**Impact of an Explicit Health Benefit Plan on support for Universal Health Care**

1. Does presenting an explicit health benefit plan increase support for Universal Health Care?
2. Is the effect moderated by participants simulating development of the HBP?

There are many theoretical reasons to believe that an explicit health benefit plan would improve implementation of universal health care. The first is that implementation is impossible without consensus as to what UHC is. Medical students for example, could be assumed to understand care distribution. However, they struggle to answer questions regarding UHC due to divergent beliefs as to exactly what ‘universal coverage’ means (Huebner, Agrawal, Sehgal, Jung, Hedgecock, & Simon, 2006). An explicit HBP sets parameters for what care at what level the government is able to subsidize. Secondly, without clear limits for care, determining if funds are spent responsibly is impossible. Indeed, the main mechanism through which racial prejudice predicts decreased support for UHC in the U.S. is ‘unfair’ disbursement of resources to undeserving minorities (Shen & Labouff, 2013). In addition to solving these two problems, studies have shown that an explicit HBP can also improve efficiency in resource allocation, create explicit entitlements for patients which help prevent marginalized individuals from being excluded from care, and reduces arbitrary restrictions on access and services (Glassman, Giedion, Sakuma, & Smith, 2015). Despite this evidence, there has been no research examining if support for UHC is increased by implementation of an explicit HBP.

We believe the best way to expose participants to a HBP is to engage in a hands on activity. Previous research indicates that a simulated experience exercise can be more impactful than simply being told facts (Weiger, Armstrong & Shaffer, 2019). We will use a decision exercise known as the “Choosing Healthplans All Together” (CHAT) in order to implement simulated learning. In CHAT, participants distribute markers to empty spaces on a board that represents different categories of health insurance services, and differing intensity of coverage. Since not all spaces can be covered, CHAT makes explicit how allocation of limited health resources work, addressing the concept of ‘value for money’ and ‘trade-offs’. Strong external validity exists as the value of markers and price per marker of care options have been actuarially analyzed to match contemporary health insurance spending. CHAT has been used in the Swiss UHC system to help set priorities (Schindler, Danis, Goold & Hurst, 2018). Lastly, CHAT makes the complicated prospect of developing an explicit HBP understandable, and is considered easy and fun to use (Danis, Ginsburg & Goold, 2010).

Finally, it is unknown whether or not support for UHC hinges on the source of the HBP itself. Previous uses of the CHAT exercise noted that 86.3% of people would accept an HBP that was developed by a group of their peers (Danis, Biddle & Goold, 2002). However, there has been no explicit comparison as to whether a HBP derived by a government agency would have a parallel level of support. As this would be the most likely implementation of an HBP for UHC, determining this support is imperative.

We will use a two-way between participants design with three levels to examine the effect of an explicit HBP on support for UHC. The first will be a control where participants complete a dummy exercise. The second level will be completing the CHAT exercise. The third level will have participants being given a completed CHAT worksheet, describing an HBP being given by a government organization. All participants will complete measures of support for UHC (Shen et al. 2013), before and after the exercise, in addition to demographic information.