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Four in Ten Adults with Disabilities Experienced Unfair Treatment in Health Care Settings, at Work, or When Applying for Public Benefits in 2022

Dulce Gonzalez, Genevieve M. Kenney, Michael Karpman, and Sarah Morriss

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Adults with disabilities¹ in the United States have worse self-reported physical and mental health status, lower employment rates, and higher rates of chronic illness, poverty, and material hardship than adults without disabilities (BLS 2023; Krahn, Walker, and Correa-De-Araujo 2015; Mitra et al. 2022; Vallas et al. 2022). Despite important federal antidiscrimination protections, disabled people also continue to experience discrimination and unfair treatment in health care settings, workplaces, and when applying for public benefits (Domzal, Houtenville, and Sharma, 2008; Gasper, Palan, and Muz 2020; Iezzoni et al. 2021; Lagu et al. 2022; McDaniel et al. 2023; Pratt et al. 2023).

Experiences of unfair treatment in these settings can reinforce health and economic disparities by limiting access to employment opportunities and services that are essential for meeting basic needs. Efforts to improve the health and well-being of people with disabilities will, therefore, require addressing unequal treatment and ableism—a set of biases and institutional practices rooted in the belief that people with disabilities are inferior (Lindsay et al. 2022; 2023).

In this brief, we used nationally representative survey data to better understand the extent to which adults experience differential treatment because of their disabilities and other personal characteristics, such as race, ethnicity, and income, and the impact of such treatment on their well-being. Drawing on December 2022 data from the Urban Institute's Well-Being and Basic Needs Survey, we examined self-reported rates at which adults ages 18 to 64 with and without disabilities felt they were treated or judged unfairly in the past year in three settings: at doctors' offices, clinics, or hospitals

(hereafter referred to as health care settings); at work; and when applying for public benefits (which we also refer to as social service settings). Our measure of disability conforms to federal data collection standards for surveys and is defined as having difficulties with one or more of the following: hearing; seeing; concentrating, remembering, or making decisions; walking or climbing stairs; dressing or bathing; doing errands alone; and communicating in one's own language (see the data and methods appendix on page 15 for more information).

Our key findings include the following:

- In December 2022, 4 in 10 adults with disabilities (40 percent) reported experiencing unfair treatment in health care settings, at work, or when applying for public benefits because of their disabilities or other personal characteristics in the previous year. Adults with disabilities were more than twice as likely as adults without disabilities to report unfair treatment in one or more of these settings (40 percent versus 18 percent).
 - » Disabled adults were more likely than adults without disabilities to report unfair treatment in each of the three settings: 32 percent versus 10 percent in health care settings, 18 percent versus 11 percent at work, and 14 percent versus 3 percent when applying for public benefits.
- Many disabled adults reported experiencing unfair treatment because of their disabilities or health conditions in the prior year: 14 percent in health care settings, 9 percent at work, and 6 percent when applying for benefits.
- Among disabled adults, Black and Hispanic/Latinx adults were more likely than white adults to report unfair treatment or judgment in each of the three settings because of their race, ethnicity, country of origin, or primary language.²
- Disabled adults frequently reported adverse consequences after experiencing unfair treatment, in many cases at rates higher than those of adults without disabilities.
 - » About 71 percent of disabled adults who experienced unfair treatment in health care settings reported a disruption to care after such treatment, including delaying (54 percent) or not getting (50 percent) needed care.
 - » Almost half (46 percent) of disabled adults who experienced unfair treatment in workplaces reported looking for a new job because of the way they were treated.
 - » About 71 percent of disabled adults who experienced unfair treatment in social service settings had difficulty receiving public benefits, including delaying (45 percent) or not getting (57 percent) benefits.

Although we were not able to determine the specific nature of the interactions with health care providers, employers, coworkers, benefits administrators, or others that were perceived as unfair treatment, these findings show that experiences of unfair treatment were common among people with disabilities, causing disruptions in health care and employment and delays in accessing public benefits to help them meet their basic needs. Experiences of unfair treatment could also take a mental and physical

health toll on people with disabilities, given past research linking discrimination to higher levels of stress and the close link between stress and physiological responses (APA 2016; Namkung and Carr 2020). The barriers and discrimination that disabled people face in these settings because of their disability are compounded among those who are also marginalized based on other characteristics, such as race, ethnicity, or primary language (Crenshaw 1989; Crossley 2022; Goodman, Morris, and Boston 2019; Yee et al. 2017). Understanding and addressing experiences of unfair treatment among people with disabilities is necessary for ensuring they have equitable access to health care, employment opportunities, and economic support.

Background

Disabled people face greater barriers to access, service quality, and equitable treatment in many settings, and experiences of unfair treatment can take various forms. Barriers to health care include limited access to sign language interpreters or other supports to facilitate communication with providers and office staff and widespread use of scales, examination tables, and other diagnostic equipment that were not designed for people with disabilities (Peacock, Iezzoni, and Harkin. 2015).³ Health care provider bias can directly manifest in the provision of lower quality care for people with disabilities, including lower rates of preventive screenings because of assumptions that people with disabilities do not require certain types of care or explicit denial of care because of provider perceptions that treating people with disabilities is too cumbersome (de Vries McClintock et al. 2016; Iezzoni et al. 2021; Lagu et al. 2022; Lindsay et al. 2022; VanPuymbrouck, Friedman, and Feldner 2020).

People with disabilities also face barriers to becoming or staying employed because of a lack of support, accommodations, and enforcement of antidiscrimination protections designed to promote workplace equity. For example, employers may hesitate to hire disabled job seekers who are qualified for open positions if they perceive the cost of providing reasonable accommodations—required under the Americans with Disabilities Act—would be too high or if they incorrectly believe disabled employees will not be able to perform job duties (Domzal, Houtenville, and Sharma, 2008; Gaspar, Palan, and Muz 2020). Employed people with disabilities may also face overt and subtle forms of discrimination because of their disability, such as microaggressions and exclusion from meetings because of a lack of accessibility support for employees with vision, hearing, mobility, or other disabilities (Graham et al. 2019; Namkung and Carr 2019; Schur et al. 2017). Further, disabilities are not always visible, as can be the case with hearing difficulties, chronic physical health conditions, or disabilities related to mental health conditions such as depression.⁴ Employed people with disabilities may choose not to disclose their disability to employers for fear of being stigmatized or otherwise treated differently, which can result in disabled employees not requesting reasonable accommodations they need and eventually lead them to leave their jobs (Schur et al. 2017).

Such barriers to working can lead to higher unemployment rates, food insecurity, and economic insecurity among disabled people (Altiraifi 2019; Heflin, Altman, and Rodriguez 2019; Vallas et al. 2022). This increased financial precarity contributes to the need for public assistance programs that pose barriers disproportionately affecting disabled people. For example, administrative burdens, such

as complicated paperwork and documentation requirements or in-person appointment requirements, are well-established factors in complicating access to public benefits (Moynihan, Herd, and Harvey 2015). These administrative barriers can become more challenging for people with disabilities if, for example, online benefit applications are not available in multiple formats to meet the needs of people with disabilities (Musumeci et al. 2022). In the Social Security Disability Insurance and Supplemental Security Income (SSI) programs, applicants face burdensome medical paperwork requirements to prove their disability and lengthy application processes that often end in denial of benefits (Schweitzer et al. 2022). SSI applicants also face asset tests that require them to have resources below a very low threshold.

Unequal treatment persists despite federal protections against discrimination based on disability status in health care, social service, employment, and other settings, including the following:

- the Americans with Disabilities Act, which prohibits discrimination based on disability in employment, state and local government activities, public transportation, public accommodations, commercial facilities, and telecommunications⁵
- the Rehabilitation Act, which prohibits discrimination based on disability in programs and activities funded by the federal government and in the employment practices of federal agencies and contractors
- the Affordable Care Act, which prohibits discrimination on the basis of disability in federally funded health care programs and services⁶ and includes other provisions that are important for disabled patients, such as protections against denying coverage or charging higher premiums to patients with preexisting health conditions⁷

In the following section, we assess reported experiences with unfair treatment or judgment in health care, employment, and social service settings for people with and without disabilities. We close with a discussion highlighting steps that could help produce better experiences and outcomes for people with disabilities.

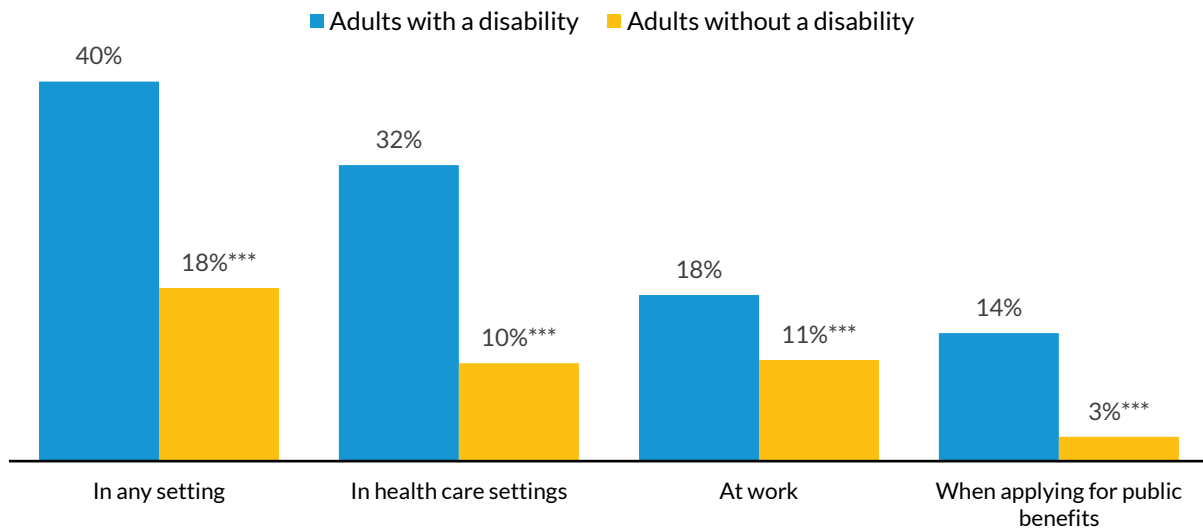
Results

In December 2022, 4 in 10 adults with disabilities reported experiencing unfair treatment in health care settings, at work, or when applying for public benefits because of their disabilities or other personal characteristics in the previous year. Adults with disabilities were more than twice as likely as adults without disabilities to report unfair treatment in one or more of these settings.

Forty percent of adults with disabilities reported they were treated or judged unfairly in health care settings, at work, or when applying for public benefits because of their personal characteristics in the past year, a rate that was over twice as high as that for adults without disabilities (18 percent; figure 1). About 17 percent of people with disabilities reported unfair treatment in two or more settings (data not shown). People with disabilities reported higher rates of unfair treatment in all three situations: health

care settings (32 versus 10 percent), at work (18 versus 11 percent), and when applying for public benefits (14 versus 3 percent).

FIGURE 1
Share of Adults Reporting Unfair Treatment or Judgment in Health Care Settings, at Work, and When Applying for Public Benefits in the past 12 Months, by Disability Status, December 2022



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Source: Well-Being and Basic Needs Survey, December 2022.

Notes: Adults are ages 18 to 64. Health care settings include a doctor’s office, clinic, or hospital. Respondents could have reported unfair treatment or judgment because of one or more of the following characteristics: race, ethnicity, gender, gender identity or sexual orientation, country of origin or primary language, health insurance coverage type (only asked for health care settings), disability or health condition, weight, income or education, or some other reason. Disability is defined as difficulties with one or more of the following: hearing; seeing; concentrating, remembering, or making decisions; walking or climbing stairs; dressing or bathing; doing errands alone; and communicating in one’s own language.

*/**/*** Estimate differs significantly from that for adults with a disability at the 0.10/0.05/0.01 level, using two-tailed tests.

One in seven adults with disabilities (14 percent) reported unfair treatment or judgment in health care settings because of their disability or a health condition, and the same share reported unfair treatment because of their weight (table 1). Nearly as many reported feeling they were treated or judged unfairly because of their health insurance coverage type (12 percent). Because of structural factors that limit their employment opportunities and incomes, disabled people have less access to private health insurance and disproportionately rely on Medicaid and other public programs for coverage (Altiraifi 2019; Musumeci and Orgera 2020; Vallas et al. 2022). Prior research has shown that publicly insured adults are more likely than those with private insurance to report being treated or judged unfairly because of their type of health insurance coverage (Gonzalez et al. 2022). This could reflect negative attitudes toward Medicaid among providers because of the program’s lower reimbursement rates, more cumbersome prior authorization and billing processes, and the greater cost of treating patients who are more likely to have complex medical needs, as well as providers’ or staff

members' implicit or explicit biases toward publicly insured patients (Alexander and Schnell 2019; Dunn et al. 2021; Grimm 2023; Polsky et al. 2015).

Just under 1 in 10 adults with disabilities (9 percent) experienced unfair treatment at work because of a disability or health condition; these adults were almost as likely to report unfair treatment for other reasons such as their gender, gender identity, or sexual orientation (8 percent) and their race, ethnicity, country of origin, or language (8 percent).

Six percent of disabled adults reported unfair treatment because of a disability or health condition when applying for public benefits, similar to the share reporting they were treated or judged unfairly because of their income or education (7 percent) or their race, ethnicity, country of origin, or language (7 percent). Relatively few adults without disabilities reported unfair treatment when applying for public benefits for any of the reasons shown in table 1.

TABLE 1
Share of Adults Reporting Unfair Treatment or Judgment in Health Care Settings, at Work, and When Applying for Public Benefits in the past 12 Months, by Disability Status and Reason for Unfair Treatment, December 2022

	In Health Care Settings		At Work		When Applying for Public Benefits	
	Adults with a disability	Adults without a disability	Adults with a disability	Adults without a disability	Adults with a disability	Adults without a disability
Share reporting unfair treatment or judgment because of:						
Disability or health condition	14%	1%***	9%	1%***	6%	0%***
Weight	14%	3%***	5%	2%***	4%	0%***
Health insurance coverage type	12%	3%***	-	-	-	-
Gender, gender identity, or sexual orientation	11%	3%***	8%	5%**	5%	1%***
Race, ethnicity, country of origin, or primary language	10%	4%***	8%	5%**	7%	2%***
Income or education	9%	2%***	5%	2%***	7%	1%***

Source: Well-Being and Basic Needs Survey, December 2022.

Notes: Adults are ages 18 to 64. Health care settings include a doctor's office, clinic, or hospital. Respondents were not asked whether they were treated unfairly at work or when applying for public benefits because of their health insurance coverage type. Disability is defined as difficulties with one or more of the following: hearing; seeing; concentrating, remembering, or making decisions; walking or climbing stairs; dressing or bathing; doing errands alone; and communicating in one's own language. Respondents could report multiple reasons for unfair treatment or judgment. Sample sizes for adults with a disability and adults without a disability are 2,194 and 5,687, respectively.

*/**/*** Estimate differs significantly from that for adults with a disability at the 0.10/0.05/0.01 level, using two-tailed tests.

Among disabled adults, Black and Hispanic/Latinx adults were more likely than white adults to report unfair treatment or judgment in each of the three settings because of their race, ethnicity, country of origin, or primary language.

Table 2 shows the share of Black, Hispanic/Latinx, and white adults with disabilities who reported experiencing unfair treatment in each setting and the reasons they felt they were treated or judged unfairly (estimates are not shown for other racial/ethnic groups because of sample size limitations). In each racial/ethnic group shown in the table, about 4 in 10 adults reported unfair treatment in at least one setting. Black adults with disabilities were likelier than white adults with disabilities to report unfair treatment in two or more settings (21 versus 16 percent; data not shown).

We observed differences by race/ethnicity when assessing rates of unfair treatment in each setting that were related to specific characteristics. Black adults with disabilities were nearly six times as likely as white adults with disabilities to report unfair treatment in health care settings because of their race, ethnicity, country of origin, or primary language (23 percent versus 4 percent). Hispanic/Latinx adults reported unfair treatment for these reasons at three times the rate of white adults (12 percent versus 4 percent).

Disabled Black and Hispanic/Latinx adults were also more likely than disabled white adults to report unfair treatment because of their race, ethnicity, country of origin, or primary language in the workplace (15 percent and 10 percent versus 4 percent) and when applying for public benefits (11 percent and 8 percent versus 5 percent).

In addition, Black and Hispanic/Latinx adults with disabilities were generally more likely than white adults with disabilities to report unfair treatment because of their income or education. For example, 11 percent of Black and Hispanic/Latinx adults with disabilities reported unfair treatment because of their income or education in health care settings, compared with 6 percent of white adults with disabilities.

TABLE 2

Share of Adults with Disabilities Reporting Unfair Treatment or Judgment in Health Care Settings, at Work, and When Applying for Public Benefits in the past 12 Months, by Race/Ethnicity and Reason for Unfair Treatment, December 2022

	Black	Hispanic/Latinx	White
Share reporting unfair treatment or judgment in any setting	40%	37%	39%
Share reporting unfair treatment or judgment in health care settings because of:			
Any reason	34%	29%	29%
Disability or health condition	15%	12%	14%
Weight	17%	13%	13%
Health insurance coverage type	12%	12%	11%
Gender, gender identity, or sexual orientation	12%	9%	9%
Race, ethnicity, country of origin, or primary language	23%	12%***	4%***/++
Income or education	11%	11%	6%**/+
	Black	Hispanic/Latinx	White
Share reporting unfair treatment or judgment at work because of:			
Any reason	20%	17%	16%
Disability or health condition	9%	8%	8%
Weight	7%	6%	4%**
Gender, gender identity, or sexual orientation	10%	8%	8%
Race, ethnicity, country of origin, or primary language	15%	10%*	4%***/++
Income or education	6%	8%	3%*/++
	Black	Hispanic/Latinx	White
Share reporting unfair treatment or judgment when applying for public benefits because of:			
Any reason	15%	15%	12%
Disability or health condition	8%	7%	5%
Weight	4%	5%	3%++
Gender, gender identity, or sexual orientation	6%	7%	4%++
Race, ethnicity, country of origin, or primary language	11%	8%	5%***/+
Income or education	9%	6%	6%*

Source: Well-Being and Basic Needs Survey, December 2022.

Notes: Adults are ages 18 to 64. Estimates for adults who are Black or white refer to those who are not Hispanic/Latinx. Estimates for non-Hispanic/Latinx adults of additional races are not shown because of small sample sizes. Health care settings include a doctor’s office, clinic, or hospital. Disability is defined as difficulties with one or more of the following s: hearing; seeing; concentrating, remembering, or making decisions; walking or climbing stairs; dressing or bathing; doing errands alone; and communicating in one’s own language. Respondents could report multiple reasons for unfair treatment or judgment.

*/**/*** Estimate differs significantly from that for Black adults with a disability at the 0.10/0.05/0.01 level, using two-tailed tests.

+/**/+++ Estimate differs significantly from that for Hispanic/Latinx adults with a disability at the 0.10/0.05/0.01 level, using two-tailed tests.

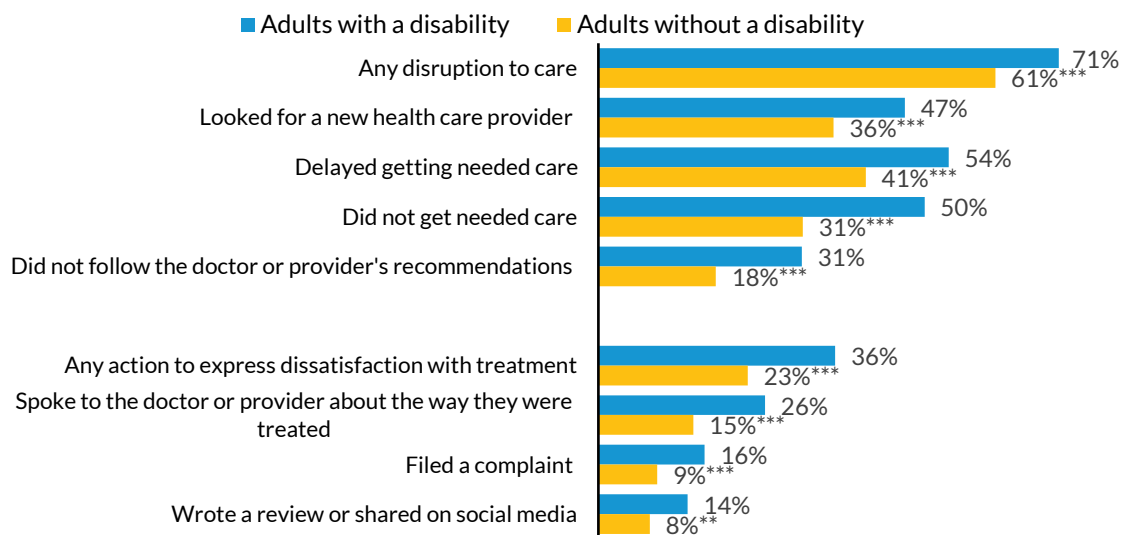
Disabled adults frequently reported adverse consequences after experiencing unfair treatment, in many cases at rates higher than those of adults without disabilities.

CONSEQUENCES OF UNFAIR TREATMENT IN HEALTH CARE SETTINGS

Overall, about 7 in 10 adults with disabilities (71 percent) who experienced unfair treatment in health care settings reported a disruption to care because of how they were treated, compared with about 6 in 10 adults without disabilities (61 percent; figure 2). Disruptions to care among people with disabilities included looking for a new health care provider (47 percent), delaying needed care (54 percent), not getting needed care (50 percent), and not following the doctor’s or provider’s recommendations (31 percent). Adults with disabilities were more likely than those without disabilities to report each of these disruptions.

Over 1 in 3 adults with disabilities (36 percent) who experienced unfair treatment in health care settings took some action to express dissatisfaction with the treatment they received, compared with just under 1 in 4 adults without disabilities (23 percent) who experienced unfair treatment. About one-quarter of adults with disabilities (26 percent) spoke to the provider about how they were treated, 16 percent filed a complaint, and 14 percent wrote a review or shared their experience on social media.

FIGURE 2
Disruptions to Care and Actions Taken in Response to Unfair Treatment or Judgment in Health Care Settings in the past 12 Months, by Disability Status, December 2022



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Source: Well-Being and Basic Needs Survey, December 2022.

Notes: Adults are ages 18 to 64. Health care settings include a doctor’s office, clinic, or hospital. Respondents could have reported unfair treatment or judgment because of one or more of the following characteristics: race, ethnicity, gender, gender identity or sexual orientation, country of origin or primary language, health insurance coverage type, disability or health condition, weight, income or education, or some other reason. Disability is defined as difficulties with one or more of the following: hearing; seeing; concentrating, remembering, or making decisions; walking or climbing stairs; dressing or bathing; doing errands alone; and communicating in one’s own language. Respondents could report multiple actions in response to unfair treatment or judgment.

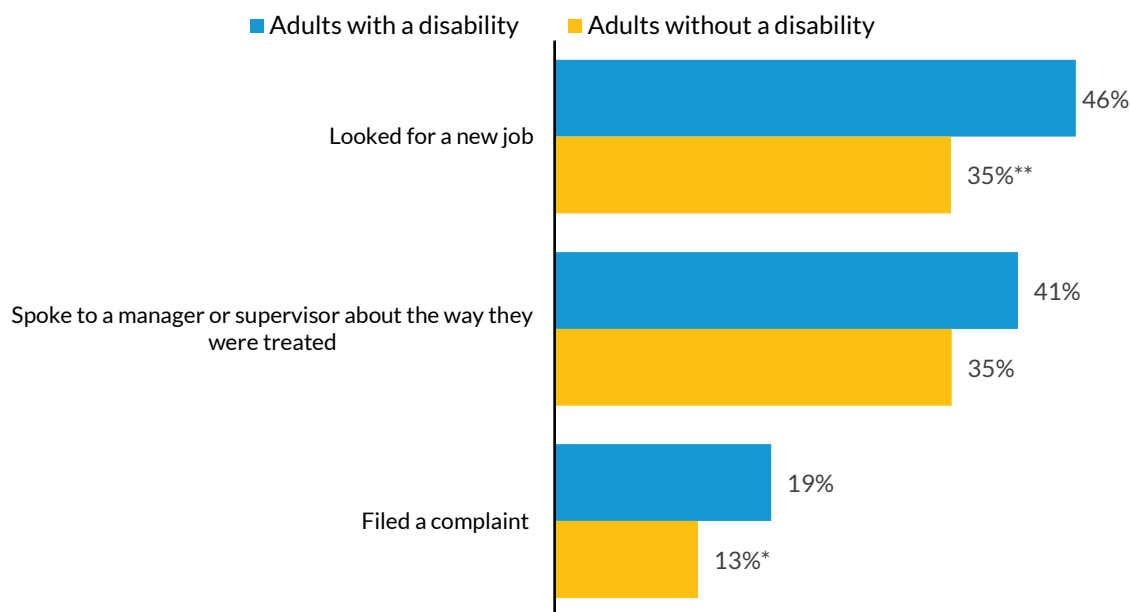
//*** Estimate differs significantly from that for adults with a disability at the 0.10/0.05/0.01 level, using two-tailed tests.

CONSEQUENCES OF UNFAIR TREATMENT AT WORK

Almost half (46 percent) of disabled adults who experienced unfair treatment in workplaces reported looking for a new job because of the unfair treatment they experienced, a share that was 11 percentage points higher than that for adults without disabilities (35 percent; figure 3). About 4 in 10 adults with disabilities (41 percent) spoke to a manager or supervisor about how they were treated, and just under 1 in 5 (19 percent) filed a complaint after the perceived unfair treatment at work.

FIGURE 3

Actions Taken in Response to Unfair Treatment or Judgment at Work in the past 12 Months, by Disability Status December 2022



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Source: Well-Being and Basic Needs Survey, December 2022.

Notes: Adults are ages 18 to 64. Respondents could have reported unfair treatment or judgment because of one or more of the following characteristics: race, ethnicity, gender, gender identity or sexual orientation, country of origin or primary language, disability or health condition, weight, income or education, or some other reason. Disability is defined as difficulties with one or more of the following: hearing; seeing; concentrating, remembering, or making decisions; walking or climbing stairs; dressing or bathing; doing errands alone; and communicating in one's own language. Respondents could report multiple actions in response to unfair treatment or judgment.

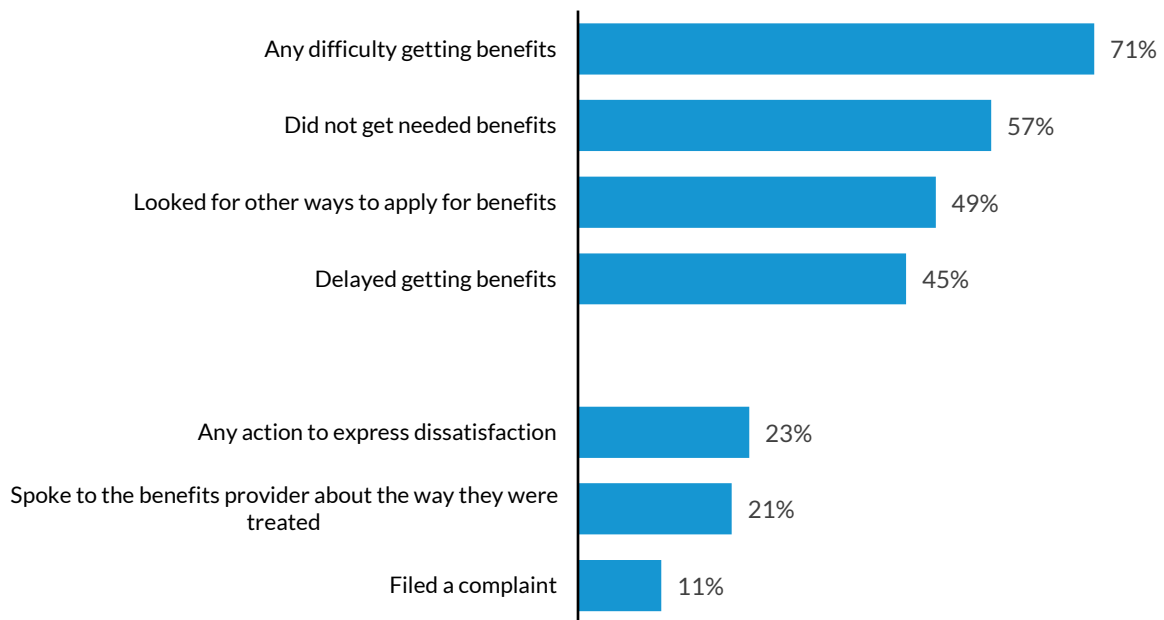
*/**/**** Estimate differs significantly from that for adults with a disability at the 0.10/0.05/0.01 level, using two-tailed tests.

CONSEQUENCES OF UNFAIR TREATMENT WHEN APPLYING FOR PUBLIC BENEFITS

Just over 7 in 10 adults with disabilities (71 percent) who experienced unfair treatment when applying for public benefits reported a problem receiving benefits because of how they were treated (figure 4). This included delaying getting benefits (45 percent), not getting needed benefits (57 percent), and looking for other ways to apply for benefits (49 percent).

Some adults with disabilities took steps to express dissatisfaction with the treatment they received when applying for benefits, including 21 percent who spoke to the benefits provider about the way they were treated and 11 percent who filed a complaint. Figure 4 does not show estimates for adults without disabilities because of small sample sizes.

FIGURE 4
Problems Getting Public Benefits and Actions Taken in Response to Unfair Treatment or Judgment When Applying for Public Benefits in the past 12 Months among Adults with Disabilities, December 2022



URBAN INSTITUTE

Source: Well-Being and Basic Needs Survey, December 2022.

Notes: Adults are ages 18 to 64. Respondents could have reported unfair treatment or judgment because of one or more of the following characteristics: race, ethnicity, gender, gender identity or sexual orientation, country of origin or primary language, disability or health condition, weight, income or education, or some other reason. Estimates for adults without disabilities are not shown because of small sample sizes. Disability is defined as difficulties with one or more of the following: hearing; seeing; concentrating, remembering, or making decisions; walking or climbing stairs; dressing or bathing; doing errands alone; and communicating in one’s own language. Respondents could report multiple actions in response to unfair treatment or judgment.

Discussion

Four in 10 nonelderly adults with disabilities reported they were treated or judged unfairly because of their personal characteristics in health care settings, at work, or when applying for public benefits in 2022, a share over twice as high as that for people without disabilities. Disabled adults’ greater average health care use and likelihood of receiving benefits may have contributed to the higher rate at which they experienced unfair treatment in health care and social service settings by exposing them to more frequent interactions. However, previous research suggests this would only account for part of the

higher rates of unfair treatment reported by disabled adults in these settings, and notwithstanding that, our findings indicate that disabled individuals are encountering unfair treatment in health care and social service settings at high rates over the course of a year (McDaniel et al. 2023).⁸ In addition, disabled adults were more likely to experience unfair treatment in the workplace despite having a lower employment rate than adults without disabilities, suggesting there are even wider disparities in unfair treatment among disabled and nondisabled workers.

The negative consequences of perceived unfair treatment also fell disproportionately on adults with disabilities. For instance, about 7 in 10 adults with disabilities who reported unfair treatment in health care settings experienced disruptions in their health care, such as delayed or forgone care, which could compromise their health and well-being. Many adults with disabilities also experienced problems receiving benefits because of the unfair treatment they received, such as delayed receipt of or not getting needed benefits, which puts them at greater risk of experiencing material hardships, stress, or having unmet health needs. In addition, repeated exposure to discriminatory treatment and marginalization have been found to have negative psychological and physiological consequences, which could contribute to worse health outcomes for people with disabilities who routinely experience unfair treatment (APA 2016; Namkung and Carr 2020).

Among those with disabilities, Black and Hispanic/Latinx adults were more likely than white adults to report unfair treatment in each setting because of their race, ethnicity, country of origin, or primary language. Our previous analyses have found that, within the overall nonelderly adult population, Black and Hispanic/Latinx adults were more likely to report unfair treatment in health care and other settings (Gonzalez et al. 2021a; 2021b). These findings underscore the role of intersectionality: in addition to bearing the stress of biases related to ableism, people of color with disabilities also encounter racism, classism, and other forms of discrimination based on social status, which compound to intensify adverse consequences of unfair treatment and mistrust in the health care system (Crenshaw 1989; Crossley 2022; Horner-Johnson 2020).

Promoting equity in health care, employment, and social service settings will require multifaceted efforts to reduce the unfair treatment of people with disabilities, including bolstering enforcement of existing antidiscrimination protections; improving disability awareness and competency training for health care providers, employers, and benefits administrators; and improving accessibility of workplaces and services.

ENFORCING ANTIDISCRIMINATION PROTECTIONS

Stronger enforcement of existing civil rights laws is a key strategy to protect people with disabilities from inequitable treatment. For instance, a recently proposed rule seeks to reinstate and bolster protections under Section 1557 of the Affordable Care Act that were weakened under the previous administration. Proposed changes include holding providers accountable for discrimination that may arise from reliance on biased clinical algorithms⁹ to drive decisionmaking in health care settings and requiring providers to ensure that their services and platforms through telehealth are accessible to people with disabilities (Obermeyer et al. 2019).¹⁰ President Biden's executive order on advancing racial

equity and support for underserved communities is another potential lever for building on enforcement, as it concerns promoting equity for people with disabilities.¹¹

Expanded access to free legal aid could also ensure greater accountability and compliance with antidiscrimination laws (Schweitzer et al. 2022). Increased education about Protection and Advocacy Systems, a network of agencies that provide legal representation and advocacy for people with disabilities, could further help ensure that the legal rights of disabled people are protected and enforced.¹²

IMPROVING DISABILITY AWARENESS AND TRAINING

Efforts to educate health care and social service providers and employers about their responsibilities under the Americans with Disabilities Act and other relevant laws and to promote disability competency training will also be needed. For example, enhancing disability curricula in medical education programs could improve physicians' understanding of disabled patients' needs (Iezzoni 2016; Meeks, Stergiopoulos, and Petersen 2022; Kaundinya and Schroth 2022). Increasing the number of disabled physicians could also lead to greater awareness of changes that address physical accessibility and communication barriers within health care settings for patients with disabilities (Iezzoni 2016).

HOLDING SYSTEMS ACCOUNTABLE

Health care systems, health insurance programs, social service agencies, and employers can monitor patterns of discrimination and unfair treatment through anonymous surveys of patients, clients, and employees.¹³ For instance, in health care settings, payers could use such information to hold health care providers and their staff accountable for reducing inequitable treatment and fostering a culture of quality improvement. In addition, building on examples of platforms where birthing people of color share reviews about their patient care experiences with and the perceived cultural competency of their health care providers, mobile applications could be developed to allow people with disabilities to provide feedback about their experiences that can help inform the choices of other patients with disabilities.¹⁴

ENHANCING PEER SUPPORT FOR NAVIGATING COMPLEX SYSTEMS

Peer-to-peer support could help disabled people access resources to address unfair treatment. In health care settings, for example, parent-mentor intervention programs connect parents with experience navigating health care for children with certain medical needs to other parents with children in similar situations. These programs have been successful in helping parents of color meet their children's health care needs and improving satisfaction with their children's care (Flores et al. 2018). Similar models could be leveraged to provide more disabled people with peer mentors who can help patients and public benefit applicants successfully navigate administrative barriers that arise in health care and social service settings and the complex systems and processes for filing applications and appeals.

IMPROVING ACCESSIBILITY

Steps to implement universal design, which entails designing environments to be “accessed, understood, and used to the greatest extent possible by all people regardless of their age, size, ability, or disability,”¹⁵

would make them more inclusive for people with disabilities. Such changes can include greater use of ergonomic tools and furniture that would benefit people with mobility difficulties and information sharing in multiple forms (i.e., visual, auditory, and written) that would benefit people with cognitive or communication difficulties in the workplace.¹⁶ In health care settings, requiring the adoption of federal criteria developed in 2017 for accessible diagnostic medical equipment (which physicians are not currently required to implement) would further improve accessibility in these settings (US Architectural and Transportation Barriers Compliance Board 2017; National Council on Disability 2021).¹⁷ A recent US Department of Health and Human Services proposed rule to further strengthen the protections in Section 504 of the Rehabilitation Act would establish enforceable standards for ensuring health care providers use accessible medical diagnostic equipment.¹⁸

In social service settings, streamlining application processes could make programs easier to apply for and navigate. Recent federal efforts calling on public benefit programs to be fair, reduce administrative burden, and better understand customers' needs and constraints (as reflected in President Biden's executive order on improving customer service experiences in government programs) could also lead to changes that improve experiences of people with disabilities and ensure that they receive public benefits for which they are eligible.¹⁹

This study has documented that many disabled adults experience unfair treatment in multiple domains in ways that undermine the continuity and quality of their health care, employment, and access to public benefits that could help them meet their basic needs. Addressing structural barriers and biases at the root of the health and well-being of disabled people will require intentional and sustained public and private sector responses developed in partnership with people with disabilities.

Appendix: Data and Methods

Data

This brief draws on data from a nationally representative sample of 7,881 adults ages 18 to 64 who participated in the Urban Institute's December 2022 Well-Being and Basic Needs Survey (WBNS). The WBNS is an internet-based survey designed to monitor changes in individual and family well-being as policymakers consider changes to federal safety-net programs. For each round of the WBNS, we draw a stratified random sample (including a large oversample of adults in low-income households) from the KnowledgePanel, a probability-based internet panel maintained by Ipsos that includes households with and without internet access. Survey weights adjust for unequal selection probabilities and are poststratified to the characteristics of nonelderly adults based on benchmarks from the Current Population Survey and American Community Survey. Participants can complete the survey in English or Spanish. For further information on the survey design and content, see Karpman, Zuckerman, and Gonzalez (2018).²⁰

Measures

DISABILITY

We measured disability status using six questions based on minimum data collection standards for disability established by the US Department of Health and Human Services and used in the American Community Survey and several other federal surveys.²¹ We also draw on another question about communication difficulties from the Washington Group Short Set on Functioning.²² We consider people as having a disability if they reported "yes" to one or more of the following questions about whether they have difficulties doing certain activities because of a health problem:

- Are you deaf or do you have serious difficulty hearing?
- Are you blind or do you have serious difficulty seeing, even when wearing glasses?
- Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?
- Do you have serious difficulty walking or climbing stairs?
- Do you have difficulty dressing or bathing?
- Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?
- Using your usual language, do you have difficulty communicating (for example, understanding or being understood)?

EXPERIENCES OF UNFAIR TREATMENT

We asked respondents whether there was a time in the past 12 months when they felt they were treated or judged unfairly in health care settings, at work, or when applying for public benefits because of any of the following: their race, ethnicity, gender, gender identity or sexual orientation, country of origin or primary language, a disability or health condition, weight, income or education, or some other reason (with an option to provide a written response). For experiences in health care settings, we also asked about unfair treatment because of health insurance coverage type.

CONSEQUENCES OF UNFAIR TREATMENT

People reporting unfair treatment in health care were asked if they took any of the following actions:

- Looked for a new health care provider
- Delayed getting care you needed
- Did not get care you needed
- Spoke to the doctor or provider about the way you were treated
- Filed a complaint
- Did not follow the doctor or provider's recommendations

- Wrote a review or shared on social media
- Other (specify)

For people reporting unfair treatment at work, we asked if they did any of the following because of the treatment they received:

- Looked for a new job
- Spoke to a manager or supervisor about the way you were treated
- Filed a complaint
- Other (specify)

For people reporting unfair treatment when applying for benefits, we asked if they did any of the following because of the treatment they received:

- Looked for other ways to apply for benefits
- Delayed getting benefits
- Did not get needed benefits
- Spoke to the benefits provider about the way you were treated
- Filed a complaint
- Other (specify)

Limitations

The WBNS has several limitations, including a low cumulative response rate, and the survey weights mitigate, but do not eliminate, potential nonresponse bias. The sampling frame for the WBNS also excludes or underrepresents certain groups of adults, including those who are homeless, have low literacy levels, and are not proficient in English or Spanish. Additionally, some people with disabilities are likely underrepresented in the survey sample, including people with visual, cognitive, and certain physical impairments. The sample also excludes adults with disabilities living in institutional settings, those ages 65 and older, and children under 18. Our questions on disability status do not fully capture the population of adults with all types of disabilities, such as those related to mental health (Hall et al. 2022). We also asked about fewer actions taken in response to or consequences resulting from the unfair treatment people reported at work; other actions or consequences, such as seeking legal help, mental health impacts, or leaving the workforce, could be relevant to people with disabilities.

Further, our measure of unfair treatment is subject to limitations. We are limited in our ability to characterize experiences of unfair treatment given that these are fully self-reported perceptions, and we cannot complement these with measures of provider or employer behavior or intent. We also cannot determine whether respondents were seeking care or benefits for themselves or someone else (e.g., a child) when they were treated or judged unfairly for the measures on unfair treatment in health care

settings and when applying for public benefits. Our estimates did not account for differences in health care use, benefit program participation, and employment that could have contributed to differences by disability status in rates of unfair treatment by exposing disabled adults to more frequent interactions in health care and social service settings and fewer interactions in employment settings. Additionally, our estimates are subject to underreporting because we asked respondents to report experiences of unfair treatment or judgment in the past 12 months, so we do not capture the experiences of people who may have experienced unfair treatment in a longer time frame or who did not see a health care provider, were not employed, or did not apply for benefits in the past 12 months, respectively. We may also be underreporting experiences of unfair treatment or judgment because respondents may not know the reason they were treated unfairly or may hesitate to classify their negative experience as discrimination without evidence (McDaniel et al. 2021).

Notes

- ¹ When referring to their disability, people have different preferences. Some see their disability as an essential part of who they are and prefer to be identified with their disability first—called identity-first language—but others prefer person-first language. In recognition of the variation in preferences, for this study, we use “people with disabilities” and “disabled people” interchangeably.
- ² Throughout this brief, references to adults who are Black or white are limited to those who are not Hispanic/Latinx. We capitalize Black to denote the unique Black experience as one characteristic of a diverse group of people, ethnicities, and cultures. The authors have not capitalized “white,” a term and label for a range of historically grouped ethnicities used to delineate a contrast with people of color. See Margaret Simms, “Say African American or Black, but First Acknowledge the Persistence of Structural Racism,” *Urban Wire* (blog), Urban Institute, February 8, 2018, <https://www.urban.org/urban-wire/say-african-american-or-black-first-acknowledge-persistence-structural-racism>. We use the term “Hispanic/Latinx” to reflect the different ways people with Latin American ancestry self-identify. Many see “Latinx” as more inclusive; unlike “Latino/a,” it is not gender specific. The term used in the Well-Being and Basic Needs Survey is “Hispanic or Latino.”
- ³ “Common Barriers to Participation Experienced by People with Disabilities,” Centers for Disease Control and Prevention, accessed September 13, 2023, <https://www.cdc.gov/ncbddd/disabilityandhealth/disability-barriers.html>.
- ⁴ Andrew Solomon, “What Happens When You’re Disabled but Nobody Can Tell,” *The New York Times*, July 10, 2020, <https://www.nytimes.com/2020/07/10/style/invisible-disabilities.html>.
- ⁵ “Guide to Disability Rights,” ADA.gov, accessed September 13, 2023, <https://www.ada.gov/resources/disability-rights-guide/>.
- ⁶ “Discrimination on the Basis of Disability,” US Department of Health and Human Services, accessed July 27, 2023, <https://www.hhs.gov/civil-rights/for-individuals/disability/index.html>.
- ⁷ Sienna Ruggeri, “The ACA’s Impact on People with Disabilities Eleven Years Later,” *Community Catalyst*, April 1, 2021, <https://communitycatalyst.org/posts/the-acas-impact-on-people-with-disabilities-eleven-years-later/>.
- ⁸ The June 2022 round of the Urban Institute’s Health Reform Monitoring Survey (HRMS) included similar questions on disability status and unfair treatment in health care settings as those that were asked in the December 2022 WBNS. The HRMS also asked about health care use in the past 12 months, including whether respondents had a routine checkup, saw or talked to their personal health care provider or any other doctors or providers, or had a telehealth visit. Our analysis of the June 2022 HRMS found that disabled adults who sought care in the past 12 months were more likely than those without disabilities who sought care to report unfair treatment because of their race, ethnicity, gender, gender identity, sexual orientation, country of origin, primary

language, health insurance coverage type, disability, health condition, weight, or income (29 percent versus 10 percent; data not shown).

- ⁹ Donna M. Christensen, Jim Manley, and Jason Resendez, “Medical Algorithms Are Failing Communities Of Color,” *Health Affairs* (blog), September 9, 2021, <https://www.healthaffairs.org/content/forefront/medical-algorithms-failing-communities-color>.
- ¹⁰ Katie Keith, “HHS Proposes Revised ACA Anti-Discrimination Rule,” *Health Affairs Forefront* (blog), July 27, 2022, <https://www.healthaffairs.org/content/forefront/hhs-proposes-revised-aca-anti-discrimination-rule>; Jennifer Lav, Elizabeth Edwards, and Georgesula Zياما, “How Changes to Section 1557 will Impact Health Care for People with Disabilities,” National Health Law Program, September 27, 2022, <https://healthlaw.org/how-changes-to-section-1557-will-impact-health-care-for-people-with-disabilities/>.
- ¹¹ “Executive Order 13985 of January 20, 2021, Advancing Racial Equity and Support for Underserved Communities Through the Federal Government,” *Federal Register* 84 (14).
- ¹² “Protection and Advocacy of Individual Rights,” Benefits.gov, accessed October 4, 2023, <https://www.benefits.gov/benefit/917>.
- ¹³ Rick Evans, Shari Berman, Esther Burlingame, and Stephanie Fishkin, “It’s Time to Take Patient Experience Measurement and Reporting to a New Level: Next Steps for Modernizing and Democratizing National Patient Surveys,” *Health Affairs Forefront* (blog), March 16, 2020, <https://www.healthaffairs.org/doi/10.1377/forefront.20200309.359946/full/>
- ¹⁴ “Irth App,” Irth, accessed August 29, 2023, <https://irthapp.com/>.
- ¹⁵ “Universal Design: What is it?” accessed July 27, 2023, <https://www.section508.gov/blog/Universal-Design-What-is-it/>.
- ¹⁶ “Inclusive Workplace Practices,” The University of Arizona Disability Resource Center, accessed July 27, 2023, <https://drc.arizona.edu/ud/inclusive-workplace-practices>.
- ¹⁷ “Standards for Accessible Medical Diagnostic Equipment,” 88 Fed. Reg. 99 (proposed May 23, 2023).
- ¹⁸ “Fact Sheet: Nondiscrimination on the Basis of Disability Proposed Rule Section 504 of the Rehabilitation Act of 1973,” US Department of Health and Human Services, updated September 7, 2023, <https://www.hhs.gov/civil-rights/for-individuals/disability/section-504-rehabilitation-act-of-1973/fact-sheet/index.html>.
- ¹⁹ “Executive Order 14058 of December 13, 2021, Transforming Federal Customer Experience and Service Delivery To Rebuild Trust in Government,” *Federal Register* 86 (239).
- ²⁰ To access the WBNS instruments, see <https://www.urban.org/research/publication/well-being-and-basic-needs-survey>.
- ²¹ “HHS Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status,” Assistant Secretary for Planning and Evaluation, October 30, 2011, <https://aspe.hhs.gov/reports/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-disability-0>.
- ²² “Washington Group Short Set on Functioning (WG-SS),” Washington Group on Disability Statistics, accessed August 22, 2023, <https://www.washingtongroup-disability.com/question-sets/wg-short-set-on-functioning-wg-ss/>.

References

- Alexander, Diane, and Molly Schnell. 2019. “The Impacts of Physician Payments on Patient Access, Use, and Health.” NBER Working Paper 26095. Cambridge, MA: National Bureau of Economic Research. <https://doi.org/10.3386/w26095>.
- Altiraifi, Azza. 2019. *Advancing Economic Security for People With Disabilities*. Washington, DC: Center for American Progress.

- APA (American Psychological Association). 2016. *Stress in America: The Impact of Discrimination*. Washington, DC: American Psychological Association.
- BLS (Bureau of Labor Statistics). 2023. "Persons with a Disability: Labor Force Characteristics—2022." Washington, DC: Bureau of Labor Statistics.
- Crenshaw, Kimberle. 1989. "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics." *University of Chicago Legal Forum* 1 (8).
- Crossley, Mary. 2022. *Embodied Injustice: Race, Disability, and Health*. Cambridge, UK: Cambridge University Press.
- de Vries McClintock, Heather F., Frances K. Barg, Sam P. Katz, Margaret G. Stineman, Alice Krueger, Patrice M. Colletti, Tom Boellstorff, and Hillary R. Bogner. 2016. "Health Care Experiences and Perceptions among People with and without Disabilities." *Disability and Health Journal* 9 (1):74–82. <https://doi.org/10.1016/j.dhjo.2015.08.007>.
- Domzal, C., Houtenville, A., and Sharma, R. 2008. *Survey of Employer Perspectives on the Employment of People with Disabilities: Technical Report*. McLean, VA: CESSI.
- Dunn, Abe, Joshua D. Gottlieb, Adam Shapiro, Daniel J. Sonnenstuhl, and Pietro Tebaldi. 2021. "A Denial a Day Keeps the Doctor Away." Working Paper 2021-80. Chicago: University of Chicago, Becker Friedman Institute for Economics.
- Flores, Glenn, Hua Lin, Candy Walker, Michael Lee, Janet Currie, Rick Allgeyer, Marco Fierro, et al. 2018. "Parent Mentoring Program Increases Coverage Rates for Uninsured Latino Children." *Health Affairs* 37 (3): 403–412. <https://doi.org/10.1377/hlthaff.2017.1272>.
- Gasper, Joseph, Martha Palan, and Benjamin Muz. 2020. *Survey of Employer Policies on the Employment of People with Disabilities*. Rockville, MD: Westat.
- Goodman, Nanette, Michael Morris, Kelvin Boston. 2019. *Financial Inequality: Disability, Race, and Poverty in America*. Washington, DC: National Disability Institute.
- Gonzalez, Dulce, Laura Skopec, Marla McDaniel, Genevieve M. Kenney. 2021a. "Perceptions of Discrimination and Unfair Judgment While Seeking Health Care." Washington, DC: Urban Institute.
- Gonzalez, Dulce, Marla McDaniel, Genevieve M. Kenney, and Laura Skopec. 2021b. "Perceptions of Unfair Treatment or Judgment Due to Race or Ethnicity in Five Settings." Washington, DC: Urban Institute.
- Gonzalez, Dulce, Genevieve M. Kenney, Claire O'Brien, Marla McDaniel, and Michael Karpman. 2022. "Publicly Insured and Uninsured Patients Are More Likely Than Other Patients to Be Treated Unfairly in Health Care Settings Because of Their Coverage Type." Washington, DC: Urban Institute.
- Graham, Kristin M., Brian T. McMahon, Jeong H. Kim, Paige Simpson, and Megan C. McMahon. 2019. "Patterns of Workplace Discrimination across Broad Categories of Disability." *Rehabilitation Psychology* 64 (2): 194–202. <https://doi.org/10.1037/rep0000227>.
- Grimm, Christi A. 2023. *High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care*. Washington, DC: Department of Health and Human Services Office of Inspector General.
- Hall, Jean P., Noelle K. Kurth, Catherine Ipsen, Andrew Myers, and Kelsey Goddard. 2022. "Comparing Measures of Functional Disability with Self-Identified Disability: Implications for Health Policy." *Health Affairs* 41 (10): 1433–1441. <https://doi.org/10.1377/hlthaff.2022.00395>.
- Heflin, Colleen M., Claire E. Altman, and Laura L. Rodriguez. 2019. "Food Insecurity and Disability in the United States." *Disability and Health Journal* 12 (2): 220–226. <https://doi.org/10.1016/j.dhjo.2018.09.006>.
- Horner-Johnson, Willi. 2020. "Disability, Intersectionality, and Inequity: Life at the Margins." In *Public Health Perspectives on Disability*, edited by Donald J. Lollar, Willi Horner-Johnson, and Katherine Froehlich-Grobe, 91–105. New York: Springer Nature.
- Iezzoni, Lisa I. 2016. "Why Increasing Numbers of Physicians with Disability Could Improve Care for Patients with Disability." *American Medical Association Journal of Ethics* 18 (10):1041–1049. <https://doi.org/10.1001/journalofethics.2016.18.10.msoc2-1610>.

- Iezzoni, Lisa I., Sowmya R. Rao, Julie Ressler, Dragana Bolcic-Jankovic, Nicole D. Agaronnik, Karen Donelan, Tara Lagu, and Eric G. Campbell. 2021. "Physicians' Perceptions of People with Disability and Their Health Care." *Health Affairs* 40 (2): 297–306. <https://doi.org/10.1377/hlthaff.2020.01452>.
- Karpman, Michael, Stephen Zuckerman, and Dulce Gonzalez. 2018. "The Well-Being and Basic Needs Survey." Washington, DC: Urban Institute.
- Krahn, Gloria L., Deborah K. Walker, and Rosaly Correa-De-Araujo. 2015. "Persons with Disabilities as an Unrecognized Health Disparity Population." *American Journal of Public Health* 105 (S2): S198–S206. <https://doi.org/10.2105/AJPH.2014.302182>.
- Kaundinya, Trisha, and Samantha Schroth. 2022. "Dismantle Ableism, Accept Disability: Making the Case for Anti-Ableism in Medical Education." *Journal of Medical Education and Curricular Development* 9. <https://doi.org/10.1177/23821205221076660>.
- Lagu, Tara, Carol Haywood, Kimberly Reimold, Christene DeJong, Robin Walker Sterling, and Lisa I. Iezzoni. 2022. "'I Am Not the Doctor for You': Physicians' Attitudes about Caring for People with Disabilities." *Health Affairs* 41 (10): 1387–1395. <https://doi.org/10.1377/hlthaff.2022.00475>.
- Lindsay, Sally, Kristina Fuentes, Sharmigaa Rangunathan, Luiza Lamaj, and Jaclyn Dyson. 2022. "Ableism within Health Care Professions: A Systematic Review of the Experiences and Impact of Discrimination against Health Care Providers with Disabilities." *Disability and Rehabilitation* 45 (17): 2715–2731. <https://doi.org/10.1080/09638288.2022.2107086>.
- Lindsay, Sally, Kristina Fuentes, Vanessa Tomas, and Shaelynn Hsu. 2023. "Ableism and Workplace Discrimination among Youth and Young Adults with Disabilities: A Systematic Review." *Journal of Occupational Rehabilitation* 33: 20–36. <https://doi.org/10.1007/s10926-022-10049-4>.
- McDaniel, Marla, Michael Karpman, Genevieve M. Kenney, Heather Hahn, and Eleanor Pratt. 2023. "Customer Service Experiences and Enrollment Difficulties Vary Widely across Safety Net Programs." Washington, DC: Urban Institute.
- McDaniel, Marla, Audrey Richardson, Dulce Gonzalez, Clara Alvarez Caraveo, Laura Wagner, and Laura Skopec. 2021. *Black and African American Adults' Perspectives on Discrimination and Unfair Judgment in Health Care*. Washington, DC: Urban Institute.
- Meeks, Lisa M., Erene Stergiopoulos, and Kristina H. Petersen. 2022. "Institutional Accountability for Students With Disabilities: A Call for Liaison Committee on Medical Education Action." *Academic Medicine* 97 (3): 341–345. <https://doi.org/10.1097/ACM.0000000000004471>.
- Mitra, Monika, Linda Long-Bellil, Ian Moura, Angel Miles, and H. Stephen Kaye. 2022. "Advancing Health Equity And Reducing Health Disparities For People With Disabilities In The United States." *Health Affairs* 41 (10): 1379–1386. <https://doi.org/10.1377/hlthaff.2022.00499>.
- Moynihan, Donald, Pamela Herd, and Hope Harvey. 2015. "Administrative Burden: Learning, Psychological, and Compliance Costs in Citizen-State Interactions." *Journal of Public Administration Research and Theory* 25 (1): 43–69. <https://doi.org/10.1093/jopart/muu009>.
- Musumeci, MaryBeth, and Kendal Orgera. 2020. "People with Disabilities Are At Risk of Losing Medicaid Coverage without the ACA Expansion." San Francisco: Kaiser Family Foundation.
- Musumeci, MaryBeth, Sweta Haldar, Emma Childress, Samantha Artiga, and Jennifer Tolbert. 2022. "A 50-State Review of Access to State Medicaid Program Information for People with Limited English Proficiency and/or Disabilities Ahead of the PHE Unwinding." San Francisco: Kaiser Family Foundation.
- Namkung, Eun Ha, and Deborah Carr. 2019. "Perceived Interpersonal and Institutional Discrimination among Persons with Disability in the U.S.: Do Patterns Differ by Age?" *Social Science and Medicine* 239: e112521. <https://doi.org/10.1016/j.socscimed.2019.112521>.
- . 2020. "The Psychological Consequences of Disability over the Life Course: Assessing the Mediating Role of Perceived Interpersonal Discrimination." *Journal of Health and Social Behavior* 61 (2): 190–207. <https://doi.org/10.1177/0022146520921371>.

- Obermeyer Ziad, Brian Powers, Christine Vogeli, and Sendhil Mullainathan. 2019. “Dissecting Racial Bias in an Algorithm Used to Manage the Health of Populations.” *Science* 366(6464):447-53.
- Peacock, Georgina, Lisa I. Iezzoni, and Thomas R. Harkin. 2015. “Health Care for Americans with Disabilities—25 Years after the ADA.” *The New England Journal of Medicine* 373 (10): 892–3. <https://doi.org/10.1056/NEJMp1508854>.
- Polsky, Daniel, Michael Richards, Simon Basseyn, Douglas Wissoker, Genevieve M. Kenney, Stephen Zuckerman, and Karin V. Rhodes. 2015. “Appointment Availability after Increases in Medicaid Payments for Primary Care.” *New England Journal of Medicine* 372: 537–45. <https://doi.org/10.1056/NEJMsa1413299>.
- Pratt, Eleanor, Marla McDaniel, Heather Hahn, Jennifer M. Haley, Dulce Gonzalez, Soumita Bose, Sarah Morriss, and Laura Wagner. 2023. “Improvements in Public Programs’ Customer Service Experiences Could Better Meet Enrollees’ Needs and Help Build Trust in Government.” Washington, DC: Urban Institute.
- Schur, Lisa, Kyongji Han, Andrea Kim, Mason Ameri, Peter Blanck, and Douglas Kruse. 2017. “Disability at Work: A Look Back and Forward.” *Journal of Occupational Rehabilitation* 27: 482–497. <https://doi.org/10.1007/s10926-017-9739-5>.
- Schweitzer, Justin, Emily DiMatteo, Nick Buffie, and Mia Ives-Ruble. 2022. *How Dehumanizing Administrative Burdens Harm Disabled People*. Washington, DC: Center for American Progress.
- Vallas, Rebecca, Kim Knackstedt, Hayley Brown, Julie Cai, Shawn Fremstad, and Andrew Stettner. 2022. *Economic Justice Is Disability Justice*. New York, NY: The Century Foundation.
- VanPuymbrouck, Laura, Carli Friedman, and Heather Feldner. 2020. “Explicit and Implicit Disability Attitudes of Healthcare Providers.” *Rehabilitation Psychology* 65 (2):101–112. <https://psycnet.apa.org/doi/10.1037/rep0000317>.
- Yee, Silvia, Mary Lou Breslin, Tawara D. Goode, Susan M. Havercamp, Willi Horner-Johnson, Lisa I. Iezzoni, and Gloria Krahn. 2017. Compounded Disparities: Health Equity at the Intersection of Disability, Race, and Ethnicity. Paper presented at The National Academies of Sciences, Engineering and Medicine.

About the Authors

Dulce Gonzalez is a research associate in the Health Policy Center at the Urban Institute. She forms part of a team working on the Urban Institute’s Well-Being and Basic Needs Survey. Gonzalez conducts quantitative and qualitative research focused primarily on the social safety net, immigration, and barriers to health care access. Her work has also focused on the impact of the COVID-19 pandemic on nonelderly adults and their families. Before joining Urban, Gonzalez worked at the Georgetown University Center for Children and Families and the nonprofit organization Maternal and Child Health Access. Gonzalez holds a BA in economics from California State University, Long Beach, and a master’s degree in public policy from Georgetown University.

Genevieve M. Kenney is a vice president and senior fellow in the Health Policy Center. She is a nationally renowned expert on Medicaid, the Children’s Health Insurance Program (CHIP), and health insurance coverage; health care access and quality; and health outcomes for low-income adults, children, and families. She has played a lead role in several Medicaid and CHIP evaluations, including multiple congressionally mandated CHIP evaluations, and has conducted state-level evaluations of the implementation of managed care and other service delivery reform initiatives and policy changes in Medicaid and CHIP. Currently, she is leading a project focused on health equity that involves working with a community advisory board and is assessing Medicaid policies related to postpartum coverage and

the unwinding of the Medicaid continuous coverage requirement. She received a master's degree in statistics and a doctoral degree in economics from the University of Michigan.

Michael Karpman is a principal research associate in the Health Policy Center. His work focuses on quantitative analysis related to health insurance coverage, access to and affordability of health care, use of health care services, and health status. His work includes overseeing and analyzing data from the Urban Institute's Health Reform Monitoring Survey and Well-Being and Basic Needs Survey. Before joining Urban in 2013, Karpman was a senior associate at the National League of Cities Institute for Youth, Education, and Families. He received his MPP from Georgetown University.

Sarah Morriss is a research assistant in the Health Policy Center. She analyzes data and provides assistance with questionnaire development for Urban's Health Reform Monitoring Survey and Well-Being and Basic Needs Survey. She also contributes to policy briefs and papers on topics related to health equity, health care access, and families' experiences with federal safety net programs. Her research interests include disability and mental health policy issues. Morriss has a bachelor's degree in economics and public policy from the University of Chicago.

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500 L'Enfant Plaza SW
Washington, DC 20024
www.urban.org

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