

## FAQs

### **Why did Morgan Health commission this analysis?**

Morgan Health's mission is to accelerate the adoption of new care models that improve the quality, equity and affordability of employer-sponsored health insurance (ESI). Morgan Health commissioned this analysis to produce a snapshot of the health status of individuals with ESI, and to identify where disparities exist within the ESI market.

To date, most ESI research has focused on the cost of insurance and medical care (including out-of-pocket costs) and geographic differences in access to care. However, research examining health disparities and inequities in ESI has been limited. Historical gaps in race, ethnicity, and income data tied to ESI claims have limited researchers' ability to study disparities in care through claims analysis. 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.

This analysis begins to fill this research gap and lays the groundwork for Morgan Health, other employers, health plans and providers to address longstanding disparities in the ESI market.

### **How should employers and corporate leaders interpret these findings?**

Business leaders need to recognize that the broader health disparity issue isn't just happening in the Medicare, Medicaid or uninsured populations alone – it's happening within their own employee base. It's critically important that companies acknowledge that they have to be engaged and committed to addressing disparities and social needs in a much more comprehensive way – that includes proactively engaging health plans, providers and others involved in benefits and care delivery to develop and execute a clear strategy to address these long-standing health concerns and issues among employees.

We are not recommending specific policy or benefit changes because each company and employer must tailor those to employees' health needs, but there are a number of options to consider. Those can include greater employer contributions or subsidies for employees in low-to-middle income ranges to offset the financial burden of coverage and medical care; a comprehensive accountable care strategy that can help proactively manage employees' health issues with timely diagnosis, treatment and follow-up; and broader assessment of employee-assistance programs and support to address unmet social needs, particularly for those facing food insecurity or broader discrimination as a result of race, ethnicity or sexual orientation.

### **What makes this study different or unique from other past assessments on health equity?**

Recent surveys measuring or assessing health inequities have focused on the population as a whole (often combining insured v. uninsured data findings) without isolating or reviewing the ESI market specifically. In addition to the Morgan Health-NORC findings coming from a large, representative sample size within ESI, the analysis also reflects self-reported data combined with biometric information to provide a more comprehensive snapshot of both the prevalence of chronic conditions and the respective diagnoses and control (disease management) of these health issues among enrollees.

**Why was the data pulled from 2017-2019?**

At the time this analysis was commissioned, the most recent data for several of the sources was collected during the start of the COVID-19 pandemic. Because the surveys use in-person interviews and examinations (NHANES) for data collection, survey operations were interrupted during the middle of 2020.

Given concerns about gaps that might exist in 2020 survey data and how the pandemic changed individuals' health care behaviors that year, researchers decided that using 2020 data would not produce representative statistics about the health of ESI enrollees. While data collection later resumed, the 2021 data was not yet available; data from these sources require time after collection to be cleaned and sorted prior to public release.

For these reasons, data was selected from pre-pandemic years, which represent a baseline of health outcomes and disparities within the ESI market prior to the onset of the pandemic. Early research analyzing the pandemic's impact on health outcomes has shown that COVID-19 has exacerbated pre-existing disparities within the health care system. This analysis is the first-of-its kind; therefore, it was important to understand health outcomes trends within the market independent of the COVID-19 pandemic. This analysis will provide context for future analyses within the ESI market.

**Are the findings representative of the ESI population as a whole?**

Yes, the findings from this study are representative (or generalizable of the broader ESI population) because they come from representative surveys with large sample sizes.

This analysis uses three nationally representative surveys – the National Health Interview Survey (NHIS), the National Health and Nutrition Examination Survey (NHANES) and the National Survey of Drug Use and Health (NSDUH) in addition to birth certificates recoded in the 2020 natality vital statistics registry. The study methodology yielded samples sizes of 12,372 from NHIS, 3,103 from NHANES, and 14,580 from NSDUH. Statistics derived from representative samples allow researchers to extrapolate those findings to the larger population.

**Does this data reflect health information from JPMorgan employees?**

No. No employee health information was provided as part of this analysis. The data reflects findings from three national public health surveys.

**How do results from this study compare to national benchmarks such as those reported by government agencies or found in government published reports?**

There are national benchmarks for some health outcomes featured in this analysis. National benchmarks contextualize this analysis's findings against outcomes for all U.S. adults.

In some instances, definitions of national benchmarks did not align with study definitions. For example, according to the Centers for Disease Control and Prevention (CDC), 12.5 percent of U.S. adults smoked cigarettes in 2020. The CDC national benchmark cannot serve as a comparator here, as this analysis's definition of tobacco use included smokeless tobacco. Below are national benchmarks that align with study definitions.

Health outcome	Description of measure	National benchmark	Source
Hypertension (high blood pressure)	Percentage of adults 18 years and older with hypertension	47.3%	<a href="#">HHS</a>
Diabetes	Percentage of people of all ages with diabetes	10.5%	<a href="#">CDC (pg. 2)</a>
Obesity	Age-adjusted percentage of US adults with obesity (including severe obesity)	42.4%	<a href="#">NIH</a>
Heavy alcohol use	Percentage of people ages 18 and older that engaged in heavy alcohol use in the past month	6.3%	<a href="#">NIH</a>
Depression	Percentage of adults aged 18 and over who experienced moderate or severe symptoms of depression in the past two weeks	7.0%	<a href="#">CDC</a>
Anxiety	Percentage of adults aged 18 and over who experienced moderate to severe symptoms of anxiety in the past two weeks	6.1%	<a href="#">CDC</a>
Low risk C-section	Percentage of singleton, head-first, term (37 or more completed weeks) first births that were cesarean deliveries	25.6%	<a href="#">America's Health Rankings</a>

### How are the various surveys used for the basis of this analysis fielded?

- [NHIS](#) – Data from the National Health Interview Survey (NHIS) are collected through interviews with participants, selected in a multi-stage, stratified random sample of U.S. civilians (non-institutionalized). Annually, the National Center for Health Statistics, a division of the Centers for Disease Control and Prevention, selects households to participate in the survey. Residents of selected households receive a letter in the mail informing them of their selection into the survey sample. At the time of interview, one adult member of the household is then chosen at random to be the “sample adult” and if present, one child is chosen to be the “sample child”. Responses to the survey are then combined with other surveyed respondents to produce the NHIS dataset.
- [NHANES](#) – Data from the National Health and Nutrition Examination Survey (NHANES) are collected through a combination of personal household interviews, physical examinations and laboratory tests. Similar to NHIS, participants for the NHANES are selected in a multi-stage, stratified random sample of U.S. civilians (non-institutionalized).

- [NSDUH](#) – Each year, a professional interviewer visits each selected participant for the National Survey on Drugs Use and Health (NSDUH) and administers the interview using a laptop computer. Similar to NHANES, the NSDUH uses a multistage area probability design, meaning that larger geographic areas are broken down into sequentially smaller areas before selecting specific households to contact regarding survey participation.

### **What are unadjusted and adjusted findings, and how are they presented throughout the paper?**

Unadjusted analyses do not consider potential confounding factors that may influence the results. For this analysis, potential confounding factors were age, sex, race and income. As a result, unadjusted findings in this paper are findings that do not control for one, multiple, or all of these variables. Adjusted analyses control for at least one potential confounding variable.

In this paper, unadjusted findings and adjusted findings are presented. Unadjusted findings are reported first and depict the overall prevalence of a measure without controlling for potential confounding variables, such as age and sex. Adjusted differences controlling for age, sex, income and/or race follow where relevant. All age and sex adjusted differences, regardless of statistical significance, can be found in the supplemental materials. All visuals and graphics presented throughout the paper reflect unadjusted findings.

### **How do definitions of disease state vary between the surveys definition and clinically-accepted definitions?**

There is some variation between the clinically-accepted and survey definitions depending on the disease state. Clinically-accepted definitions are more encompassing than the survey definitions, which tend to be limited due to survey constraints. For example, in a clinical setting, diabetes can be diagnosed using a Glycated Hemoglobin (HbA1c) test, Fasting Plasma Glucose Test, the Oral Glucose Tolerance Test or the Random Plasma Glucose Test. However, the NHANES examination did not perform the oral glucose tolerance test in the years being analyzed and the number of respondents who were fasting at the time of their examination (the fasting subsample) for the plasma glucose test was too small to be to produce reliable statistics. As such, diabetes status was determined solely with an HbA1c test.

### **What are the study limitations?**

Self-reported data is this study's primary limitation. The NHIS, NHANES, and NSDUH collect self-reported data, and such data is subject to biases, such as social desirability bias. Social desirability bias is a form of response bias in which survey participants may underreport or inaccurately report behaviors that are perceived to be unfavorable to others or society. This bias may be especially relevant in the NSDUH as it focuses on stigmatized behaviors such as tobacco, alcohol, and drug use and other mental health related behaviors. However, some data sources were resistant to such biases due to the nature of their collection. Data from the physical examination and laboratory testing components of the NHANES and data from vital statistics are not subject to response bias.