morganhealth

March 2025

Quality and Outcomes Gaps in Employer-Sponsored Insurance

JPMorganChase

Table of Contents

Executive Summary

Introduction

Employer-sponsored insurance (ESI) is the most common type of coverage in the U.S., with approximately 160 million individuals receiving health care from the workplace. Each year, Morgan Health develops a snapshot of health outcomes and disparities among adult individuals with ESI. Since 2022, when Morgan Health first published its report on health disparities in employer-sponsored insurance, some disparities have improved, while others linger or worsen.

Similar to previous reports, Morgan Health analyzed nationally representative health survey data to assess health disparities by race/ethnicity, income, and sexual orientation across population health metrics like health conditions, preventive health behaviors, health care use, maternal health, mental health and substance use, and food insecurity. Overall, our report illustrates persistent health disparities in the employer market by income, race/ethnicity, and sexual orientation. Based on these findings, we present actionable recommendations for employers looking to improve health outcomes across their plan membership.

Methods

This report updates the findings in our 2022[i] and 2024[ii] reports and we use a similar methodology throughout this analysis. In short, we used the most recent data available during the writing of this report from three nationally representative surveys - 2023 National Health Interview Survey (NHIS), 2022 National Study on Drug Use and Health (NSDUH), and the 2023 National Vital Statistics System (NVSS) – to evaluate income, racial, and sexual orientation-based disparities in population health and health care utilization metrics in the ESI population. We estimated prevalences of each metric via regression models that adjusted for age, sex, and race/ethnicity, and/or income; these analyses were population weighted and accounted for the complex samples of these surveys. Unless otherwise noted, we present adjusted prevalence estimates for an example person covered by ESI[1]: a white man (or woman for cervical cancer and mammography screenings) aged 45-54 making $50,000-$74,999 annually. For maternal outcomes, we only adjusted for age and race since income data are not available; those estimates reflect a white woman in the 30-34 age range who gave birth.

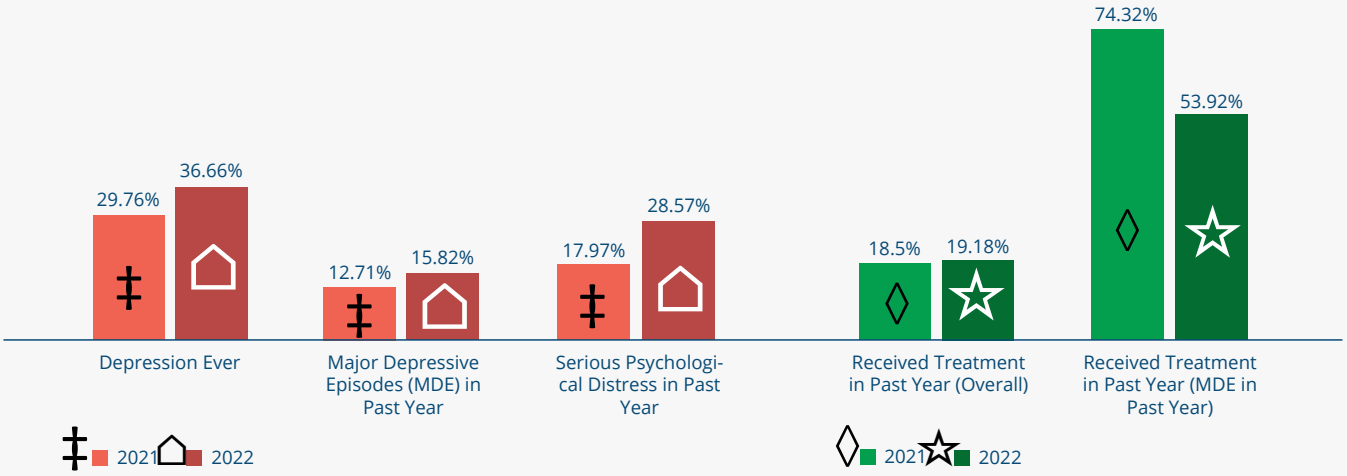
One notable departure from previous years is that we have employed logistic regression models to calculate predicted probabilities, which serve as the estimated adjusted prevalence rates in the analysis. This is in place of linear regression models used in the past; this modeling update helps improve the accuracy and robustness of the estimated prevalences. Throughout this report, we present metrics from 2021 and 2022 data for comparison, which were re-generated with the same updated logistic regression method. Additional details on our methodology, including implications for comparing to prior reports, can be found in the Appendix.[iv]

1. Due to how the NVSS dataset is coded, maternal health related results are based on women aged 25 and older who are insured under any commercial plan, which may include plans that are not employer sponsored.

Finding 1: Mental health burden has worsened over time, with notable gaps in treatment for underserved populations.

LGB populations experienced a 3% increase in depression and 11% increase in serious psychological distress from 2021 to 2022, along with widening gaps in substance use behaviors.

FIGURE 1A **LGB ESI Population Mental Health Outcomes**

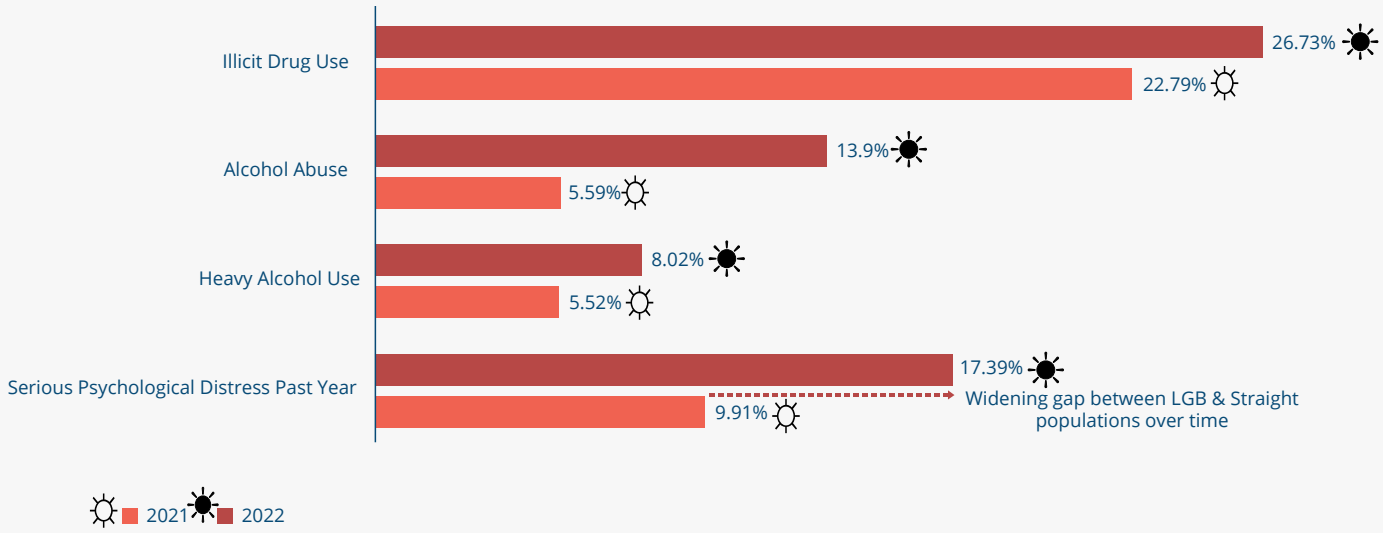


Estimates are adjusted for age, sex, and race/ethnicity; percent prevalence is based on predicted probabilities and is shown for an average white male aged 45-54. Source: National Study on Data Use and Health (NSDUH), 2021 & 2022

Mental health burden has worsened in the Lesbian, Gay and Bisexual (LGB) population in recent years. The prevalence of those experiencing depression (+3.1%) and serious psychological distress (+10.6%) in the prior year has increased from 2021 to 2022 (Figure 1). Although LGB individuals continue to access mental health care at higher rates than their Straight counterparts, there is a pattern of reduced care use even as mental health worsens that is more pronounced in the LGB population. Alarmingly, among those who reported experiencing a depressive episode in the prior year, the percentage of LGB individuals receiving either counseling or prescription treatment *decreased* from 74% to 54%, while the Straight counterparts' care usage also decreased, but by less (55% to 46%). This underscores a growing trend of unmet mental health need in the LGB population.

This unaddressed mental health burden is coupled with widening gaps in substance use patterns between Straight and LGB populations during the same time period (Figure 2). Although we observed increased substance use in the overall population following the COVID-19 pandemic, rising substance use in the LGB population outpaced use in the Straight population. This has led to a growing gap between the two groups across dangerous health behaviors, such as vaping, binge drinking, alcohol abuse and illicit drug use.

FIGURE 1B **Differences in Mental Health & Substance Use between LGB & Straight Populations**



Estimates are adjusted for age, sex, and race/ethnicity; percent prevalence is based on predicted probabilities and is shown for an average white male aged 45-54. Source: National Study on Data Use and Health (NSDUH), 2021 & 2022

Black individuals (-9%) and Hispanic individuals (-6%) receive a depression diagnosis at lower rates than white counterparts – but those with a diagnosis have worse outcomes and treatment rates.

Black and Hispanic individuals with ESI report lower levels of depression and serious psychological distress in the prior year compared to white counterparts. However, this doesn't necessarily translate to a lower mental health burden across these populations. Notably, Black and Hispanic individuals also report lower rates of receiving treatment, which could indicate undiagnosed or unrecognized mental health burden in this population. Primary care practitioners can serve as a first line of diagnosis and treatment for mental health conditions; but in contrast to white individuals, Black and Hispanic individuals discuss their mental health with a doctor at 5% and 3% lower rates, respectively.

Among those with a prior diagnosis of mental health challenges, notable racial disparities in their current burden and treatment were evident. Compared to white counterparts with a history of depression, Black and Hispanic individuals with a history of depression:

- Had higher rates of major depressive episode in the past year (Black: 53%; Hispanic: 55%; white: 47%)
- Received treatment at lower rates (Black: 22% lower than white; Hispanic: 5% lower than white)
- Were less likely to speak to any health care professional about mental health (Black: 18% lower than white; Hispanic: 4% lower than white)

These disparities reflect a need for greater screening and initial access to mental health services for Black and Hispanic individuals with ESI coverage *and* support for those with history of depression for ongoing treatment.

FIGURE 1C **Lower-income individuals are almost twice as likely to experience serious psychological distress and depression as higher-income individuals.**

Mental health outcome prevalence by income level	<$50,000	$50,000 to $74,999	$75,000 or more
Serious psychological distress (past year)	18.1%***	16.5%***	10.7%
Depression (past year)	9.8%***	8.6%***	5.7%

****p<0.001, **p<0.01, *p<0.05. Asterisks indicate p-value for test difference for an income group vs >=$75,000. Estimates are adjusted for age, sex, and race/ethnicity; percent prevalence is based on predicted probabilities and is shown for an average white male aged 45-54. Source: National Study on Data Use and Health (NSDUH), 2022*

Compared to the highest earning income group composed of individuals earning $75,000 or more, those who are in the lowest income group (<$50,000) experienced serious psychological distress and depression in the prior year at almost double the rate.

Among those who have a history of depression, the extent of mental health burden is similar to or bigger than those actively receiving mental health treatment – most prominently in lower-income groups:

- In the lower-income group, more people were having needs than treatment: slightly more than half (51%) had a major depressive episode in the past year but less than half (46%) had received mental health care treatment
- In the highest income group, more people were receiving treatment than having needs: 37% experienced a major depressive episode and 39% received treatment during the same time period

While a larger proportion of lower-income individuals receive care than higher earning groups, there is still notable unmet need in this population.

Recommendations for employers

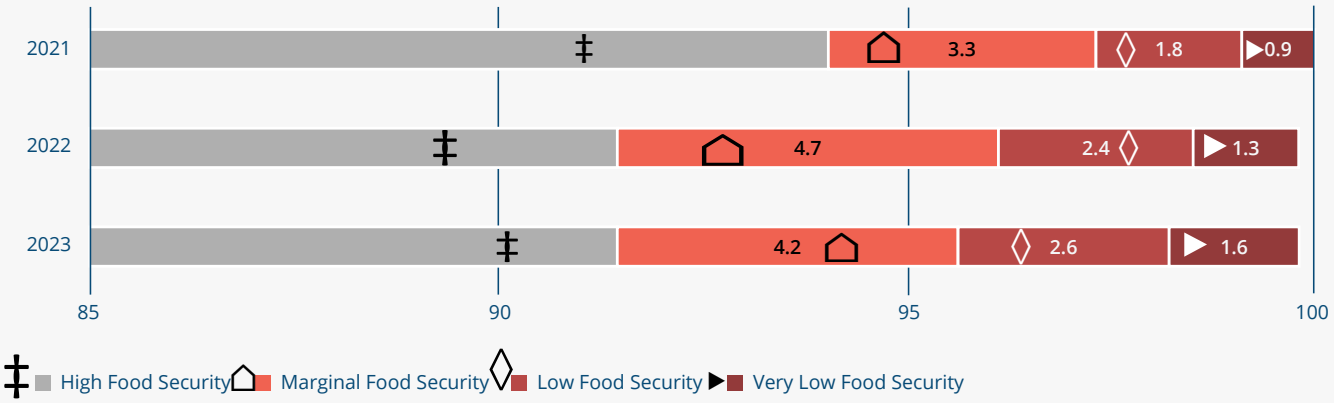
As more and more mental health providers move out-of-network with major insurance carriers[iv], employers should consider expanding out-of-network coverage for mental health care or providing providing plan incentive dollars to ease lower-income individuals' financial burden when seeking therapy. Employers can also offer Employee Assistance Programs that include a network of diverse and culturally concordant providers, including providers who themselves are members of underrepresented communities.

To lower the barrier for initial mental health screenings, employers can leverage existing care navigation tools and digital platforms so that employees can complete preliminary screenings virtually and proactively identify mental health care needs.

Finding 2: Food insecurity has worsened over time in the ESI population.

Greater proportions of individuals with ESI rely on government-sponsored nutrition programming to meet their family's needs

FIGURE 2A **Food Insecurity in ESI**



Source: National Health Interview Survey (NHIS), 2022-2023

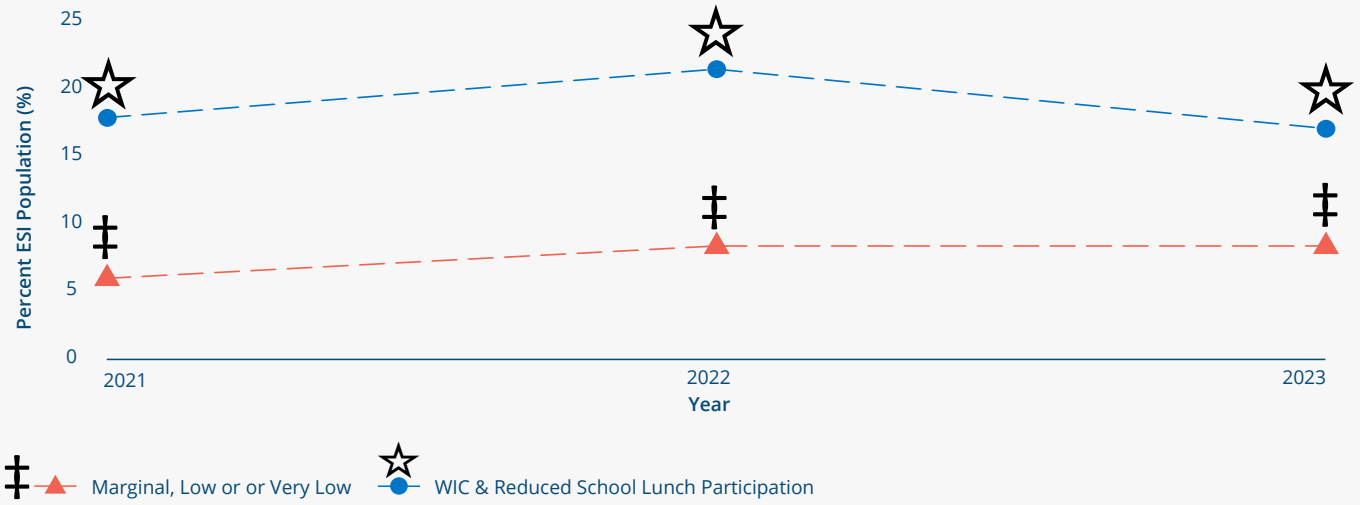
With lingering inflation and higher grocery bills in recent years, food insecurity has worsened in the ESI population –which has historically been viewed mostly as a Medicaid issue. In 2021, 5.9% of individuals with ESI experienced some degree of food insecurity, and this rate has grown to 8.5% in 2022. There was no improvement in 2023; in fact, there was a slight shift from marginal food insecurity to more severe levels of low or very low food security in 2023. Research has demonstrated a link between food insecurity and poor long-term health[v].

From 2021 to 2022, participation in the Women, Infants, and Children program (WIC) and reduced or free school lunches increased from 18% to 22%. However, many eligibility and benefit expansions in government-sponsored programs[2] ended when the COVID-19 public health emergency expired. Participation in these nutrition programs dropped to 17% in 2023, even though many families faced greater food insecurity than before the pandemic.

There are also clear racial disparities in access to nutritious food. After adjusting for age, sex and income, Black individuals in the ESI population report being food secure at rates 7% lower than their white counterparts, and Hispanic individuals report being food secure 3% less than white individuals. However, Asian individuals report being food secure at rates that are 5% higher than white individuals with ESI.

2. Nutrition program participation rates reported do not include SNAP participation, which remained around ~4% from 2021-2023

FIGURE 2B **Supplemental Nutrition Program Participation**



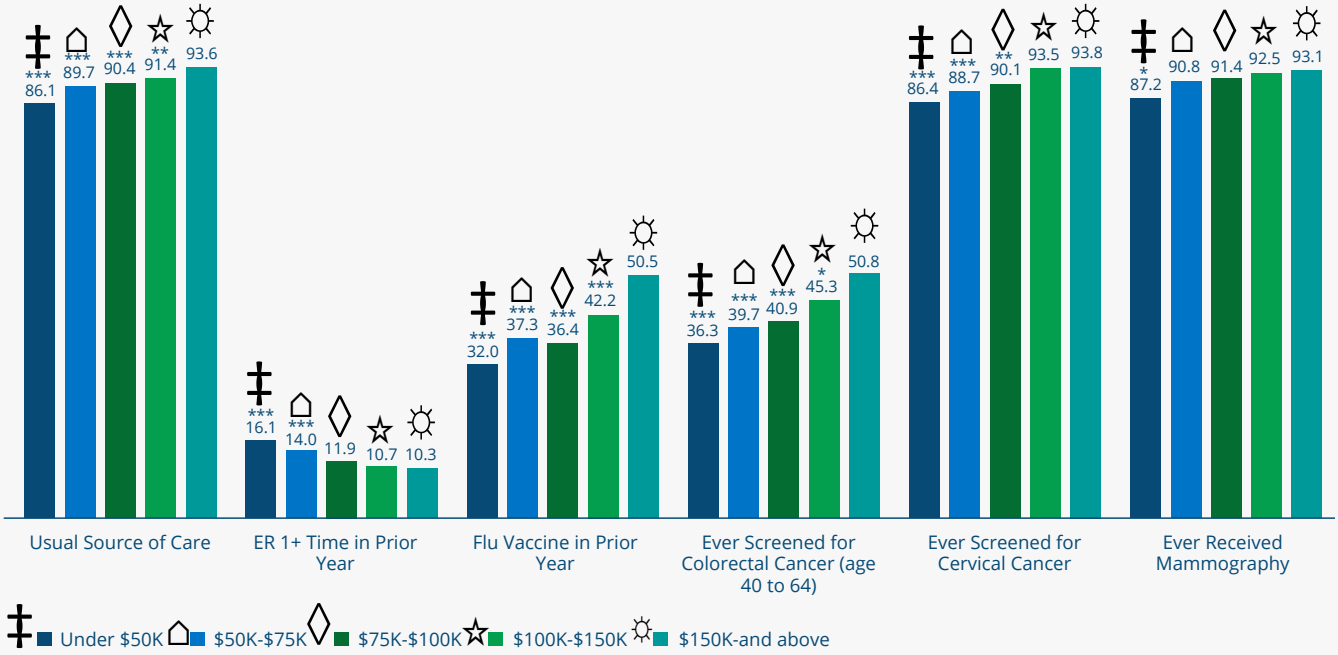
Source: National Health Interview Survey (NHIS), 2021-2023

Recommendations for employers

Employers can consider expanding their health care coverage offerings to include food prescription boxes, which have been shown to help manage chronic conditions through reducing HbA1C levels[vi] and improve food security. Employers can also subsidize workplace Community Supported Agriculture (CSA) programs as an additional benefit to streamline access to fresh, local produce at an affordable price.

Finding 3: Primary and preventive care are not being accessed by low-income individuals and are inconsistently accessed by Black and Hispanic groups, leading to over reliance on emergency services.

FIGURE 3 **Access to Primary Care & Preventive Services by Income Level**



****p<0.001, **p<0.01, *p<0.05. Asterisks indicate p-value for test difference for an income group vs >=$150,000. Estimates are adjusted for age, sex, and race/ethnicity; percent prevalence is based on predicted probabilities and is shown for an average white male aged 45-54.*
Source: National Health Interview Survey (NHIS), 2023

The likelihood that a patient will engage with preventive services, including colorectal, cervical & mammography screenings, and vaccinations, is directly correlated with their income level. Those in the lowest income group (<$50,000) have an 18% lower rate of flu vaccinations compared to the highest income group (>$150,000), as well as a 15% lower rate of colorectal cancer screening, a 7% lower rate of cervical cancer screening, and a 6% lower rate of mammography screening.

In general, compared to those making >$150,000, those earning less than $50,000 have lower rates of a usual source of care (-8%) and report visiting the Emergency Room (ER) in the past year at higher rates (+6%), which is often used as a stop gap for those without adequate access to primary care. Use of the ER in place of primary care drives up cost and does not improve health outcomes.

In the context of race, Black and Hispanic individuals report similar rates of having a usual source of care (~90%) as their white counterparts. In fact, Black individuals report having a wellness visit in the past year at a rate 9% higher than the rate of white individuals. However, Black and Hispanic individuals in the ESI market have lower rates of receiving the flu vaccine (Black: -6%; Hispanic: -5%) and visit the ER at higher rates (Black: +5%; Hispanic: +2%) than white individuals.

Although gaps have closed in some preventive measures like mammography screening rates, there are still racial disparities in cervical cancer screening rates with Black women (-6%), Hispanic women (-12%), and Asian women (-24%) receiving screenings at lower rates than white women.

Recommendations for employers

It is possible that these groups lack access to comprehensive primary care, and improved care navigation to high-quality providers may help bridge these gaps. Additionally, employers can consider contracting directly with advanced primary care providers for more coordinated, high-quality care.

Employers can collaborate with payors to share provider quality guides, like those from Embold Health*, whose mission is to offer clear, data-driven insights into health care quality to help employees make informed decisions when choosing a new provider.

Behaviors of delaying and avoiding care in lower income groups due to financial hardship extend to preventive services, which often have low to no cost sharing for employees. Benefits teams, carriers and third party administrators should ensure that they are clearly communicating the expected costs employees would face for seeking care and reinforce robust coverage of preventive services under existing plans.

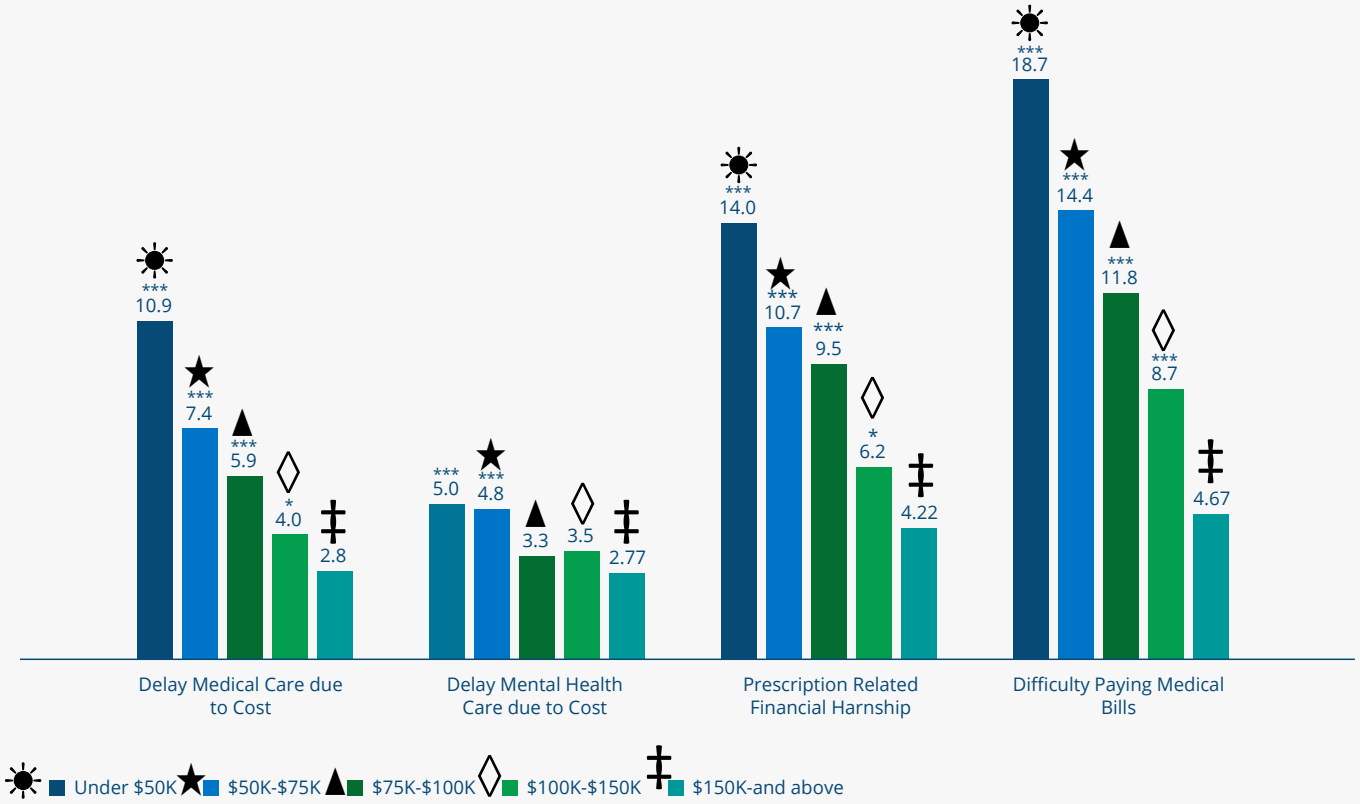
Other drivers, such as lack of flexibility at work, family obligations and transportation barriers may play a role in limiting access to primary and preventive services. To address these, employers can consider both seasonal solutions, such as on-site flu vaccination and annual biometric screening events, as well as longer-term, more permanent options like on-site clinics. Studies show that regular engagement with a primary care provider leads to healthier lives by preventing illnesses and managing diseases early, which saves money by reducing the need for expensive hospital stays. Employers enhancing access to quality health care services for their employees is a recent example of proactive workplace wellness initiatives aimed at reducing disparities.

In 2022, JPMorganChase began offering comprehensive health services to its Columbus-based employees and their families by two trusted partners — Vera Whole Health (Vera)* and Central Ohio Primary Care (COPC) — at four on-site and near-site clinics specializing in advanced primary care. While it's still early in the program, the utilization rates have been encouraging. In 2024, more than 6,000 unique patients visited a Vera/COPC clinic, with 67% of patients returning after their first visit for additional care. The clinics have also consistently maintained a net promoter score of 86 or higher.

** JPMorganChase holds a non-controlling interest in this company.*

Finding 4: Lower-income people with ESI have pronounced gaps in access and financial hardship associated with medical care.

FIGURE 4 **Financial Hardship by Income Level**



****p<0.001, **p<0.01, *p<0.05. Asterisks indicate p-value for test difference for an income group vs >=$150,000. Estimates are adjusted for age, sex, and race/ethnicity; percent prevalence is based on predicted probabilities and is shown for an average white male aged 45-54.*
Source: National Health Interview Survey (NHIS), 2023

The burden of rising health care costs on lower-income individuals has led to alarmingly high rates of delaying or avoiding medical and mental health care, as well as skipping or delaying filling prescriptions. These individuals are also more likely to have existing unpaid medical bills, further inhibiting access to additional care they may need.

Among those making less than $50,000, 11% delayed medical care due to cost, 9% avoided necessary medical care, and 14% adapted to prescription related financial hardships by skipping medication, taking less medication, or delaying and not filling their prescriptions. Although less prevalent, medical and prescription related financial hardship is also observed across higher income levels in the

ESI population, with 6% delaying medical care, 5% avoiding necessary care, and 10% facing prescription related financial hardship in the $75,000-$99,999 income bracket.

Against the backdrop of lingering inflation, the financial burden of health care is becoming more pervasive and can worsen long-term health outcomes when medical conditions are not addressed and managed in a timely manner.

Recommendations for employers

To help address these disparities, employers might consider structuring health plans and pharmacy benefits to include graduated premiums or reduced cost-sharing depending on income levels. Additionally, they could explore offering a plan with a more narrowly curated network, allowing employees to access a focused provider network at lower, more predictable out-of-pocket costs.

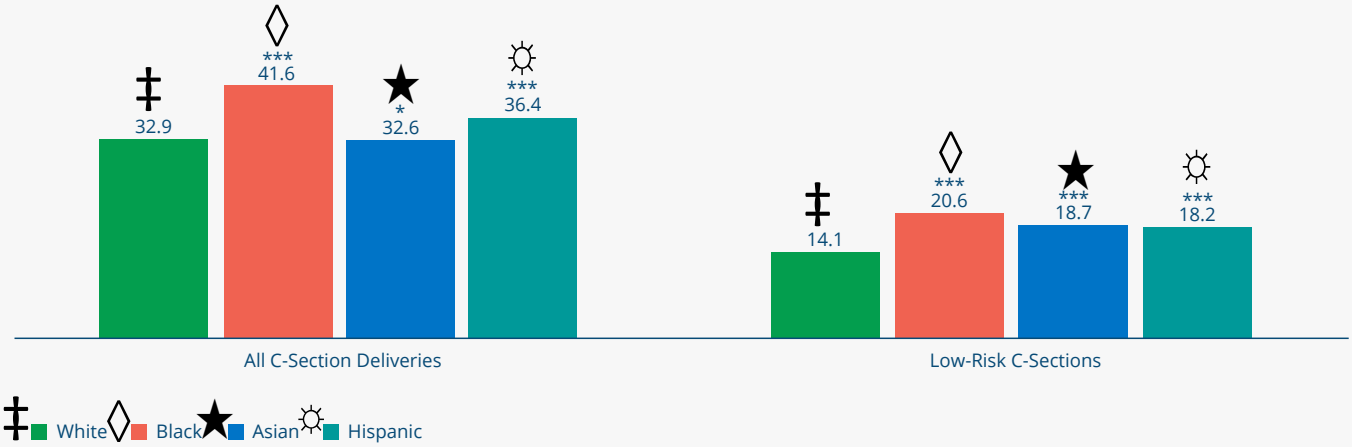
In 2025, JPMorganChase introduced a new plan option for its Dallas-Fort Worth employees through Centivo*, which offers access to a curated network of providers and lowers overall costs. Plan members are required to select a primary care physician from the Centivo network, who will then help them navigate their care and make the most of preventive services. Plan members benefit from low, predictable costs thanks to key features, including: no deductible; $0 primary care visits, OB/GYN visits, mental health visits, and pre-set copays for all other services. Centivo's approach demonstrates that employers can improve access to care through affordable plan options.

** JPMorganChase holds a non-controlling interest in this company.*

Finding 5: Racial disparities in maternal health persist.

Black and Hispanic women have big gaps in the quality of labor and delivery care they receive, and experience much higher rates of c-section births for low-risk pregnancies

FIGURE 5 **Cesarean Delivery Rates**



****p<0.001, **p<0.01, *p<0.05. Asterisks indicate p-value for test difference for each race/ethnic group vs White. Estimates are adjusted for age; percent prevalence is based on predicted probabilities and is shown for a woman aged 30-34. Source: National Vital Statistics System (NVSS), 2023*

Maternal health disparities reported in past years continue to persist, with Black women having c-sections at rates 9% higher than white women and Hispanic women having c-sections at rates 4% higher than white women. When considering low-risk pregnancies where c-sections are not often medically necessary and can pose additional complications, Black women (+7%), Hispanic women (+4%), and Asian women (+5%) have low-risk c-sections at higher rates than their white counterparts.

Recommendations for employers

Morgan Health recently published a report[vii] on maternal health care, exploring racial disparities in financial hardship in more depth, as well as unaddressed postpartum depression across the broader birthing population. Employers can drive innovation in the maternal health space and leverage learnings from recent Medicaid program enhancements, such as expanding benefits to cover doula and midwifery services, to help bridge gaps and improve the quality of maternal health care.

References

i. https://www.jpmorganchase.com/content/dam/jpmc/jpmorgan-chase-and-co/who-we-are/our-business/documents/jpmc-morgan-health-norc-report-ada.pdf

ii. https://www.morganhealth.com/assets/documents/jpmc-morgan-health-norc-report-2023-ada.pdf

iii. https://www.morganhealth.com/assets/documents/appendix-a-methodology-update_linear-to-logistic-regression-models.pdf

iv. https://www.npr.org/sections/shots-health-news/2024/08/24/nx-s1-5028551/insurance-therapy-therapist-mental-health-coverage

v. https://www.nimhd.nih.gov/resources/understanding-health-disparities/food-accessibility-insecurity-and-health-outcomes.html

vi. https://newsroom.heart.org/news/free-weekly-produce-delivery-improved-blood-sugar-food-security-in-low-income-adults

vii. https://www.morganhealth.com/assets/documents/maternal-health.pdf