

What Drives Trust in Health Insurance? Secondary Analysis of a Nationally Representative U.S. Survey

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Abstract

Background

Trust in health insurance plays a crucial role in shaping individuals' engagement with healthcare services, particularly as insurers assume more proactive roles in care delivery. However, limited research has examined which factors influence trust in health insurance plans and companies at the national level.

Methods

We used data from 7,702 adults in the 2021 Health Reform Monitoring Survey (HRMS) to assess factors associated with trust in health insurance. The primary outcome was a binary indicator of trust, derived from agreement with the statement: "I trust my health insurance plan and company." Weighted bivariate analyses were employed to assess the relationships between trust and sociodemographic, health-related, and insurance-related characteristics. Variables significantly associated with trust in bivariate analyses were included in a multivariate logistic regression model to assess their independent effects. All analyses accounted for the survey's probability weights.

Results

Among the 7,702 respondents, 69.1% reported trusting their health insurance provider. In bivariate analyses, trust varied significantly by age, race, education, income, self-rated health, usual source of care, type of insurance, perceived respect from the insurer, and perceived affordability of care (all $p < 0.01$). In the multivariate logistic regression model, individuals with better health status, lower income, lower education, a usual source of care, or non-private insurance had higher odds of trusting their insurance. Notably, respondents who felt respected by their insurer had substantially higher odds of reporting trust (adjusted odds ratio (OR) = 67.41; 95% confidence interval (CI): 52.25–86.97). Perceived affordability of care was also positively associated with trust (adjusted OR = 1.21 per unit increase in score; 95% CI: 1.11–1.31). Race and age were not independently associated with trust after adjusting for other variables.

Conclusions

Both access-related experiences and perceived interpersonal respect from insurers shape conclusions about trust in health insurance. These findings underscore the importance of fostering dignity and responsiveness in insurance interactions, as well as addressing affordability barriers to strengthen beneficiaries' trust, particularly as insurers assume a greater role in population health and care coordination.

Background

Trust is a critical component of the healthcare system, particularly within the patient-physician relationship. Patients who trust their providers are more likely to disclose relevant information, adhere to treatment recommendations, and express higher satisfaction with care, factors that contribute to better health outcomes (1-5). Physicians, in turn, actively work to earn and sustain this trust (6). While trust is multifactorial and complex, it is shaped not only by specific provider behaviors but also by institutional structures that influence patients' access to, experience with, and perceptions of care (7).

Although numerous studies have examined trust within the physician-patient dyad (8), institutional factors—particularly the role of health insurance companies—also significantly affect patients' perceptions and behaviors (9). Insurance companies influence decisions regarding access to care, affordability, and coordination, thereby shaping patients' experiences within the healthcare system (10, 11).

In recent years, health insurers have assumed more active roles in promoting health through population-based initiatives and value-based payment models (12-14). These efforts, which emphasize prevention and address social determinants of health, include examples such as Humana's "Bold Goal" program and other initiatives designed to improve local partnerships and community well-being (15-17). As insurers transition from passive financial intermediaries to active participants in healthcare delivery, understanding public trust in insurers is more critical than ever.

The stakes of trust in insurance have grown increasingly visible. A tragic 2024 incident involving the death of UnitedHealth Group's former CEO, reportedly at the hands of a young man frustrated by unresolved insurance disputes, drew national attention to the deep mistrust some individuals feel toward insurers (18). While an extreme and rare event, the episode highlights how distrust in health insurance can lead to anger, alienation, and disengagement. More routinely, individuals who lack trust in their insurer may ignore outreach, skip preventive services, or delay needed care, diminishing the promise of value-based care and population health initiatives.

To improve healthcare performance and outcomes, understanding what drives trust in insurance is critical. Although trust is conceptually tied to perceptions of affordability, respect, and fairness, limited research has directly examined these associations in the context of U.S. health insurance at the national level. By examining trust at the institutional level, this study contributes to a growing body of work focused on consumer engagement and equity in insurance systems.

Using nationally representative data from the 2020 Health Reform Monitoring Survey (HRMS), this study investigates the sociodemographic and experiential factors associated with trust in health insurance. The findings may help inform strategies to foster trust, improve equitable access to care, and enhance the effectiveness of insurer-led health initiatives.

Methods

Data source

The HRMS is a nationally representative, internet-based survey of adults aged 18 to 64, conducted since 2013. It monitors trends in health insurance coverage, health outcomes, and the implementation of key provisions of the Affordable Care Act, while also collecting data on a broad range of health-related topics. Survey participants are drawn from the Ipsos KnowledgePanel, the largest probability-based online research panel in the United States. Initially administered quarterly (2013–2014), HRMS transitioned to a semi-annual schedule in 2015 and 2019, and later to an annual schedule. Each wave consists of a different cross-sectional sample. This study focuses on the first quarter (Q1) of 2020 (19), as it is the only wave that includes specific questions regarding participants' trust in their health insurance plan and provider. These trust-related measures form the basis for our analysis of the dependent variable. After excluding cases with missing responses on variables used in the study, the final analytic sample consists of 7,702 individuals.

The dependent variable

The dependent variable in our analysis is based on participants' responses to the following question from the 2020 survey: "I trust my health insurance plan and company." Responses were recorded on a five-point Likert scale, where 1 = "never true," 2 = "rarely true," 3 = "sometimes true," 4 = "often true," and 5 = "always true." To facilitate analysis and address the relatively small number of responses in the lower categories (1–3) and the conceptual similarity between the higher categories (4 and 5), we created a binary variable that classifies respondents as "trust" (if they selected "often true" or "always true") or "don't trust" (if they selected "never true," "rarely true," or "sometimes true").

The independent variables

With the dependent variable defined as trust in health insurance, we next examine the independent variables that could influence this trust. These variables were selected based on their conceptual relevance to trust and their availability in the 2020 HRMS. Sociodemographic characteristics include age group (18–29, 30–44, 45–59, and 60+), educational attainment, race (White, Black, Hispanic, and other), and income group. Educational attainment was categorized into four groups: less than high school, high school, some college, and bachelor's degree or higher. The income variable was derived from four original HRMS household income indicators and categorized into four levels: less than \$30,000, \$30,000–\$59,999, \$60,000–\$124,999, and \$124,999 or more.

Health-related variables included self-rated health status (excellent, very good, good, fair, or poor) and whether the respondent had a usual source of care (yes or no), defined as a regular place to go when sick or in need of medical advice. Insurance-related characteristics included type of insurance coverage (private, public, or other), perceived respect from insurers (yes or no), and perceived affordability of care. The affordability score was constructed from responses to a survey item that asked whether, in the past year, the respondent had needed but did not receive any of the following services: prescription drugs, a general doctor visit, a specialist visit, medical tests, treatment, or follow-up care. Each item was coded as 0 ("yes") or 1 ("no"), and the scores were summed to create an index ranging from 0 to 4. Higher scores indicated fewer missed services due to cost, and thus a greater perceived ability to afford needed care. For interpretive purposes, we labeled the resulting index as follows: 0 = very low affordability, 1 = low affordability, 2 = moderate affordability, 3 = high affordability, and 4 = very high affordability.

Statistical analysis

After identifying and categorizing the key independent variables, we employed statistical analysis to examine their relationships with trust in health insurance. Descriptive statistics were calculated to summarize respondents' sociodemographic, health-related, and insurance-related characteristics (Table 1). Both unweighted counts and survey-weighted percentages are reported for all variables.

To assess the relationship between respondent characteristics and trust in health insurance, we conducted bivariate analyses using survey-weighted cross-tabulations (Table 2). These analyses present unweighted counts and survey-weighted row percentages to show the distribution of trust within each subgroup. Design-based *F*-tests were used to evaluate whether the distribution of trust differed significantly across levels of each characteristic.

Multivariate analysis was then conducted, focusing only on characteristics that showed statistically significant associations with trust in health insurance in the bivariate analysis ($p < 0.05$). This approach ensures the model remains parsimonious and avoids overfitting. The multivariate regression model estimated the adjusted associations between selected characteristics and the likelihood of trusting one's health insurance (Table 3). Adjusted odds ratios (aORs) and 95% confidence intervals (CIs) are reported. All analyses were conducted using Stata version 19.5 (20).

Following the multivariable regression analysis, we assessed the model's performance to ensure its predictive accuracy by calculating the Brier Score and drawing a calibration plot (21, 22). This step is crucial to determine how well our model estimates the likelihood of trust in health insurance based on the selected characteristics. The Brier Score quantifies predictive accuracy by measuring the weighted mean squared difference between the model-estimated probability and the observed binary outcome. It ranges from 0 (perfect prediction) to 1 (poor prediction), with lower scores indicating better predictive accuracy. The calibration plot visually assesses the model's calibration by comparing observed and model-estimated probabilities across deciles of predicted values. All calculations incorporated HRMS's sampling weights.

Results

Sample characteristics

Table 1 describes the characteristics of the analytical sample ($N = 7,702$). Overall, 69.11% of respondents reported trusting their health insurance, while 30.89% did not. The sample was diverse in terms of age, education, race, and income. The largest age group was 45–59 years (33.08%), followed by 30–44

years (31.08%), 18–29 years (25.14%), and 60 years or older (10.7%). Most respondents had at least some college education, with 37.44% holding a bachelor's degree or higher and 28.78% reporting having finished some college. Most respondents were identified as White (63.11%), followed by Hispanic (15.37%), Black (12.09%), and other racial groups (9.43%). Nearly one-quarter (24.47%) of respondents reported annual household incomes below \$30,000, while 23.05% earned \$30,000–\$59,999, 30.77% earned \$60,000–\$124,999, and 21.71% earned over \$125,000.

Regarding health and insurance-related characteristics, 54.65% of respondents reported “excellent” or “very good” health, and 85.04% reported having a usual source of care. The majority had private insurance (70.38%) and reported feeling respected by their insurance providers (81.2%). The distribution of the perceived affordability score was skewed toward higher scores, with 82.5% of respondents reporting a score of 4 (very high affordability).

Bivariate Associations with Trust in Health Insurance

Table 2 summarizes the associations between respondent characteristics and trust in health insurance. Insurance trust varied significantly across all examined characteristics ($p < 0.01$ for all comparisons).

Respondents with better self-rated health were more likely to report trusting their insurance: 75.14% of those in excellent health trusted their plan, compared to 63.34% of those in poor health. Similarly, 71.26% of those with a usual source of care trusted their insurance, versus 56.87% without one. Public insurance enrollees had the highest trust levels (77.25%), followed by those with other forms (74.79%) and private insurance (65.87%). Trust was exceptionally high among those who felt respected by their insurer (83.44%) and those with higher affordability scores (e.g., 71.98% at the highest score vs. 56.99% at the lowest). Trust was also more common among older adults, those with lower educational attainment, Hispanics, and those in lower income brackets. For example, 77.22% of adults aged 60 and above trusted their insurance, compared to 67.09% of those aged 18–29.

Multivariate Logistic Regression Analysis

Table 3 displays aORs from the logistic regression model predicting trust in health insurance. Several factors remained significantly associated with trust after adjusting for covariates.

Respondents with better self-rated health were more likely to trust their insurance. Compared to those in excellent health, those in poor health had significantly lower odds of trust (aOR = 0.36, 95% CI: 0.19–0.66). Having a usual place to go for care was associated with higher trust (aOR = 1.53, 95% CI: 1.23–1.89).

Compared to individuals with private insurance, those with public (aOR = 2.04, 95% CI: 1.65–2.53) or other types of insurance (aOR = 1.96, 95% CI: 1.34–2.87) had significantly higher odds of trust. Feeling respected by one's insurance company was the strongest predictor, with an aOR of 67.41 (95% CI: 52.25–86.97). Each one-point increase in perceived affordability score was associated with 21% higher odds of trust (aOR = 1.21, 95% CI: 1.11–1.31).

Educational attainment and race were also significantly associated with trust. Compared to those with a bachelor's degree or higher, those with lower levels of education had significantly higher odds of trust (e.g., high school: aOR = 1.52, 95% CI: 1.22–1.89). Hispanic respondents had higher odds of trust compared to White respondents (aOR = 1.65, 95% CI: 1.29–2.11). Respondents in higher income groups had lower odds of trust compared to those with household incomes below \$30,000 (e.g., aOR = 0.64, 95% CI: 0.49–0.84 for those with incomes of \$125,000 and above).

While age was significantly associated with trust in the bivariate analysis, it was not a significant predictor in the multivariable model, suggesting its effect was explained by other covariates in the model.

Model Performance and Predictive Accuracy

The logistic regression model demonstrated good predictive performance. The Brier Score was 0.162, suggesting that the model's estimated probabilities were, on average, well aligned with the observed outcomes. The calibration plot (Figure 1) showed close agreement between observed proportions and model-estimated probabilities across deciles, with points aligning closely to the 45-degree reference line, indicating strong calibration.

Discussion

This study examined factors associated with trust in health insurance using nationally representative data from the 2020 HRMS. Approximately 69% of respondents reported trusting their insurance plan, while 31% expressed distrust in it. Our findings highlight the importance of health system experiences—such as perceived respect, affordability of care, and having a usual source of care—as key predictors of trust, even after adjusting for sociodemographic and health-related characteristics.

Feeling respected by the insurer emerged as the strongest predictor of trust in health insurance in our analysis. Respectful interactions signal fairness, attentiveness, and concern for enrollees' needs, fostering the perception that the insurer is acting in their best interest. This behavior enhances confidence in the insurer's integrity and reliability. Such interpersonal dynamics are fundamental in healthcare, where individuals often feel vulnerable and depend on institutions for support. In this study, those who perceived respect had nearly 67 times greater odds of reporting trust, highlighting the central role of dignity and responsiveness in building trust. Our findings reinforce the idea that trust is shaped not only by plan features but also by how individuals are treated during their interactions with insurers (23, 24).

Perceived affordability of care was significantly associated with trust in health insurance. In this study, affordability was measured by whether respondents had unmet healthcare needs due to cost, such as for medications, doctor visits, or tests. Individuals facing fewer affordability barriers were more likely to trust their insurance plan, suggesting that financial access to care is a key indicator of the value of insurance. When coverage enables access to care without

financial strain, trust in the plan's adequacy increases; conversely, persistent cost barriers may erode that trust. Recent survey data also indicate that only about one-third of insured Americans believe health insurance ensures affordable care for everyone, reflecting broader skepticism about the system's effectiveness (25). Thus, affordability is not just about access but also central to how people evaluate the trustworthiness of their coverage.

Other health system factors—such as having a usual source of care—were similarly linked with trust, suggesting that continuity and coordination of care enhance individuals' confidence in their coverage. A usual source of care facilitates smoother navigation of the healthcare system, including scheduling visits, securing referrals, and managing chronic conditions—all of which depend on adequate insurance. When insurance supports these ongoing care relationships without frequent disruptions, individuals may perceive their plan as more reliable and beneficial. Thus, sustained engagement with the health system—enabled by a usual source of care—can serve as a concrete demonstration of insurance value, reinforcing trust in coverage. This finding aligns with prior research, which shows that greater continuity of care is significantly associated with increased confidence in healthcare providers (26), extending to trust in the insurance that facilitates that care.

Our analysis reveals a significant association between self-rated health status and trust in health insurance, showing that individuals with poorer health are less likely to trust their health insurance compared to those who rate their health as “excellent.” This finding aligns with existing literature, which suggests that poorer self-rated health is associated with lower trust in health insurance (27). Individuals in poorer health may have more frequent interactions with healthcare providers and insurers, increasing their exposure to issues such as coverage limitations or financial burdens that can erode trust. Conversely, individuals in excellent health, with fewer interactions, may report higher levels of trust. Addressing the concerns of those in poorer health is crucial for enhancing the perceived fairness and reliability of health insurance systems.

Our study also finds that individuals with public or other types of health insurance report higher levels of trust in their insurance compared to those with private coverage. Several features of public insurance may explain this finding, including standardized benefits, predictable coverage, and protections against excessive out-of-pocket costs. These factors can foster greater trust and satisfaction among beneficiaries. In contrast, private insurance plans often vary widely in coverage, including complex cost-sharing structures, and frequently change provider networks, all of which may undermine trust. Research supports this interpretation: patients with public coverage report fewer affordability-related barriers to care and greater satisfaction than those with private insurance (28). Moreover, public insurance is often viewed as less profit-driven and more equitable (29), contributing to perceptions of reliability. Thus, the greater trust observed among publicly insured individuals may reflect both practical experiences and broader attitudes toward the role and purpose of public versus private insurance.

Although our regression shows adults under 60 had lower odds of trusting their health insurance compared to those aged 60 and older, the difference was statistically insignificant. This pattern may reflect age-related differences in insurance experiences. Older adults are more likely to be covered by Medicare, a program generally rated more favorably than other types of insurance (30). At the same time, younger individuals often rely on employer-sponsored or marketplace plans that can vary in coverage and reliability (31). The absence of a significant association suggests this relationship may be weak, sample-specific, or influenced by unmeasured factors.

Our multivariate logistic regression also suggests that individuals with lower educational attainment (less than high school, high school, and some college) have higher odds of trusting their health insurance compared to those with a bachelor's degree or higher. This somewhat counterintuitive finding aligns with prior research indicating that individuals with lower levels of education may exhibit greater institutional trust (27), possibly due to lower health insurance literacy and a reliance on providers to interpret complex systems. In contrast, individuals with higher education may possess greater critical capacity and access to diverse information sources, which can foster skepticism or lower trust in insurance systems. These results suggest that trust in health insurance is not solely a function of policy quality or access but may also be shaped by individuals' cognitive and informational contexts. Tailored communication strategies that consider educational background may therefore be essential in improving informed engagement with health insurance systems.

Our analysis reveals that Hispanic individuals have significantly higher odds of trusting their health insurance compared to White individuals. This result may reflect cultural factors, as Hispanics often have stronger community and familial ties, which can foster a more positive view of collective institutions (32), such as health insurance. Such collective cultural attitudes toward healthcare (33) may shape greater trust in the system. In contrast, White populations may adopt a more individualistic approach to healthcare (34), which could potentially explain lower levels of trust. These findings underscore the importance of considering cultural perspectives when assessing trust in health insurance.

The inverse relationship between household income and trust in health insurance suggests that factors beyond financial access or coverage shape perceptions of insurers. Individuals with higher incomes may have higher expectations regarding service quality, transparency, and value, and may become dissatisfied when those expectations are not met. They also tend to navigate more complex insurance features—such as high deductibles, cost-sharing requirements, and administrative procedures—which can contribute to frustration and a lack of trust. Furthermore, socioeconomic advantage is often associated with higher education and health literacy, enhancing individuals' capacity to recognize inefficiencies or shortcomings within insurance systems. These dynamics underscore the importance of addressing not only access but also the design and delivery of insurance services to foster trust across different income groups.

Before discussing the study's limitations, it is essential to highlight that the model's predictive performance supports the reliability of the reported associations. As shown in the results, the calibration plot and weighted Brier Score of 0.162 indicate strong alignment between predicted and observed outcomes. This level of calibration suggests that the model's probability estimates are trustworthy, providing a solid foundation for interpreting associations between individual characteristics and trust in health insurance. While other performance metrics, such as the Area Under the Receiver Operating Characteristic Curve (AUC) or the Hosmer–Lemeshow test, are commonly used, they are less suitable for survey-weighted data, as standard AUC calculations do not incorporate sampling weights and may yield biased assessments of discrimination. The combined use of calibration plots and the Brier Score, therefore, offers a more appropriate and informative evaluation of model performance in this context (21, 22).

Several limitations should be noted. First, the cross-sectional nature of the HRMS data limits the ability to make causal inferences. Second, although sampling weights were applied, the dataset includes only probability weights without strata or cluster variables, which may affect variance estimation. Third, the perceived affordability score, though helpful, was constructed based on reported unmet needs and may not capture all dimensions of cost-related access. Lastly, while our binary categorization of trust simplifies analysis, it may not fully capture the spectrum of attitudes toward insurance.

Conclusions

This study highlights that trust in health insurance is shaped not only by sociodemographic characteristics but, more importantly, by individuals' lived experiences with their coverage. Perceived respect from insurers emerged as the strongest predictor of trust, suggesting that interpersonal respect may outweigh plan type or demographics in shaping trust. Additionally, individuals who reported better affordability and a usual source of care were significantly more likely to trust their insurance.

These findings suggest that improving trust in health insurance requires more than expanding coverage—it also involves enhancing the experience of coverage. Strategies that promote respectful, transparent communication, reduce cost-related barriers, and support consistent access to care may help build stronger, more trusted insurance systems. In doing so, they may also improve engagement with care and contribute to better health outcomes.

Abbreviations

Health Reform Monitoring Survey (HRMS), adjusted odds ratio (aOR), confidence interval (CI), Area Under the Receiver Operating Characteristic Curve (AUC),

Declarations

Ethics approval and consent to participate

The analytical sample of patients originated from a publicly available dataset. Therefore, ethics approval and consent were not applicable for this analysis.

Consent for publication

Not applicable.

Availability of data and materials

The analyzed dataset is available in the Health and Medical Care Archive as part of the Health Reform Monitoring Survey (First Quarter 2020), <https://www.icpsr.umich.edu/web/HMCA/studies/38110> (19).

Competing interests

Not applicable.

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Authors' contributions

APB: conceptualization, data curation, formal analysis, methodology, original draft preparation, review, and editing.

EL: conceptualization, data curation, formal analysis, validation, visualization, review, and editing.

WL: analytical framework, interpretation of results, and manuscript revision.

DCW: literature review, proofreading, and formatting.

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Tables

Table 1: Characteristics of the Analytical Sample (N=7,702)

Characteristic	Unweighted N	Weighted %
Trust in health insurance		
Yes	5,366	69.11
No	2,336	30.89
Self-rated health status		
Excellent	938	14.31
Very good	3,011	40.34
Good	2,647	33.21
Fair	919	10.36
Poor	187	1.78
Has a usual place to go for healthcare		
Yes	6,600	85.04
No	1,102	14.96
Type of health insurance coverage		
Private	5,101	70.38
Public	2,160	24.29
Other	441	5.33
Feeling respected by the insurance company		
Yes	6,287	81.20
No	1,415	18.80
Perceived affordability of care (range: 0–4, higher = more affordable)		
0 (very low affordability)	265	3.22
1 (low affordability)	255	2.83
2 (moderate affordability)	386	4.67
3 (high affordability)	605	6.79
4 (very high affordability)	6,191	82.50
Age		
18-29	1,436	25.14
30-44	2,189	31.08
45-59	2,899	33.08
60+	1,178	10.70
Educational attainment		
Less than high school	390	7.85
High school	1,794	25.93
Some college	2,491	28.78
Bachelor's degree or higher	3,027	37.44

Race		
White	5,040	63.11
Black	836	12.09
Hispanic	1,201	15.37
Other	625	9.43
Household income		
Below \$30,000	1,885	24.47
\$30,000–59,999	1,775	23.05
\$60,000–124,999	2,370	30.77
\$125,000 and above	1,672	21.71

Table 2: Univariate Associations with Trust in Insurance (*N*=7,702)

Characteristic	Trust (n, %)	Don't Trust (n, %)	p-value
Self-rated health status			0.00
Excellent	709 (75.14)	229 (24.86)	
Very good	2,166 (71.8)	845 (28.20)	
Good	1,756 (65.16)	891 (34.84)	
Fair	610 (63.97)	309 (36.03)	
Poor	125 (63.34)	62 (36.66)	
Has a usual place to go for healthcare			0.00
Yes	4,729 (71.26)	1,871 (28.74)	
No	637 (56.87)	465 (43.13)	
Type of health insurance coverage			0.00
Private	3,360 (65.87)	1,741 (34.13)	
Public	1,673 (77.25)	487 (22.75)	
Other	333 (74.79)	108 (25.21)	
Feeling respected by the insurance company			0.00
Yes	5,254 (83.44)	1,033 (16.56)	
No	112 (7.17)	1,303 (92.83)	
Perceived affordability of care (range: 0–4, higher = more affordable)			0.00
0 (very low affordability)	155 (56.99)	110 (43.01)	
1 (low affordability)	128 (48.28)	127 (51.72)	
2 (moderate affordability)	229 (58.45)	157 (41.55)	
3 (high affordability)	358 (55.95)	247 (44.05)	
4 (very high affordability)	4,496 (71.98)	1,695 (28.02)	
Age			0.00
18-29	931 (67.09)	505 (32.91)	
30-44	1,431 (65.46)	758 (34.54)	
45-59	2,086 (71.44)	813 (28.56)	
60+	918 (77.22)	260 (22.78)	
Educational attainment			0.00
Less than high school	294 (74.29)	96 (25.71)	
High school	1,360 (74.78)	434 (25.22)	
Some college	1,767 (69.61)	724 (30.39)	
Bachelor's degree or higher	1,945 (63.70)	1,082 (36.30)	
Race			0.00
White	3,408 (66.77)	1,632 (33.23)	
Black	616 (72.94)	220 (27.06)	
Hispanic	925 (76.70)	276 (23.30)	
Other	417 (67.49)	208 (32.51)	

Household income		0.00
Below \$30,000	1,402 (74.74)	483 (25.26)
\$30,000–59,999	1,256 (70.18)	519 (29.82)
\$60,000–124,999	1,595 (67.89)	775 (32.11)
\$125,000 and above	1,113 (66.36)	559 (33.64)

Note: Unweighted counts and survey-weighted row percentages are reported. Percentages reflect the distribution of trust in health insurance within each category of the predictor variable. *P*-values reflect the overall association between each predictor and trust in health insurance. All estimates are derived using sampling weights from the 2020 HRMS.

Table 3: Multivariate Logistic Regression Predicting Trust in Health Insurance

Characteristic	Adjusted odds ratios (aORs)	95% CI		p-value
		LCL	UCL	
Self-rated health status				
Excellent (reference)				
Very good	0.76	0.59	0.99	0.04
Good	0.56	0.43	0.73	0.00
Fair	0.43	0.31	0.60	0.00
Poor	0.36	0.19	0.66	0.00
Has a usual place to go for healthcare				
Yes	1.53	1.23	1.89	0.00
No (reference)				
Type of health insurance coverage				
Private (reference)				
Public	2.04	1.65	2.53	0.00
Other	1.96	1.34	2.87	0.00
Feeling respected by the insurance company				
Yes	67.41	52.25	86.97	0.00
No (reference)				
Perceived affordability of care (range: 0–4, higher = more affordable)	1.21	1.11	1.31	0.00
Age				
18-29	0.82	0.62	1.09	0.18
30-44	0.88	0.68	1.13	0.32
45-59	0.92	0.72	1.17	0.49
60+ (reference)				
Educational attainment				
Less than high school	1.50	1.01	2.22	0.04
High school	1.52	1.22	1.89	0.00
Some college	1.22	1.01	1.47	0.04
Bachelor’s degree or higher (reference)				
Race and ethnicity				
White (reference)				
Black	1.14	0.88	1.48	0.33
Hispanic	1.65	1.29	2.11	0.00
Other	1.37	1.00	1.87	0.05
Household income				
Below \$30,000 (reference)				
\$30,000–59,999	0.75	0.58	0.96	0.02
\$60,000–124,999	0.66	0.52	0.83	0.00
\$125,000 and above	0.64	0.49	0.84	0.00

Note: Estimates are based on sampling weights from the HRMS. aOR = adjusted odds ratio; CI = confidence interval.

Figures

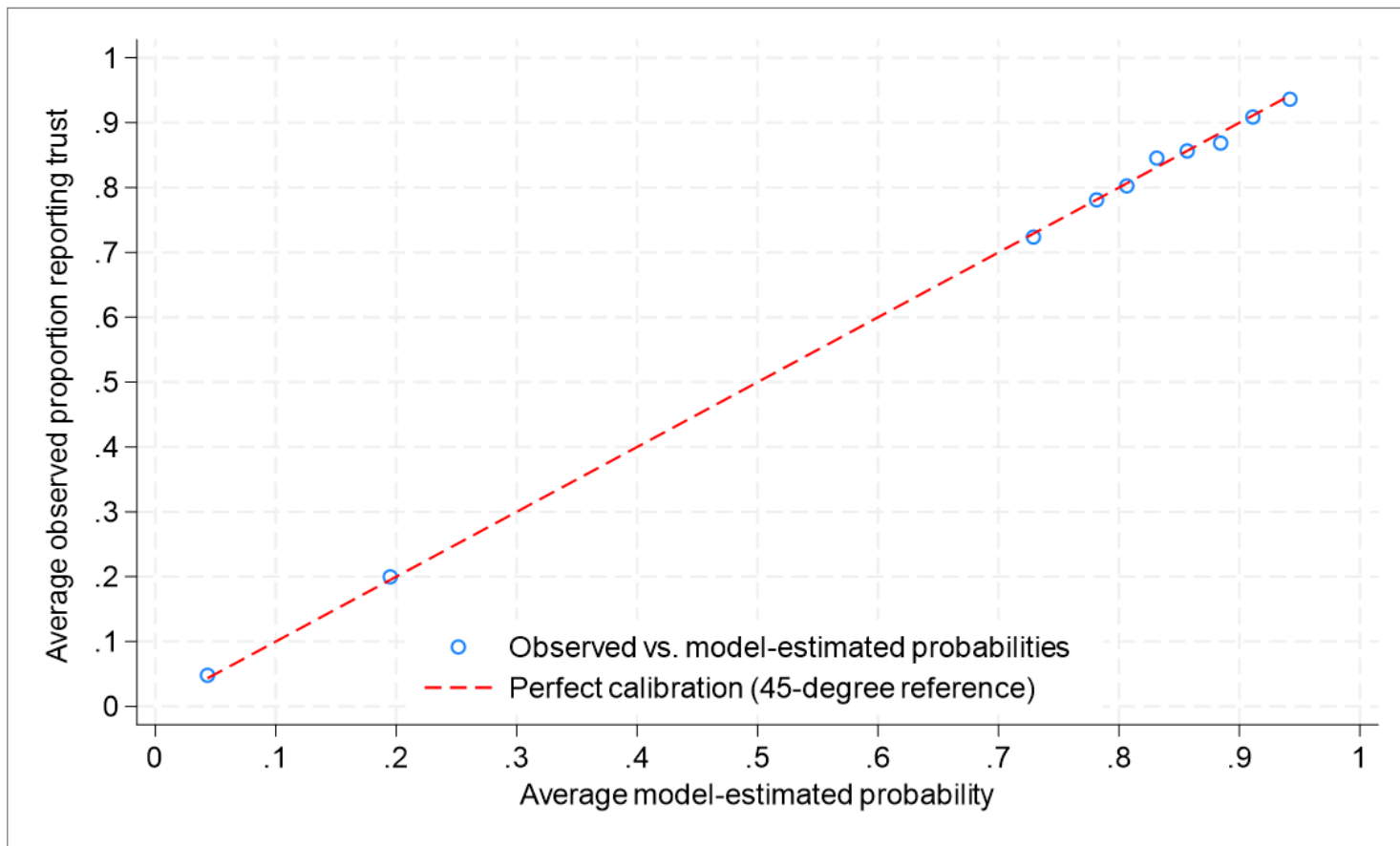


Figure 1

Calibration plot comparing average observed and model-estimated probabilities of trust in health insurance

Note: Each point represents the average observed proportion of individuals reporting trust within deciles of model-estimated probability. The dashed 45-degree line represents perfect calibration, where the predicted and observed probabilities are equal. Points near this line indicate that the model provides well-calibrated estimates of trust in insurance across different risk levels.