**Discussion**

The purpose of Study 1 was to determine if an HBP based intervention would lead to increased support for UHC. Furthermore, our secondary goal was to determine if our active intervention condition would have a greater increase in support for UHC than participants in our passive intervention condition. The results of our linear-mixed model did not support our two hypotheses, H1a and H1b. Our Bayesian estimation provided support of H1a, indicating that participants in both our intervention conditions had greater support for UHC as compared to our control. However, our Bayesian estimation did not support H1b; Participants in our active intervention condition did not have a greater increase in support for UHC compared to our passive condition.

One plausible explanation regarding our conflicting results is the confusion regarding the experimental procedure and materials for participants in our active intervention condition. Primarily, our qualitative free-response section indicated that a significant portion of participants in our active intervention condition did not fully understand the instructions necessary. Considering the complexity and numerical engagement necessary to participate, a lack of understanding could plausibly blunt the impact of the intervention. Furthermore, if participants in our active intervention exhibited confusion, while participants in our passive intervention did not, as they had much simpler instructions, that would be a confounding variable when attempting to determine if active instruction is superior for communicating on UHC as compared to passive instruction.

**Limitations**

Study 1 recruited participants from a large midwestern university located in a medium sized midwestern city. This is not necessarily reflective of the bulk of the insurance buying population. The design of Study 1 required the ability to calculate relative value, and thus numeracy, which makes it difficult to adapt for lower-numeracy populations. Lastly, our control condition was an uninformative control, which is not necessarily a realistic comparison point regarding commonly available information on UHC. Comparing our intervention condition instead to what would be considered ‘standard’ messaging that is publicly available regarding UHC would improve external validity.

**Future Directions**

The single largest priority in moving from Study 1 to Study 2 was improving the experimental design and materials. Executing a pseudo-replication of the study, with a protocol that is designed to reduce confusion would significantly reduce potential confounding variables. The second-most priority was to alter our control condition to reflect the messaging more accurately on UHC that is already available in an attempt to improve external validity.