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Om Samir Ghetia

omghetia@gmail.com

University of Connecticut Health Center: UConn Health https://orcid.org/0000-0003-3206-1193

Josie G. Ford

University of Connecticut School of Medicine

Lucia F. Duenas-Bianchi

University of Connecticut School of Medicine

Taiwo Folake Ajibola

University of Connecticut Health Center: UConn Health

YunQi Wang

University of Connecticut Department of Statistics

Sarah Grady

Holy Cross College

Kyrinda Richardson

Urban League of Greater Hartford

David Hopkins

Urban League of Greater Hartford

Helen Wu

University of Connecticut Department of Psychiatry https://orcid.org/0000-0001-8968-9286

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Authors: Om S. Ghetia MPH[1], Josie G. Ford BS[3], Lucia F. Duenas-Bianchi MPH MD[2,3], Taiwo Folake Ajibola MPH[1], YunQi Wang[3,4], Sarah Grady[5], Kyrinda Richardson[6], David Hopkins[6], Helen Wu PhD[1,2]

Affiliations:

[1]University of Connecticut School of Medicine, Public Health Sciences, Farmington, CT

[2]University of Connecticut School of Medicine, Departments of Psychiatry, Farmington, CT

[3]University of Connecticut School of Medicine, Farmington, CT

[4]University of Connecticut Department of Statistics, Storrs, CT

[5]College of the Holy Cross, Worcester, MA

[6]Urban League of Greater Hartford, Hartford, CT

Corresponding author:

Helen Wu, PhD

Associate Professor

Department of Psychiatry

Department of Public Health Sciences

University of Connecticut Medical School

261 Farmington Ave

Farmington, CT 06030

zwu@uchc.edu

Abstract

Medicare and Medicaid policy projections often emphasize downstream consequences, such as coverage loss, but may overlook concerns arising before implementation. Through an established community survey platform with the Urban League of Greater Hartford, we conducted an anonymous rapid survey in December 2025 and March 2026 to assess anticipated quality-of-life impacts of potential policy changes. Among 109 respondents with outcome data, 58.7% anticipated negative impacts. Negative impact was not significantly associated with insurance type (65.5% Medicare/Medicaid vs. 50.0% private/other; P = .103) but was significantly associated with food insecurity (74.5% vs. 47.9%; P = .008) and assistance program participation (71.4% vs. 48.3%; P = .015). These findings suggest that anticipated quality-of-life concerns may emerge before measurable policy consequences, particularly among urban residents experiencing food-related vulnerabilities. Rapid community assessments may help identify emerging concerns associated with safety-net policy uncertainty before changes in coverage, healthcare utilization, or health outcomes become measurable.

Keywords: Medicare; Medicaid; food insecurity; quality of life; rapid community assessment; sentinel surveillance

Introduction.

National forecasts project that Medicare and Medicaid policy changes under Public Law 119-21 will result in 10 million more uninsured individuals by 2034 and major SNAP cuts [1,2]. These projections emphasize downstream effects but overlook the pre-implementation period, when residents may already anticipate changes to healthcare, food access, finances, and daily supports. Prior policy changes show that harm can begin in this window: after Arkansas implemented Medicaid work requirements in 2018, more than 18,000 adults lost coverage, and one-third of targeted adults had not heard of the policy [3]. For safety-net–reliant populations, uncertainty may itself have negative effects. Anticipatory stress—the physiological and behavioral response to an uncertain future threat [4]—may emerge before policy changes are implemented and contribute to changes in healthcare-seeking and other daily behaviors [5,6].

Existing data systems are poorly positioned to capture this window. National surveys report estimates long after collection and describe the average resident of a jurisdiction rather than the people community programs serve. Race and ethnicity data are also uncertain: recent federal changes have removed race and ethnicity breakdowns from some national datasets [7], and health records can misrecord race, particularly for multiracial and Hispanic patients; at one academic medical center, race was misrecorded for 13% of patients [8]. Sentinel surveillance addresses a similar problem by monitoring purposively selected sites, trading representativeness for timeliness [9]. Applying this logic, we used an established community survey platform to examine whether anticipated quality-of-life impact, defined as perceived well-being across health, material, and daily-life domains [10], varied by insurance status, food insecurity, and reported assistance program participation among Greater Hartford residents.

Methods.

Hartford, Connecticut's capital, has concentrated urban poverty, substantial racial and ethnic diversity, and high reliance on public programs. More than 26% of residents live in poverty, about 42% are enrolled in Medicaid, and SNAP use is 38% citywide [11-14]. These characteristics make Hartford a well-suited setting for examining safety-net policy uncertainty.

The rapid community survey platform was established by university public health researchers and physicians in partnership with the Urban League of Greater Hartford and other community agencies. Guided by community-based participatory research [15] and the National Academy of Medicine's Assessing Meaningful Community Engagement framework [16], researchers and community partners select survey topics together. Brief, anonymous surveys are administered at recurring community events at sites chosen for their reach to residents served by partner programs rather than for representativeness. Each survey has two parts. Core questions, developed with community partners and repeated across surveys, cover demographics, household composition, insurance, employment, dietary habits, and food insecurity using a validated two-item screen [17], allowing persistent needs to be tracked over time. Topic questions are added as new community concerns arise; topics have included medically tailored meals, digital health literacy, liver health, physical activity, and, in this study, potential Medicare and Medicaid policy changes. Responses are harmonized across survey versions using a variable crosswalk. Medical, graduate, and undergraduate students from UConn and other Connecticut state universities, who volunteer at partner community activities, assist with survey development, administration, and data entry. Since spring 2023, they have participated through the UConn School of Medicine Lifestyle Medicine Interest Group, formally approved by the American College of Lifestyle Medicine. Since 2022, approximately 700 surveys have been collected at more than 15 community events.

The study used a rapid, cross-sectional anonymous community survey conducted in December 2025 and March 2026. Because findings were consistent across the two collection periods, data were pooled for analysis. This program underwent review by the UConn Health Institutional Review Board and received Determination Outcome HSD–GP1779. Participation was voluntary and anonymous, and verbal informed consent was obtained from all participants before survey completion. No personally identifying information was collected. Participants were recruited through convenience sampling at community sites; the sample was not intended to be representative, and findings should not be interpreted as population-level prevalence estimates. Because the number of individuals approached was not recorded, a conventional response rate could not be calculated.

The primary outcome was perceived quality-of-life impact, based on the survey item, "if policy changes to Medicaid/Medicare programs were reduced/eliminated, how might this affect your quality of life?" Perceived quality-of-life impact was measured from −5 to +5 and categorized as negative (<0), neutral (0), or positive (>0), then dichotomized as negative versus neutral/positive for primary analyses. Vulnerability indicators included insurance status (Medicare/Medicaid vs. private/other), food insecurity [17], and reported assistance program participation. Respondents were asked whether they or a family member participated in programs including SNAP, Meals on Wheels, homecare/personal-care programs, and other assistance programs, with multiple selections permitted. Selecting at least one program was classified as reported assistance program participation. Because no explicit "none" response option was provided, respondents with no program selected could not be distinguished from those who did not answer the item and were classified as no assistance program reported. Respondents also indicated anticipated effects of potential policy changes using a select-all-that-

apply item covering healthcare access, basic needs, financial well-being, and reliance on community resources. Demographic characteristics included race/ethnicity, education, employment status, and household composition. For optional select-all-that-apply items, such as household composition and cardiometabolic risk, nonselection could not be interpreted as absence of the characteristic and was treated as missing. Associations between negative perceived quality-of-life impact and vulnerability indicators were assessed using chi-square or Fisher's exact tests, as appropriate. Statistical significance was defined as $\alpha = .05$. Analyses stratified by collection period were used to assess consistency of findings before pooling.

Results.

Among 109 respondents, 64 (58.7%) anticipated that proposed Medicare/Medicaid policy changes would negatively affect their quality of life, compared with 45 (41.3%) anticipating no impact or a positive impact (Table 1). Negative anticipated impact was significantly associated with food insecurity (74.5% vs. 47.9%; P = .008) and reported assistance program participation (71.4% vs. 48.3%; P = .015). In exploratory bivariate analyses, quality-of-life impact also varied by race/ethnicity (P = .018) and employment status (P = .043). Medicare or Medicaid beneficiaries were more likely than those with private or other insurance to anticipate a negative impact (65.5% vs. 50.0%), although the difference was not significant (P = .103). No statistically significant associations were detected for age, gender, or education. Household composition and cardiometabolic risk comparisons were limited by substantial nonresponse/nonselection.

Among respondents anticipating a negative impact, the most common concerns were increased stress about health or finances (50.0%), difficulty obtaining medical care (46.4%), and cutting back on food or other essentials (41.1%) (Figure 1). Other concerns included losing daily support (26.8%) and skipping medications or appointments (17.9%). Respondents anticipating

no impact most often reported no concerns (60.0%), while 10.5% anticipating a positive impact cited improved access to services or providers. Several effects differed across quality-of-life groups ($P < .05$).

Discussion.

In this rapid community survey, negative anticipated quality-of-life impact was common overall and particularly evident among residents with food-related resource vulnerabilities. Although the proportion was also higher among Medicare/Medicaid beneficiaries than among those with private/other insurance, this difference was not statistically significant. Responses suggest that Medicare/Medicaid policy uncertainty may already be reflected in concerns about medication access, healthcare access, and access to food and other essentials. Prior research similarly shows that insurance coverage uncertainty is associated with delayed healthcare access, difficulty managing conditions, and anxiety about future medical expenses, even before coverage loss occurs [18].

What we know already exists regarding this issue.

Medicaid unwinding and SNAP retrenchment have contributed to coverage loss, interrupted access, and worse health outcomes [19-24]. Administrative burden can create learning, compliance, and psychological costs before formal implementation [5, 6]. Current surveillance largely captures downstream effects rather than pre-implementation responses.

What this study adds

Traditional surveillance may miss the period when residents anticipate and respond to policy uncertainty [5, 6, 18, 25]. Our findings suggest these concerns may emerge before implementation. Food-insecure residents were significantly more likely to anticipate negative quality-of-life impacts ($P = .008$), while Medicare/Medicaid beneficiaries also reported greater

negative impacts, although this difference was not statistically significant. Because the survey was fielded through an established community platform, these concerns were documented within months of enactment and before major provisions take effect. Early identification may help urban communities and providers target support as safety-net policies evolve.

Limitations of this study

The small convenience sample from a single community platform limits generalizability. Because respondents were not followed over time, the study cannot assess within-person change, and the observational design does not permit causal inference. The primary outcome was purpose-built and not independently validated, and the policy item addressed potential changes broadly rather than specific provisions.

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Author Contributions

Om S. Ghetia contributed to investigation, data collection, formal analysis, and writing of the original draft. Josie G. Ford and Lucia F. Duenas-Bianchi contributed to participant recruitment and data collection. Taiwo Folake Ajibola contributed to data collection and formal analysis. YunQi Wang contributed to formal analysis. Sarah Grady contributed to data collection. Kyrinda Richardson and David Hopkins facilitated community engagement and provided access to the Urban League of Greater Hartford as a community-based study site. Helen Wu served as principal investigator and provided study supervision and oversight. All authors reviewed and approved the final manuscript.

Statements and Declarations

Ethical Considerations

This program underwent review by the UConn Health Institutional Review Board and received Determination Outcome HSD–GP1779.

Consent to Participate

Participation in the anonymous community survey was voluntary. Verbal informed consent was obtained from all participants before survey completion, and no personally identifying information was collected.

Consent for Publication

Not applicable.

Declaration of Conflicting Interest

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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Data Availability

The data generated and analyzed during this study are not publicly available because of participant privacy and ethical considerations but may be available from the corresponding author upon reasonable request and subject to applicable institutional and ethical requirements.

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Figure Legends

Fig. 1 Anticipated effects of potential Medicare and Medicaid policy changes by perceived quality-of-life impact. Bars show the percentage of respondents selecting each anticipated effect, stratified by negative, neutral, or positive anticipated quality-of-life impact. Asterisks indicate statistically significant associations with quality of life ($P < .05$). Missing responses were excluded

Alt text: Grouped horizontal bar chart comparing 10 anticipated effects across negative, neutral, and positive quality-of-life impact groups. The negative group had higher percentages for increased stress about health or finances (50.0%), trouble getting medical care (46.4%), cutting back on food or essentials (41.1%), and losing important daily supports (26.8%), while 60.0% of the neutral group reported no concerns or expected effect. Asterisks identify statistically significant associations with quality of life ($P < .05$).

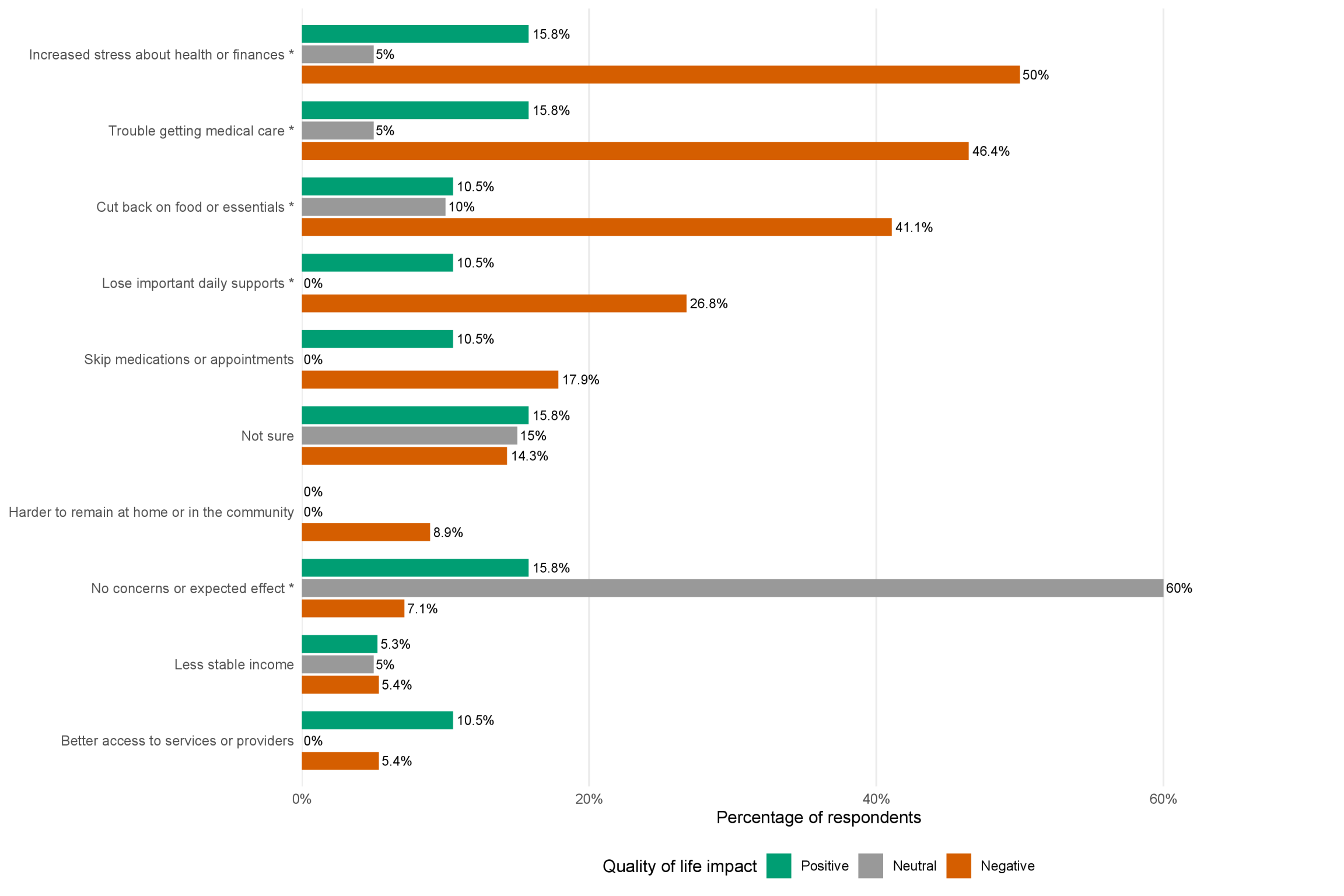
Table I. Descriptive characteristics by negative versus neutral/positive anticipated quality-of-life impact

Characteristic	Total n = 109	Negative n = 64	Neutral/Positive n = 45	P value
Age, % (n)				0.098
18-29	11.0% (12)	75.0% (9)	25.0% (3)	
30-39	32.1% (35)	48.6% (17)	51.4% (18)	
40-49	24.8% (27)	48.1% (13)	51.9% (14)	
50+	32.1% (35)	71.4% (25)	28.6% (10)	
Gender, % (n)[a]				0.099
Female	76.1% (83)	62.7% (52)	37.3% (31)	
Male	21.1% (23)	43.5% (10)	56.5% (13)	
Missing	2.8% (3)	66.7% (2)	33.3% (1)	
Race/Ethnicity, % (n)				0.018
White	8.3% (9)	55.6% (5)	44.4% (4)	
Black or African American	45.0% (49)	73.5% (36)	26.5% (13)	
Hispanic	24.8% (27)	44.4% (12)	55.6% (15)	
Other	14.7% (16)	37.5% (6)	62.5% (10)	
Missing	7.3% (8)	62.5% (5)	37.5% (3)	
Education, % (n)				0.226
College/more	35.8% (39)	48.7% (19)	51.3% (20)	
Some college	22.0% (24)	54.2% (13)	45.8% (11)	
High school/GED	26.6% (29)	72.4% (21)	27.6% (8)	
Less than High School	3.7% (4)	50.0% (2)	50.0% (2)	
Missing	11.9% (13)	69.2% (9)	30.8% (4)	
Employment status, % (n)				0.043
Full time (≥40 hours a week)	39.4% (43)	44.2% (19)	55.8% (24)	
Part time (<40 hours)	13.8% (15)	66.7% (10)	33.3% (5)	
Not working/ homemaker	17.4% (19)	73.7% (14)	26.3% (5)	
Retired	10.1% (11)	81.8% (9)	18.2% (2)	
Missing	19.3% (21)	57.1% (12)	42.9% (9)	
Insurance type, % (n)				0.103
Private/Other	45.9% (50)	50.0% (25)	50.0% (25)	
Medicare/Medicaid	53.2% (58)	65.5% (38)	34.5% (20)	
Missing	0.9% (1)	100.0% (1)	0.0% (0)	
Food insecurity, % (n)				0.008

Characteristic	Total n = 109	Negative n = 64	Neutral/Positive n = 45	P value
Food secure	44.0% (48)	47.9% (23)	52.1% (25)	
Food insecure	43.1% (47)	74.5% (35)	25.5% (12)	
Missing	12.8% (14)	42.9% (6)	57.1% (8)	
Reported Assistance Program Participation, % (n)				0.015
No assistance program reported[b]	55.0% (60)	48.3% (29)	51.7% (31)	
≥1 assistance program reported	45.0% (49)	71.4% (35)	28.6% (14)	
Minors (under 18 years old) in household, % (n)				1.000
No minors	0.9% (1)	100.0% (1)	0.0% (0)	
Has minors	49.5% (54)	53.7% (29)	46.3% (25)	
Missing	49.5% (54)	63.0% (34)	37.0% (20)	
Cardiometabolic risk, % (n)				0.072
Risk score 0	4.6% (5)	20.0% (1)	80.0% (4)	
Risk score ≥1	46.8% (51)	64.7% (33)	35.3% (18)	
Missing	48.6% (53)	56.6% (30)	43.4% (23)	

[a] Gender information was not reported for three respondents and was classified as missing.

[b] The survey did not include an explicit “none” response option; therefore, “no assistance program reported” includes respondents who did not select a listed program and those who may not have answered the item.


Increased stress about health or finances *
15.8%
5%
50%
Trouble getting medical care *
15.8%
5%
46.4%
Cut back on food or essentials *
10.5%
10%
41.1%
Lose important daily supports *
10.5%
0%
26.8%
Skip medications or appointments
10.5%
0%
17.9%
Not sure
15.8%
15%
14.3%
Harder to remain at home or in the community
0%
0%
8.9%
No concerns or expected effect *
15.8%
60%
7.1%
Less stable income
5.3%
5%
5.4%
Better access to services or providers
10.5%
0%
5.4%
0%
20%
40%
60%
Percentage of respondents
Quality of life impact
Positive
Neutral
Negative