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THE DEARTH OF KNOWLEDGE OF HEALTH INSURANCE LITERACY WITHIN THE UNITED STATES

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by

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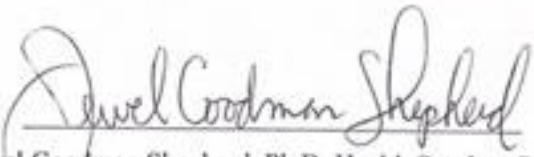

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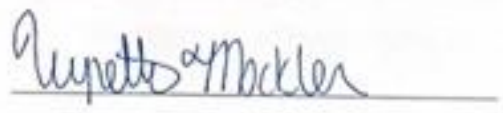

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ABSTRACT

The Dearth of Knowledge of Health Insurance Literacy in the United States

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This literature review and cross-comparison were conducted to combine resources that bring to light the lack of knowledge on health insurance, the impact of this low health insurance literacy (HIL), and the lack of research being done in this subject field. This thesis analyzes and compares different research that measures HIL levels and compares these findings. At the same time, this thesis presents the complex history of health insurance and how this understanding can contribute to lower population HIL and proposes different ways to accurately measure HIL. The purpose is to show the necessity for more research into the field of HIL and increase public awareness of this issue that poses as a modern barrier to health care. Finally, the thesis presents proposed solutions to the current issues that are occurring in the HIL research field and the necessity for the increase of HIL education efforts to be furthered.

Key Words: Health Insurance Literacy (HIL)

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Chapter One: Introduction

This literature review and cross-comparison of research will examine different content related to HIL to show the impact that low HIL has on the population of the United States. Chapter two of this paper will begin this discussion by presenting the impact that HIL levels have on the overall population as well as the expansive impact that health insurance itself has to display the importance of HIL levels within the population. Chapter three goes in-depth on the complex history of health insurance coverage in the country and how this can actively contribute to the modern-day studies that show Americans maintaining low HIL levels. In chapter four, there will be an exploration of the formal definition of what is considered to be covered under HIL. Chapter five will present the intersection of HIL and health insurance in the 21st century, and how current perceptions of health insurance tarnish the population's willingness to increase their HIL levels. Chapter six is a cross-comparative literary review of three recent research articles that all propose correlations between HIL and certain demographics. This cross-comparison aims to show the relatively low level of research being conducted in the field and the lack of information that currently exist in these research methods. Chapter seven is the proposal of a solution to not only the issues with current research on HIL but, also, the larger scale issue that HIL poses to the population of the United States. In conclusion, chapter eight is intended to culminate the literary review in addition to the other sections that have been proposed.

Chapter Two: Nature and Magnitude

When considering the impact that health insurance literacy has on not only the health care market but each participant in the health care market, it is important to discuss three large-scale fields to understand the total impact. First, the United States is composed of many different general demographics that relate to the fields of race, gender, and socioeconomic status. All of these factors play a key part in understanding who is buying health insurance and its affordability. Next, health-related demographics show what exactly Americans are dying from and how that can influence their health spending, which is the final category. All of these lay the groundwork when starting the discussion of health insurance literacy.

First, when looking at the general demographics, the current population of the United States is 334 million people as estimated by the United States Census Bureau in 2023 and is constantly rising. With births and immigration, the population is expected to increase exponentially in the next decade, and with this increase in population, the usage of health care resources is also expected to rise. There are around 125,736,353 households that were registered in 2022, and the amount of people per household has dropped to an average of 2.57 residents (*US Census Bureau*, 2022).

Regarding health insurance literacy, employment is a key factor in the accessibility and understanding of health insurance. The number of the population that is currently employed as estimated in the year 2021 is 128,346,299, which has also faced a significant drop of 4.3% between the years 2020-2021 (*US Census Bureau*, 2022). Around 63% of the population that is 16 years or older is estimated to be in the workforce in some capacity between the years of 2018 and 2022 (*US Census Bureau*, 2022). Of the current employment estimations, the total number of non-employer establishments in 2020 is around 27,151,987 (*US Census Bureau*, 2022). The

median household income within the United States is a considerable factor when discussing health insurance in its totality. The median household income in 2022 dollars is $75,149 and the per capita income is estimated at around $41,261 (*US Census Bureau,* 2022). Around 11.5% of the population or around 1 in 10 people are considered to be in poverty in the United States as well (*Healthy People 2030,* 2022).

Health demographics, additionally, within the United States play a considerable role in understanding the ground level of health insurance literacy. The average life expectancy as of 2021 for the population is around 76.4 years with an infant mortality rate of 5.44 deaths per 1,000 live births (CDC, 2023). The average life expectancy for men is lower than women coming in at 73.5 and 79.3 in that order (CDC, 2023). This average is a decrease in life expectancy from 2019 of around 2 years, and a large gap exists between the drop in other countries' life expectancy rates and the United States (Becker et al., 2021). There are many theories for why the United States is suffering the recent drop in life expectancy, but most point to the COVID-19 pandemic as the main cause. As of 2023, the leading cause of death is heart disease followed by cancer and COVID-19 (CDC, 2023). With the increased influence of the aging population within the United States and common underlying causes of death, it is important to consider these questions of how long the average citizen is living as this is directly proportional to the increased usage of insurance plans and health care spending.

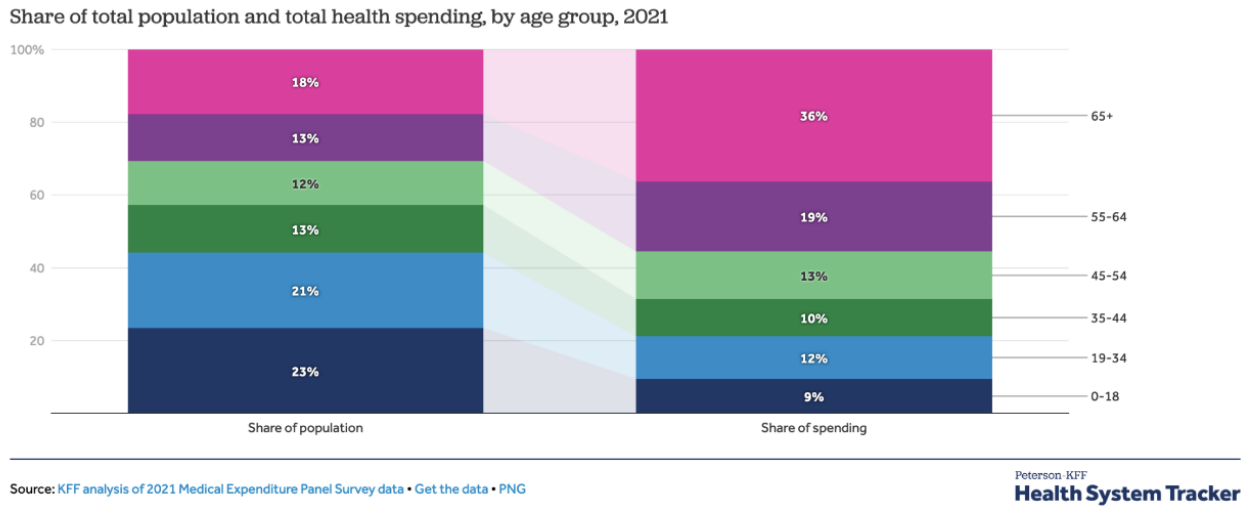
Lastly, understanding health care spending plays a significant role within the basics of health insurance, and considering the demographics of those who spend is necessary to explore. This data was primarily pulled from the Medical Expenditure Panel Survey of 2021. “Estimates account for the MEPS survey design, including the estimation weight, sampling strata, and primary sampling unit. Health spending includes individual out-of-pocket payments and

payments made by payers for care provided during the year" (McGough et al., 2024). According to the Peterson-KFF Health System Tracker, Figure 1 shows that those over the age of 55 account for around 55% of all health spending within the United States and comprise only around 30% of the population (McGough et al., 2024). In 2021, those who spent the most individually on health care (the top 5% specifically), accounted for half of all the health spending that year alone, and this ranged from anywhere around $71,000 to $166,000 spent per individual per year (McGough et al., 2024). The bottom 50% of individuals with the lowest health spending only accounted for around 3% of the total health spending in the year 2021 with an average of $400 spent (McGough et al., 2024). For families as a whole, the data remains the same, as the top 5% of those with the most health care spending accounted for around 40% of the total spending in the year 2021 (McGough et al., 2024). In total, both insurance and out-of-pocket spending is used on a combination of categories, with the most spending being done on prescription medications, ambulatory services, and inpatient hospital visits (McGough et al.,

2024). Figure 2 ties both the top percentage of spenders and what they are spending their money on together.

When solely focusing on out-of-pocket expenses, there is a clear winner for what the top 5% of spenders are using their money on, and this is ambulatory/emergency services. Spending was also significantly impacted by diagnosis, with cancer being the diagnosis with the highest spending associated with it (McGough et al., 2024). Based on sex, health care spending shows significant trends at different points in life. Women are more likely to spend more on health care than men from ages 18-64, especially in the range from 19-34 where the spending is almost double that of men (McGough et al., 2024). This is substantially due to this being a popular

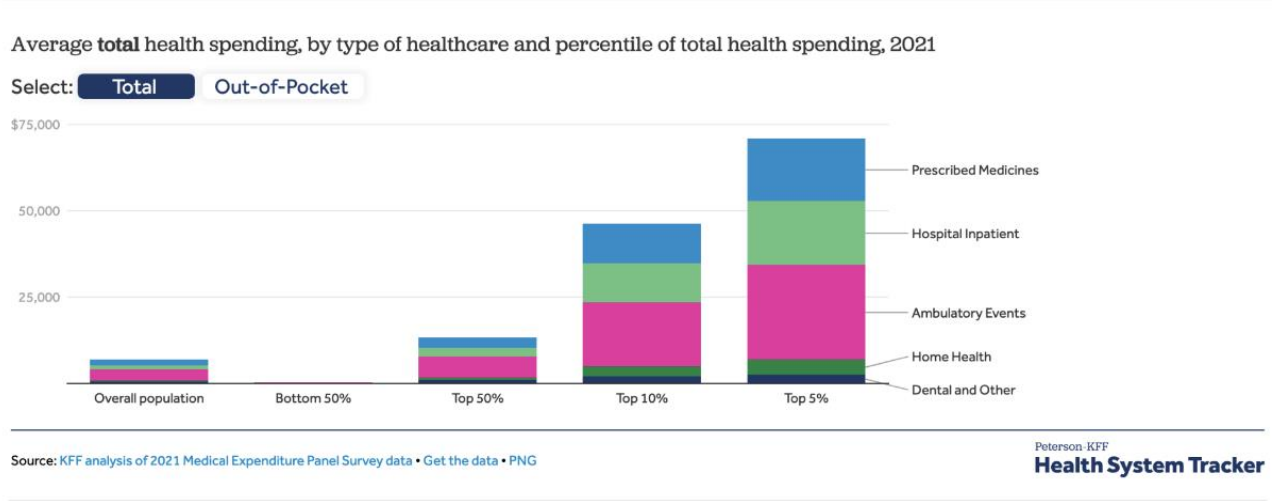
Figure 1.



range for births for women. However, from ages 18 and under and 65 and over, men are more likely to outspend women in health care (McGough et al., 2024). All of these combined make up the face of health care spending within the United States, and it proves that there are significant

and vast divides created spending-wise between the average American and those contributing to

Figure 2.



spending the most.

Other contributing factors that are significant to the discussion of health spending are those based on race and socioeconomic status. Those who identify as white are on average spending more than any other race at $8,500 on average (McGough et al., 2024). This is followed by those who identify as other race/multicultural, but the average spending between their white counterparts is divided by over $2,000 on average (McGough et al., 2024). Black and Hispanic populations rank next with their average spending falling around $6,000 and $4,000 respectively. At the bottom, those who identify as Asian are spending the least on their health care averaging around $3,500 in the year 2021 (McGough et al., 2024). These statistics could be directly tied to health insurance literacy and accessibility within the United States, but can also be attributed to average ages, incomes, and lifestyles. It is estimated that "(a)bout three in four Asian and White people are enrolled in private health plans at some point in a given year, while about one in two Black and Hispanic people are covered by private plans at some point in a

given year" (McGough et al., 2024). Additionally, immigrants have a lower spending average on health care, and with most immigrants in the United States being classified as Asian or Hispanic, this could explain some of the lower spending levels (McGough et al., 2024).

There is also a significant relationship between socioeconomic status and health care spending. health care costs have only increased within the United States in the past decade. In general, the more a person makes, the greater access to quality health care they are more likely to have. It also proportionally impacts their lifestyle choices that can influence health care spending like diet, exercise, education, housing, and drug/alcohol usage (*Healthy People 2030,* 2020). Furthermore, conditions and diseases can impact people's ability to work, leaving them unable to afford treatment or regular medical care, and in turn, worsening their conditions (*Healthy People 2030,* 2020).

Chapter Three: A Brief History of Health Insurance within the United States

The 1800s to the 1920s

As far back as the beginning of our country, health care has been around although, perhaps not in the same light in which we know health care today. Health care in the early years of the United States was unregulated and unruly (Moseley, 2008). Although there is little information on the way formal care was provided, it is understood that "(f)or most of the 1800s, hospitals had been a place where the chronically ill and indigent received charitable care because they had no family capable of shouldering the burden" (Gorman, 2006). Additionally, health care was something that was only sought after when the affliction would interfere with a loss of wages (and could not be managed by the family), so anything minor was commonly disregarded (Gorman, 2006). During this time, "(w)hen patients saw a physician, they paid their fees out-of-pocket; they were more concerned about the wages they would lose if illness kept them out of work than about the cost of their medical care" (Moseley, 2008).

The early history of health insurance was pioneered by Chancellor Otto von Bismarck in the late 1880s when he was the first to provide a social form of health care to working-class men in Germany (Ross, 2002). "His scheme, organized through independent sickness funds, was a means, primarily, to stabilize income and provide sickness insurance together with funeral benefits for three-fourths of Germany's employees, or about one-third of the population" (Ross, 2002). This initiative was proven to benefit the general population's health and prompted other countries to consider establishing insurance before World War I (Ross, 2002).

At the end of the Civil War, the first major shift in the medical field began as research efforts started to point out that poor conditions were linked to disease outbreaks and death (National Library of Medicine, 1976). Because of this shift, in 1870, the American Health

Association was established to aid in national health initiatives, and this was followed by the American Medical Association in 1879. Both contributed to the start of the standardization of the field (National Library of Medicine, 1976). By 1910, membership in the AMA increased from 8,000 to 70,000, pushing forward a new standard of practice for physicians and the creation of their credibility (Moseley, 2008). As the quality and standards of the health care industry rose in the early 1920s, so did the cost of affording care, which began the history of commercial health insurance.

Within the early 1900s, for-profit commercial insurance companies were not issuing health-focused policies as there was no way to get around the risks of adverse selection. This is the concept that the healthy population would choose to not opt into insurance to cover those who were sick and would opt into insurance (Moseley, 2008). There is little information that speaks formally about health insurance in the United States or the idea of anything along the same concept before the early 1920s (Morrisey, 2020). Post-World War I, the socialized insurance push, government only run health insurance programs usually in addition to government run health care, made its way to the U.S. but was ultimately struck down due to backlash from private physicians and commercial insurance providers (Moseley, 2008).

The 1930s to the 1940s

The stock market crash in 1929 followed by the Great Depression took its toll on the health care industry. With people out of jobs, health care, which already maintained a poor reputation, was ruled out for many as an unaffordable expense across the United States. For example, it was reported that “between 1929 and 1930, Baylor University Hospital, in Texas, saw its receipts drop from $236 to $59 per patient. Occupancy rates dropped from 71.3 to 64.1

percent, and contributions were down by two-thirds. Charity care, in contrast, was up 400 percent" (Morrisey, 2020).

Against all odds, one of the first standardized insurance policies was introduced. The first health plan was proposed by Justin Baylor in 1929, and it granted "a group of Dallas school teachers, contracted with Baylor University Hospital, to receive up to 21 days of inpatient care a year for regular monthly payments of 50 cents." Around 1,250 teachers were enrolled in this pilot program (which can loosely be termed as the first preferred provider organization) and was proved to be a success for those enrolled. The plan style was later picked up by other hospitals to ensure a steady income during the Depression and most plans only covered hospital services (Morrisey, 2020). In 1932, a plan was created in Sacramento similar to the above but covered all hospitals within a declared area. This led to an expansion into 26 facilities picking up a similar offering to share coverage benefits (Moseley, 2008). These plans, when partnered with the American Hospital Association as a regulatory service and confirming agency, formed the Blue Cross health plan in 1946 (Morrisey, 2020). This created the first "pay-as-you-go" insurance program within the United States (Gorman, 2006).

With the threat of competition posed by the hospital insurance plans as well as potentially not charging whatever they wanted, in 1939, physicians decided to band together to form a type of insurance that would cover their costs (Moseley, 2008). This would eventually become Blue Shield, conveniently named because of the way it "shielded" doctors from having Blue Cross entering the provider sector (Moseley, 2008). Additionally, these medical groups were the ones who banded together to strike down President Roosevelt's intentions to include universal health care within the Social Security Act of 1935 (Morrisey, 2020). These plans would conjoin

together in 1977 as they are more famously known as Blue Cross and Blue Shield, one of the largest health insurance providers today.

Once proven successful, these plans reshaped the former idea that the health insurance market could not be profitable. This, coupled with the new idea to community rate their policyholders, created the perfect storm for the introduction of more policies. Pre-World War II, it was estimated that only 9% of the United States had health insurance, and after, the number increased to 25% (Gorman, 2006). This increase could be associated with the fact that employers were limited by wage and price controls during wartime, so they could not offer higher salaries as a method of recruiting employees and would choose to use benefits like health insurance instead (Moseley, 2008). This created a major shift in the health insurance market that is still around today.

In this period, the 1947 Taft-Hartley Act declared that health insurance was a condition for employment and a point for labor negotiations, and the IRS declared that health insurance was both tax deductible for employers and was excluded from taxable income for employees (Morrisey, 2020). This is an important detail because "(t)he tax code effectively encourages employees and their employers to shift compensation toward untaxed health insurance and away from taxed money income" (Morrisey, 2020). The Hill-Burton Act, passed in 1946, was also a major monument for this period and in the history of health insurance. It provided many forms of financial support to encourage the rapid building of hospitals across the United States and the refurbishment of older facilities (Moseley, 2008).

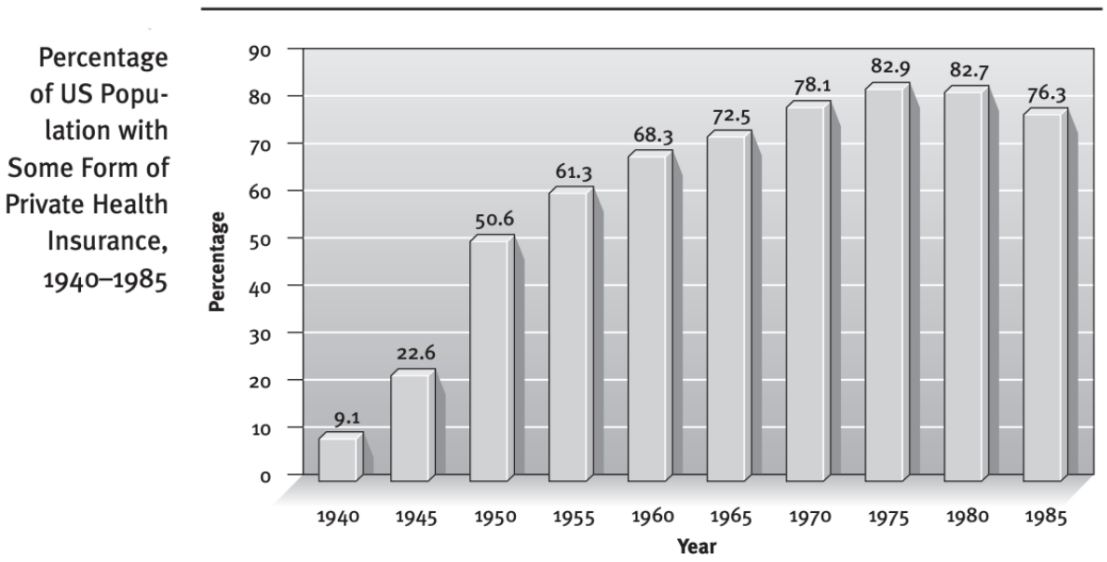
The 1950s to 2000s

Throughout the 1950s, there was a great increase in medical expenditures as more scientific discoveries like vaccines, medical breakthroughs, and infectious disease treatment, proved to be successful. With health care and insurance entering a new era of innovation and success, some problems arose that impacted the health insurance market. In the 1960s, the market for health care remained largely unregulated. This was one major reason that plans shifted from the formerly popular community rating (rating individuals based on location) to rating based on experience (lifestyle, job, age, and more) (Morrisey, 2020). Essentially, health insurance companies could charge whatever they wanted to per individual. For example, a construction worker might have a substantially higher premium than someone who works in an office facility. Additionally, older generations had to pay much higher rates as they were a greater risk. This created affordability problems for certain targeted groups and prompted a government response.

The large Democrat majority in the United States Congress during President Truman's term posed the greatest opportunity for solutions to these issues. These proponents for a universal health care plan, which finalized with Lyndon B. Johnson in the 1940s, understood that a total shift in health care to socialized medicine was too intense and would receive too much backlash. Therefore, to bridge the gap for some of the unprotected population, Medicare and Medicaid were established to be a governmental program that would provide care to both the elderly and the poor respectively (Moseley, 2008). "The House passed the full bill 315 to 115, and after further debate and amendments, the Senate passed it by a 68 to 21 vote margin. President Johnson signed the legislation in former President Truman's hometown of Independence, Missouri, in July 1965" (Morrisey, 2020).

Overnight, the government of the United States became the single largest buyer of health care within the country (Moseley, 2008). Figure 3 shows the doubling of those plans and the continued rise of plans into the 1980s (Moseley, 2008). Medicare and Medicaid have a controversial reputation in the health insurance market and the United States economy. Linda Gorman in her book, The History of Health Care Costs and Health Insurance, critiques their

Figure 3.



creation because "(r)ather than encourage people to pay for their health care with their own money, Medicare and Medicaid institutionalized the notion that people could buy health care and pay for it with other people's money… (and) unlike private insurance policies… Congress can change benefits at will." Medicare and Medicaid's passage catapulted forward the already increasing price inflations of health care costs (Moseley, 2008).

The early 1970s were shaped by the creation of other forms of managed payment plans. First, Health Maintenance Organizations, which is where "(p)atients pay a flat fee for their health care, a capitated payment, and the HMO promises to provide all of the health care an individual

needs", were gaining popularity for their cost containment focus (Gorman, 2006). These policies limit patients to only seeing the partnered health providers and have been critiqued for having a model where doctors are not as patient focused as they partner with the insurance instead of the individual (Gorman, 2006). The Health Maintenance Organization Act of 1973 was passed to encourage this form of insurance plan within the workplace through the means of governmental financial support, and this effort proved to be successful as, "(i)n the 1970s, there were 26 plans with about 3 million subscribers nationwide; by 1991 the numbers had grown to 556 plans with 35 million enrollees" (Moseley, 2008). In the 1980s, Preferred Provider Organizations developed in response to the Employee Retirement Income Security Act which was created in response to an automobile plant that closed with an underfunded pension plan for employees (Morrisey, 2020). Essentially, this act establishes bottom-line health insurance requirements that are necessary for for-profit companies to follow and shifted companies to provide insurance themselves (Gorman, 2006). PPOs are best explained through this example. "(A) local hospital negotiates a price below hospital billed charges in exchange for encouraging (future) subscribers to use this hospital. One similarly obtains agreements from physicians who have privileges at this hospital. These hospitals and physicians are preferred providers" (Morrisey, 2020). These are beneficial to companies as they pose no underwriting risk and provide more coverage to employees. Costs during this time continue to rise (Morrisey, 2020).

The early 1990s were clouded by the success of these managed care plans as they were able to negotiate lower prices because contracts were selective between each party (Morrisey, 2020). However, towards the latter half of the decade and with a large increase in health care spending, a shift in questioning doctors and policies began. Doctors were accused of "padd(ing) their income by recommending unnecessary tests and procedures" (Gorman, 2006). Additionally,

the gate-keeping nature of having to see a general provider before a specialist was becoming largely disliked among the population (Morrisey, 2020). The Clinton Administration attempted to reform this with the “managed competition” proposal but ultimately failed due to its large number of proposed regulations and low perceived success rate in current market conditions (Weil, 1993). Medicare and Medicaid were expanded during this time as well. Medicare Part D was created during the Bush Administration to aid the elderly in the purchase of prescription drugs (Morrisey, 2020). Medicaid saw expansions that impacted pregnant women and children. In 1997, the Children's Health Insurance Program (CHIP), was established to extend coverage to family’s children up to 300 percent of the Federal poverty level (Morrisey, 2020).

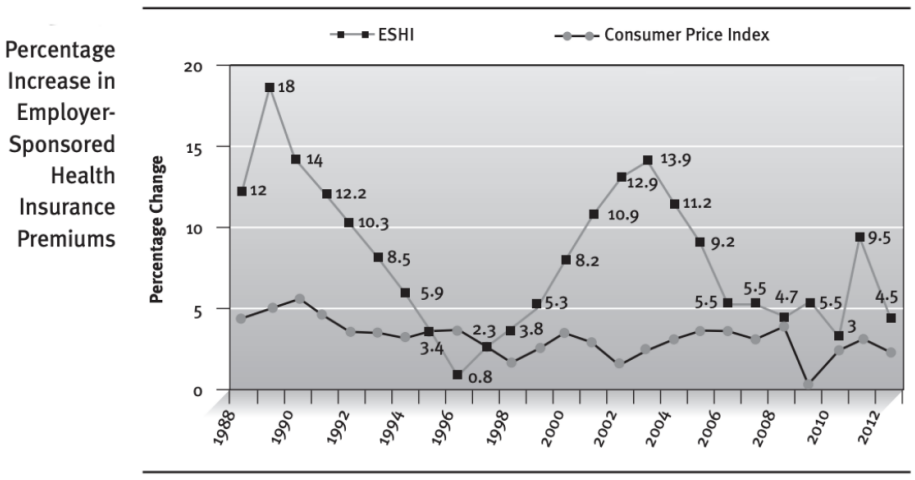
The 2010s to Now

One of the most controversial changes in health insurance history occurred in the 2010s when the Obama Administration and Congress passed the Patient Protection and Affordable Care Act. After the housing market crash of 2008, the country was in recession, and 50 million Americans could not afford insurance; health care was also making up around 15 percent of the GDP. The market was out of control (Rawal, 2016). Figure 4 depicts the market dip as well as the insurance dip at the time. With the data predicting that health care costs would only increase at a rapid rate, the Obama Administration responded and proposed the act in 2008 (Rawal, 2016). The act would take two years to pass, and this was primarily due to the highly partisan disputes over the act itself. It would pass on March 21, 2010, without a single Republican vote supporting it, and would forever shape the American health insurance market (Rawal, 2016).

There was one primary goal that the Affordable Care Act sought to achieve in the health care market, to make insurance more affordable for those within the country. It did this in several

ways. One way was through offering tax credits to those with incomes 100%-400% below the federal poverty level and cost-sharing reductions for insurance to help lower out-of-pocket costs that policyholders have to pay for monthly expenses (*About the ACA*, 2022). The act sought to

Figure 4.



SOURCE: Data from Gabel et al. (2005), KFF and HRET (2012).

expand Medicaid as well, introducing coverage to those who are 138% below the poverty level (*About the ACA*, 2022). One of the largest attempts to make health care more affordable came through the act's ban on denial of coverage to those with pre-existing conditions. Essentially, insurance companies could no longer opt into not covering a policyholder due to a previous diagnosis (*About the ACA*, 2022). This also protected from the potential of losing coverage of your insurance if your health status changed. This requirement "(p)rotected more than 133 million people with pre-existing conditions, like cancer, asthma, diabetes, or pregnancy, from being denied coverage for their pre-existing condition" (*About the ACA*, 2022). The act also mandated that insurance cover, at minimum, ten essential categories: ambulatory services, emergency services, hospitalization, prescription drugs, rehabilitation services, labs, pediatric care, free preventative care, maternity care, and mental/behavioral health treatment (*CMS*, 2023).

In 2014, the last section went into effect that would assist in attempting to lower health care costs across the United States. The Affordable Care Act mandated that everyone have some form of health insurance, or else, face a tax penalty (*What is the individual mandate?,* 2023). It also required companies with over 50 employees to be required to provide insurance to employees. However, in 2018, the fine was removed with the passing of the Tax Cuts and Jobs Act of 2017, essentially creating no real enforcement of the minimum policy requirement of the act (*What is the individual mandate?,* 2023). One of the last goals of the act was to promote health care innovation specifically dedicated to decreasing the cost of health care (*About the ACA*, 2022).

One of the largest unanswered questions was did the ACA achieve what it sought to do: lower health care costs overall and expand health insurance coverage. In part, yes. Authors Sherry Glied, Sara Collins, and Saunders Lin for the Common Wealth Fund argue that "a review of the research literature on the effects of the ACA indicates that the law helped protect Americans against the financial risks of illness, reduced the uninsured rate, improved access to care, and lowered out-of-pocket spending. But subsequent court decisions, along with congressional and executive branch actions, have limited the ACA's reach" (Glied et al., 2020). However, the main failure of the plan was that there was no longer a financial punishment, so young healthy individuals did not join to cover costs for the sick and elderly. Overall, the ACA presented the perfect grounds for the monumental changes needed to help with health care affordability in the United States but was stifled along the way. Since then, "the average family premium has increased 22% since 2018 and 47% since 2013" (*Cost of health insurance*, 2023). With this being the last large impact on the health insurance market, health care costs have only

increased. One interesting trend during the COVID-19 pandemic was that health insurance companies experienced their most profitable years since before 2008 (Shrivatsa, 2022).

Health Insurance 2022

One of the best, and most recent, determinants of the long-term effects of the Affordable Care Act can be analyzed by the Health Insurance Coverage Report of 2022 conducted by the United States Census Bureau. Before diving into health insurance literacy, it is important to understand the makeup of the health insurance market. This report provides great insight into the necessary background of what health insurance literacy looks like today.

The US Census Bureau uses The Current Population Survey Annual Social and Economic Supplement (CPS ASEC), the longest-running household survey conducted, to analyze population coverage by broadly categorizing insurance wielding as public or private. This includes "coverage at any time during the calendar year for the civilian, noninstitutionalized population of the United States" (*US Census Bureau*, 2023). Private coverage is defined as insurance that is employer-sponsored, direct purchase, or TRI-CARE which is an insurance program for uniformed service members. Public coverage is defined as insurance through Medicare, Medicaid, Veterans Affairs, or CHAMPVA. The purpose of the report is to show the differences between health insurance enrollment changes from 2021 to 2022 from survey information recorded in 2023.

2022 reached a record high of those enrolled in health insurance programs with 304.0 million having health insurance at some point during the year (*US Census Bureau*, 2023). Figure 5 expresses the overall increases in plan enrollment raised from 91.7 to 92.1, seeing the greatest increases in public plan enrollment by 0.4 and a decrease in private plans by 0.3 (*US Census*

Bureau, 2023). This growth in public plans can primarily be associated with the population shift of those now categorized as 65 and up. It is estimated that around 7.9 percent of the population went without insurance in 2022, which was one of the lowest rates seen in national history.

Figure 5.

Number and Percentage of People by Health Insurance Coverage Status and Type: 2021 to 2022

(Numbers in thousands. Margins of error in thousands or percentage points as appropriate. Population as of March of the following year. Information on confidentiality protection, sampling error, nonsampling error, and definitions is available at <https://www2.census.gov/programs-surveys/cps/techdocs/cpsmar23.pdf>)

Coverage type	2021				2022				Change in percent (2022 less 2021)
	Number	Margin of error[1] (±)	Percent	Margin of error[1] (±)	Number	Margin of error[1] (±)	Percent	Margin of error[1] (±)	
Total	**328,100**	**148**	**X**	**X**	**330,000**	**130**	**X**	**X**	**X**
Any health plan	**300,900**	**748**	**91.7**	**0.2**	**304,000**	**746**	**92.1**	**0.2**	***0.4**
Any private plan[2, 3]	216,400	1,077	66.0	0.3	216,500	1,399	65.6	0.4	-0.3
Employment-based[2]	178,300	1,123	54.3	0.3	179,800	1,369	54.5	0.4	0.1
Direct-purchase[2]	33,550	705	10.2	0.2	32,800	661	9.9	0.2	*-0.3
Marketplace coverage[2]	11,390	447	3.5	0.1	11,840	461	3.6	0.1	0.1
TRICARE[2]	8,299	527	2.5	0.2	7,817	485	2.4	0.1	*-0.2
Any public plan[2, 4]	117,100	911	35.7	0.3	119,100	1,183	36.1	0.4	0.4
Medicare[2]	60,230	378	18.4	0.1	61,570	392	18.7	0.1	*0.3
Medicaid[2]	61,940	843	18.9	0.3	62,050	1,112	18.8	0.3	-0.1
VA and CHAMPVA[2, 5]	3,151	192	1.0	0.1	3,354	214	1.0	0.1	0.1
Uninsured[6]	**27,190**	**727**	**8.3**	**0.2**	**25,940**	**739**	**7.9**	**0.2**	***-0.4**

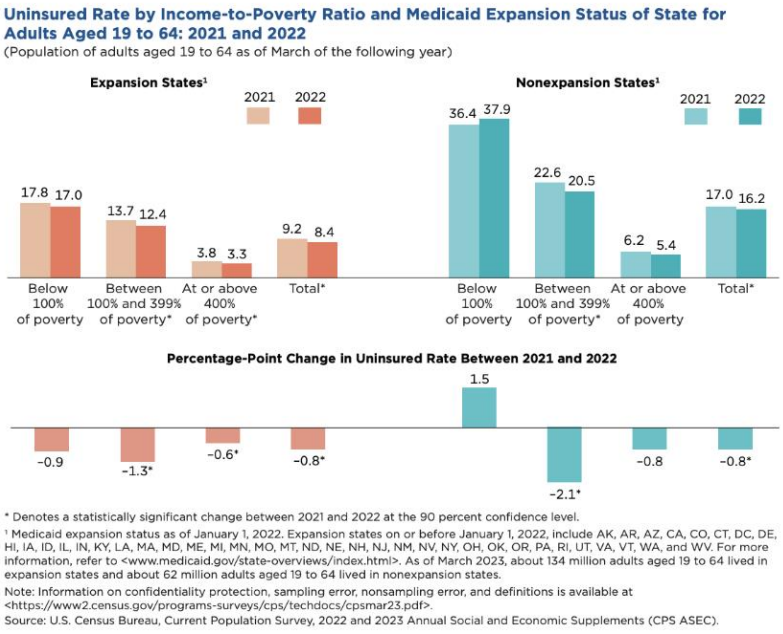
* An asterisk preceding an estimate indicates change is statistically different from zero at the 90 percent confidence level.
X Not applicable.
[1] A margin of error (MOE) is a measure of an estimate's variability. The larger the MOE in relation to the size of the estimate, the less reliable the estimate. This number, when added to and subtracted from the estimate, forms the 90 percent confidence interval. MOEs shown in this table are based on standard errors calculated using replicate weights.
[2] The estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of health insurance during the year.
[3] Private health insurance includes coverage provided through an employer or union, coverage purchased directly, or TRICARE.
[4] Public health insurance coverage includes Medicaid, Medicare, CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs), and care provided by the Department of Veterans Affairs and the military.
[5] Includes CHAMPVA, as well as care provided by the Department of Veterans Affairs and the military.
[6] In the CPS ASEC, individuals are considered to be uninsured if they did not have health insurance coverage for the entire calendar year.
Note: Estimates may differ from previous publications due to additional rounding implemented to protect respondent privacy.
Source: U.S. Census Bureau, Current Population Survey, 2022 and 2023 Annual Social and Economic Supplements (CPS ASEC).

One of the largest focuses of this report was on the population's age ranges and their coverage category. As the overall average age of the population increased, the uninsurance rate statistically decreased. The survey found that "(b)etween 2021 and 2022, the uninsured rate for working-age adults aged 19 to 64 decreased 0.8 percentage points… (and) among working-age adults, those aged 19 to 25 had the highest rate (14.0 percent) uninsured for the entire calendar year of 2022, followed by those aged 26 to 34 (12.5 percent), adults aged 35 to 44 (11.2 percent), and those aged 45 to 64 (8.6 percent). In 2022, 9.8 percent of workers were uninsured, a decline of 0.9 percentage points from 2021" (*US Census Bureau*, 2023). These findings show how public

coverage is affected by national trends occurring in the economy. These results also point to the trend that younger adults remain the least likely group of the population to purchase insurance.

Other findings, when focusing on the working class from ages 19-64, revealed insightful trends in the current health insurance industry, specifically concerning race. In recent years, Hispanic, Black, and White non-Hispanic uninsurance rates have decreased by around an average of 1.2 percentage points combined, whereas the uninsurance rate for Asian adults had no substantial change (*US Census Bureau*, 2023). The largest decrease in uninsurance rates was among Native populations dropping from a 9.1% uninsurance rate to 8.2% (*US Census Bureau*, 2023). Other characteristics that showed significance in this study were marital status, region, household income, and state of residency's Medicaid expansion status. Figure 6 goes more in-

Figure 6.



depth about the Medicaid Expansion status with health insurance coverage and shows that expansion states have significantly lower rates of uninsurance (*US Census Bureau*, 2023).

The conclusion of the 2022 survey found that the total uninsurance rate dropped 0.4 percent from the previous year with the most significant increase in enrollment in Medicare of 0.3 percentage points as projected to increase with the retirement of the Baby Boomer generation, those born in the years 1946 to 1964 (*US Census Bureau,* 2023). The ACA's impact is ever present in today's health care market, and looks, from the outside, to have accomplished its goal thus far of decreasing uninsurance rates. Other unique market impacts could be present from the coronavirus pandemic of 2020 which could have prompted those without insurance to seek coverage out of fear or necessity. However, just because the population is insured does not ensure that they are well educated on their plans or using them properly.

Chapter Four: The Definition of Health Insurance Literacy

Health insurance is defined by the United States Census Bureau in 2022 as “a means for financing a person’s health care expenses… (and this) coverage provides access to medical care, protection from high unexpected costs, and more economic stability for people and families” (*US Census Bureau,* 2023). Today, most people are covered by some form of private insurance which is usually employer-sponsored through jobs. Government-sponsored programs like Medicaid, Medicare, and Veteran Affairs Programs fill the slot for the next most popular style of coverage.

With the complex history of health insurance within the United States, how can we accurately measure if buyers understand their health insurance since it is mandated through the ACA? Health insurance literacy (HIL) is defined as, “a person's ability to seek, obtain, and understand health insurance plans, and once enrolled use their insurance to seek appropriate health care services” (Edwards et al., 2019). This is mainly defined through the user's understanding of the terms and costs that are associated with health insurance policies, as well as how these are associated with the confidence that the person has when using this insurance (Edwards et al., 2019). “Notably, health literacy, numeracy, and financial literacy are necessary components of HIL” (Kakar et al., 2022). When HIL is measured, generally, it can predict many different factors associated with health care usage. Recurring items are present in HIL research that help measure this data. Some common terms that are asked to be defined include: “premium, deductible, copayments, coinsurance, maximum annual out-of-pocket spending, provider network, and covered services” (Edwards et al., 2019). Lastly, confidence in usage is vital to understanding HIL. Self-reporting confidence scales and financial literacy are used in these studies to understand HIL more deeply (Kim, et al., 2013).

Measuring HIL is complex. Because of this, there are arguments by experts that a shortage of information exists when studying health insurance literacy within the United States. Nonetheless, there exist some modern HIL studies that gather data on groups of people using health insurance, but no national standard or survey exists to measure people's understanding uniformly. Essentially, with all of this research, the way different questions are proposed and responded to could result in different statistics and results. Within these studies, there are often limitations to the research being conducted. It is common for these studies to use self-reporting as their measure for HIL understanding and confidence, and this, in research, should always be taken cautiously when interpreting results (Edwards et al., 2019). Additionally, many different health insurance aspects vary from state to state, like Medicaid, so it is hard to accurately measure HIL on a national level when different standards apply on a state-by-state basis (Edwards et al., 2019).

Chapter Five: Health Insurance Literacy Confidence Measures

There are many barriers to health care in the United States. Cost, insurance, and access are some of the most popularly cited in research. Until recent years, HIL has not been considered as an addition to these barriers to people seeking care. Since confidence in usage of care is an important aspect of HIL measures, it is important to understand what give a user confidence in usage. In a study conducted by the Institute for Health Care Advancement, Dr. Rishtya Kakar and her fellow authors discuss how to measure confidence in usage and argue in support of the focus of adding HIL to this formal list of health care barriers.

Focus groups were interviewed ranging between the ages of 18 and 85 to gather their perspectives on their confidence in health insurance and HIL. The study demographic report stated that "(n)early all participants (96%) reported currently having health insurance coverage, with 40% covered by private insurance (either employer-sponsored insurance [ESI] or purchased through the health care exchange), 31% by Medicare, 13% by Medicaid, and 11% by Veterans or TRICARE insurance. In the past two years, 22% had changed their health insurance" (Kakar et al., 2022). Once interviewed, the data revealed four domains exist that lead to the optimal level of confidence and coverage in health insurance policies. These were the system's structural context (costs/complexities), individual measures (HIL, life skills, experiences), the intersection of the systems and individual measures (current enrollment, care access), and health care reform (Kakar et al., 2022).

The first domain, the structure of the system, found that the surveyed population believed that "the health care system generally—and health insurance specifically—complex and confusing to navigate" (Kakar et al., 2022). Further, they believe that this was an intentional setup to create confusion among the population which leads to a general mistrust of these

programs. Most complexities and mistrust within the system are related to issues with billing and costs associated with the purchase of insurance. “Participants described feeling caught between providers and insurers, often bearing responsibility for the bill until the problem was resolved” (Kakar et al., 2022). These surprise bills and issues were perceived to lead to forgone care as well as large dissatisfaction due to taking a significant portion of wages. In addition, the consensus among the surveyed population was that health insurance was valuable to have as an emergency net but did not have a high perceived everyday value (Kakar et al., 2022).

The second domain, the individual context, was more personal from participant to participant. Overall, most participants were found to have a good base level of knowledge of insurance but struggled with the applications of insurance to their own health-related choices. Essentially, some participants “described not fully understanding their plan's details, (and) they did not know if they made the right insurance coverage decision until they had a major medical issue” (Kakar et al., 2022). Several individual factors led to a range of responses during the focus groups. Those who had worked in a health care setting or gone through former insurance issues tended to have higher confidence in their understanding of health insurance (Kakar et al., 2022). Additionally, employment status, socioeconomic status, and transition stage were all perceived to be associated with confidence in HIL, and those employed stated that health insurance was the greatest benefit that was provided by their employers (Kakar et al., 2022). Those of lower socio-economic status who were uninsured stated that they were hoping for no emergencies in their near future and tried not to think about health insurance too much (Kakar et al., 2022). Lastly, those in insurance transition (due to job change, retirement, or disability) had lower confidence levels in health insurance post-switch (Kakar et al., 2022).

The third domain is the intersection of the individual and the system (i.e. the ownership of health insurance or health care interactions). When researching plans, participants "reported difficulty understanding plan details, gathering household health and financial information, and making a good decision in the time allotted to open enrollment" (Kakar et al., 2022). In essence, most plans were chosen due to affordability, network, and family needs but typically not considering a full understanding of the coverage. Next, the cost of health care was a common thread between all individuals interviewed. The cost of purchasing health care influences people's spending on visits, tests, and other health-related visits, only wanting what is covered by their health insurance policies. Other perceptions about the health care industry influenced this dimension, like the belief that insurance companies and health providers care (or lack care) about a patient's health and well-being (Kakar et al., 2022). Overall, health care and health insurance markets are perceived to be complex and hard to understand by customers making users lack confidence in their ability to navigate these markets.

Continuing in this dimension, the mode of delivery of health care and health insurance information was perceived to play a key role in the confidence level of participants. Participants seemed to want information tailored to their specific situations rather than general topics of health insurance. They "perceived that print, online, phone, and in-person support each had positive and negative attributes… (however, a) common thread was that insurance information must be made easier to understand, whatever the delivery method" (Kakar et al., 2022). It was found that in-person delivery of information had the highest perceived value for participants of the study, particularly someone who was viewed as unbiased and could provide neutral information (Kakar et al., 2022). The study did not go into the fourth domain, health care reform, with the focus groups for unstated reasons.

Overall, the study shows that, without possessing all of the categories that lead to a positive perception of health insurance, Americans tend to have negative perceptions of the health insurance industry. Confidence has a large impact on HIL, and it is important to note that this measure could be the most vital to higher rates of HIL. This “lack of confidence” has been shown to bleed into the reality of the current research that exists on the topic.

Chapter Six: Current Research on Health Insurance Literacy

Post-ACA, the creation of HIL studies was established as a result of more consumers entering the insurance market unequipped with the proper knowledge. What research is currently being conducted to prove this low level of HIL, and what are the implications that arise from these findings? These studies have been conducted to research the correlation between HIL, health insurance, demographics, health care spending, and more. When looking into some of these HIL studies at a general glance, a cross-comparison of results can give a broad understanding of how this data impacts health care and the importance of further research into the HIL's impact on health care.

Study #1: "Development of the Health Insurance Literacy Measure (HILM): Conceptualizing and Measuring Consumer Ability to Choose and Use Private Health Insurance."

This field study, conducted in 2014, collected data on HIL measures via a self-reporting survey of 800 participants from all different ranges of demographics to establish a unified measurement for HIL. It is noted that the study struggled to find a healthy sample of those from lower incomes as well as all racial minorities, thus skewing the results (Paez et al., 2014). Before the survey, the authors spent an extensive amount of time reviewing the literature to assess what a health insurance literate person should know. This literary review strongly references Lynn Quincy, who is well known for her contributions to early health care policy and insurance research. After obtaining some background, they invited experts, mostly insurance-related, to a roundtable to discuss what questions should be answered by this study. Lastly, they did stakeholder interviews ranging from academic to governmental employees to solidify their measurements. This led the researchers to the conclusion that four sectors are present when

determining the HIL self-efficacy within a participant of their study. These sectors were knowledge of health insurance, information-seeking channels, document literacy, and cognitive skills (Paez et al., 2014).

The field study was conducted online and included people who were uninsured and insured with either private or public coverage. The average age of respondents in the unweighted sample was 44.1 years old with over half of the respondents being female identifying (51.3%). Additionally, “three-quarters of those completing the survey were non-Hispanic White, 9.5% were Black and 5% were Hispanic with the remaining falling into the ‘other’ category (10.1%) or identifying as mixed race (2.8%) (Paez et al., 2014). One-third of respondents reported having at least a high school degree or below, and about 35% of people earned less than $50,000 annually (Paez et al., 2014). Over 65% of people surveyed stated that they were the primary chooser for their or their families' health insurance policy, with most also stating they only visit a physician a few times per year (Paez et al., 2014).

The researchers abandoned their four-sector model post-survey and created two broader categories of health insurance literacy measures: selection and usage. “The item difficulty ranges of the scales are as follows: confidence choosing, 41.04 to 60.07; comparing plans, 46.61 to 54.96; confidence using, 45.55 to 59.03; and being proactive, 38.99 to 61.52” (Paez et al., 2014). Additionally, the “health insurance literacy self-assessment scales were positively correlated with the objective knowledge and skills scale. The correlation was greatest for comparing plans (.37) and being proactive (.32). The correlation was not as strong for the two scales that measured confidence: confidence choosing (.18) and confidence using (.13). These findings suggest that greater endorsement of confidence and self-reported behaviors measured by the HILM are likely to be related to actual health insurance knowledge and skills” (Paez et al.,

2014). The research concludes by stating that there seems to be a weak correlation between HIL and confidence in choosing/using a health insurance plan but a strong correlation between individuals' experience and HIL knowledge. This study is the most unique in light that it finds a weak correlation between HIL and insurance usage whereas most studies find strong correlations.

Study #2: "Significant Disparities Exist in Consumer Health Insurance Literacy: Implications for Health Care Reform"

This data analysis study was conducted in 2019 by reviewing the results of the Health Reform Monitoring Survey which was conducted in 2016 comprising 15,168 participants, between the ages of 18 and 64 years (Edwards et al., 2019). "The objectives of this study were to assess sociodemographic disparities in HIL, including knowledge of health insurance terms and costs, and confidence in using insurance to access health care in a nationally representative adult sample" (Edwards et al., 2019). This survey used two measures, knowledge of terms related to insurance and confidence in the usage of insurance to measure HIL. Participants used a self-reporting scale from 1 to 4 (1 being very confident) to measure their perceived HIL (Edwards et al., 2019).

"Most of the sample was between ages 25 and 64 years (84.9%), non-Hispanic (62.4%), living above the federal poverty level (81.9%), living in a metropolitan area (85.5%), U.S. citizens (92.2%), and insured (90.3%). More than one-half the sample was female (50.9%), working full- or part-time (67.6%), educated past high school (59.2%), and currently married (53.1%)" (Edwards et al., 2019). The data found that more than one-half of the participants (51%) did not possess adequate levels of HIL Literacy and around half (48%) had low

confidence levels in their usage of insurance (Edwards et al., 2019). The logical regression indicated that there were disparities among certain demographics. "(Y)oung adults, females, those with Hispanic ethnicity, non-U.S. citizens, and those who were currently unmarried" were the most likely groups to test low in HIL and confidence scales (Edwards et al., 2019). Other factors that showed a significant influence on HIL levels were those who are unemployed, have an income below the poverty level, with government insurance participants, and without a high school education. This data points to the idea that demographics greatly influence the likelihood of possessing HIL to a certain level.

The data is limited within its scope of research. The author states that the "cross-sectional design and lack of longitudinal data do not allow (them) to fully understand the nature of the relationship between the health insurance coverage status and HIL levels of survey respondents over time" (Edwards et al., 2019). This reiterates the idea that HIL measurements are complex and self-reported, making them hard to rely on for an unbiased or unscrewed source of data collection. Other limitations brought up how policy differences from state to state can have a large impact on HIL results (Edwards et al., 2019). Overall, this secondary resource reveals many different results compared to the first study by stating that HIL has a major impact on health insurance usage.

Study 3: "Association of Health Insurance Literacy with Health Care Utilization: A Systematic Review"

This study was conducted by comparing literature that compares and contrasts HIL and health care utilization. Additionally, a "search and extraction protocol was developed using guidelines from the Preferred Reporting Items for Systematic Reviews and Meta-Analyses

(PRISMA) and made publicly available via PROSPERO before study initiation" (Yagi et al., 2021). Preceding this study, few articles particularly used HIL as the term to measure literacy of insurance, therefore, the article had to compile a large bank of data using key terms like health knowledge, attitudes, practice, and health literacy to work with initially. The authors started with 4686 articles that mentioned the above terms. Crossing over multiple databases, from any date or region, this complex list of articles was narrowed down by their specific relation to health care utilization rather than economics, public health, or other factors. Studies that did not show a significant relationship between utilization and HIL were excluded. At the end of their review, the researchers ended with twenty-one articles that showed the association between HIL and utilization of health care.

The results of the study showed, from the 21 resources, 19 yielded that increased levels of HIL were related to an increased level of health care utilization (Yagi et al., 2021). These levels of utilization ranged from specific health care services (i.e. pediatrics, mammography) to overall services (i.e. visits per year). Ten of the studies showed the relationship between "HIL and utilization of primary care or other preventive services" (Yagi et al., 2021). Eight out of the nine studies conducted that spoke on delay of care showed there was a significant relationship between lower HIL levels and the prolonged delay of care. When referencing emergency services, three articles found no relationship between HIL, one found an increase in service usage with lower levels of HIL, and one found lower usage of services based on lower levels of HIL (Yagi et al., 2021).

One inconsistency pointed out by the study was there is no one way to define HIL between the articles reviewed. The researchers "identified 21 different ways of measuring HIL across the 21 studies, 19 of which were novel measures created specifically for the study" (Yagi

et al., 2021). A centralized measure, the Health Insurance Literacy Measure (HILM) as mentioned in study #1, was referenced as what should be the new standard to measure HIL. Essentially, this can be associated with the low volume of research that is being conducted on this measure.

Cross-comparison Implications

After a review of these three studies, several points are brought up that bring light to common issues within HIL in the population along with the research field. There are significant findings that HIL impacts health care spending measures and public health measures significantly. These have long-term effects on the health care market that can point to a strong need for more education on HIL.

Since "(h)ealth insurance is one of the most complex and costly products that consumers purchase and use in their lifetime", having low knowledge of the product causes massive concern for the health care market (Edwards et al., 2019). Thus, the first category of comparison between these studies points to issues related to low HIL levels and health care spending. Concerning insurance spending, lower HIL is primarily related to unconscious cost-related issues for families purchasing plans and/or using plans. "More than one-half (63.8%) of respondents were unsure about their family's out-of-pocket costs in the past year, and more than one-half (65.8%) of those with insurance coverage were unsure about their health insurance deductible amounts" (Edwards et al., 2019). One of the largest issues was patients' understanding of what visits were exactly covered by their insurance. For example, "in a study of adults with high-deductible health plans in the Kaiser Permanente System, 24% of those who mistakenly thought that their deductible applied to all office visits (when, in fact, preventive care visits had no out-of-pocket costs) said

they delayed or avoided a preventive office visit because of cost, while only eight percent of those who correctly understood the cost-sharing scheme did so" (Yagi et al., 2021). This misunderstanding is what could point to a distrust in the health care and insurance markets when customers feel unsure about the clarity of their plans. Another common problem that was brought up within this cross-comparison was troubles calculating the costs of full health care coverage.

Insurance experts also "reported that consumers fail to understand the underlying purpose of health insurance as a hedge against major medical costs" (Edwards et al., 2019). Thus, without this proper knowledge, patients are at risk to incur more costs than necessary while increasing the risk of crippling medical debt during emergencies. This also ties to patients' inability to afford care with the rising costs in the United States post-pandemic. In a survey conducted by the Common Wealth Fund in 2023, over 51% of all those polled said it was difficult for them to be able to afford health care costs (Collins et al., 2023).

The second category, public health implications, was brought up as a secondary issue in most of the research when concerning economic factors. All of the studies found some correlation between delay of care and lack of understanding of HIL. Study #3, which compared over 21 HIL-related research, stated that "lower HIL was associated with lower health care utilization or greater avoidance of a wide variety of health care services… For example, eight of the nine studies that assessed delayed or forgone care found that lower HIL was associated with avoidance of needed care. This suggests that HIL is a key mediator of effective navigation of the many layers of the US health care system" (Yagi et al., 2021). This also varies greatly among different demographics as well, putting more minority populations at risk for this forgone care. Those most at risk for delay of care include non-citizens of the United States, those of lower

economic brackets, those of lower educational status, and young adults. 57% of working adults reported a delay in care or medical treatment that caused a serious issue because of the forgone care (Collins et al., 2023). In conclusion, low HIL levels point to an endless cycle of high costs or delay of care that traps the patient.

The last issue brought up consistently was the lack of HIL research available. “In summary, the literature addressing the association between HIL and health care utilization is limited and lacks standardized measures to assess HIL” (Yagi et al., 2021). All studies reviewed used different methods to conduct their research as well as came to different conclusions as a result of these different methods. With so little data, and most of it being inconsistent, there exists a clear problem for solving the issues of health insurance knowledge within the United States. The only solution to this problem lies in the support of more initiatives to research and provide proof of the need for HIL-related public health interventions.

Chapter Seven: Proposed Solutions to HIL Issues

With the ever-present gap of knowledge in the United States on health insurance literacy, there needs to be changes and initiatives to aid in this epidemic. With the passing of the insurance mandate through the ACA, there was no creation of programs to aid the massive inflow of insurance purchasers in their HIL understanding. With over 304.0 million having health insurance in the year 2022, and that number continuing to grow every year, the need for interventions is ever-rising (*US Census Bureau*, 2023). One of the most relevant proposals to aid with HIL is through educational intervention programs. This can take different forms, but two primary focuses, employer and governmental, are the two most common educational channels that can aid in these efforts. Before beginning on this, a research standard for health insurance literacy should be the forefront of consideration to prove not only the need for these interventions, but to equip researchers with the proper tools to be able to compare and prove results cross sectionally.

With about 160 million of the population using employer-sponsored health insurance, it seems fitting for education interventions to occur within this level of the purchasing process. In order to save money and increase efficiency for not only the employer but the employee, having a full understanding of health insurance and how to use it can aid greatly in HIL intervention efforts. This is especially vital for those entering the workforce for the first time as well as those who are considered at risk for low literacy levels. Intervention examples could be including HIL training in onboarding processes or offering supplemental information for employees to reference at their convenience.

The next intervention must be offered to those with government insurance. One program already established, the Coverage to Care, a program that was developed by the Center for

Medicare and Medicaid Services, aims to help connect the public with the proper coverage based on their needs. This source includes educational material on telehealth, getting coverage for a chronic condition, preventative care, and more (*CMS*, 2023). Although this resource is useful for obtaining coverage, it does not specifically educate the public on HIL efforts. Creating more educational-focused resources along with those that connect people with health insurance would provide a more comprehensive approach to aid in HIL efforts. Additionally, the loosely enforced insurance mandates created by the government through the ACA, should provide required materials to those who are using these government programs at the point of purchase.

One last consideration could be the support for more organizations that help with health insurance counseling efforts. As stated above, people prefer to have face-to-face meetings with insurance providers about their specific situations. It makes sense to create more and aid existing programs that allow insurance purchasers to ask the necessary questions to gain confidence in their usage of health insurance. For example, the State Health Insurance Assistance Program (SHIP) is an example of a volunteer service that aids the elderly with their questions about Medicaid services. These efforts can connect individuals with those who have high levels of HIL and can explain the transition to them clearly and concisely. Combining education with real personal aid can perhaps be the most beneficial way to help HIL efforts across the United States.

Chapter Eight: Conclusion

Health insurance is an important preventative method when it comes to patients and their interaction with health care. However, it is evident that there exists a severe lack of knowledge and education among the general population when it comes to health insurance literacy and its proper usage. This leads to the avoidance of care, crippling medical debt, and an overall negative perception of insurance within the United States. Additionally, the complex nature combined with the so-called "insurance mandate" of the Affordable Care Act has created a large rift in the population's understanding and comprehension of health insurance and how to properly use it. This is even more magnified between certain demographics who are at greater risk for low health insurance literacy efforts. Overall, there proves to be a greater need for more research to be conducted on health insurance literacy and its impact as a barrier to health care in the modern era. There also needs to be a greater push for educational and support initiatives to combat the issues that accompany low health insurance literacy levels. With more information blended with a stronger approach to combating low health insurance literacy levels, purchasers within the health insurance market will be better equipped to make conscious decisions, and it will create a more equitable foundation for health care across the United States.

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