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Health Disparities in Employer-Sponsored Insurance

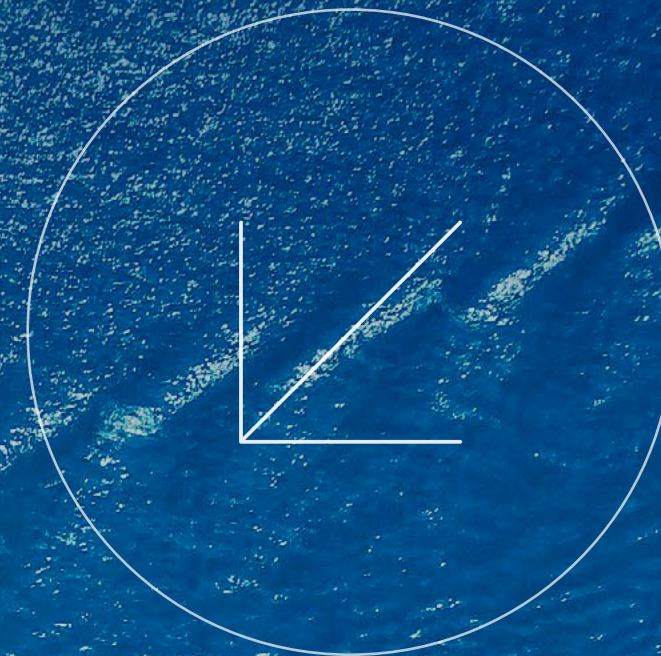


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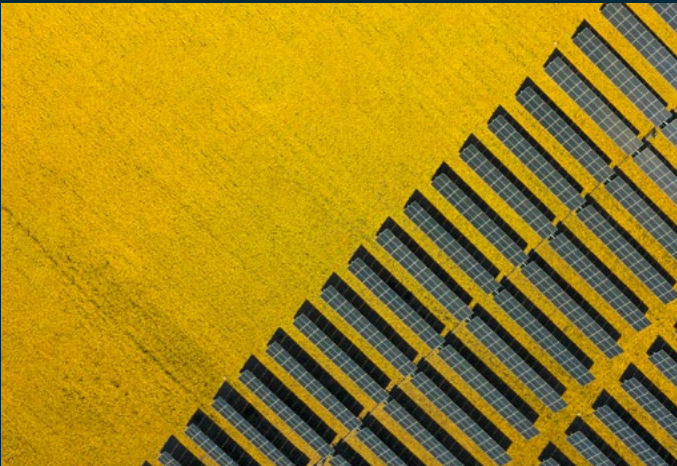
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Executive Summary



01

With 180 million covered lives, employer-sponsored insurance (ESI) is the most common type of coverage in the U.S. and offers access to high-quality health care for many consumers. But despite significant investments by both employers and their employees in health care, some populations see stark disparities in access to services and health outcomes. Some of these disparities have lessened over time, while others stubbornly persist. To assess these disparities and track their evolution, Morgan Health developed a snapshot of health outcomes and disparities among individuals with ESI.

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Lower-income individuals with ESI are less connected to basic health care.

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Lesbian, Gay and Bisexual (LGB) individuals with ESI experience greater mental health needs and substance use.

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Black, Hispanic and Asian individuals with ESI had significantly better mental health and lower rates of substance use than white counterparts.

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Black, Hispanic and Asian populations with ESI interacted with their health care with varying levels of affordability and notable gaps in preventive care.

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Black and Hispanic individuals with low-risk pregnancies delivered by cesarean section at higher rates.

01

Lower-income individuals in ESI are less connected to basic health care.

Alarming, data showed that the lowest income group (<\$50,000) had less connection to primary care – meaning they were less likely to have a usual source of care and more likely to seek care from the emergency department. Of note, 4.4 percentage points fewer of those in the lowest income group had a usual source of care and 3.0 points higher reported visiting the emergency department 2+ times in the prior year compared to those in the highest income group.

Unsurprisingly, the lowest income group continues to shoulder a higher burden of their health care costs and are less likely to receive preventive care – adding to a growing body of evidence showing that income and health outcomes are directly linked. In fact, the lowest income group (<\$50,000) reported difficulty paying medical bills - 20.1 points higher than the highest income group.

02

Lesbian, Gay and Bisexual (LGB) individuals with ESI experience greater mental health needs and substance use.

LGB individuals had higher rates of mental health treatment overall and also specifically among all people with depression: 18.8% compared to 4.1% of Straight individuals. The silver lining here, though, is that LGB individuals had a high willingness to seek help and engage in mental health services. Compared to Straight-identified individuals, LGB individuals were significantly more likely (more than twice as much) to report having seen a doctor about their mental health and receiving treatment.

LGB individuals also had higher rates of tobacco use; alcohol use, including drinking behavior considered as alcohol abuse or dependence; and illicit drug use, including at levels considered illicit drug abuse or drug dependence. Most notably, illicit drug use for LGB individuals was 14.9% compared to 8% for Straight individuals.

03

Black, Hispanic and Asian individuals with ESI had significantly better mental health and lower rates of substance use than white counterparts.

Compared to their white counterparts, Black, Hispanic and Asian individuals had lower mental health burden and less need for mental health care. This includes lower prevalence of serious psychological distress, depression, or major depressive episode in the prior year.

However, one notable disparity emerged among those with depression: Asian individuals with depression had statistically significantly lower rates (4X less likely) of getting treatment than whites, yet they were impacted by depression at the same rate. This likely points to a stigma in the Asian community associated with receiving care. We believe these are two untold stories within the mental health space that require additional attention and focus.

04

Black, Hispanic and Asian populations with ESI interacted with their health care with varying levels of affordability and notable gaps in preventive care.

A few key distinctions:

Asian individuals reported fewer financial barriers to care (11.2% reported difficulty paying for medical care) and had mixed evidence of preventive health care use.

Hispanic individuals reported lower financial burden of care (14.8% reported difficulty paying for medical care), but had consistently lower rates of preventive health care use.

Black individuals had higher financial burden of care (18.5% reported difficulty paying for medical care), and higher rates of preventive health care use.

*For reference, 13.8% of white individuals reported difficulty paying for medical care.

05

Black and Hispanic individuals with low-risk pregnancies delivered by cesarean section at higher rates than white individuals.

Black and Hispanic individuals had significantly higher rates of delivery by cesarean section, while Asian individuals had a lower rate. Yet, for low-risk pregnancies specifically, Black, Hispanic and Asian individuals experienced higher rates of cesarean section deliveries.

All C-section Deliveries:

White Women	32.5%
Black Women	41.8%
Asian Women	31.8%
Hispanic Women	35.8%

Low Risk C-sections:

White Women	13.7%
Black Women	20.4%
Asian Women	17.6%
Hispanic Women	17.1%



“To make improvements in employer-sponsored health care, we must first understand where disparities exist within the ESI population.”

Bea Capistrant | Vice President

Introduction



02

Employer-sponsored health insurance (ESI) is the largest source of health insurance coverage in the U.S., serving almost 180 million Americans.

Despite the breadth of the ESI market, the health status and health outcomes of enrollees are not well understood. To date, most ESI research has focused on the economic value of employer-provided health insurance, the cost of medical care and insurance (including out-of-pocket costs), utilization of health care services and access to care. Furthermore, research examining health disparities and inequities in ESI is limited. Historical data gaps related to race, ethnicity and income tied to ESI claims limit what health disparities researchers can currently study in claims-based analyses. Many survey-based or qualitative studies include data on income, race and sexual orientation but lack health-related data to enable a comparison of health behaviors or health outcomes across race and income levels.

Morgan Health is committed to improving health outcomes, reducing disparities and helping to make care more affordable for those with ESI. To make improvements in employer-sponsored health care, we must first understand where disparities exist within the ESI population.

As part of this commitment, Morgan Health sought to establish a snapshot of health status for those with ESI, the nation's largest health insurance segment.

The analysis examines engagement in preventive health behaviors, health outcomes associated with chronic conditions, maternal health, substance use and behavioral health conditions and access to care and food insecurity.

The analysis includes descriptive statistics, along with age, race/ethnicity and income-adjusted differences between population subgroups. This work will support future analyses focused on affordability, health disparities, health outcomes and social needs in the ESI market during and after the pandemic.

Methods



03

This report updates the analysis in our [2022 report](#)¹ and uses the same methods throughout this analysis. In short, this report used 2021 data from three nationally representative surveys – National Health Interview Survey (NHIS), National Study on Drug Use and Health (NSDUH), and the National Vital Statistics System (NVSS) – to evaluate income, racial, and sexual orientation-based disparities in population health and health care utilization metrics.

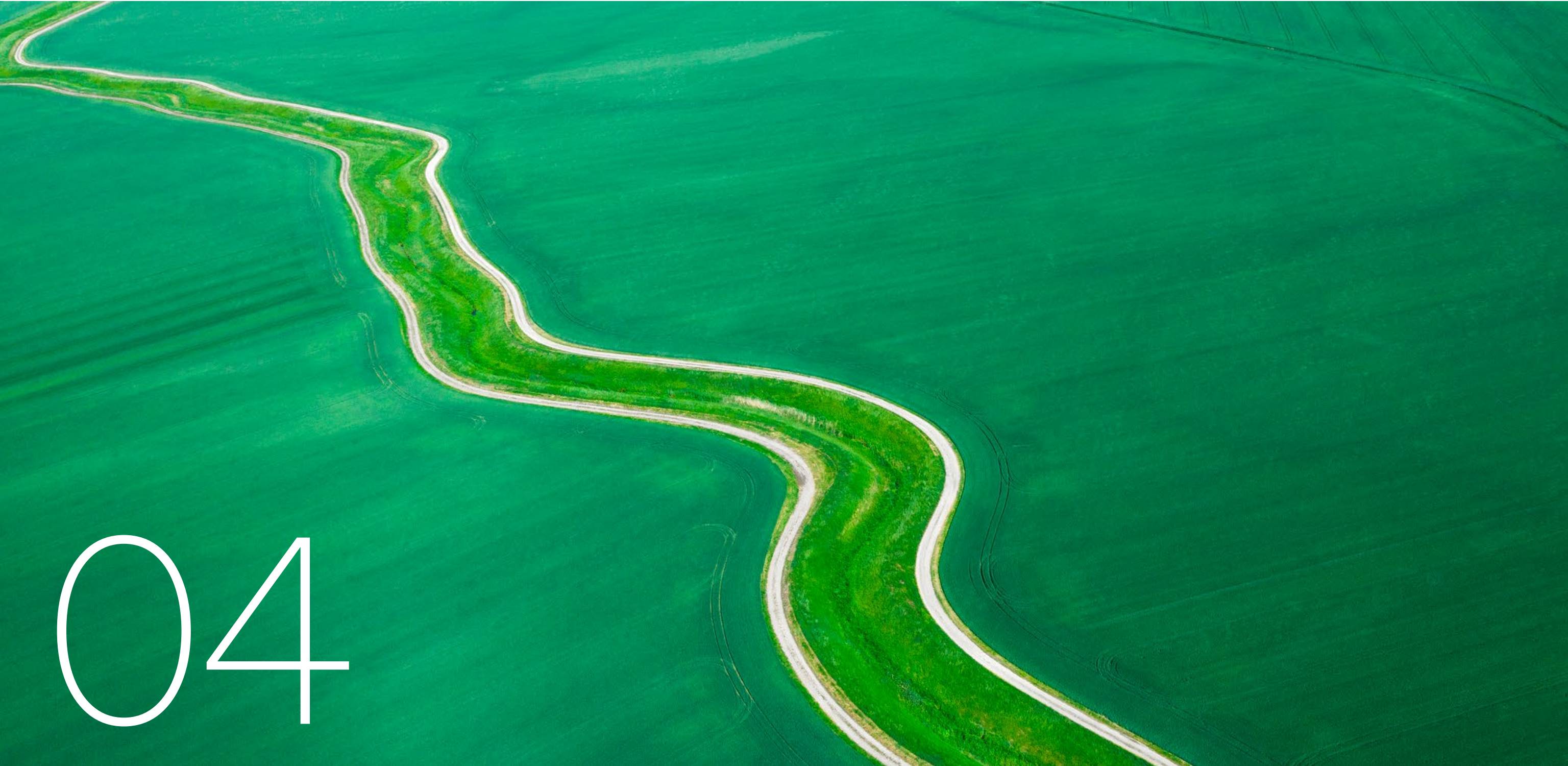
We used weighted analyses that accounted for the complex samples of these surveys to estimate prevalence of a condition, prevalence adjusted for age and sex, and prevalence adjusted for age, sex, and race/ethnicity and/or income. We present adjusted prevalence estimates for an example, common person covered by ESI: a white man (or woman for cervical cancer screenings) aged 45-54 making \$50,000-\$74,999 per year. For maternal outcomes, we only age and race adjust; those estimates reflect a 30-34 year old woman who gave birth.

A group's prevalence is reported as a percent, and the disparity is calculated as the absolute difference between two groups' percents. The units of the disparity or difference metric is thus percentage points (or simply 'points'). For example, if Group 1 had 20% and Group 2 had 5% prevalence of a metric, the difference, or disparity, is 15 points.

The other data source from the previous report (NHANES) was not available at the time of the analysis. NHIS changed its study design in 2019 such that some questions were no longer asked annually, so some questions, especially on mental health were omitted.

We used NSDUH data on mental health in lieu of NHIS data; however, NSDUH includes three income groups, so the income disparities are between three income groups instead of five. NSDUH changed its data collection process during 2020 because of COVID, and comparisons should not be made to previous analyses with NSDUH data. Additional details on our methodology can be found in the [2022 report](#).

Findings



04

Finding 1:

Significant and profound disparities between lowest and highest income groups

Income levels and primary care access inextricably linked

Lower income levels reported visiting ED two or more times a year – often a pattern among those who lack access to primary care

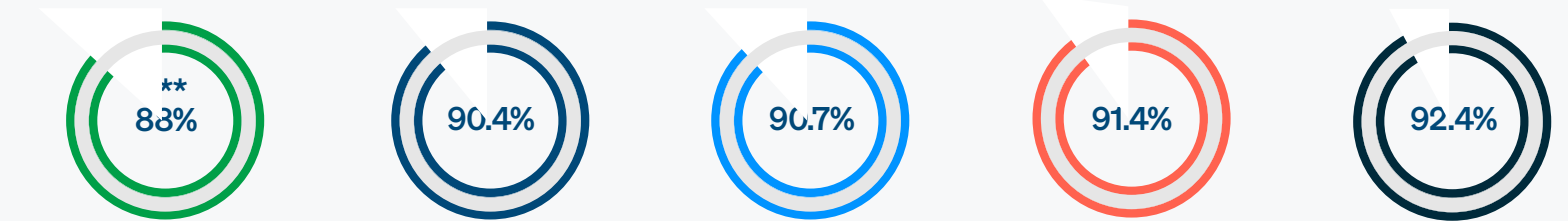
Compared to those with the highest income (\$150,000+), people covered by ESI in the lowest income groups were significantly less likely to have a “usual source” of care; 4.4% fewer of those in the lowest income group (<\$50,000) had a usual source of care. These patterns were similar, and still statistically significant, after accounting for age, sex, and race/ethnicity. Since the overall rate in the population is quite high – 91.3% of adults with ESI report having a usual source of care – seemingly modest income disparities are notable.

Individuals with lower income are seeking care at the emergency department significantly more often than people in the highest income group. The lowest three groups reported using the ED in the last year significantly more than the highest income group: 6.4, 5.8, and 4.1 percentage points higher, respectively, after adjusting for age, sex, and race. Lower income individuals’ ED use was more frequent: they were also significantly more likely to have used the ED 2+ times in the last year (3.0 points for the lowest percentages; 2.1 points for the second lowest) than the highest income group.

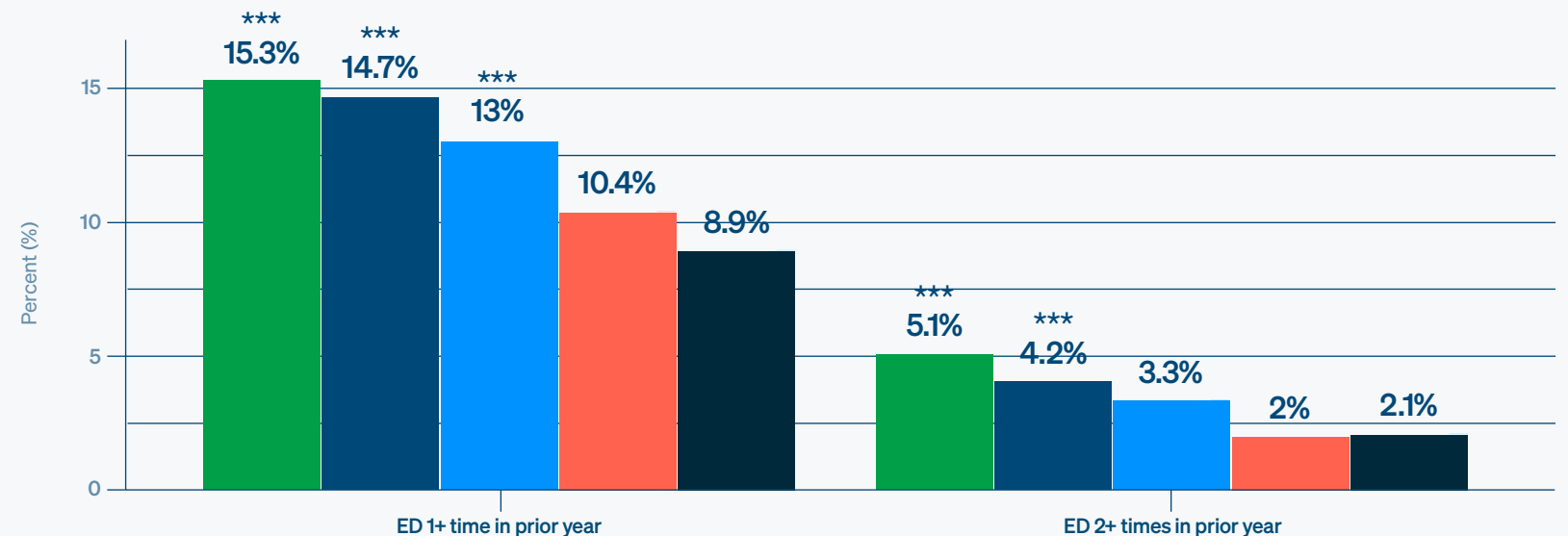
While our analysis was unable to test whether individuals used care from the ED as a substitute for primary care, other evidence [has](#) shown that pattern. The results suggest that primary care-focused initiatives can help reverse these disparities:

- Targeted incentives to connect lower-income individuals to a usual source of care, and
- Clinical programs and/or plan incentives to divert costly ED use, especially for avoidable visits.

People With a Usual Source of Care



Emergency Department Use



Income Group ● <\$50,000 ● \$50,000–\$74,999 ● \$75,000–\$100,000 ● \$100,000–\$149,999 ● ≥\$150,000

*** p<0.001, ** p<0.01, * p<0.05. Asterisks indicate p-value for test difference for an income group vs. ≥\$150,000 income group. Estimates are adjusted for age, sex, and race/ethnicity; percent prevalence is shown for an average white male aged 45-54. Source: National Health Interview Survey (NHIS), 2021

Finding 1:

Significant and profound disparities between lowest and highest income groups (Continued)

Lower income groups skipping doctor visits, foregoing medication adherence

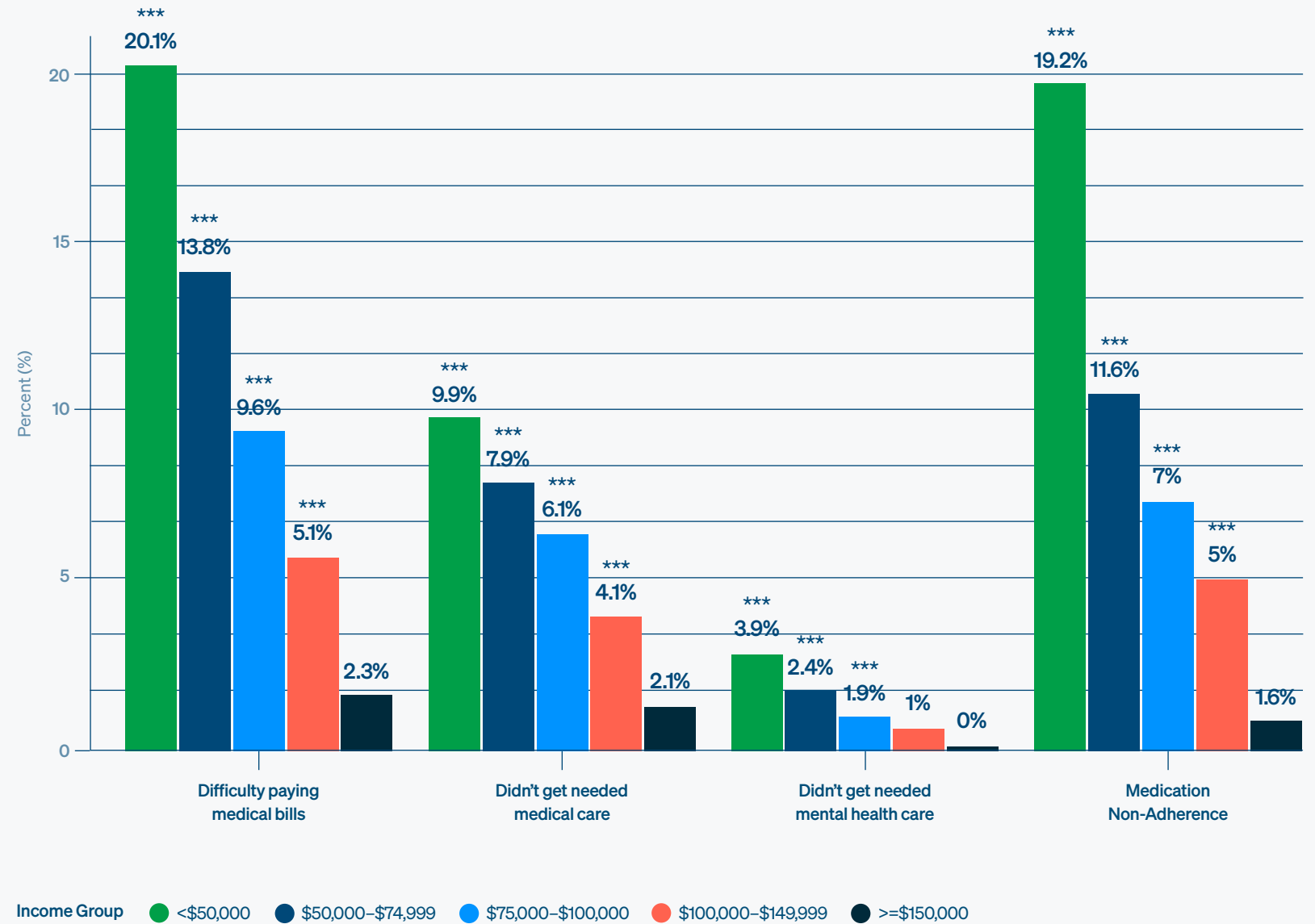
One-fifth of patients in the lowest income group skipped the medications due to cost.

Every income group below \$150,000 reported significantly higher financial barriers to care than the highest income group, including difficulty paying medical bills, delaying care because of cost, and not adhering to medications as prescribed due to cost. The lowest income group (<\$50,000) reported difficulty paying medical bills — 20.1 points higher than the highest income group, after adjusting for age, sex, and race/ethnicity. This gradient of significant income disparities persisted across all income groups.

Beyond having difficulty paying medical bills, lower income groups delayed and skipped necessary care and medications because of cost. Compared to the highest income group, individuals with ESI in lower income groups reported delaying and not getting needed care for both medical and mental health due to cost at significantly higher rates. There was also significantly higher reports of not following medication treatment as prescribed due to cost. The most common ways lower income groups adapted their medications to save money were delaying filling prescriptions, taking less medication, and not filling prescriptions due to cost.

Employers may want to consider structuring health plans and pharmacy coverage to address these disparities through expanding care covered without a co-payment and wider access to medications common among lower income employees. Employers may also benefit a great deal from evaluating whether these gaps expand under current, historic rates of inflation.

Impact of Health Care Costs



*** p<0.001, ** p<0.01, * p<0.05. Asterisks indicate p-value for test difference for an income group vs. >=\$150,000 income group. Estimates are adjusted for age, sex, and race/ethnicity; percent prevalence is shown for an average white male aged 45-54. Source: National Health Interview Survey (NHIS), 2021

Finding 1:

Significant and profound disparities between lowest and highest income groups (Continued)

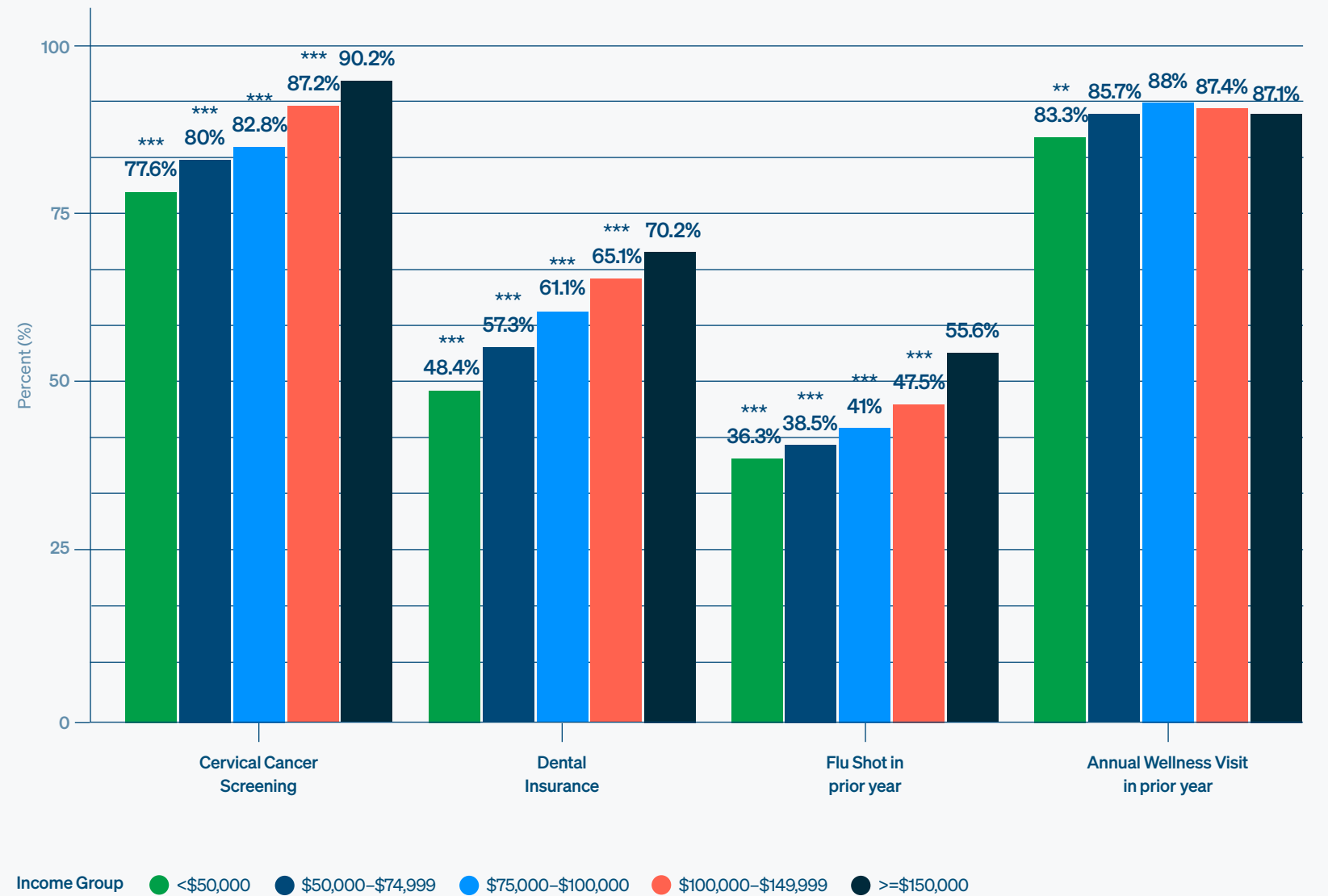
Key preventive health services often seen as optional among lower income groups

Lowest income groups got influenza vaccine 20% less often than the highest income group and well below the national average

All lower income groups were less likely to have received preventive vaccines, cancer screenings, or have non-medical coverage like dental or vision insurance. The lowest income group received the influenza vaccine at a rate nearly 20 points lower than the highest income group in the previous year, and 12.5 points lower on cervical cancer screenings than the highest income group. The lowest income group was also significantly less likely to have had an annual wellness visit in the past 12 months.

Employers may want to incentivize screenings, preventive vaccines, and wellness visits. Given the connection between oral and physical health, additional education about benefits and plan design for costs of dental insurance – especially for lower income employees – may be useful to consider to improve employee population health.

Preventive Health Care Metrics



*** p<0.001, ** p<0.01, * p<0.05. Asterisks indicate p-value for test difference for an income group vs. >=\$150,000 income group. Estimates are adjusted for age, sex, and race/ethnicity; percent prevalence is shown for an average white male aged 45-54. Source: National Health Interview Survey (NHIS), 2021

Finding 1:

Significant and profound disparities between lowest and highest income groups (Continued)

Lower income individuals prioritize access to mental health services / treatment – underscoring the disproportionate impact across income groups

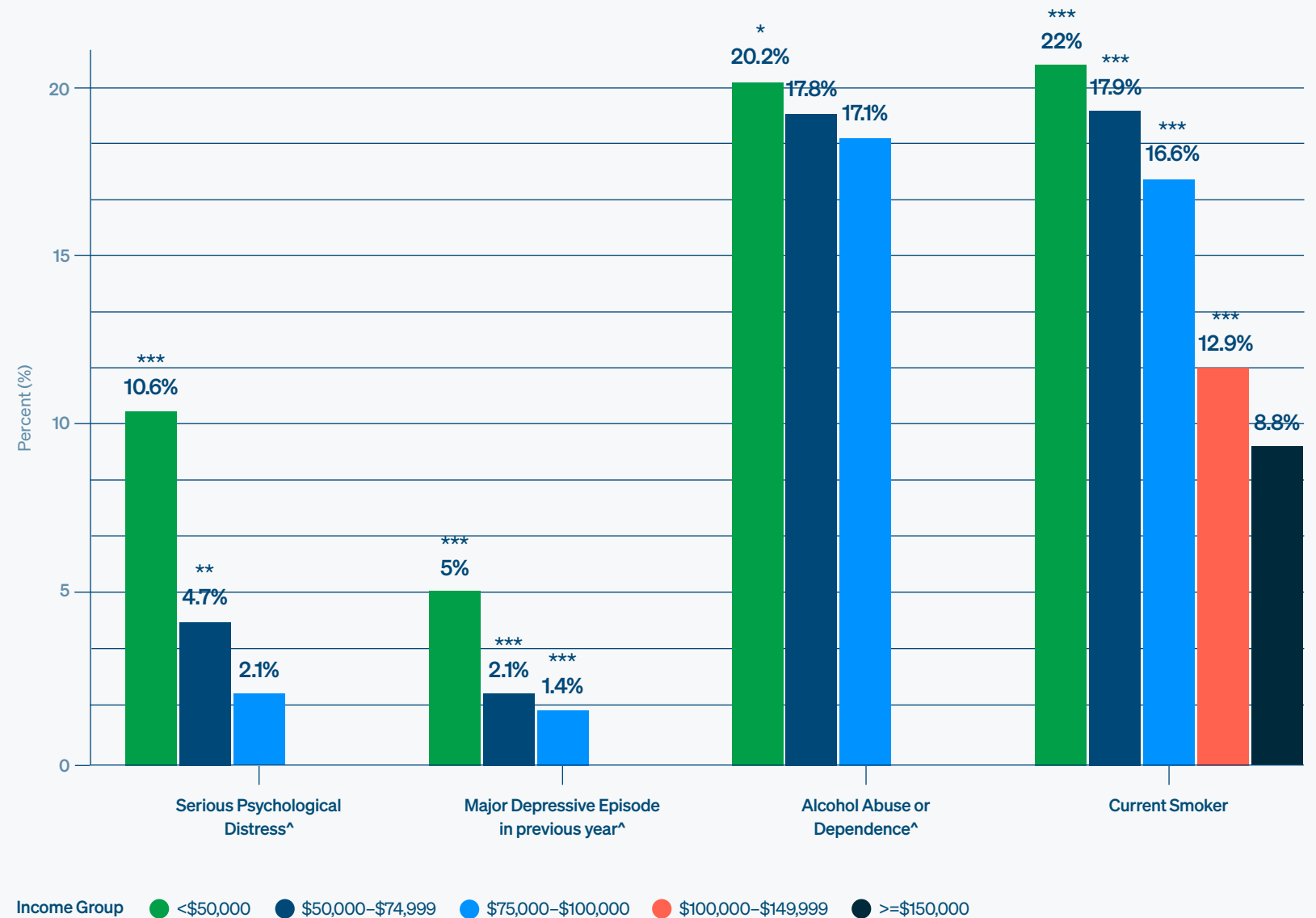
Lower income individuals reported seeing a doctor about feelings 7.9% more frequently than higher income individuals.

As a group, lower income individuals had substantially higher prevalence of psychological distress, depressive symptoms consistent with a clinical diagnosis of depression, and a major depressive episode in the last year – more than twice the rate of individuals in the highest income group. These data come from a survey where the highest income category they collect is \$75,000+, so the mental health and substance use disparities only have the lower three income categories; the comparison is still from the lowest to the top income group (<\$50,000 vs. \$75,000+). Despite lower income individuals having lower mental health than higher income individuals, they were more likely to be receiving care: of those with depression, lower income individuals reported seeing a doctor about feelings 7.9 points higher than higher income individuals, after adjusting for age, sex and race .

Substance use was also significantly higher among lower income individuals with ESI than higher income individuals. All lower income individuals were significantly more likely to currently use tobacco products than the highest income group. For the lowest income group, they were also significantly more likely to have alcohol and illicit drug use consistent with clinical definitions of alcohol or illicit drug abuse or dependence.

Services like expanded EAP offerings, smoking cessation and substance use treatment programs that are incentivized for lower income employees, and plan design to further expand mental health care access and use may all be considered to address this dimension of income-based health disparities.

Mental Health and Substance Use Metrics



[^] The mental health, alcohol, and drug use data come from National Survey on Drug Use and Health, which top codes income at ≥\$75,000. *** p<0.001, ** p<0.01, * p<0.05. Asterisks indicate p-value for test difference for an income group vs. ≥\$150,000 income group. Estimates are adjusted for age, sex, and race/ethnicity; percent prevalence is shown for an average white male aged 45-54. **Source:** National Health Interview Survey, 2021; National Study on Drug Use and Health (NSDUH), 2021

Finding 2:

Pronounced sexual orientation disparities in mental health and substance use

High willingness to engage in mental health services among LGB

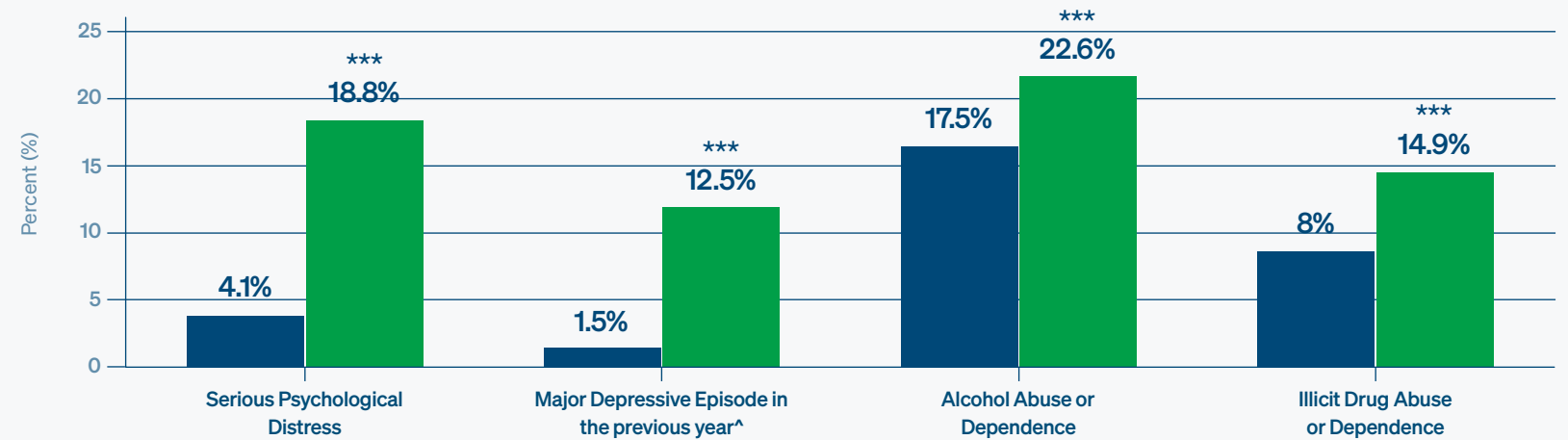
While this suggests there is less stigma associated with mental health care among LGB individuals, the extent of mental health and substance use burden remains significant.

Consistent with our previous report and other evidence on sexual orientation health disparities,^{iv,vii,viii} lesbian, gay and bisexual (LGB) individuals have rates of mental health conditions like severe psychological distress and prevalence of major depressive episode in the previous year that are substantially higher – more than double – their Straight counterparts, after adjusting for age, sex, race and income. LGB individuals also use alcohol and illicit drugs in an amount consistent with abuse or dependence at significantly higher rates than Straight counterparts with ESI.

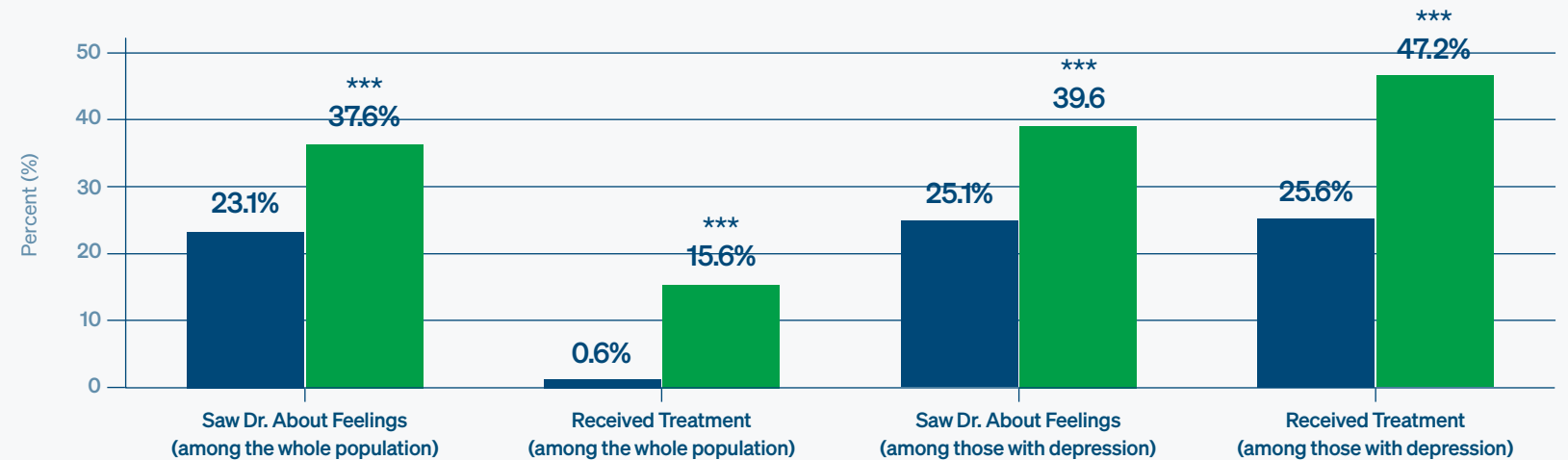
Despite the much higher burden of mental health conditions and substance use, LGB individuals with ESI have higher rates of using mental health services – across the entire ESI population as well as among those who have a history of depression. LGB individuals are substantially more likely – more than twice as much – to be receiving treatment for mental health conditions than Straight counterparts.

This suggests that stigma for mental health care and treatment may be lower for LGB individuals, and LGB individuals may have a high willingness to engage in mental health care. However, given the extent of mental health and substance use burden, additional incentives and tailored solutions should be offered to LGB individuals, like an expanded network of LGB therapists and EAP services.

Mental Health and Substance Use Metrics



Mental Health Care and Treatment Metrics



Sexual Orientation ● Straight ● Lesbian, Gay, or Bisexual

*** p<0.001, ** p<0.01, * p<0.05. Asterisks indicate p-value for test difference for LGB individuals vs. Straight counterparts. Estimates are adjusted for age, sex, income, and race/ethnicity; percent prevalence is shown for an average white male aged 45-54 with \$50,000-74,999 income. Source: National Study on Drug Use and Health (NSDUH), 2021

Finding 3:

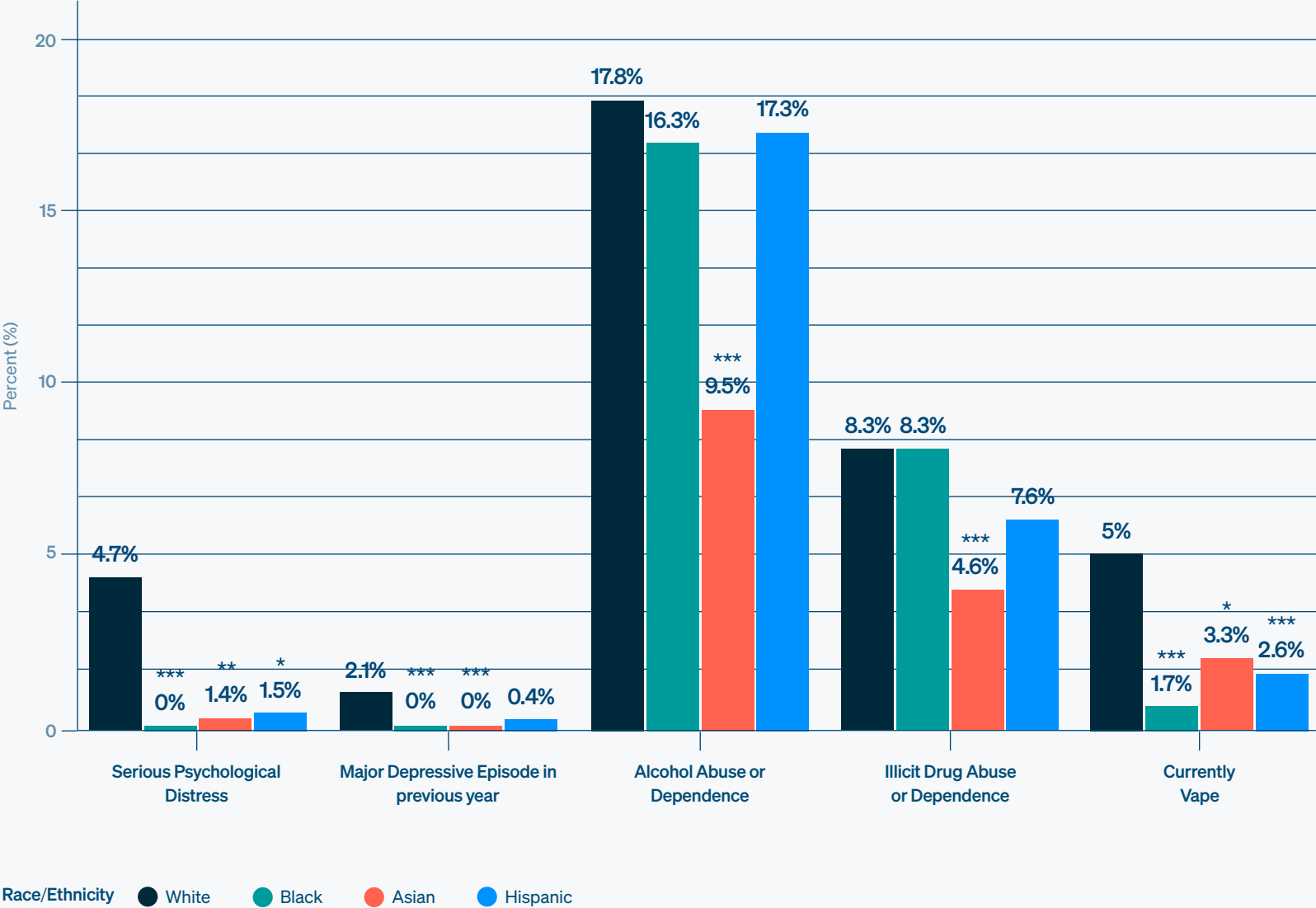
Disparities in Mental Health, Preventive Care and Financial Barriers by Race

Non-white individuals experience better mental health overall

Across non-white individuals, there are similar or lower rates of alcohol and illicit drug abuse or dependence

Compared to white individuals with ESI, individuals in all other race/ethnicity groups with ESI reported better mental health: every group had a significantly lower prevalence of psychological distress, and most groups had significantly lower experience of major depressive episodes in the last year. There were also similar or lower rates of alcohol and illicit drug abuse or dependence – significantly so for Asian individuals compared to white individuals – and an overall lower use of e-cigarettes or vaping.

Mental Health and Substance Use



*** p<0.001, ** p<0.01, * p<0.05. Asterisks indicate p-value for test difference for each race/ethnicity groups vs. white. Estimates are adjusted for age, sex, and income; percent prevalence is shown for an average male aged 45-54 with \$50,000-74,999 income. Source: National Study on Drug Use and Health (NSDUH), 2021

Finding 3:

Disparities in Mental Health, Preventive Care and Financial Barriers by Race (Continued)

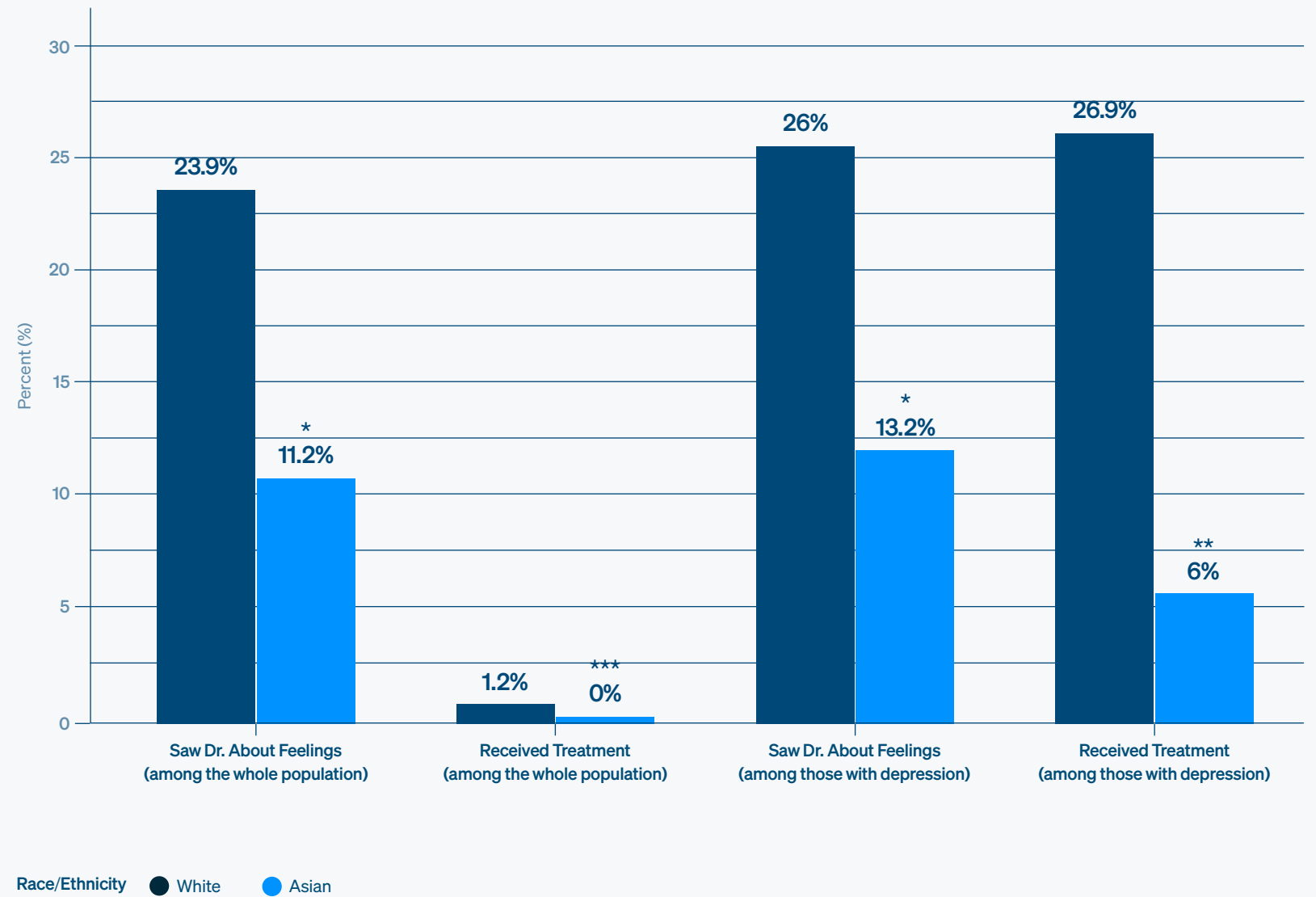
Asian individuals less likely to seek help/treatment for mental health

Compared to white individuals, Asian individuals with depression were 5x less likely to receive treatment – underscoring the need for additional research to overcome potential barriers and stigma.

Asian individuals saw mental health providers and received mental health treatment at significantly lower rates than white individuals (all other groups were not statistically significant). The lower burden of mental health among Asian individuals with ESI likely accounts for the lower use of mental health care among the whole population.

However, Asian individuals with depression were significantly less likely to receive treatment, which highlights a key disparity and opportunity for additional research and solutions. Outreach to and collaboration with employee resource groups for Asian employees and partnering with external organizations could help understand these dynamics and co-create tailored solutions to close this mental health treatment gap.

Mental Health Treatment Gaps



*** p<0.001, ** p<0.01, * p<0.05. Asterisks indicate p-value for test difference for each race/ethnicity groups vs. white. Estimates are adjusted for age, sex, and income; percent prevalence is shown for an average male aged 45-54 with \$50,000-74,999 income. Source: National Study on Drug Use and Health (NSDUH), 2021

Finding 3:

Disparities in Mental Health, Preventive Care and Financial Barriers by Race (Continued)

Distinct patterns of disparities in preventive care and financial burdens for Black, Asian and Hispanic individuals

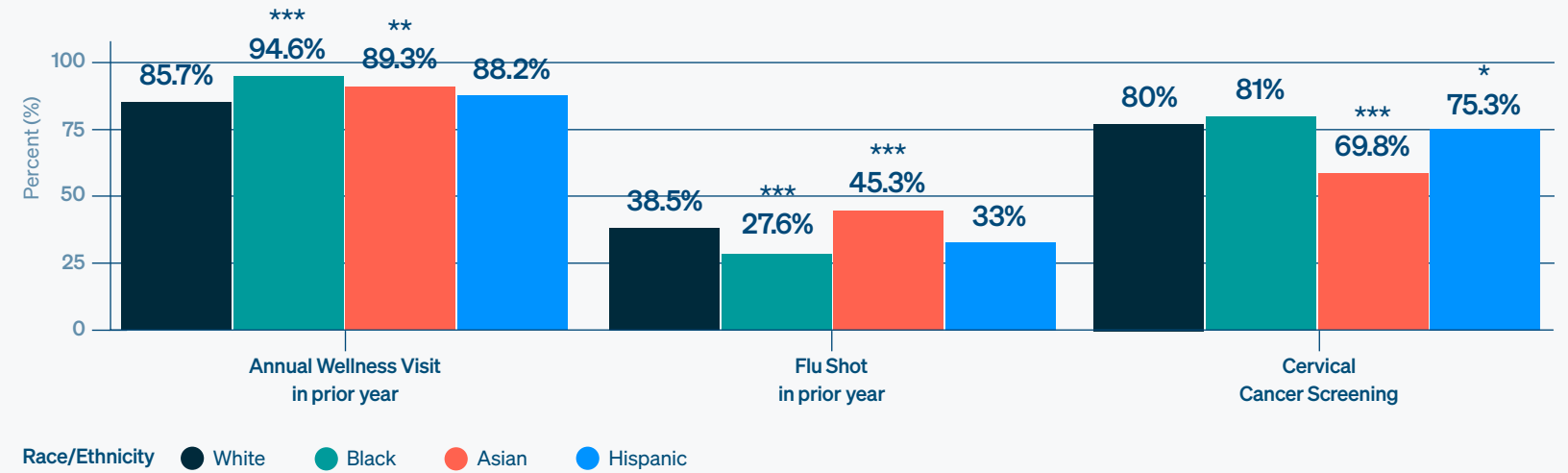
Tailored approaches by race/ethnicity are needed to improve preventive care use

Despite generally similar overall health care utilization – no significant differences in the prevalence of a usual source of care, and Asian individuals significantly using the ED less than white individuals – and similar rates of supplemental, non-medical insurance, there were some idiosyncratic patterns of preventive care use and financial burdens by race/ethnicity.

Black individuals generally had higher rates of preventive care, like wellness visits and cancer screenings, than white individuals with a notable exception: significantly lower rates of receiving a flu shot in the prior year. Black individuals were slightly – but not significantly – less likely to delay medical care due to cost than white individuals. However, they had significantly higher rates of difficulty paying medical bills than white individuals.

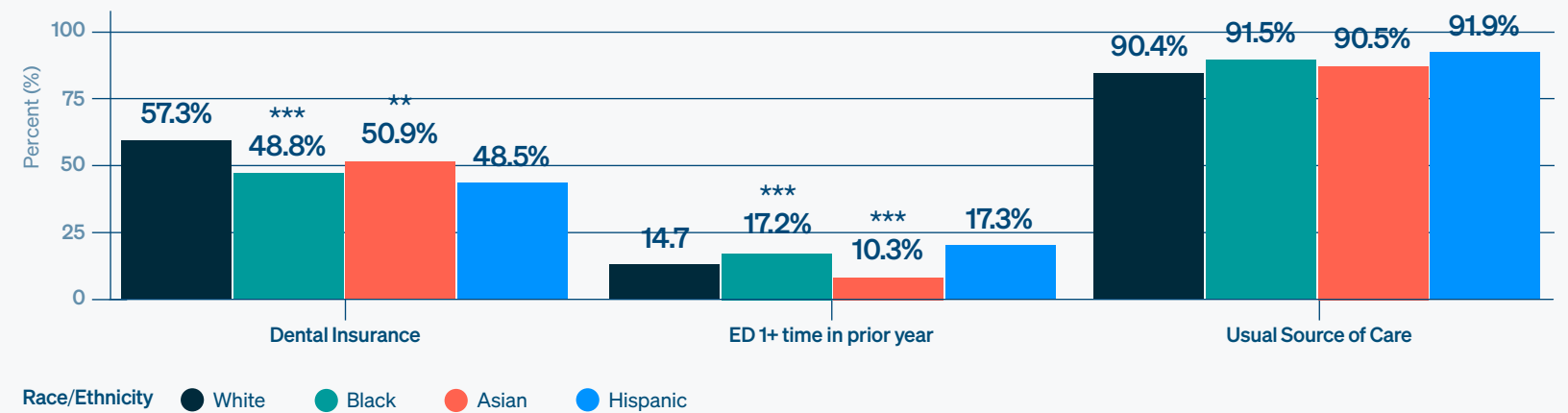
Black individuals generally had higher rates of preventive care, like wellness visits and cancer screenings, than white individuals with a notable exception: significantly lower rates of receiving a flu shot in the prior year. Black individuals were slightly less, but not significantly so, likely to delay medical care due to cost than whites individuals. However, they had significantly higher rates of difficulty paying medical bills than white individuals.

Preventive Health Care Metrics



*** p<0.001, ** p<0.01, * p<0.05. Asterisks indicate p-value for test difference for each race/ethnicity groups vs. white. Estimates are adjusted for age, sex, and income; percent prevalence is shown for an average male (or woman for cervical cancer) aged 45-54 with \$50,000-74,999 income. Source: National Health Interview Survey (NHIS)

Insurance Coverage and Access to Care



*** p<0.001, ** p<0.01, * p<0.05. Asterisks indicate p-value for test difference for each race/ethnicity groups vs. white. Estimates are adjusted for age, sex, and income; percent prevalence is shown for an average male aged 45-54 with \$50,000-74,999 income. Source: National Health Interview Survey (NHIS), 2021

Finding 3:

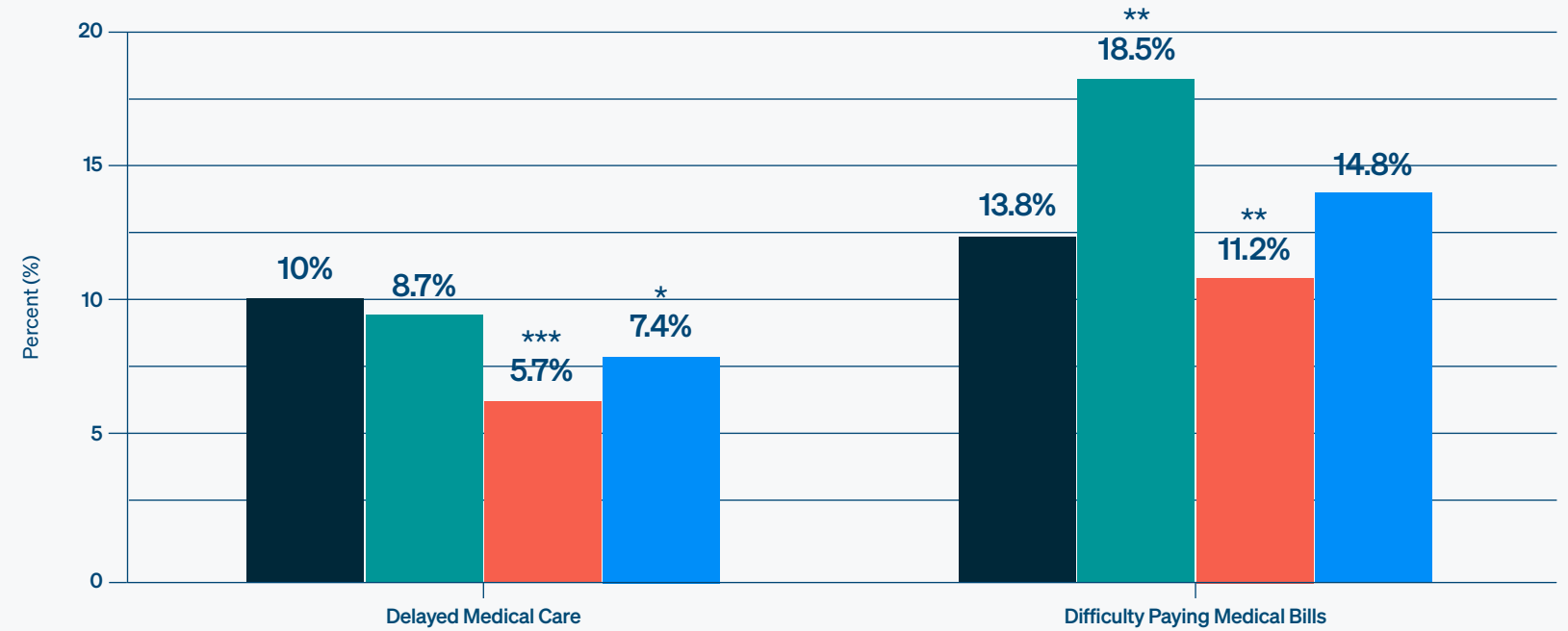
Disparities in Mental Health, Preventive Care and Financial Barriers by Race (Continued)

Hispanic individuals had higher rates of wellness visits, but lower rates on other metrics compared to white individuals, including lower rates of flu shots and cancer screenings. However, they were also significantly less likely to delay medical care due to cost than white individuals.

Asian individuals had higher rates of wellness visits and flu shots than white individuals, but lower cancer screenings. They also had lower financial burden than white individuals.

Taken together, tailored solutions may address these racial disparities - a one-size-fits-all approach may not work for all groups. Instead, employers should consider replicating analyses like this one to accurately identify and monitor racial gaps – after taking into account other factors like income.

Preventive Health Care Metrics



Race/Ethnicity ● White ● Black ● Asian ● Hispanic

*** p<0.001, ** p<0.01, * p<0.05. Asterisks indicate p-value for test difference for each race/ethnicity groups vs. white. Estimates are adjusted for age, sex, and income; percent prevalence is shown for an average male aged 45-54 with \$50,000-74,999 income. Source: National Health Interview Survey (NHIS), 2021

	Black (vs. White)	Asian (vs. White)	Hispanic (vs. White)
Wellness visits	+	+	+
Flu Shot	-	+	-
Cancer Screening	+	-	-
Financial Burden	+	-	-
Summary / Implications	<ul style="list-style-type: none"> • Opportunity to offset difficulty paying medical bills • Incentivize preventive vaccines 	<ul style="list-style-type: none"> • Strong wellness behaviors • Encourage cancer screenings 	<ul style="list-style-type: none"> • Encourage cancer screenings & preventive vaccines

Finding 4:

Non-white Women Have Higher Rates of C-Section Deliveries

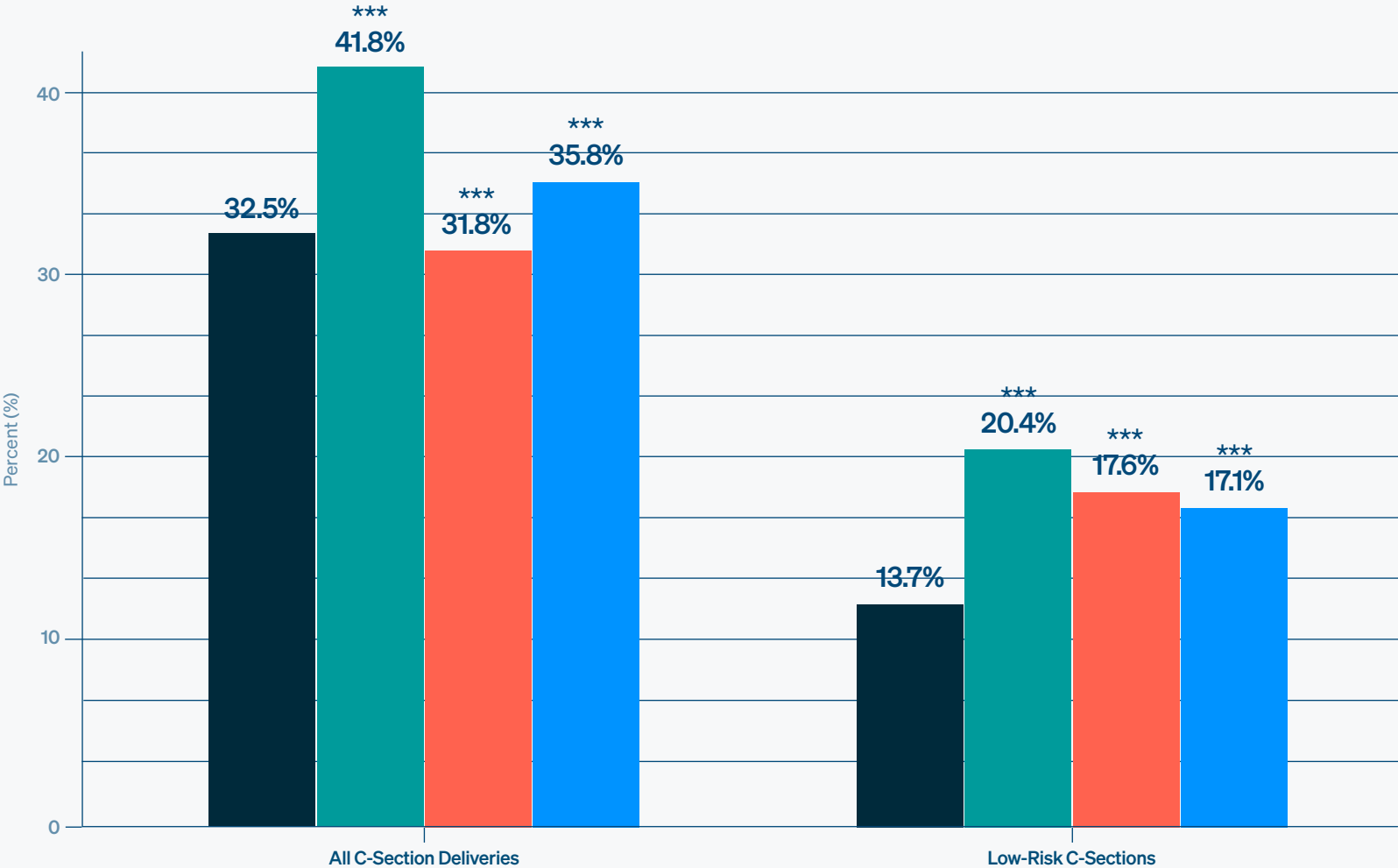
Cesarean deliveries are more common for Black, Hispanic and Asian women than for white women

Low-risk pregnancy c-sections may be an opportunity for innovation

Compared to white women, Black, Asian and Hispanic women were more likely overall and in low-risk pregnancies to have a c-section, after adjusting for age.

The employer-sponsored insurance market may benefit from innovative solutions seen in Medicaid and newly emerging in commercial populations, such as doula and midwifery care, as a way to support mothers during labor and avoid unnecessary cesarean deliveries.

Cesarean Delivery Rates



Race/Ethnicity ● White ● Black ● Asian ● Hispanic

*** p<0.001, ** p<0.01, * p<0.05. Asterisks indicate p-value for test difference for each race/ethnicity groups vs. white. Percent prevalence is shown for a woman aged 30-34.
Source: National Vital Statistics System (NVSS), 2021

Conclusion

05



Recommendations

It is our intent that these findings help employers take action to reduce disparities and improve health outcomes across their plan membership. With that in mind, we offer six key recommendations.

Introduce financial incentives for lower income employees to access primary and preventive care.

Expand mental health and substance use support for all employees, with particular emphasis on LGB communities; consider incentives for LGB individuals to access mental health care.

Consider tailored preventive care services, such as culturally sensitive or population-specific primary care, which emphasize subpopulations' unique needs and use targeted patient engagement strategies.

Use employee resource groups as channels for connecting less engaged employee subpopulations to relevant care options.

Incorporate doula services and midwifery care into maternal health care offerings, both of which are associated with lower rates of cesarian sections for low-risk pregnancies.

Consider additional support for employees to find lower-cost, high-quality care, such as publishing quality scores for in-network providers or steering employees toward new price transparency data tools.

The disparities highlighted by this report do not exist in a vacuum. Instead, disparities in population health statistics reflect broader social, historical, and economic dynamics that determine health, well-being, and engagement with the health care system. Some aspects of the American health care system can even deepen existing disparities. In turn, health care disparities create downstream impacts on employee productivity and businesses' success. Employers must seek to understand the origins of these disparities and conduct outcomes research about the solutions they implement to know the true impact on health equity in the ESI population. The health of employees – and by extension, all employers' businesses – requires it.

References

06



References

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