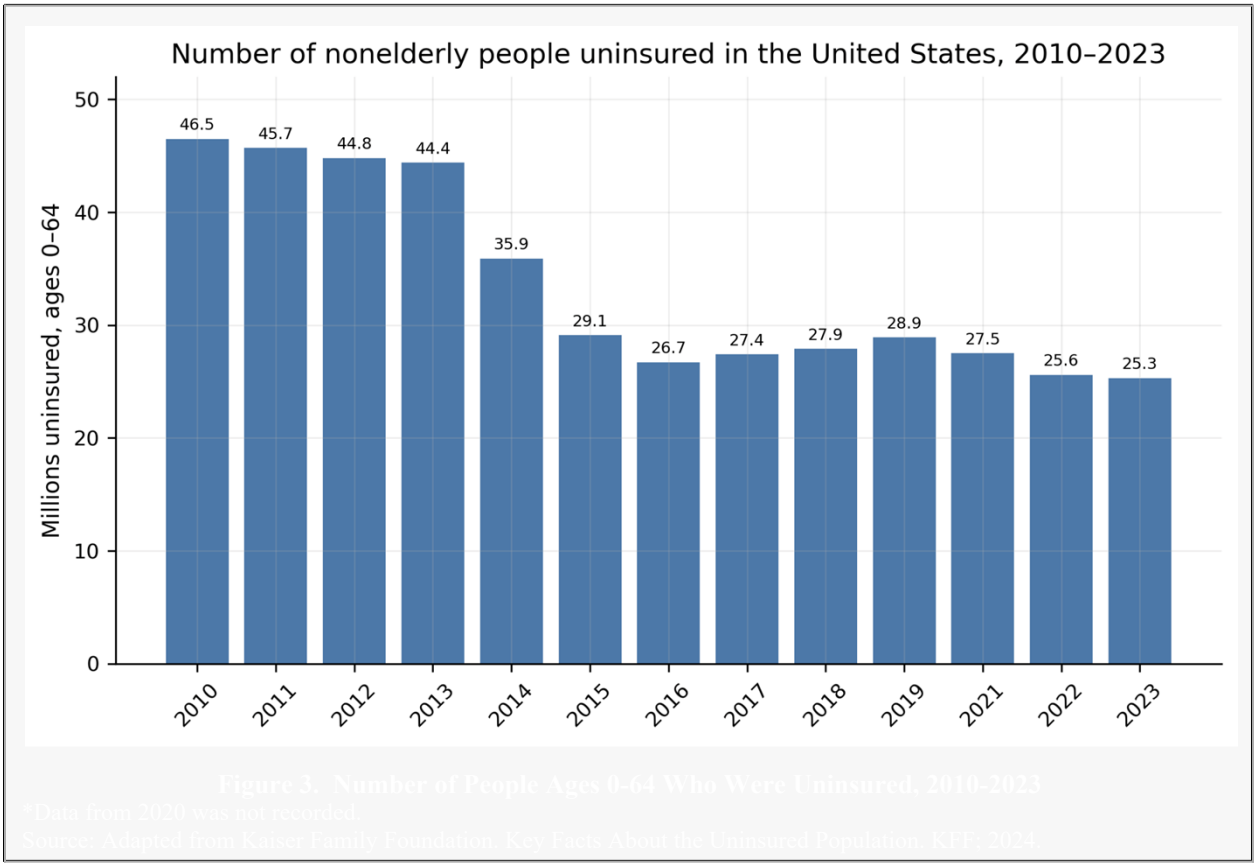

Figure 3. Number of People Ages 0-64 Who Were Uninsured, 2010-2023

*Data from 2020 was not recorded.

Source: Adapted from Kaiser Family Foundation, Key Facts About the Uninsured Population, KFF, 2024

National insurance coverage data from the Kaiser Family Foundation illustrate the scale of the population without continuous coverage. In 2023, approximately 25.3 million non-elderly Americans remained uninsured, with rates significantly higher in states without Medicaid expansion. As shown in Figure 3, the uninsured population declined overall following

Affordable Care Act (ACA) implementation, approaching a historic low during the COVID-19 pandemic due to continuous enrollment protections. Following these pre-pandemic declines, post-pandemic insurance rates have shown renewed instability following the unwinding of continuous-coverage protections (discussed further in Section 1.3), trends that may correspond to the fluctuating patterns of ED reliance documented in national surveillance data (Kaiser Family Foundation, 2024).

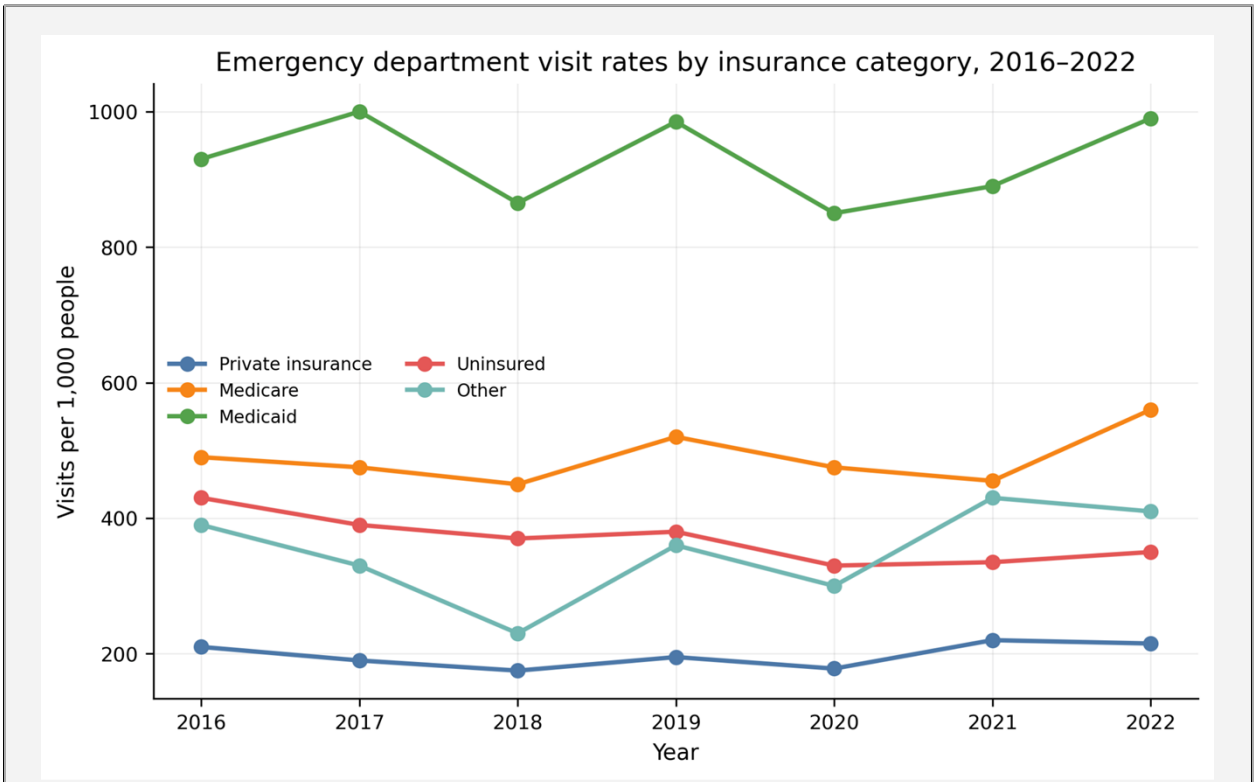

Figure 4. Emergency Department Visit Rates per 1,000 People by Insurance Category Over 2016-2022
Source: Adapted from the National Center for Health Statistics, NHAMCS Emergency Department Visits Data, CDC, 2024

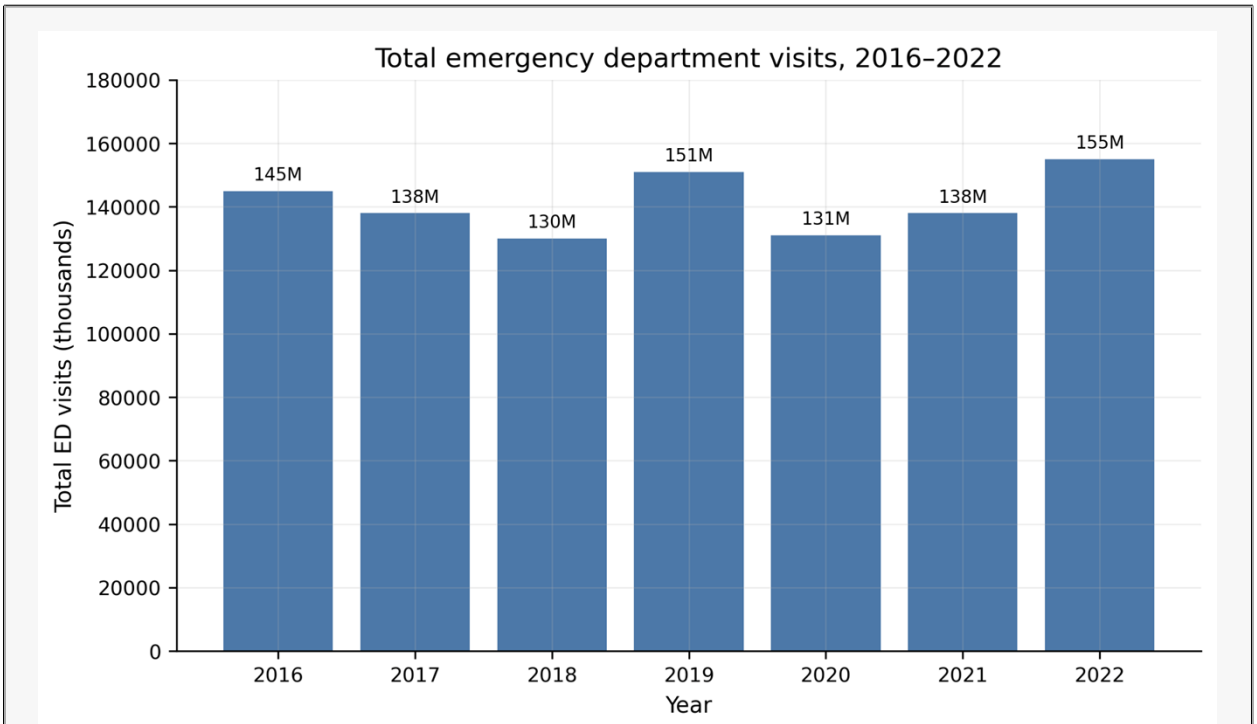

Figure 5. Total Emergency Department Visit (in thousands), 2016–2022

Source: Adapted from the National Center for Health Statistics, NHAMCS Emergency Department Visits Data, CDC, 2024.

Emergency department visit data by year and insurance group, derived from the CDC's National Center for Health Statistics and shown in Figures 4 and 5, show that publicly insured populations had a generally higher rate of ED visits throughout and after the peak of the pandemic, while the uninsured population maintained a relatively similar ED visit rate across all years despite a decrease in the size of the uninsured population during the continuous coverage period. This pattern - a stable visit rate among the uninsured alongside a declining uninsured population - is consistent with the interpretation that uninsured individuals who do present to the ED represent a population with persistently high reliance on acute care, regardless of how the size of that population changes over time (National Center for Health Statistics, 2024). Because Medicare eligibility is determined primarily by age and disability status rather than by income or access to outpatient care, Medicare's visit patterns are discussed separately from Medicaid and

uninsured patterns throughout this manuscript and should not be interpreted as a simple marker of socioeconomic disadvantage.

Patterns of Delayed Care and Severity at Presentation, and Outcomes

The most consequential pattern documented in the literature reviewed is the pattern of delayed and avoided care observed across the reviewed period. National surveillance data from the CDC's Morbidity and Mortality Weekly Report show that 40.9% of U.S. adults reported delaying or avoiding any medical care because of COVID-19-related concerns, including urgent or emergency care (12.0%) and routine care (31.5%). This avoidance was not uniformly distributed. Non-Hispanic Black adults and Hispanic adults showed significantly higher rates of urgent or emergency care avoidance compared to White adults, with adjusted prevalence ratios of 1.6 and 1.5, respectively (Czeisler et al., 2020). Young adults aged 18-24, persons with disabilities, and unpaid adult caregivers were among the other groups most likely to forgo emergency care - groups that are also disproportionately represented among those with no insurance or public insurance compared to other groups.

Income and insurance status are both factors associated with care delay and tend to move together. A cross-sectional study of delayed care across 2020 and 2021 documented that 40.5% of those who delayed care in 2020 had incomes below $50,000, and that 55.8% of those who delayed care in 2021 had at least one pre-existing condition - up from 37.2% in 2020 - a pattern consistent with sicker, lower-income individuals continuing to defer care into the post-acute pandemic period (Gertz et al., 2022). Because lower income is associated with higher rates of public insurance enrollment or lack of insurance, both metrics point toward a related pattern in delay of care, though this study cannot establish which factor, if any, is causally primary.

The clinical consequences of these structural delays were measurable and notable in magnitude. HCUP Statistical Brief No. 298 documents that total ED visits fell from 63,848,000 in April-December 2019 to 47,455,000 in the equivalent period of 2020 - a reduction of more than 16 million visits - while the ED admission rate (the proportion of ED visits resulting in hospitalization) increased during 2020 compared to 2019. This pattern is consistent with the interpretation that individuals who presented to the ED during this period were, on average, more acutely ill than in the prior year (Barrett et al., 2022). This inverse relationship between visit volume and severity of presentation aligns with the hypothesized effects of delayed care: patients who defer treatment may arrive later in the disease course, when intervention is more urgent and outcomes tend to be more severe.

CDC NSSP surveillance data further illustrate this pattern and its magnitude. During the early pandemic period of March 29-April 25, 2020, total U.S. ED visits were 42% lower than during the same period in 2019, declining from a weekly mean of approximately 2.1 million to 1.2 million (Hartnett et al., 2020). A subsequent CDC update reported that even by December 2020-January 2021, ED visits had remained approximately 25% below pre-pandemic levels, with the steepest declines observed among children and in regions most heavily affected by pandemic surges (Adjemian et al., 2021).

Time-sensitive emergency conditions and cumulative conditions appear to be among the most adversely affected by these avoidance behaviors. During the early pandemic period, ED visits for acute myocardial infarction declined by approximately 1,156 mean weekly visits, and visits for nonspecific chest pain fell by 24,258 mean weekly visits, a pattern consistent with patients deferring evaluation for conditions with significant risk of preventable mortality. Simultaneously, the proportion of emergency visits for cardiac arrest and ventricular fibrillation increased (prevalence ratio 1.98), consistent with patients arriving at a more critical and often irreversible stage of illness (Hartnett et al., 2020). While these national patterns were observed

during a period when insurance-related delays in care were also documented, this synthesis cannot establish that insurance status directly caused these specific clinical presentations; the patterns are presented as concurrent and thematically related rather than causally linked.

Post-Pandemic Policy Changes and the Persistence of Insurance-Based Inequities

The structural inequities documented during the acute pandemic period did not resolve with the formal end of the public health emergency. The termination of emergency-era coverage protections was followed by a new wave of insurance instability that coincides with continued strain on emergency departments serving populations identified as vulnerable in this synthesis (McIntyre et al., 2024; Giannouchos et al., 2025).

Beginning April 2023, states were authorized to resume Medicaid eligibility redeterminations following the expiration of the continuous coverage requirement enacted at the start of the pandemic. The scale of the resulting disenrollment was substantial: over 25 million individuals were disenrolled during the first year and a half of unwinding - the largest single decline in Medicaid enrollment in the program's history. Disenrollment was concentrated among structurally vulnerable groups, with significant Medicaid enrollment decreases documented among young adults, recently pregnant adults, and women (McIntyre et al., 2024).

The effects on emergency department payer composition were measurable and occurred over a short timeframe. A retrospective interrupted time-series analysis of over 44 million ED visits across 281 hospitals in California found that during the unwinding period, Medicaid ED visits declined by 0.37 percentage points per quarter while uninsured ED visits increased by 0.16 percentage points per quarter ($p < .001$), corresponding to approximately a 10.2% increase in uninsured visits relative to pre-Medicaid-unwinding averages. The largest increases in uninsured visits occurred at rural hospitals (46.7% increase) and hospitals in high-poverty areas (7.7%

increase), a pattern consistent with the interpretation that safety-net institutions serving structurally vulnerable populations may absorb a disproportionate share of this burden (Giannouchos et al., 2025).

Taken together, the evidence discussed in Sections 1.1-1.3 is consistent with the broader pattern that this study examines: insurance status is associated with reliance on the ED, delay of care is associated with greater severity at ED presentation, and post-pandemic policy changes coincide with continued or renewed strain on EDs serving structurally vulnerable populations. EMTALA ensures access to stabilization but not to timely primary or preventive care, which may help explain why EDs remain a visible point of contact for broader system gaps.

Secondary Analysis Findings

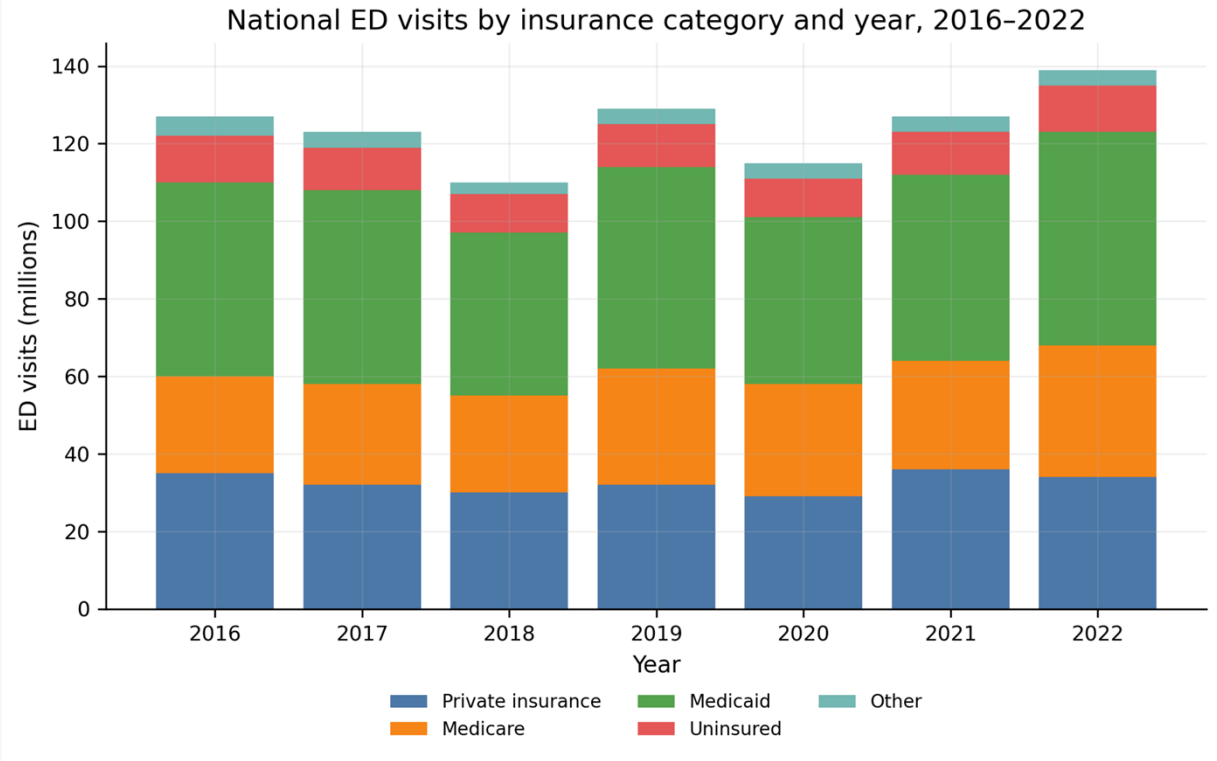

Figure 6. National Estimates of Number of ED Visits (thousands) by Insurance Category and Year, 2016-2022 (Stacked Column)

Source: Adapted from the National Center for Health Statistics, Emergency Department Visits Data, CDC, 2024

Organizing the data into a stacked column graph shows that total ED visit counts differed across insurance categories, with the Medicaid group accounting for the largest share of total visits in every year. As shown in Figure 6, total ED visits declined in 2020 compared with 2019, followed by increases in 2021 and 2022. These counts reflect the combined effect of visit frequency and insurance group size and should not be interpreted as evidence of relative ED reliance without considering population size influences (see visit-rate analysis below).

Source	Sum of Squares (SS)	df	Mean Square (MS)	F statistic / p-value
Treatment	8,988.49	4	2,247.12	F = 264.7690; p = 1.11e-16
Error	254.6132	30	8.4871	
Total	9,243.10	34		

Figure 7. One-way ANOVA significance results of Coverage to ED visits, from 2016 to 2022
Source: Synthesized from the National Center for Health Statistics. Emergency Department Visits Data. CDC; 2024.

Source	Sum of Squares (SS)	df	Mean Square (MS)	F statistic / p-value
Treatment	2,186,517.31	4	546,629.33	F = 218.5269; p = 1.11e-16
Error	75,042.86	30	2,501.43	
Total	2,261,560.17	34		

Figure 8. One-way ANOVA significance results of Coverage to ED Visit Rates, from 2016 to 2022
Source: Synthesized from the National Center for Health Statistics. Emergency Department Visits Data. CDC; 2024.

The first ANOVA model (Figure 7) shows a statistically significant difference in total ED visit counts across insurance coverage categories ($p < 0.001$). The second ANOVA model (Figure 8) also shows a significant difference in ED visit rates by insurance category ($p = 0.01$). As noted in the Methods, both results should be interpreted as descriptive comparisons rather than inferential tests. The distinction between the two models is informative: visit counts are strongly influenced by the size of each insurance population, while visit rates account for population size and are more directly relevant to questions of relative ED reliance. Therefore, visit rates are prioritized in the following interpretations presented.

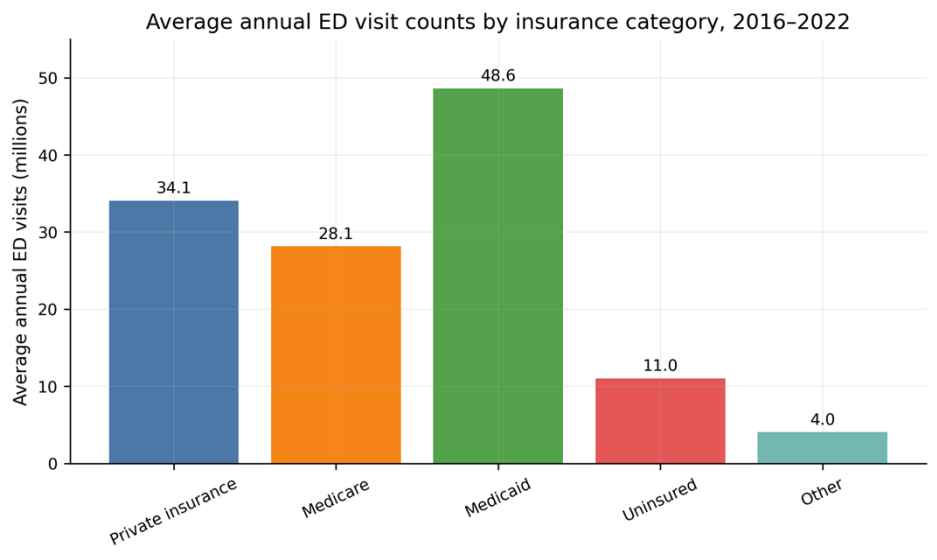

Figure 9. Bar Graph representing the average ED visits for Private Insurance, Medicare, Medicaid, Uninsured, and Other (2016-2022)

Source: Adapted from the National Center for Health Statistics. Emergency Department Visits Data. CDC; 2024.

Figure 9 shows the mean annual ED visit counts for each insurance group from 2016-2022. In terms of total visit counts, the Medicaid group has the largest average annual number of visits before, during, and after the pandemic, followed by private insurance, Medicare, uninsured, and other. However, these counts are heavily influenced by each group's population size. The "other" category shows the lowest total counts, likely reflecting the smaller number of individuals covered under these heterogeneous payment sources rather than lower per-capita ED reliance. As shown in the visit-rate analysis (Figures 4, 5, and 8), private insurance has the lowest visit rate despite having the second-highest total visit count after Medicaid - illustrating why visit counts and visit rates must not be interpreted interchangeably when assessing relative reliance on emergency departments.

Tukey HSD pairwise comparisons: ED visit counts

Comparison	Q statistic	p-value	Inference
Private vs Medicaid	5.3990	0.0052757	p < .01
Private vs Medicare	13.1975	0.0010053	p < .01
Private vs Uninsured	20.9298	0.0010053	p < .01
Private vs Other	27.2830	0.0010053	p < .01
Medicaid vs Medicare	18.5964	0.0010053	p < .01
Medicaid vs Uninsured	15.5308	0.0010053	p < .01
Medicaid vs Other	21.8840	0.0010053	p < .01
Medicare vs Uninsured	34.1272	0.0010053	p < .01
Medicare vs Other	40.4804	0.0010053	p < .01
Uninsured vs Other	6.3532	0.0010053	p < .01

Figure 10. Tukey HSD results of Differences Between Visit Counts Individual Insurance Levels: Private, Medicaid, Medicare, Uninsured, and Other

Source: Adapted from the National Center for Health Statistics. Emergency Department Visits Data. CDC. 2024.

Tukey HSD pairwise comparisons: ED visit rates

Comparison	Q statistic	p-value	Inference
Private vs Medicaid	15.4997	0.0010053	p < .01
Private vs Medicare	38.9343	0.0010054	p < .01
Private vs Uninsured	9.3104	0.0010053	p < .01
Private vs Other	8.2599	0.0010053	p < .01
Medicaid vs Medicare	23.4347	0.0010053	p < .01
Medicaid vs Uninsured	6.1893	0.0011867	p < .01
Medicaid vs Other	7.2397	0.0010053	p < .01
Medicare vs Uninsured	29.6240	0.0010053	p < .01
Medicare vs Other	1.0504	0.0010053	p < .01
Uninsured vs Other	0.3730	0.9000000	ns

Figure 11. Tukey HSD results of Differences Between Visit Rates in Individual Insurance Levels: Private , Medicaid, Medicare, Uninsured, and Other

Source: Adapted from the National Center for Health Statistics. Emergency Department Visits Data. CDC. 2024.

The Tukey-HSD test on visit counts (Figure 10) shows statistically significant pairwise differences between all insurance categories ($p < .01$), consistent with the strong ANOVA result for visit counts. The Tukey-HSD test on visit rates (Figure 11) shows that nearly all pairwise comparisons are also significant ($p < .01$), with the sole exception of Uninsured vs Other ($p = 0.90$). This pattern indicates, within the scope of the samples used within the study, that when population size is accounted for, ED visit rates differ meaningfully across virtually all insurance category pairs - not only at the extremes of the coverage spectrum. As with all results in this analysis, these comparisons should be interpreted as descriptive and exploratory given the small number of aggregate observations per group, the likely temporal correlation across years, and the absence of survey-design adjustments. Medicare should be interpreted cautiously, as enrollment in this program is driven primarily by age and disability eligibility rather than socioeconomic disadvantage alone.

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Discussion

Summary of Findings

This study examined insurance-related inequities in emergency department utilization following the COVID-19 pandemic using a narrative review and a secondary analysis of national NHAMCS data from 2016-2022. Three main patterns emerged. First, ED visit rates differ substantially by insurance category, with Medicaid showing the highest rates, and private insurance showing the lowest. The narrative review identified consistent evidence of delayed and avoided care, before, during and after the pandemic, concentrated among lower-income, publicly insured, and uninsured populations, alongside increased ED admission rates suggesting greater

illness severity at presentation. Post-pandemic Medicaid unwinding coincides with increased uninsured ED visits, particularly at rural and high-poverty hospitals.

Findings Directly Observed in the Secondary Analysis

The secondary analysis, based on the CDC's aggregate sample data of emergency department visits from 2016-2022 (National Center for Health Statistics, 2024), found an exploratory, statistically significant difference in total ED visit counts between insurance categories ($p < 0.001$) and a weaker, though still significant, difference in visit rates ($p = 0.01$). These differences reflect, in part, differences in the size of each insurance population and do not, on their own, indicate that insurance status determines delay of care or ability to pay. The Tukey-HSD results indicate that nearly all pairwise differences in visit counts are individually distinguishable, while only the private-versus-Medicaid comparison is individually distinguishable for visit rates.

Findings Synthesized from the Narrative Review

The narrative synthesis indicates that inequities extend beyond ED utilization to care delay and the severity of care needed at presentation. During COVID-19, delayed or avoided care disproportionately affected populations with public insurance, no insurance, or low income; during the same period, declines in total ED visits co-occurred with higher admission rates, a pattern suggesting possible greater illness severity at presentation. Evidence on Medicaid "unwinding" shows substantial disenrollment and corresponding increases in uninsured ED visits, with the greatest impact on rural and high-poverty hospitals. These findings suggest that post-pandemic policy changes have not, to date, resolved the access barriers identified in this synthesis, and may instead have shifted some of these pressures onto emergency departments.

Interpretive Hypotheses Linking These Findings

Although this study cannot establish a direct causal relation, the secondary-analysis findings and the narrative review findings are consistent with (but do not demonstrate) a broader, hypothesized pathway in which insurance-related barriers may contribute to delayed care, which in turn may be associated with more acute presentations when patients eventually access emergency services. EMTALA ensures access to stabilization, but not to timely primary or preventive care, which may help explain why EDs continue to function as sites where broader system gaps become visible. This pathway is offered as a hypothesis for future research rather than as a finding directly demonstrated by either component of this study.

Policy Implications

The patterns identified here suggest several directions for policy attention, while acknowledging that this study did not evaluate any specific policy intervention and cannot establish which interventions would most effectively reduce ED reliance. The persistence of high visit rates among Medicaid enrollees and the increase in uninsured ED visits following Medicaid unwinding are both consistent with the broader literature's emphasis on insurance continuity as a factor associated with reduced reliance on EDs as a substitute for primary care. Expanding access to outpatient and preventive care - particularly in rural and high-poverty areas, where the largest increases in uninsured ED visits were observed - may plausibly help address some of the structural pressures described in this synthesis, though this remains an implication requiring dedicated evaluation rather than a tested conclusion. EMTALA's stabilization mandate means

that EDs will likely continue to serve as a safety net regardless of policy changes elsewhere in the system.

Limitations

- As a narrative evidence synthesis, source selection involved authorial judgment about thematic relevance rather than a fully pre-specified, reproducible algorithm; this introduces the possibility of selection bias toward sources consistent with the synthesis's organizing framework.
- The search strategy was targeted rather than exhaustive; no formal protocol was registered in advance, reference lists of included sources were not systematically hand-searched, and gray literature beyond the government and policy sources listed was not comprehensively searched. Therefore, relevant studies may have been missed.
- Google Scholar and PubMed searches are not fully reproducible across sessions or users, which limits the transparency of the peer-reviewed literature search component.
- The narrative synthesis identifies consistent patterns but does not establish causality; findings from individual sources reflect associations in those sources' own designs, and the synthesis cannot rule out confounding or publication bias across the body of evidence reviewed.
- The secondary analysis demonstrates exploratory correlations via ANOVA and Tukey-HSD tests, which inherently describe associations rather than causal effects, and the small per-group sample (n = 7 annual observations) limits the validity of formal inferential interpretation.
- The secondary analysis is based on annual, population-level aggregate data rather than individual-level records; conclusions drawn from aggregate data about individual patients risk ecological fallacy, and no individual-level conclusions about why a given patient used the ED can be drawn.

- Annual observations may not be fully independent, since underlying trends (e.g., the pandemic) likely affect multiple consecutive years similarly.
- The published NHAMCS visit-rate estimates carry their own confidence intervals, standard errors, and survey design effects, which were not incorporated into the ANOVA models presented here.
- The secondary analysis cannot adjust for confounding factors such as age, comorbidity, disability status, geography, race/ethnicity, employment, or state-level Medicaid policy differences.
- Insurance category may itself reflect age, disability status, employment, and eligibility rules rather than access barriers alone; Medicare enrollment in particular is governed primarily by age and disability eligibility rather than by income or access to outpatient care, which may partly explain differences in visit patterns between Medicare and other insurance groups independent of any direct effect of insurance type.
- Delayed care and clinical severity were not directly measured in the secondary analysis; statements about delayed care and severity in this manuscript are based on findings reported in the narrative synthesis, not on the NHAMCS dataset analyzed here.
- NHAMCS is a multistage probability sample designed to reduce sampling bias through its staged sampling design; however, this design does not eliminate the confounders described above.

This study identifies correlative, descriptive patterns; further research incorporating individual-level data, formal adjustment for the covariates noted above, and dedicated causal study designs would be needed to draw stronger conclusions about the relationship between insurance status and ED reliance.

Conclusion

The national data, clinical evidence, and exploratory statistical findings synthesized here are consistent with - though they do not independently demonstrate - the broader pattern that post-pandemic recovery in ED utilization has differed across insurance groups, and that insurance instability may be associated with delayed care and reliance on emergency departments among publicly insured and uninsured populations. As a narrative evidence synthesis, these findings are best understood as descriptive and hypothesis-generating, reflecting the authors' thematic interpretation of a targeted but non-exhaustive body of evidence rather than the output of a fully systematic review. Addressing the inequities documented here may plausibly involve policy interventions that improve insurance continuity, expand access to regular outpatient care, and reduce structural barriers before conditions escalate to more severe presentations - though confirming the effectiveness of any specific intervention would require further evaluation.

Statements and Declarations

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Availability of Data and Materials: This study relies entirely on publicly available aggregate data and published literature. The secondary analysis used National Hospital Ambulatory

Medical Care Survey (NHAMCS) emergency department data tables published by the National Center for Health Statistics (NCHS/CDC), available at https://www.cdc.gov/nchs/dhcs/ed-visits/index.htm. Additional national estimates were drawn from publicly available NCHS data briefs and Kaiser Family Foundation reports cited in the reference list. No new individual-level or restricted-access data were generated or analyzed.

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Ethical Approval: Not applicable. This study used only publicly available, de-identified, aggregate data and previously published literature; no original human-subjects research was conducted, and institutional review board approval was therefore not required.

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Post-Pandemic Barriers to Public Benefit Access Among People with Disabilities: A Sociological Perspective on Recovery and Health Inequities

Lilly Lidya Vincent Kirubakaran

Abstract

Background:
The COVID-19 pandemic disrupted access to public benefit programs — including Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Medicaid, the Supplemental Nutrition Assistance Program (SNAP), and Women, Infants, and Children (WIC) — which are critical for the health and socioeconomic stability of people with disabilities. This review examines post-pandemic barriers to benefit access through a sociological lens.

Methods:
This review was conducted as a structured scoping review following the PRISMA 2020 extension for scoping reviews (Page et al., 2021; Tricco et al., 2018). A literature search was conducted in PubMed and Google Scholar (January 2020–December 2025). Keywords included combinations of ("access" OR "barriers") AND ("Medicaid" OR "SSI" OR "SNAP" OR "SSDI" OR "WIC") AND ("disability") AND ("COVID-19" OR "post-pandemic"). Additional sources were identified through reference mining and targeted searches of policy repositories. The initial search yielded 16,704 records; after screening, 190 full texts were assessed for eligibility and 24 sources met inclusion criteria for thematic synthesis. Evidence specific to WIC and disability in the post-pandemic period was sparse; this gap is noted in the results and limitations.

Results:
Four major themes emerged: (1) administrative and bureaucratic barriers (e.g., Social Security Administration field office closures, complex eligibility, information access gaps); (2) digital access and telehealth challenges (e.g., lack of broadband, devices, digital literacy, and accessible platform design); (3) food and nutrition insecurity (disproportionately higher among disabled adults, exacerbated by SNAP access barriers); and (4) temporary policy adaptations with persistent post-pandemic gaps (e.g., unwinding of continuous enrollment, expiration of expanded benefits). The pandemic exacerbated structural inequities rather than creating them de novo.

Conclusion:
Barriers to public benefit access for people with disabilities are multifactorial and rooted in institutional arrangements. Temporary pandemic policies were necessary but insufficient. Lasting reforms require addressing administrative burden, digital inclusion, accessible program design, and targeted outreach from a disability equity perspective.

Keywords: *disability, public benefits, social determinants of health, health inequities, post-pandemic, Medicaid, SNAP, SSI, administrative burden, digital divide*

Introduction

For people with disabilities in the United States, the COVID-19 pandemic did not so much create a crisis as expose one that had been quietly accumulating for decades. The federal programs that disabled Americans depend on most — Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Medicaid, the Supplemental Nutrition Assistance Program (SNAP), and Women, Infants, and Children (WIC) — are not merely administrative conveniences. They function as structural determinants of health, shaping whether individuals can afford housing, whether they can access medical care, and whether they eat consistently (Brookings Institution, 2023; National Academies of Sciences, Engineering, and Medicine, 2024). When those programs became difficult or impossible to navigate during the pandemic, the consequences were not felt uniformly. They landed hardest on a population that was already navigating a system built with significant friction.

People with disabilities represent a substantial and growing share of the U.S. adult population — approximately 27% report at least one functional limitation — yet they experience rates of poverty, unemployment, food insecurity, and unmet healthcare need that far exceed those of their non-disabled counterparts (Okoro et al., 2021; Turk & McDermott, 2021). This disparity is not incidental. It reflects the structure of public programs themselves, which often require extensive documentation, in-person verification, regular recertification, and a capacity for self-advocacy that many applicants — especially those with cognitive, sensory, or mobility-related limitations — find difficult to sustain (Henly et al., 2026; McBride-Henry et al., 2023). In this sense, the systems designed to support people with disabilities can function, paradoxically, as barriers to the support they are meant to provide.

The early months of the pandemic made this dynamic visible in ways that had previously been easy to overlook. Social Security Administration field offices suspended in-person services

almost entirely, creating backlogs in disability determinations that left applicants in extended limbo — unable to receive benefits they had applied for, and unable to get clear answers about when decisions would be made (Farid et al., 2024). Medicaid agencies, stretched by surging caseloads and reduced administrative capacity, struggled to maintain continuity of enrollment even as continuous enrollment policies attempted to hold coverage steady. Food assistance programs faced parallel disruptions, as recertification requirements collided with office closures and a population that was already at elevated food insecurity risk.

These service disruptions did not occur in a vacuum — they converged with a second, equally serious problem. The rapid shift of service delivery to digital platforms, often inadequately planned, created new access barriers at exactly the moment when existing ones were being stripped of their workarounds. Applying for benefits online, attending virtual appointments, and managing paperwork through automated portals all assume access to reliable broadband, a functional device, and sufficient digital literacy to navigate unfamiliar systems. For many people with disabilities — particularly older adults, those with cognitive disabilities, and those in rural or low-income households — those conditions simply did not hold (McLean et al., 2024). Telehealth expanded rapidly as a substitute for in-person care, and for some populations it worked reasonably well. But studies consistently show that it failed to substitute adequately for people with complex access needs, including those requiring sign language interpretation, accessible platform design, or assistive communication technologies (Cvitanovic et al., 2025; Hall et al., 2022). What looked like a solution in the aggregate masked significant inequities at the margins.

Food insecurity offers a particularly clear illustration of how these structural failures converged. Adults with disabilities were more likely than adults without disabilities to experience food insecurity during the pandemic, even after accounting for income level — a gap documented across multiple national household surveys (Assi et al., 2022; Friedman, 2021; Karpman &

Zuckerman, 2021). Emergency SNAP allotments helped, but they reached only those already enrolled in the program. The individuals who might have newly qualified — those who had lost employment due to disability-related health vulnerability, or who had never successfully navigated the application process — were largely left out. As Swenor (2021) has argued, disability inclusion has long been a missing ingredient in food system equity, and the pandemic did not change that; if anything, it sharpened the consequences of the omission.

Sociologists of inequality have a framework for understanding why eligible individuals so frequently fail to access the programs intended to serve them. The concept of administrative burden — the learning costs associated with understanding program rules, the compliance costs of meeting documentation requirements, and the psychological costs of navigating systems that can feel stigmatizing or hostile — captures something real about how public programs filter out those who cannot absorb those costs (Henly et al., 2026; Bercaw et al., 2023). For people with disabilities, those costs are not merely inconvenient; they can be functionally prohibitive. A program that requires annual in-person recertification at an office with limited accessible parking is not a neutral policy. It is a policy that distributes access unevenly, in ways that correlate predictably with disability status, income, and geography.

Geography deserves particular emphasis. The barriers described above are compounded for people with disabilities living in rural and remote communities, where provider shortages, inadequate broadband infrastructure, limited public transportation, and fewer disability-specific services create layered access challenges that urban-focused policy responses rarely address (Quon et al., 2026). A recent scoping review found that rural residents with disabilities face not just geographic isolation but what researchers have termed a "time tax" — the disproportionate expenditure of time, energy, and money required to obtain care and services in settings where resources are sparse (Quon et al., 2026). The pandemic's digital pivot, rather than alleviating these burdens, in many cases intensified them.

The post-pandemic period has not resolved these issues. Many of the emergency policy adaptations that temporarily improved access — Medicaid's continuous enrollment provision, expanded SNAP allotments, flexible telehealth reimbursement — have since expired or been curtailed. Early evidence suggests that people with disabilities may be disproportionately represented among those losing Medicaid coverage during redetermination, as recertification requirements that were suspended during the public health emergency are reimposed on a population that was already struggling to meet them (Staiger et al., 2024). In this respect, the post-pandemic period represents something more than a return to baseline; it represents a return to a baseline that was already inadequate, now further complicated by the backlogs, disruptions, and eroded institutional capacity left in the pandemic's wake.

This review examines these dynamics from a combined sociological and public health perspective. Drawing on empirical studies, policy analyses, and systematic reviews published primarily between 2021 and 2026, it identifies the structural, administrative, socioeconomic, and digital barriers that have shaped public benefit access for people with disabilities in the post-pandemic period. It examines the consequences of those barriers for health and wellbeing, assesses the policy adaptations introduced during the pandemic and their subsequent erosion, and identifies the evidence base for reforms that could reduce rather than perpetuate existing inequities. The organizing argument throughout is that the barriers documented here are not technical malfunctions in otherwise functional systems. They are, in most cases, predictable products of how those systems were designed — and understanding them requires a framework attentive to institutional structure, not just individual circumstance.

Methods

Search Strategy

This review was conducted as a structured scoping review, following the general reporting principles of the PRISMA 2020 extension for scoping reviews (Page et al., 2021; Tricco et al., 2018). Scoping review methodology was selected because the research question spans multiple benefit programs, population subgroups, and study designs, and because the goal was to map the breadth of available evidence rather than to produce a pooled quantitative estimate. A literature search was conducted across two electronic databases: PubMed and Google Scholar. The search covered publications from January 2020 through December 2025, with the earlier boundary set to capture pandemic-onset disruptions and their documented effects on benefit access.

Search terms were structured using Boolean operators to maximize retrieval across relevant program areas, population groups, and contextual conditions. The primary search string was:

> *("access" OR "barriers") AND ("Medicaid" OR "SSI" OR "SSDI" OR "SNAP" OR "WIC") AND ("disabled" OR "disability") AND ("COVID-19" OR "pandemic" OR "post-pandemic")*

Where available, Medical Subject Headings (MeSH) terms were applied in PubMed to supplement keyword searching and improve precision across indexed literature. These included: Disabled Persons, Health Services Accessibility, Social Welfare, and COVID-19. Google Scholar searches used the same keyword combinations without formal subject headings, given the database's indexing structure.

Google Scholar searches were conducted in January 2026. Given the volume of results returned by this database, screening was limited to the first 200 results per search, sorted by relevance — an approach consistent with established scoping review practice for Google Scholar (Haddaway et al., 2015). Duplicate records appearing across both databases were identified manually and

removed prior to title screening. All searches were conducted and screened by a single reviewer; this is noted as a methodological limitation in the Limitations section.

To supplement database searching and capture policy-relevant grey literature not consistently indexed in PubMed or Google Scholar, targeted searches were conducted across several recognized policy repositories: the Urban Institute, the Center on Budget and Policy Priorities, the Center for Retirement Research at Boston College, the Center for Law and Social Policy (CLASP), and the National Council on Disability. Reference lists of all studies meeting full-text inclusion criteria were also screened for additional relevant sources not captured in the original searches.

Figure 1 presents the PRISMA 2020 flow diagram summarizing the study selection process.

Figure 1. PRISMA 2020 Flow Diagram of Study Selection

Stage	Description	Count
Identification	Records identified from PubMed	1,204
Identification	Records identified from Google Scholar (first 200 results by relevance)	15,500
Identification	Total records identified	16,704
Screening (Title)	Records after duplicates removed (manual deduplication)	12,890
Screening (Title)	Records excluded at title stage (not U.S.-focused, not disability-specific, no benefit access outcome)	7,700
Screening (Abstract)	Records screened at abstract level	5,190
Screening (Abstract)	Records excluded at abstract stage (wrong population, wrong intervention, no original data)	5,000
Screening (Full Text)	Full-text articles assessed for eligibility	190
Screening (Full Text)	Full-text articles excluded	166
Screening (Full Text)	└ Wrong population	60
Screening (Full Text)	└ Wrong outcome	50
Screening (Full Text)	└ Non-U.S. focus	40
Screening (Full Text)	└ Commentary/opinion	16
Inclusion (Database)	Studies included from database search	24
Additional — Grey Literature	Records identified from policy repositories (Brookings Institution, Urban Institute, CLASP, Center for Retirement Research, National Council on Disability)	8
Additional — Reference Mining	Records identified through reference list screening of included studies	4
Additional — Excluded	Additional records not meeting inclusion criteria after full-text review	8
TOTAL INCLUDED	Total unique sources included in final thematic synthesis	24

Note. Adapted from Page et al. (2021). PRISMA 2020 flow diagram for scoping reviews. Grey literature and reference-mined sources are reported separately from database records. Total unique included sources = 24 (overlap between database and supplementary sources accounted for in deduplication).

Inclusion and Exclusion Criteria

Studies were included if they met all the following criteria:

- Program focus: Examined access to at least one of the designated public benefit programs — SSI, SSDI, Medicaid, SNAP, or WIC — among people with disabilities.
- Outcome focus: Provided empirical data, qualitative findings, or substantive policy analysis on barriers to access, service disruptions, policy adaptations, or downstream health and socioeconomic outcomes.
- Geographic focus: Focused on the United States context, or in limited cases offered direct comparative insight into structural barriers with clear analogues to U.S. systems.
- Temporal focus: Included post-pandemic observations or data, or provided pre-pandemic baseline information directly relevant to interpreting pandemic-era and post-pandemic findings.

Studies were excluded if they met any of the following criteria:

- Commentaries, opinion editorials, or non-peer-reviewed content from sources without recognized methodological or policy credentialing.
- Non-U.S. studies without clear analytical relevance to U.S. systems.
- Studies examining COVID-19 health outcomes among people with disabilities without any reference to benefit access, service utilization, or social determinants of health.

Grey literature sources — including policy reports, government analyses, and institutional briefs — were included if they originated from recognized research, governmental, or policy

organizations; addressed U.S.-based public benefit access; included disability-relevant findings or analysis; and demonstrated sufficient methodological or analytical transparency to support evidentiary claims. Sources were excluded if they lacked identifiable authorship, institutional affiliation, or analytical basis.

Screening and Data Extraction

All records passing the title-level filter were screened at the abstract level by the primary reviewer for relevance to the study's inclusion criteria. Full texts were obtained for all abstracts meeting provisional inclusion criteria. Final inclusion decisions were made at the full-text stage, with exclusions documented by reason (see Figure 1). Additional sources identified through reference mining and grey literature searches underwent the same abstract and full-text screening process before inclusion.

From each included study, the following information was systematically extracted:

- The benefit program or programs examined
- The type and category of barriers identified (administrative, digital, structural, geographic)
- Population characteristics, including disability type, age group, and socioeconomic context where reported
- Key outcomes, such as enrollment rates, service utilization patterns, food security measures, or health impacts
- Where applicable, the nature and reported effectiveness of policy adaptations

Given the heterogeneity of study designs, populations, and outcomes across the included literature — spanning quantitative analyses of national survey data, qualitative studies of lived

experience, systematic and scoping reviews, and policy evaluations — a meta-analytic synthesis was not appropriate. Results were synthesized descriptively, with studies organized thematically according to the four conceptual domains that emerged from the literature: (a) administrative and bureaucratic barriers; (b) digital access and telehealth inequities; (c) food and nutrition insecurity; and (d) policy adaptations with post-pandemic gaps.

Theoretical Framework

The analysis was guided by three interlocking theoretical frameworks drawn from sociology and public health: structural inequality theory, the administrative burden framework, and the social determinants of health (SDOH) model. These frameworks were not applied sequentially or in isolation; rather, they operate in the analysis as complementary lenses that illuminate different dimensions of the same underlying problem.

Structural inequality theory, as developed within the sociology of institutions, holds that disparate outcomes across social groups frequently reflect the architecture of institutions themselves rather than the characteristics of the individuals within them (Turk & McDermott, 2021). Applied to disability and benefit access, this framework directs attention toward program design — the eligibility rules, recertification schedules, documentation requirements, and communication formats that shape who can realistically participate in public programs. From this perspective, an eligible individual who fails to enroll in SSI is not simply uninformed or unmotivated; they may be encountering a set of institutional requirements that are, in practice, incompatible with the constraints imposed by their disability, their geography, or their household resources. The pandemic made this dynamic harder to ignore by disrupting the compensatory

workarounds — assistance from caseworkers, in-person help at libraries or community organizations — that many individuals had relied upon to navigate complex systems.

The administrative burden framework, developed most fully by Herd and Moynihan and elaborated in the disability policy context by scholars including Henly and colleagues (2026), offers a more granular account of the mechanisms through which institutional barriers operate at the individual level. The framework identifies three distinct cost categories: learning costs (the cognitive effort required to understand what programs exist, what one is eligible for, and how to apply); compliance costs (the time, documentation, and procedural effort required to meet program requirements and maintain enrollment); and psychological costs (the stigma, stress, and loss of dignity associated with navigating systems that may treat applicants as suspects rather than beneficiaries). For people with disabilities, each of these cost categories is elevated. Cognitive and sensory limitations complicate form completion and telephone communication. Mobility limitations make in-person requirements more burdensome. And the historical context of disability policy in the United States — which has often been shaped by skepticism about the legitimacy of disability claims — adds a psychological dimension to benefit navigation that further discourages participation among those with the greatest need (Brookings Institution, 2023; Henly et al., 2026).

The social determinants of health model situates these administrative and structural dynamics within a broader understanding of health as a socially produced outcome. Health, in this framework, is not primarily a function of individual behavior or biological risk, but of the conditions in which people are born, live, work, and age — including their access to income support, nutrition assistance, stable housing, and healthcare (National Academies of Sciences, Engineering, and Medicine, 2024). Public benefit programs, on this account, are health interventions as much as they are income transfer mechanisms. Disruptions to SNAP access are disruptions to nutritional health. Delays in Medicaid enrollment are delays in healthcare access.

The administrative burden that prevents a person with a disability from successfully navigating an SSI application is, in a direct and measurable sense, a determinant of their health trajectory. Together, these three frameworks support an analysis that is attentive to institutional design, to the mechanisms through which that design produces unequal outcomes, and to the downstream health consequences of those inequities. They also share a common implication for policy: that addressing disparities in benefit access requires structural reform, not behavioral change. The barriers documented in this review are products of how programs are built and administered. They will not be resolved by educating individuals about their options or encouraging them to persist through difficult application processes. They require changes to the programs themselves.

Results

Study Selection and Characteristics

The search and screening process identified 24 sources for final inclusion: 16 peer-reviewed articles or working papers and 8 policy reports or systematic reviews from recognized policy institutions. Included studies were heterogeneous in design by necessity — the research landscape on disability and public benefit access does not lend itself to uniform methodological treatment, and a synthesis that restricted itself to randomized or quasi-experimental designs would exclude much of the most policy-relevant evidence. The final corpus spans quantitative analyses drawing on national survey datasets (Assi et al., 2022; Friedman, 2021; Okoro et al., 2021), qualitative and mixed-methods studies examining lived experience (McBride-Henry et al., 2023; Cvitanovic et al., 2025), systematic and scoping reviews (Bercaw et al., 2023; Jesus et al., 2021; Henly et al., 2026), and policy analyses evaluating program-level changes and their effects (Burnside et al., 2025; Farid et al., 2024; Staiger et al., 2024). Table 1 summarizes the key characteristics and findings of included studies.

Table 1. Summary of Key Studies Included in Thematic Synthesis

Author(s) & Year	Study Type	Program(s)	Population	Key Findings
Assi et al. (2022)	Cross-sectional survey	SNAP, Medicaid	Adults with/without disabilities	Adults with disabilities reported significantly higher food insecurity and healthcare access barriers during the pandemic, persisting after income adjustment
Bercaw et al. (2023)	Systematic review	Medicaid HCBS	Adults seeking long-term services	Waiting lists, fragmented coordination, and state-level variation produced inequitable HCBS access across the U.S.
Boudreau et al. (2024)	Retrospective claims analysis	Medicare Advantage (telehealth)	Access-challenged Medicare Advantage enrollees	Telehealth use rose during the pandemic but remained lowest among those with the greatest access barriers
Brookings Institution (2023)	Policy analysis	SSI, SNAP	Older adults and adults with disabilities	Enrollment complexity and recertification burden are primary drivers of SSI and SNAP participation gaps
Burnside et al. (2025)	Policy report	SNAP, TANF	People with disabilities; Long COVID patients	Emergency allotments excluded newly eligible individuals; Long COVID patients face compounded barriers navigating benefit systems
Cvitanovic et al. (2025)	Qualitative study	Medicaid (telehealth)	Adults with intellectual/developmental disabilities	Platform inaccessibility, communication barriers, and provider inexperience with AAC were major telehealth obstacles
Farid et al. (2024)	Policy/economic analysis	SSI, SSDI	SSA applicants nationally	SSA office closures produced measurable application declines and persistent backlogs; first-time applicants were most affected
Friedman (2021)	Secondary data analysis	SNAP, Medicare	Medicare beneficiaries with disabilities	Food insecurity was elevated among Medicare beneficiaries with disabilities despite existing healthcare coverage
Hall et al. (2022)	Mixed-methods survey	Medicaid, Medicare (telehealth)	Adults with physical and cognitive disabilities	Telehealth increased but many users reported platform navigation difficulty and absent disability accommodations
Henly et al. (2026)	Scoping review	SSI, SSDI	Populations underrepresented in Social Security programs	Information barriers and absent outreach are primary drivers of under-enrollment among high-need populations
Jesus et al. (2021)	Scoping review with thematic analysis	Multiple programs	People with disabilities during COVID-19 lockdowns	Lockdown disparities reflected pre-existing structural vulnerabilities; access barriers were amplified rather than created by the pandemic

Karpman & Zuckerman (2021)	Survey/policy analysis	SNAP	Low-income adults with and without disabilities	SNAP participation among eligible individuals with disabilities lagged the broader low-income population; administrative barriers were primary contributors
Kuhn et al. (2024)	Utilization analysis (state-level)	Medicaid (telehealth)	Medicaid enrollees in North Carolina	Post-pandemic telehealth use remained elevated but access disparities by geography and disability status persisted
McBride-Henry et al. (2023)	Scoping review	Multiple healthcare/	Adults with disabilities, pandemic context	Complex administrative processes, poor provider communication, and absent disability-competent staff were consistent barriers
Author(s) & Year	**Study Type**	**Program(s)**	**Population**	**Key Findings**
		benefit programs		
McLean et al. (2024)	Secondary analysis (national survey)	SSI, SSDI	U.S. households receiving SSI/SSDI	Loss of in-person services was inadequately replaced by remote alternatives; device shortages and inaccessible portals were key barriers
Staiger et al. (2024)	Quasi-experimental	Medicaid, SSI, SSDI	Adults with disabilities by race/ethnicity	Medicaid expansion was associated with increased disability benefit take-up; effects varied significantly by race and ethnicity

Note. HCBS = home- and community-based services; AAC = augmentative and alternative communication; SSA = Social Security Administration. Table includes 16 of 24 sources contributing primary evidentiary claims. Remaining sources contributed primarily to contextual framing and thematic corroboration.

Programs examined across the included literature encompassed all five designated benefit areas: SSI, SSDI, Medicaid, SNAP, and WIC. Study populations included individuals with physical, cognitive, sensory, and developmental disabilities across a range of age groups and socioeconomic circumstances, with several studies specifically attending to populations facing compounded disadvantage — rural residents (Quon et al., 2026), older adults navigating long-term services and supports (Bercaw et al., 2023), people with Long COVID navigating new disability status (Burnside et al., 2025), and individuals at the intersection of disability, racial minority status, and poverty (Staiger et al., 2024). Four major interrelated themes emerged from the synthesis and are reported below.

Theme 1: Administrative and Bureaucratic Barriers

The most consistently documented finding across the included literature is that the administrative architecture of public benefit programs functions, in practice, as a set of barriers to the populations those programs are intended to serve. This was true before the pandemic, and the pandemic made it significantly worse.

The suspension of in-person services at Social Security Administration field offices represents the most clearly documented instance of pandemic-related administrative disruption. Farid and colleagues (2024) examined the effects of this suspension on SSI and SSDI applications and allowance rates, finding that the closure of field offices produced measurable declines in new applications and substantial processing backlogs that persisted well beyond the acute phase of the public health emergency. The individuals most affected were first-time applicants — those without established case relationships with SSA staff — and those whose applications required in-person verification steps that could not be readily transferred to remote channels. The implications extended beyond inconvenience: for applicants depending on SSI as a gateway to Medicaid eligibility, delays in benefit determination were simultaneously delays in healthcare access.

Beyond the specific disruptions attributable to the pandemic, structural administrative barriers were a persistent theme across the literature. McBride-Henry and colleagues (2023), in a scoping review of disabled people's experiences accessing healthcare services during the pandemic, identified complex administrative processes, inadequate communication from service providers, and the absence of disability-informed staff as recurring obstacles to care and benefit access. These are not new problems, but they were amplified during the pandemic when the informal

support structures that many applicants relied upon — assistance from family members, community navigators, social workers — were themselves disrupted.

Henly and colleagues (2026) provide perhaps the most direct evidence of information-related administrative burden in the SSI/SSDI context. Their scoping review identified limited awareness of eligibility criteria, difficulty understanding application requirements, and the absence of targeted outreach as central mechanisms through which otherwise eligible individuals fail to enroll. The administrative burden framework is useful here precisely because it disaggregates the problem into distinct failure modes, each requiring a distinct remedial response.

An individual may know that SSI exists but not understand what documentation is required. They may understand the requirements but lack the physical capacity or social support to meet them consistently. Or they may meet the requirements but find the process sufficiently stigmatizing that they abandon it before completion. For people with cognitive, sensory, or mobility-related limitations, these failure points are not hypothetical — they reflect the ordinary experience of benefit navigation in a system that was not designed with them in mind.

In the Medicaid context, Bercaw and colleagues (2023) documented persistent and substantial disparities in access to home- and community-based services (HCBS), finding that waiting lists, fragmented service coordination across state agencies, and significant state-level policy variation produced inequitable access to long-term supports that is only nominally uniform across the federal program structure. For people with significant disabilities who depend on HCBS for basic daily functioning, these administrative barriers translate directly into unmet care needs and increased reliance on more costly institutional settings — an outcome neither efficient nor equitable from a policy standpoint.

The Brookings Institution (2023) analysis of SSI and SNAP participation rates among older and disabled adults provides additional quantitative grounding for the administrative barrier

argument, estimating that a significant share of individuals eligible for these programs do not participate — a gap attributable not to lack of need but to the complexity of enrollment and recertification processes that many potential beneficiaries cannot navigate without assistance that is rarely provided at sufficient scale.

Theme 2: Digital Access and Telehealth Inequities

The pandemic's rapid shift of benefit navigation and healthcare delivery toward digital platforms introduced a second major axis of inequity. For individuals with reliable broadband access, functional devices, and sufficient digital literacy, the transition to online applications, telephone case management, and telehealth appointments was manageable, if imperfect. For a substantial portion of the disability population, it was not.

McLean and colleagues (2024) examined the pandemic's impact on receipt of needed medical care and at-home support among households receiving SSI and SSDI, finding that loss of in-person services was not adequately compensated by remote alternatives for many respondents. Barriers included inadequate internet access, lack of appropriate devices, difficulty navigating online portals, and the absence of accommodations for disability-related communication needs in virtual service environments. These findings are consistent with the broader digital divide literature, which frames differential technology access not as a personal failing but as a structural inequality — one that reflects decades of underinvestment in broadband infrastructure in low-income and rural communities and the persistent absence of universal design requirements in publicly funded digital systems (McLean et al., 2024).

Telehealth is the domain where the gap between promise and delivery has been most clearly documented in the disability context. Boudreau and colleagues (2024) found that telehealth utilization increased among access-challenged populations in Medicare Advantage during the

pandemic, but that utilization rates remained lower among those with the greatest access barriers — precisely the population for whom telehealth was most needed as an in-person substitute. The pattern suggests that telehealth expanded access at the margins without reaching the core of the access-challenged population.

Adults with intellectual and developmental disabilities did not, on the whole, experience telemedicine as a convenient alternative to in-person care — they experienced it as a new source of difficulty. Cvitanovic and colleagues (2025), in a qualitative study of this population, documented platform inaccessibility, communication barriers without the visual cues available in in-person settings, and provider unfamiliarity with augmentative and alternative communication (AAC) devices. Many participants relied on caregivers or family members to facilitate telehealth visits in ways that raised privacy concerns and altered the clinical dynamic. The study's conclusion — that accessibility in telehealth requires deliberate design, not merely technical availability — is a finding with direct implications for how telehealth policy is structured going forward.

Kuhn and colleagues (2024) offer a state-level perspective on telehealth's post-pandemic trajectory, examining Medicaid telehealth utilization in North Carolina after the expiration of emergency waivers. Their findings suggest that telehealth use has remained elevated relative to pre-pandemic levels, but that access disparities by geography and disability status have persisted, raising questions about whether the expanded telehealth infrastructure has been distributed equitably or has primarily benefited populations that were already comparatively well-resourced.

For rural residents with disabilities, the digital access problem intersects with geographic isolation in ways that compound both. Quon and colleagues (2026), in a scoping review of healthcare access experiences among people with disabilities in rural and remote communities, found that inadequate broadband infrastructure was a near-universal theme, accompanied by additional barriers — limited local provider capacity, inaccessible physical healthcare

environments, transportation burdens that function as a "time tax" on care-seeking, and the relational dynamics of small communities where privacy concerns may deter individuals from accessing local services. Digital solutions, even well-designed ones, cannot substitute for the full range of services that rural residents with disabilities need.

Theme 3: Food and Nutrition Insecurity

Food insecurity among people with disabilities emerged in the literature as both a direct consequence of pandemic-related disruptions and a downstream indicator of the broader failure of public benefit systems to maintain adequate support during a period of acute need.

The quantitative evidence on food insecurity prevalence is consistent across multiple nationally representative studies. Assi and colleagues (2022) used cross-sectional survey data to document that adults with disabilities were significantly more likely to report food insecurity and barriers to healthcare access during the pandemic than adults without disabilities, with disparities persisting after adjustment for income and other socioeconomic characteristics. Friedman (2021) found similar patterns among Medicare beneficiaries with disabilities — a population already enrolled in federal healthcare coverage — suggesting that even program participation does not insulate against food insecurity when SNAP enrollment gaps are present. Karpman and Zuckerman (2021) documented that SNAP participation rates among eligible individuals with disabilities lagged behind participation rates in the broader low-income population, with administrative barriers — complex applications, recertification requirements, office closures — identified as key contributors to the gap.

The SNAP emergency allotments authorized under pandemic relief legislation provided temporary benefit increases to enrolled households and represented a meaningful, if limited, policy response. However, as Burnside and colleagues (2025) documented in their analysis of

disability equity and access in SNAP and TANF for people with Long COVID, the benefits of emergency allotments were restricted to households already enrolled in the program. Individuals who had not successfully navigated enrollment prior to the pandemic — or who became newly eligible due to pandemic-related income loss or emerging disability — faced the same application barriers during the pandemic as before it, with in-person assistance options further reduced by office closures.

Keisler-Starkey and Bunch (2022) provide additional census-based evidence that disability status is independently associated with SNAP participation gaps, even among income-eligible households. The mechanisms are consistent with the administrative burden framework: eligible individuals with disabilities are less likely to be enrolled because enrollment requires navigating a system with which many have had limited prior experience, and the costs of doing so — in time, documentation, and cognitive effort — are elevated relative to the non-disabled population.

Swenor's (2021) argument that disability inclusion is a structurally missing ingredient in food system equity operates at a level somewhat above individual program participation, attending to the design of food access infrastructure itself. Distribution sites that are physically inaccessible, online grocery ordering systems with inadequate screen-reader compatibility, and emergency food programs that do not account for dietary restrictions related to specific disabilities are all examples of how food access interventions can fail people with disabilities not through deliberate exclusion but through the routine omission of disability considerations in program design. This distinction matters: improving SNAP participation rates among people with disabilities is necessary but not sufficient. The food system itself — its physical infrastructure, digital interfaces, and emergency response architecture — must be redesigned with disability access as a first-order requirement, not an afterthought.

WIC-specific evidence examining disability-related access barriers in the post-pandemic period was sparse within the identified literature. WIC serves a population with substantial overlap with

disabled adults — particularly women with disabilities of childbearing age — peer-reviewed empirical studies focusing specifically on WIC access and disability during or after COVID-19 were not identified in this search. This represents a meaningful gap in the existing evidence base and warrants dedicated future research.

Theme 4: Policy Adaptations and Post-Pandemic Rollback

The COVID-19 pandemic prompted an unusually rapid and expansive set of policy adaptations to existing benefit programs, several of which represented meaningful improvements in access for people with disabilities. Equally important — and perhaps more consequential for the long term — is what has happened as those adaptations have been wound down.

The Medicaid continuous enrollment provision, authorized under the Families First Coronavirus Response Act, prohibited states from disenrolling Medicaid beneficiaries during the public health emergency in exchange for enhanced federal matching funds. Available evidence suggests this was associated with historically low Medicaid disenrollment rates — a natural experiment in what may happen when the recertification burden is suspended. Staiger and colleagues (2024) examined the relationship between Medicaid expansion and disability benefit take-up by race and ethnicity, finding that expanded Medicaid coverage was associated with increased participation in disability benefit programs, suggesting that coverage continuity has enrollment spillover effects across programs. The unwinding of continuous enrollment that began in 2023 appears to have reversed some of these gains: early evidence suggests that people with disabilities may be disproportionately represented among those losing Medicaid coverage during redetermination, as states reimpose recertification processes that many cannot navigate without support (Staiger et al., 2024).

Telehealth reimbursement flexibilities introduced during the pandemic — including parity requirements between in-person and telehealth reimbursement, expanded eligible service types, and removal of geographic restrictions — similarly improved access for portions of the disability population during the public health emergency. Boudreau and colleagues (2024) found that these flexibilities were associated with increased primary care telehealth utilization among access-challenged Medicare Advantage beneficiaries, suggesting genuine access gains. However, the partial rollback of these flexibilities in the post-pandemic period, and the uncertainty about their permanent status, has complicated providers' capacity to sustain telehealth programming and patients' ability to plan their care (Kuhn et al., 2024).

The expiration of emergency SNAP allotments in early 2023 produced immediate and measurable benefit reductions for millions of households. Burnside and colleagues (2025) document that people with disabilities and individuals with Long COVID — a population navigating new disability-related needs without established program relationships — were particularly hard hit by the expiration, facing reduced benefits precisely as their healthcare costs and functional limitations placed additional strain on household finances.

Jesus and colleagues (2021), writing at the close of the pandemic's first wave, concluded that the disparities experienced by people with disabilities during the lockdown period reflected pre-existing structural vulnerabilities that were amplified by the crisis rather than generated by it. That framing remains accurate and is arguably more important in the post-pandemic context than it was during the acute emergency. The policy adaptations introduced during the pandemic demonstrated that rapid structural change is achievable when institutional will is present — that recertification requirements can be suspended, that telehealth reimbursement can be expanded, that benefit levels can be increased. The question the post-pandemic period poses is whether the political and institutional conditions that enabled those temporary changes can be sustained long enough to produce permanent reform. Available evidence suggests that without deliberate

structural intervention, systems tend to revert to their pre-pandemic configurations, and the populations most harmed by those configurations will bear the cost.

Discussion

The findings reviewed in this paper tell a story that is, at its core, not primarily about the COVID-19 pandemic. The pandemic is the occasion for the analysis, and its disruptions provide some of the most vivid documentation available of what happens when benefit systems fail the populations they are designed to serve. But the administrative backlogs, digital exclusions, food insecurity gaps, and program participation shortfalls documented across the included literature are not pandemic-era anomalies. They are the predictable outputs of systems whose design has never adequately accounted for the specific circumstances, constraints, and needs of people with disabilities. The pandemic stripped away the compensatory mechanisms that ordinarily soften the worst edges of those design failures, making visible what had always been structurally present.

The Structural Argument

From a sociological standpoint, the most important contribution of this review's evidence base is not any single finding about a specific program but the cumulative pattern across programs, populations, and time periods. Whether examining SSA field office closures and their effects on disability determinations (Farid et al., 2024), persistent Medicaid HCBS waiting lists and state-level service variability (Bercaw et al., 2023), SNAP participation gaps among income-eligible disabled households (Karpman & Zuckerman, 2021; Keisler-Starkey & Bunch, 2022), or telehealth platform failures for users requiring accessible design (Cvitanovic et al., 2025), the mechanism is structurally consistent: programs impose costs — in time,

documentation, cognitive effort, physical mobility, and psychological endurance — that are distributed unequally across the population of eligible individuals, and the distribution of those costs correlates reliably with disability status, income, geography, and race.

This is precisely what structural inequality theory would predict. Institutions do not produce unequal outcomes only through discriminatory intent; they produce them through the accumulated weight of design choices that reflect the needs and capacities of some people more than others. An application process that assumes reliable internet access, a recertification system that assumes consistent availability for phone appointments, a food distribution site that assumes physical mobility — none of these requires conscious exclusion to produce exclusionary outcomes. They require only the absence of deliberate inclusion, which has historically characterized U.S. disability policy far more often than its presence (McBride-Henry et al., 2023; Brookings Institution, 2023).

The administrative burden framework sharpens this argument by specifying the mechanisms. Henly and colleagues (2026) document that information barriers — not knowing that a program exists, not understanding what one qualifies for, not knowing how to apply — are a primary driver of under-enrollment in Social Security disability programs among populations with high potential eligibility. This reflects the absence of institutional investment in reaching people who may not have the social capital, prior government program experience, or advocacy networks that make program navigation easier. The compliance and psychological costs are, if anything, more severe for people with cognitive, sensory, or psychiatric disabilities, for whom form completion, phone communication, and in-person visits with government caseworkers may be genuinely prohibitive rather than merely inconvenient. None of that changed during the pandemic. What changed was the removal of the informal supports — family assistance, community navigator programs, library computer access, social worker accompaniment — that many individuals had been using to absorb these costs all along.

The Digital Divide as Social Inequality

The digital access findings deserve more careful attention than they typically receive in policy discussions. The dominant framing — digital exclusion as a gap to be closed by infrastructure investment and digital literacy training — is not inaccurate so much as insufficient. It treats what is fundamentally a social problem as if it were a technical one.

McLean and colleagues (2024) and the broader digital divide literature both document that the problem is not primarily about bandwidth. It involves device access, digital literacy that may never have been developed in contexts offering little opportunity for technology engagement, online systems designed without screen-reader compatibility or cognitive accessibility in mind, and telehealth platforms that assume a level of technical fluency and self-directed navigation that many users with disabilities do not have and cannot reasonably be expected to acquire quickly (McLean et al., 2024). Cvitanovic and colleagues (2025) found that adults with intellectual and developmental disabilities experienced telemedicine as a source of additional difficulty — unfamiliar interfaces, communication barriers, privacy concerns, and provider inexperience with augmentative communication all converging to make virtual visits less effective than the in-person encounters they were meant to replace.

The digital divide is, in this sense, a social inequality that has been given a technological surface. It reflects decades of differential investment in the infrastructure and institutions that would have enabled broader digital participation, and it reflects program design processes that have consistently treated the median, able-bodied, English-literate, broadband-connected user as the default. Addressing it requires more than broadband subsidies and app redesigns, though both are necessary. It requires reconceiving accessible design as a non-negotiable program requirement

rather than an accommodation to be added after the fact — a shift that has implications for procurement, contracting, and regulatory standards across the federal benefit system.

Rural Disability and Compounded Inequity

The rural dimension of this analysis deserves treatment as more than a geographic footnote. People with disabilities in rural and remote communities do not experience a version of the barriers described above that is simply more severe due to distance; they experience a qualitatively distinct configuration of disadvantage that interacts with disability in ways that urban-centered policy frameworks routinely fail to capture.

Quon and colleagues (2026) describe what they term the "time tax" of care in rural disability contexts — the disproportionate expenditure of time, energy, and money required to access services in settings where providers are sparse, transportation options are limited, and each appointment may require hours of travel that individuals with significant functional limitations may find genuinely exhausting or impossible. This time tax operates as an additional administrative burden layered on top of the program-level burdens already described, and it is one that telehealth was expected to alleviate. In practice, inadequate broadband infrastructure in many rural communities means that telehealth is not reliably available as an in-person substitute, and when it is available, the disability-specific accommodations it requires — accessible platforms, provider competency in alternative communication, captioning, sign language interpretation — are often absent (Quon et al., 2026).

There is also a relational and privacy dimension to rural healthcare and benefit access that is not captured in administrative data. In small communities, the absence of anonymity can deter individuals from seeking services, particularly for conditions associated with stigma. These dynamics are difficult to quantify but are well-documented in the qualitative literature on rural

health, and they represent a genuine barrier to access that policy responses focused on process simplification alone will not address (Quon et al., 2026; McBride-Henry et al., 2023).

Intersectionality and the Distribution of Burden

The review's evidence also points, though sometimes indirectly, toward the role of intersecting social identities in shaping how administrative and structural barriers are experienced. Disability does not operate as an isolated social position; it intersects with race, income, age, and geography in ways that concentrate disadvantage among specific subpopulations within the already-disadvantaged disability population as a whole.

Staiger and colleagues (2024) found that the effects of Medicaid expansion on disability benefit take-up varied significantly by race and ethnicity — a finding that complicates any account of structural barriers that treats disability as a single, homogeneous category. Burnside and colleagues (2025) make a related point in their focus on Long COVID patients, a population disproportionately drawn from the working class and from communities of color, navigating new disability status without the prior program experience that might make benefit navigation somewhat less opaque. What these findings share is an implication that administrative burden is not distributed uniformly even within the disability population: the costs fall heaviest at the intersection of disability with poverty, racial minority status, and geographic isolation.

Policy responses designed without attention to intersectionality will systematically underperform for the populations most in need. A SNAP simplification initiative that streamlines the online application but does not address broadband access in rural communities will benefit some disabled applicants while leaving others behind. The evidence base reviewed here does not fully resolve these intersectional dynamics — most included studies did not systematically disaggregate findings by race, income, and disability type simultaneously — but it points clearly

enough toward their importance that future research and policy design should treat them as central rather than supplementary concerns.

The Policy Adaptation Paradox

Perhaps the most consequential finding of this review, from a policy standpoint, is the one that emerges from Theme 4: that the pandemic demonstrated the feasibility of rapid structural change in benefit programs, and that the post-pandemic period has largely squandered that demonstration.

Available evidence suggests that Medicaid's continuous enrollment provision was associated with historically low disenrollment rates — indicating that eliminating recertification requirements need not produce program instability. Emergency SNAP allotments demonstrated that benefit adequacy can be scaled up when there is political will to do so. And the telehealth reimbursement flexibilities made something plain that had always been true: geographic and format restrictions on healthcare delivery are policy choices, not technical necessities. Each of these adaptations was introduced quickly, under emergency conditions, without the years of deliberative process that typically precede major program changes. Their relative success suggests that the barriers to permanent reform are not primarily technical or administrative. They are political.

The unwinding of continuous Medicaid enrollment, the expiration of emergency SNAP allotments, and the uncertain future of telehealth parity reimbursement all represent decisions to return to program configurations whose inadequacy is extensively documented in the literature reviewed here. As Jesus and colleagues (2021) argued at the pandemic's outset, the disparities experienced by people with disabilities during the crisis reflected pre-existing structural vulnerabilities. The post-pandemic period's return to those pre-existing structures suggests that

the lesson of the pandemic — that rapid, large-scale improvement in benefit access is achievable — has not been institutionalized in the ways that evidence would recommend.

Limitations

Several limitations of this review warrant acknowledgment. The search was conducted across two databases — PubMed and Google Scholar — supplemented by reference mining and targeted grey literature searches, but this approach may not have captured all relevant empirical work, particularly studies published in discipline-specific journals outside public health and sociology. Google Scholar screening was limited to the first 200 results sorted by relevance, which may not have captured all relevant records, and all screening was conducted by a single reviewer without independent verification. The synthesis is descriptive rather than meta-analytic, reflecting the heterogeneity of study designs and outcome measures across the included literature; effect sizes and precise prevalence estimates should therefore be drawn from individual studies rather than from this review's aggregate conclusions. Most included studies examined specific programs or disability subpopulations, which limits the generalizability of findings across the full range of benefit programs and disability types. Additionally, most studies did not systematically disaggregate findings by race, income, and disability type simultaneously, which constrains the intersectional analysis possible from this literature. WIC-specific disability-focused evidence was sparse and represents a gap in the existing literature. The rapid pace of post-pandemic policy change means that some findings — particularly those related to Medicaid unwinding and telehealth reimbursement status — may require updating as new data emerge. Because this review follows a scoping methodology, formal risk-of-bias assessment was not conducted; however, sources were evaluated for institutional credibility, methodological

transparency, and relevance to the review's inclusion criteria prior to inclusion, and evidence strength is noted where relevant in the narrative synthesis.

Conclusion

There is a version of this paper's findings that reads as discouraging — a catalogue of systems that failed the people most dependent on them, of temporary reforms that didn't last, of structural problems that a public health emergency made visible without making soluble. That reading is not inaccurate, but it misses something important in the evidence. The pandemic period demonstrated, with unusual clarity, that the administrative and structural barriers documented throughout this review are not immovable features of the policy landscape. They are design choices. And design choices can be redesigned.

Available evidence suggests that the suspension of Medicaid recertification requirements was associated with historically low disenrollment rates rather than program instability. Emergency SNAP allotments, for their part, appear to have reduced food insecurity in a population for whom that condition was already chronic, without producing the dependency effects their critics predicted. And the removal of geographic restrictions on telehealth reimbursement appears not to have compromised care quality, though longer-term outcome data remain limited. Taken together, these findings point toward the same conclusion: the gap between what U.S. public benefit programs provide to people with disabilities and what they are capable of providing is a function of political will, not administrative impossibility.

That gap matters because the stakes are not abstract. Access to SSI and SSDI determines whether a person with a disability can pay rent and buy medication in the same month. Access to Medicaid determines whether they receive preventive care or wait until a condition becomes a

crisis. These are social determinants of health in the most literal sense — the material conditions that shape physical and mental health trajectories over a lifetime. When benefit access is disrupted by administrative burden, digital exclusion, or geographic isolation, the consequences are clinically meaningful, and they fall with greatest force on individuals whose health is already most precarious.

The sociological perspective this review has applied insists on something that purely technocratic policy analysis sometimes misses: that inequitable outcomes are produced by institutional structures, and that changing those outcomes requires changing those structures. Simplifying recertification processes, mandating accessible design in digital benefit platforms, making telehealth parity reimbursement permanent, investing in rural healthcare infrastructure, and conducting targeted outreach through disability-led organizations are not a wish list. They are the evidence-based responses to a documented set of structural failures. The pandemic showed that implementation is possible. The post-pandemic period has shown what happens when implementation is reversed.

People with disabilities in the United States have long been asked to absorb the costs of systems that were not designed with them in mind — to navigate complex applications without adequate support, to access services through inaccessible channels, to maintain enrollment in programs that treat recertification as a barrier rather than a formality. The post-pandemic moment offers a choice about whether that arrangement continues. The evidence reviewed here suggests it should not, and it suggests with reasonable specificity what a more equitable arrangement would look like. Whether that specificity is translated into policy is a question this paper cannot answer. It is, ultimately, a political one.

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