

New Consumer Testing Shows Limited Consumer Understanding of Short-Term Plans and Need for Continued State and NAIC Action

NAIC Spring 2019 National Meeting – April 2019

The undersigned consumer representatives to the National Association of Insurance Commissioners (NAIC)¹ remain concerned that the proliferation of short-term, limited duration insurance coverage will confuse consumers, leaving some who sign up for short-term plans facing higher out-of-pocket costs, denied claims, and unpaid medical bills, while also leading to adverse selection that harms states' individual insurance markets. A previous report prepared by Christina Goe and presented at the NAIC's 2018 Spring National Meeting in Milwaukee outlined similar concerns.¹ These concerns have been exacerbated by the following recent developments:

- **Enrollment in short-term coverage is likely increasing.** Short-term plans can now be offered for up to one year and extended or renewed for longer, if a state does not prohibit it. Comprehensive data on the sale of these plans is not yet available. However, industry data suggests that sales are increasing. According to a prominent web broker, 70 percent of its customers that did not qualify for marketplace subsidies enrolled in a short-term policy, up from 56 percent during the same period in 2017.² One insurer noted a 24 percent increase in total months sold for its short-term plan business in the first two months of 2019, with the expectation that "longer duration [short-term] plans will provide significant upside to our business in 2019 and in future years."³
- **Short-term plans are being aggressively marketed to consumers and sold through out-of-state associations.** A January 2019 study shows that brokers are using aggressive sales tactics for short-term plans and that consumers may not be getting information about Affordable Care Act coverage.⁴ Consumers are being pushed to purchase a policy over the phone with minimal information, and some brokers are steering healthy and subsidy-eligible people to short-term plans. A separate January 2019 analysis shows that short-term plans in at least six states are being marketed through out-of-state associations that are exempt from state regulation.⁵
- **States have had to take multi-state enforcement action against short-term plan insurers.** In April 2018, 42 state insurance departments reached a \$5 million settlement with a short-term plan insurer following a multi-state market conduct exam. That company is banned from marketing or selling new policies for at least five years.⁶

In light of these developments and ongoing concern for consumers, we commissioned Kleimann Communications Group⁷ to test whether consumers shown the marketing brochure for a popular, six-month short-term plan could understand the plan's benefits, limits, and out-of-pocket costs. We also wanted to test the sufficiency of the federally mandated disclosure and whether consumers thought it adequately conveyed the limitations of the policy. The attached report includes the following findings:

¹ The NAIC works closely with consumer representatives to assist state regulators in their primary objective of protecting insurance consumers. The undersigned individuals do not represent or work for the NAIC, and the views expressed here do not necessarily reflect the views of the NAIC. More information about consumer participation at the NAIC is available [here](#).

Few consumers initially understood the concept of a short-term plan. Some thought the plan was a supplemental policy to cover extra medical bills; others thought it served as a disability insurance plan. One participant thought the pictures in the brochure showed what was covered and therefore assumed the plan would cover a gym membership or even pet insurance. From the beginning of the interview, only two participants—both healthy—clearly understood the overall purpose of the short-term health plan and that it was designed for healthy people who are unlikely to become ill.

Consumers did not understand the short-term plan because they have been shaped by their experience and expectations of the market since the passage of the Affordable Care Act. Participants assumed that short-term plans would offer the same coverage and benefits as a “typical” health plan, including benefits such as maternity care and prescription drugs (even though the plan included very limited coverage of these benefits). They simply did not expect plans that did not cover preexisting conditions. Participants analyzed the brochure with a preexisting psychological anchor and frame where they expected to find the same things that their experience told them would be there. For many participants, it took a significant period of time before they understood that they were not looking at a plan that was similar to what they were expecting. This forced them to reset their expectations. Some participants never did so, even over the course of a full hour dedicated to the brochure. As a result, many misunderstood even the basic concept of the short-term plan.

Most consumers struggled to understand the short-term plan’s coverage benefits and limitations. Consistent with the previous finding, some participants were confused because they thought plans could not exclude people under the Affordable Care Act. Others recognized that the short-term plan did not cover preexisting conditions but did not

understand what would be considered a preexisting condition. Some participants understood the possibility that their coverage could be denied or their policy rescinded if they became seriously ill. Still others were “confident” they would be covered even in circumstances where they likely would not be under this plan.

The federally mandated disclosure went largely unnoticed and was ineffective at reducing consumer confusion. Few participants looked at the disclosure language included on the cover page of the short-term brochure. Participants did not notice the disclosure because it was de-emphasized through its placement on the cover in very small font. When the disclaimer was pointed out to them, participants thought it was important but few noticed it on their own and it did not eliminate or reduce the confusion identified throughout the other findings.

Consumers had low health insurance literacy and significant difficulty in understanding the plan’s cost implications. Many consumers struggle with insurance terminology. Here, coinsurance baffled nearly all participants; other terms were also difficult to understand. The only term most did not struggle with was “deductible” because they were familiar with it in the context of auto insurance. In part because of their lack of familiarity with the terminology, participants struggled with correctly calculating three basic financial scenarios that would show their potential out-of-pocket costs. These challenges were exacerbated by the confusing presentation of plan information in the brochure.

Consumers found the short-term plan’s low premium to be appealing but many wanted more comprehensive coverage. Most participants wanted a plan with more coverage and at least lower deductibles. Some participants had chronic health needs or were looking for maternity coverage or dental or prescription benefits, so more comprehensive

coverage was of great interest. A few participants understood the tradeoff between higher premiums and higher out-of-pocket

costs. Others wanted, but did not think they had the financial resources to pay for, a comprehensive plan over a short-term plan.

Discussion and Recommendations for Continued State and NAIC Action

These findings confirm what many stakeholders already know: consumers face significant challenges in understanding the differences between short-term plans and other types of coverage. This lack of understanding—especially when coupled with concerns about the aggressive marketing of short-term plans—likely result in consumers inadvertently enrolling in short-term plans when doing so may not be appropriate for their health needs or financial situation. We remain concerned that many of these consumers will enroll in a short-term plan only to find out that it does not cover their health care needs once they become ill, potentially leaving their families with thousands of dollars in medical debt.

Consumer confusion is exacerbated by the fact that most consumers have become accustomed to, and now expect, their health insurance to reflect the Affordable Care Act’s consumer protections. Many consumers had a difficult time fathoming that a short-term plan would not include what are now regarded as basic consumer protections. Because health insurance literacy is generally low, consumers may also have challenges understanding certain aspects of Affordable Care Act plans, such as cost-sharing. However, the study underscores that consumers do not expect short-term plans to lack the basic benefit standards, cost-sharing parameters, preexisting condition guarantees, and other features that help insulate consumers from financial harm when they buy an Affordable Care Act plan.

Although assisters could help better explain the material, many consumers are shopping on their own, and short-term plans do not have to provide a standardized Summary of Benefits and Coverage, which has been shown to help consumers understand plan details and directly compare plan options. Even with dedicated in-person attention during the one-hour interview, it was challenging for consumers in the study to understand how a short-term plan worked.

Finally, disclosures alone did not adequately address or reduce consumer confusion. Even after spending an hour with the marketing brochure, consumers did not notice the federally mandated short-term plan disclosure. Much attention has been paid to the need for disclosures—both by the federal government and among policymakers in Congress—to alert consumers to how short-term plans differ from comprehensive individual coverage. However, our study shows that the disclosure did not have its intended effect of warning consumers about the limitations of short-term plans. Some of the changes that participants said would make the disclosure more effective—such as a “CAUTION” or warning heading—were expressly rejected by federal regulators in the final rule on short-term plans.⁸ We remain concerned that disclosures, while necessary, are not sufficient to ensure that consumers understand the limitations of short-term plans.

Given these findings, we make the following recommendations to state policymakers and the NAIC:

- Model Regulation 171, which will be considered by the NAIC in 2019, should include robust standards for short-term plans. These standards should include additional marketing and disclosure standards (such as standardized marketing materials), the application of state-level benefit mandates, and the adoption of a minimum medical loss ratio.

- The Market Regulation and Consumer Affairs (D) Committee should expedite approval of its data call to collect additional information on the sale of short-term plans nationwide. These data are critically important for state insurance regulators to understand the effect of short-term plans on their market and make recommendations for policy changes as needed.
- Policymakers should further regulate short-term plans. States could prohibit short-term plans or apply additional consumer protections to these plans by limiting their duration or renewability, applying state health insurance mandates to the coverage, and/or increasing oversight of marketing, product forms, and rate filings.

Sincerely,

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¹ Christina Goe, [Non-ACA-Compliant Plans and the Risk of Market Segmentation](#) (Mar. 2018).

² eHealth, [Half-Time Report – The ACA Open Enrollment Period for 2019 Coverage](#) (Nov. 2018).

³ Health Insurance Innovations, Inc. CEO Gavin Southwell on Q4 Results, [Earnings Call Transcript](#) (Mar. 2019).

⁴ Sabrina Corlette et al., [The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses](#), Georgetown University Center on Health Insurance Reforms (Jan. 2019).

⁵ Emily Curran et al., [Short-Term Health Plans Sold Through Out-of-State Associations Threaten Consumer Protections](#), The Commonwealth Fund (Jan. 2019).

⁶ See, e.g., California Department of Insurance, [“Investigation into Sale of Short-Term Health Policies Leads to \\$5 Million Settlement with HCC Life Insurance Company,”](#) Press Release (Apr. 10, 2018).

⁷ Kleimann Communications Group has a history of working with the NAIC and federal and state insurance regulators. Kleimann previously worked with the NAIC to test the proposed Summary of Benefits and Coverage templates.

⁸ See 83 Fed. Reg. 38212, 38224-25 (Aug. 3, 2018).



Report on Testing Consumer Understanding of a Short-Term Health Insurance Plan

March 15, 2019

Submitted to

Georgians for a Healthy Future *on behalf of consumer representatives
to the National Association of Insurance Commissioners*



Background

Georgians for a Healthy Future (GHF)—on behalf of a group of consumer representatives to the National Association of Insurance Commissioners (NAIC)—contracted with Kleimann Communication Group (Kleimann) to test with consumers their understanding of the marketing brochure of a popular short-term health insurance plan. The goal was to assess whether consumers could understand the benefits offered by the plan, the limits on the benefits, and the out-of-pocket costs.

The NAIC consumer representatives had concerns about the understandability of short-term health insurance plans. The plans are offered as an alternative to the Affordable Care Act-mandated plans, which provide minimum essential coverage and coverage for pre-existing conditions. The NAIC consumer representatives were concerned that consumers were misunderstanding the plan brochures and thinking that the short-term plans offered more complete coverage than they do. They were also concerned that consumers, attracted by the lower monthly premiums, did not understand the higher out-of-pocket costs these plans required.

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Methodology

Overall

With these goals in mind, the Kleimann team identified 5 research questions:

- Can consumers understand the basic concept of a short-term health plan?
- Can consumers identify basic coverage and non-coverage on the policy?
- Do consumers read and use the federally-mandated disclosure on the first page of the brochure?
- Can consumers understand and apply the terminology and information in the health plan options charts?
- Can consumers understand the trade-off of affordability versus coverage?

Where and who we tested

In St. Louis, Missouri, we recruited 5 participants with chronic conditions and 5 with non-chronic conditions, but one participant failed to appear. In general, we recruited for a mix of

demographic characteristics, including race, ethnicity, gender, education level, and age. (See Appendix A for specific demographics.)

We specified household income to be between \$50,000 and \$129,999. Of the 9 participants we interviewed, 8 participants currently had some sort of insurance, including 2 with Medicare or Medicaid; only 1 participant currently was without insurance. Three participants said they had some familiarity with short-term health insurance policies, but their answers during the interviews suggested that they were thinking of supplemental insurance policies or disability insurance policies.

What we did

We used a 2018 brochure from a well-known national health care company that offers a short-term health insurance policy¹.

We used one-hour, one-on-one interviews that we divided into a 30-minute session of a think-aloud and a 30-minute session of structured questions. In Part 1, the think-aloud, we provided an overview to the project and asked participants to skim through the brochure to get an overview of the content, so they would know what it contained. We then asked them to go back to the sections in which they wanted to read more carefully.

In Part 2, we asked a series of structured questions on the following topics:

- Definitions of insurance terms used in the charts and brochure;
- Eligibility requirements;
- Coverage allowances and limits;
- Costs of services before deductibles were paid based on a plan with Deductible, Coinsurance, and Coinsurance Out-of-pocket Maximum scenario we provided;
- Affordability of the short-term plan's monthly premium (we used premium calculated for each individual participant based on their demographic information); affordability considering their monthly expenses; affordability compared to estimated cost of an unsubsidized ACA plan with more benefits and fewer limitations; and
- Overall Assessment of the short-term health insurance plan.

We audiotaped each interview. After the interviews, the two researchers identified key themes. They then reviewed the transcripts to further identify themes and quotes from participants

¹ The brochure we used was designed for the states DE, KS, LA, MO, NV, SC, and WY. A copy of the brochure is available here: <https://www.ehealthinsurance.com/ehealthinsurance/benefits/st/UHO/201810/45072CE-G201809.pdf>.

Findings: Can consumers understand the basic concept of a short-term health plan?

Initially, five of the nine participants completely misunderstood the basic concept of a short-term medical plan.

Participants missed that the plan was short-term. Some thought it was a supplemental insurance to cover extra medical bills, especially those for surgery or pregnancy, thus missing the non-coverage of pre-existing conditions. Some thought it served as a disability insurance plan. One assumed that the pictures indicated what was covered so thought he would get gym memberships or even pet insurance.

I probably have short-term disability. I'm sure my company pays a percentage of it, or at least up to a certain amount. And then if I want excess . . . Yeah, I'm just not sure how the health insurance and the short-term, how they would play with each other . . . is it to help me pay the medical benefit or is it going to help me with my income during that time period? . . . Yeah, I started thinking it was more of a disability, I think. Short-term disability versus medical. Participant 01 with no health condition

We have a separate short-term policy for my wife outside of my insurance through her work because she doesn't have maternity leave at work, so we have it for that. Participant 01 with chronic condition

They'd be helping you get in the gym. That's what they present on the first page as they give it to you . . . I see an animal on there so I'm not sure if the insurance covers the animal or not. Participant 04 with no health condition

Like say my wife, I'm worried about her health and I'm thinking she might need a lot of surgery and/or hospitalization, and I'm thinking my copays will be too much on Medicare alone, so I could buy something like this for a month or two months . . . So, I could buy this for a month and then she [my wife] could go ahead and try to take care of whatever her problems are, whatever her medical needs are. This way I would have more coverage than my basic Medicare. Participant 03 with chronic condition

Some participants developed a slightly better sense of who could best use a short-term health plan, yet still were fundamentally confused.

As these participants moved through the one-hour interview, they acquired more information from the interview questions. Yet, when asked at the end of the interview for whom they thought this insurance plan would be best suited, their answers showed an odd logic. Two people thought the policy was best suited for older people with higher incomes because they would be better able to pay the high cost-sharing. Two thought the policy was best suited for people who could get injured on the job, such as athletes or those who have jobs with risks of injury. Two mentioned people who were getting ready to die. These types of individuals are typically not ideal candidates for a short-term insurance policy and may not even be eligible for such a policy. Thus, it seems as if the participants still may have missed the larger picture of the intended audience.

Probably the older person who lost their job, who is going to have no problem hitting the \$2,000, \$5,000, or \$10,000 out-of-pocket maximum so that the company can pay the rest. Participant 01 with no health condition

I think it would probably help people who have athletic jobs where they get injured and can't continue working or have a risk in their job that could provide an injury. People like that. . . The older you get, the higher the costs would be [so likely good for them or people with] previous conditions. Participant 01 with chronic condition

People that maybe work. That's maybe just like insurance, just in case if they got hurt on the job . . . Or people that's about to, maybe get ready and die, or something like that. Maybe they need short term, I guess, because they know they're going to get ready and die. Participant 04 with no health condition

Basically, a person that's not going to live that long. Participant 04 with chronic condition

Only two participants understood the overall purpose of the short-term plan from the start.

Only two participants were clear from the start that short-term health plans are basically for healthy people who are unlikely to become ill. Neither participant had health conditions which might have given them more familiarity with health plans or more awareness of benefit limits.

People who live healthy, who barely get sick. It's not a plan for a person who gets sick all the time or is going to need medicine all the time. It's not that type of plan. Participant 03 with no health condition

In my mind, the ideal person for this plan is someone who is in their twenties, who's relocating or switching jobs or going through transition . . . Because I feel is if that would be the demographic that would be less likely to have any preexisting conditions. Participant 02 with no health condition

Findings: Can consumers identify basic coverage and non-coverage on the policy?

Participants made assumptions about what was covered.

As we could see in the very first finding of this report, many participants expected the short-term health plan to have the same coverage as a typical health plan—with benefits such as pregnancy and prescriptions. Although they might have some sense of some of the accompanying limitations to that coverage, they thought that they would receive some coverage. This was true even though the plan clearly noted that prescription drugs were not covered and enrollees would only receive a prescription drug discount card with a \$3,000 maximum benefit. The plan defined pregnancy as a preexisting condition and stated that “no benefits are payable for expenses . . . due to pregnancy (except complications), except as provided in this policy.”

Like say my wife, I'm worried about her health and I'm thinking she might need a lot of surgery and/or hospitalization . . . Participant 03 with chronic condition

I believe it does cover some expenses that have to do with pregnancy, but I want to say that you can't get this policy if you're already pregnant when you get it. Participant 02 with no health condition

As long as it's predated pregnancy it would be [covered]. She is not currently pregnant. Participant 01 with condition

. . . That just seems weird that you would only need radiation and chemo for 30 days. Participant 01 with no health condition

. . . I'd be looking for pretty much mostly dental because I do a lot of dental work . . . And also drug prescriptions. Participant 04 with no health condition

. . . I would be looking to make sure that the prescriptions that I was on, that they would be covered or mostly covered. Participant 01 with no health condition

It says, yes because it says diabetes equipment supplies and services. So prescription is a supply so, yes. Participant 04 with chronic condition

Participants who recognized the limitations of coverage linked it to the short period of the coverage.

A few participants saw the limitations and recognized that the policy was covering very little. In general, they linked this to the brevity of the policy term, but also recognized that the policy would not cover some of the needs that could occur during that period. Others saw the policy as basically covering emergencies only—which matched their perception that it was a policy that was better than nothing.

Wow, there's a lot of stuff here that's not covered. Just the sheer volume of things that are not covered it seems like it's going to be a very limited . . . that the policy is going to be very limited in what it will provide. Participant 04 with chronic condition

Because they don't cover nothing for real, it don't cover a lot, it's really short term, so guess that's why . . . I mean I understand that it's short-term, but it don't cover for short-term things that could happen. Participant 03 with no health condition

I think there's a lot of exclusions. That worries me. But yet, I think maybe they'll cover emergencies only. It's pretty much what I'd consider this policy for . . . I know a lot of insurance companies have a lot of different rules and exclusions, but this seems like what I'd consider a better than nothing policy, overall. Participant 02 with no health condition

Some participants recognized that pre-existing conditions were not covered but disagreed on what would be considered a pre-existing condition.

Some participants understood that they would not be covered at all. Others thought that the plans could not exclude you because of the Affordable Care Act. One participant thought she would be able to get the policy with a pre-existing condition, but would receive no coverage for that condition, but would for other services. Some were concerned that if they were at risk for a disease, such as sickle cell anemia, they might not be eligible, while others dismissed that as a concern.

If you're asking what I've always thought it was we just don't do insurance with you if you have any of these preexisting conditions, whether it's diabetes, you know. Participant 05 with chronic condition

Well, I would think that they couldn't exclude you anymore. I thought that was the big thing with the Obamacare. Participant 02 with chronic condition

I would say yes [I can get this policy with preexisting conditions]; however, those issues are excluded from coverage . . . Because there's a lot of questions for me in terms of what they'll cover based on the pre-existing thing. Participant 02 with no health condition

. . . so I feel like . . . just how they say if you have sickle cell in your family, I feel like I wouldn't qualify for this policy because they feel like eventually I'm going to get cancer . . . Because they don't want to pay too much in what you have going on and they don't give you a lot. Say if I have a medical condition already, I'm going to need a lot of doctor's visits and they don't cover that. Participant 03 with no health condition

I would think I would be eligible, because just because he [a brother] has it [a pre-existing condition, like heart disease], doesn't necessarily mean I'm going to get it even though he's my brother, even my father and mother, if they had it. A lot of people don't get it, although some things are genetically probably inherited. Participant 03 with chronic condition

I think I would be [eligible], yes, because I don't have it [a pre-existing condition]. You can't rate me on what other people have that are sitting next to me. It's not my fault they smoke or whatever. Participant 01 with no health condition

Some participants expressed concern that if they developed a serious illness the insurance company would look for evidence to not cover them.

We asked participants what would happen if they became seriously ill while they had this short-term policy. Some were confident that they would be covered. Others were concerned that the policy would review their records looking for evidence that the illness was a pre-existing condition. Some thought they would need to fight for the coverage. Others were relatively sure that the policy would not allow them to extend their coverage. And one particularly insightful participant realized the policy was largely limited to young people who haven't used medical services or haven't voiced concerns about their own health that have been documented in their medical records.

If it [pre-existing condition] is not diagnosed, it should still be covered. Participant 01 with chronic condition

Then I think they would cover it. I think you could fight to have them cover it because it wasn't a known . . . Participant 01 with no health condition

[If I] Became terminally ill they could not cancel you out because you didn't have the pre-existing condition. Participant 04 with chronic condition

Let's say I had high blood pressure and it was listed at a doctor's visit and I was talking about heart palpitations or other issues; perhaps they could look back at the records and say, "You had a documented issue within the last 24 months so we're not covering your stay at the hospital for that." I'd be concerned if I had anything like that documented. If I was the type of person that went to the doctor frequently and had a lot of different little things going on, then I'd be concerned that because that was noted in my medical chart, then that would cause me not to have the correct coverage I needed in case of an issue with those issues . . . Participant 02 with no health condition

I would say as long as I didn't have any complaints noted in my chart, then there's a possibility they would cover it . . . I just worry that they might go through there with a fine-tooth comb and try to find something to exclude it if it's a very costly issue. Participant 02 with no health condition

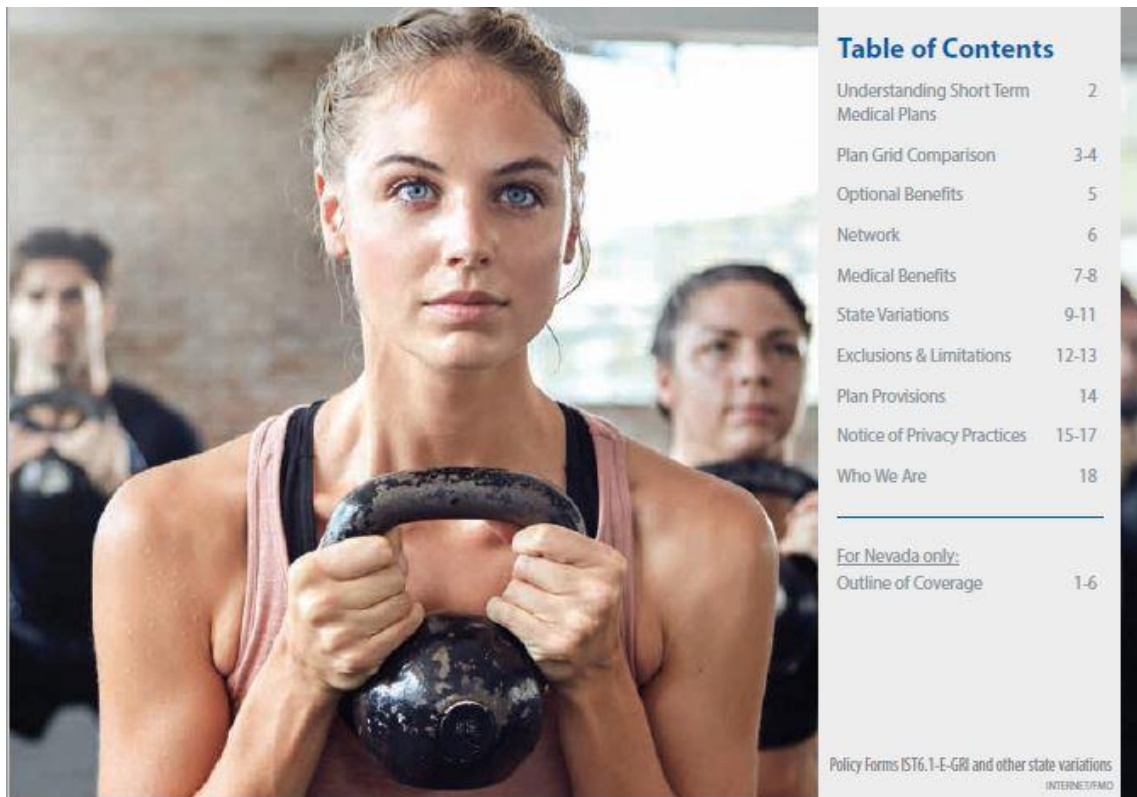
Yes, they should cover me then. Common sense you would think obviously, I just developed this problem. I didn't have it before, but I have it now, so pay for my costs . . . Once you're seriously ill and then your term expires and you're trying to re-up? . . . now that they know I have it [a pre-existing condition], they're not going to let me purchase the policy again knowing full well that I have it. I think. Participant 03 with chronic condition

[I could not renew] because if I get sick, I feel like they're going to terminate me. Participant 03 with no health condition

Findings: Do consumers read and use the federally mandated disclosure on the first page of the brochure?

The federally required disclosure language appears on the first page on the brochure used in testing. It states that the policy does not comply with the Affordable Care Act requirements. It cautions consumers that the policy's benefits are more limited and to check the policy for limitations. It further cautions consumers about lifetime or annual dollar limits and potential

waiting periods to be covered by another insurance policy. The disclosure is clearly intended to alert consumers about the limits and drawbacks to a short-term health plan.



The image shows a woman in a gym setting, holding a kettlebell. To her right is a 'Table of Contents' sidebar. The sidebar lists the following items:

Table of Contents	
Understanding Short Term Medical Plans	2
Plan Grid Comparison	3-4
Optional Benefits	5
Network	6
Medical Benefits	7-8
State Variations	9-11
Exclusions & Limitations	12-13
Plan Provisions	14
Notice of Privacy Practices	15-17
Who We Are	18
<hr/>	
For Nevada only: Outline of Coverage	1-6

Below the table, it says: Policy Forms IST6.1-E-GRI and other state variations (INTERNET/FORMS)

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage. Also, this coverage is not "minimum essential coverage." If you don't have minimum essential coverage for any month in 2018, you may have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Few participants looked at the disclosure on the cover.

When we pointed out the federally mandated disclosure, many felt that it was important, explaining that it emphasized what they should be reading for in the text since it gave a high-level overview of important topics to consider about this plan. However, they felt it was de-emphasized by the size of the font (too small) and the location below the very large photo. Some suggested adding the words: "Read this. Important!" to the text. Others suggested moving it to the inside of the booklet and giving it prominence on page 2.

I did not pay much attention to the cover page. Participant 01 with chronic condition

It's in tiny writing and I didn't really pay attention to it, most people don't . . . Put a star by it, put this is important . . . please read . . . something, because I went right past it . . . because if you read this it would make you want to read more. Participant 03 with no health condition

I noticed it but I didn't read it . . . So, if this tells me that this isn't even considered minimum essential coverage, then obviously it's not very comprehensive . . . I guess they're taking advantage of that loophole to say, "Oh, look what we can offer you for cheaper, but we don't have to make it super comprehensive." Participant 02 with no health condition

I would say that because it has such a large ad of a picture on the front, that it kind of made me feel like it was just all frou-frou stuff that wasn't important for me to read over. Like the guts of it were in the middle and I needed to move right over to that. That was my first impulse . . . I honestly feel like it would be better put, even though it's front and center on the first page, at the top of a page. Participant 02 with no health condition

Findings: Can consumers understand and apply the terminology and information in the health plan options charts?

The health plan options chart lays out for the 4 different plans offered in this brochure along with three types of information:

1. the coverage term length, the deductible type, and the deductible amount as well as the Option for a Supplemental Accident Benefit.
2. the options the consumer can choose for coinsurance percentage and for coinsurance out-of-pocket maximum; and
3. the copay and coinsurance costs for doctor office visits, urgent care centers, emergency room, out-patient services, hospital services, and pharmacy.

Two charts were included in this brochure. One chart appeared on page 3 on the right-hand side of the page. The four plans on this chart were Value Select, Plus Select, Copay Select, and Plus Elite. The second chart was on page 4 and required turning the page to read it. Thus to compare the charts, consumers needed to flip the page back and forth. The four plans on this chart were identical except that they added the letter "A" after the name of the plan, such as Value Select A.

Lifetime Maximum Benefit we will pay (per person):		\$2 million on these plans			
Short Term Medical Plans:		Value Select A	Plus Select A	Copay Select A	Plus Elite A
Coverage Term Length		Choose length: minimum 30 days (1 month in MO); maximum days available varies by state.			
Deductible Type		Per Term (One deductible for selected length of coverage)			
Deductible Amount (per person)	You pay up to:	Choose \$1,000 ¹ , \$2,500, \$5,000, \$10,000, or \$12,500			
> Option: Add Supplemental Accident Benefit	We pay up to:	\$1,000 ¹ , \$2,500, \$5,000, \$10,000, or \$12,500 (Choose any amount to help cover your expenses in the case of an accident.)			
Coinsurance (% of covered expenses you pay after deductible)	You pay:	Choose 30% or 40%	Choose 20% or 40%	20%	0%
Coinsurance Out-of-pocket Maximum (after deductible, per person, copays not included)	You pay up to:	Choose \$5,000 or \$10,000	Choose \$2,000, \$5,000 or \$10,000	\$5,000	\$0
Doctor Visits ²					
Doctor Office Visit, History, and Exam only	You pay:	Chosen coinsurance after deductible	Chosen coinsurance after deductible	\$50 copay ³	Coinsurance after deductible
Urgent Care Center		\$75 copay			
Outpatient ²					
Emergency Room	You pay:	\$250 copay, then subject to deductible and coinsurance.			
Outpatient Surgery, Labs, X-rays, and PSA Screening		Coinsurance after deductible			
Inpatient ²					
Hospital Services	You pay:	Coinsurance after deductible			
Pharmacy ²					
Prescription (Rx) Drugs (\$3,000 max benefit)	Not covered. Discount Card only ⁴	Preferred Price Card & coinsurance after deductible You pay for prescriptions at the point of sale, at the lowest price available, and submit a claim to us with the Preferred Price Card. Once your plan deductible is met, you then pay only your coinsurance.			

¹ \$1,000 not available with the Plus Elite A plan

Lifetime Maximum Benefit we will pay (per person):		\$600,000 on these plans			
Short Term Medical Plans:		Value Select	Plus Select	Copay Select	Plus Elite
Coverage Term Length		Choose length: minimum 30 days (1 month in MO); maximum days available varies by state.			
Deductible Type		Per Term (One deductible for selected length of coverage)			
Deductible Amount (per person)	You pay up to:	Choose \$1,000 ¹ , \$2,500, \$5,000, \$10,000, or \$12,500			
> Option: Add Supplemental Accident Benefit	We pay up to:	\$1,000 ¹ , \$2,500, \$5,000, \$10,000, or \$12,500 (Choose any amount to help cover your expenses in the case of an accident.)			
Coinsurance (% of covered expenses you pay after deductible)	You pay:	Choose 30% or 40%	Choose 20% or 40%	20%	0%
Coinsurance Out-of-pocket Maximum (after deductible, per person, copays not included)	You pay up to:	Choose \$5,000 or \$10,000	Choose \$2,000, \$5,000 or \$10,000	\$5,000	\$0
Doctor Visits ²					
Doctor Office Visit, History, and Exam only	You pay:	Chosen coinsurance after deductible	Chosen coinsurance after deductible	\$50 copay ³	Coinsurance after deductible
Urgent Care Center		\$75 copay			
Outpatient ²					
Emergency Room	You pay:	\$250 copay, then subject to deductible and coinsurance.			
Outpatient Surgery, Labs, X-rays, and PSA Screening		Coinsurance after deductible			
Inpatient ²					
Hospital Services	You pay:	Coinsurance after deductible			
Pharmacy ²					
Prescription (Rx) Drugs (\$3,000 max benefit)		Not covered. Discount Card only ⁴	Preferred Price Card & coinsurance after deductible You pay for prescriptions at the point of sale, at the lowest price available, and submit a claim to us with the Preferred Price Card. Once your plan deductible is met, you then pay only your coinsurance.		

¹ \$1,000 not available with the Plus Elite plan

Most participants struggled with the insurance term “coinsurance.”

Participants had particular difficulty with the term “coinsurance.” Some participants were confused by the percentage for which they were responsible. Some were not sure if they were the coinsurer. Some simply missed the concept entirely, thinking it was a second insurance. Some thought it was like a co-signer of a loan. Some confused the term with a copay, and some just said the word had no meaning for them.

[I would be paying] 70% after the \$5,000 [deductible] limit was reached. . . After whatever the copay is. Participant 01 with chronic condition

. . . Now the coinsurer is yourself? Would [it] be myself or the insurance, the plan itself? Participant 04 with chronic condition

Well, I think it [coinsurance] means if I have another insurance policy, such as my Medicare, they said they would coordinate the benefits so that I don't get rich off of this. Participant 03 with chronic condition

I guess I'm not 100 percent positive that I'm correct in it, but would it [co-insurance] be when you have a second insurance? Participant 02 with chronic condition

[Coinsurance is] Something that somebody else would pay . . . Just like I be buying a car and they want a co-person on your . . . [like] A cosigner, yes. It's like a cosigner . . . The percentages [are what] the other person would pay. I mean choosing . . . they could be aiming to choose if they want to pay 30% or 40%, maybe they want to pay 20%.

Participant 04 with no health condition

I don't know what it [coinsurance] would mean if it was just me because . . . I don't know. It doesn't have any meaning in my world . . . Because I would just ask why are you using the word coinsurance instead of insurance? Participant 04 with chronic condition

Several participants commented on not understanding other terms as well, and a few felt comfortable defining the term “deductible.”

Several participants commented on not understanding the terms “lifetime,” “no-balance billing,” and the maximum benefit in prescription benefits among others. One participant misread the deductible amounts. Interestingly, those participants who seemed comfortable with the concept of “deductible” linked it to deductibles in automobile insurance.

Is lifetime really lifetime, or is it . . . the definition of lifetime. Is lifetime for the rest of my life, or while I'm enrolled in this plan? Participant 01 with no health condition

What do they mean by no balance billing? Participant 03 with no health condition

I'm looking at prescription drugs, when they say \$3,000.00 max benefits does that mean that's all they're going to give you for medicine? Participant 03 with no health condition

. . . but a deductible is—now, as far as cars go, I have a better understanding. Say, I'm in a wreck and I have damage and my deductible is 1,000. I have to pay 1,000 and then they pay the rest. I guess that's the same with medical insurance. Participant 03 with chronic condition

. . . basically the deductible is a set price say [like] with the car insurance, your deductible is \$500 so you'll be responsible for that \$500 and insurance pays the rest. Participant 04 with chronic condition

Many found the layout of the two charts confusing.

Aside from the terminology difficulties, participants had trouble with understanding the visual presentation of the two charts and even why there were two charts. One participant noticed that the colors that showed the different plans didn't quite work as columns since the deductible didn't have the colors. It wasn't clear that he understood why the colors weren't there. When asked about the difference in the two charts, he saw no difference. Two other participants did see the difference but thought it quite difficult to see a very subtle difference. They were frustrated by having to flip between pages 3 and 4 to find the difference. One suggested having the tables on opposite pages rather than verso pages.

Not really lining up with the colors selected on here. Like you've got the colors selected on here, but with the deductible amount you don't got a color on it. Participant 04 with no health condition

[The difference between the two charts is] This one say Elite A plan and this one say Plus Elite plan . . . It's the exact same thing. It don't say nothing different. Participant 04 with chronic condition

. . . I'm trying to figure out the differences between the two [charts] . . . So this is \$600,000. This is \$2 million. I have to look closely at that. I don't think people would see that . . . It would be nice if they were side by side to compare. I would probably copy one and put it next to it so I can look at it easier. Everything looks the same. This one's just whether you want \$600,000 or \$2 million in lifetime per person. Participant 01 with no health condition

I still don't really understand what the difference between these two charts are on page 3 & 4. I'm going to read into detail to see if I can determine that. I see that they both require network doctors, except for emergencies. It's not clear to me what the policy differences are on these two charts, except for that the lifetime maximum benefit is different. I guess there's Value Select A; they're called A plans instead of the basic plans listed. The deductible amounts are the same. It looks like all the other costs listed are pretty similar in terms of copays and percentages. I'd assume that the A plans are more expensive based on the fact that the lifetime maximum benefit is higher; but other than that, I'm not really sure at this point. Participant 02 with no health condition

Few participants correctly could apply the concepts to a scenario of costs.

Not surprisingly, with such a weak grasp of basic definitions and the ability to read the charts, participants applied these concepts in short scenarios with varied results, especially to more

complicated situations (See **Table 1. Three Questions about Costs.**) Although for the first question, nearly 2/3 of the participants are able to answer the question correctly, for the two following questions, the percentage of correct answers is quite low.

In the Table, we identified the concepts in column 2 that the participants needed to understand to be able to correctly answer each question. We also provided the questions we asked to have participants apply the information in the tables on pages 3 and 4. We gave them a simple scenario that they had selected:

- Six-month Value Select plan with
- \$5,000 deductible
- 30% coinsurance
- \$10,000 out-of-pocket maximum

These parameters were selected because, at the time of the study, this policy was listed as a “best seller” on the website of a prominent web broker that offers short-term plans. For question 1, since “deductible” was the best understood term, six of the 9 participants were able to correctly answer the first question. Those who answered incorrectly failed to consider that they had not met their deductible and said that they would pay 30% of the \$200, a slightly more sophisticated answer than the participant who assumed he would pay nothing.

For the more complicated question 2 about the Emergency Room visit and only a partially met deductible, only one participant correctly answered the question completely mentioning the deductible, the coinsurance, and the ER copayment. Four other participants failed to mention the ER copay and one participant mentioned the ER copay but forgot the coinsurance payment. Three participants missed at least two of the three concepts. Of these, all missed the ER copay and two forgot that the deductible had to be reached. One reversed the coinsurance percentage, thinking that he had to pay 70%, instead of 30%.

For question 3, we did not ask two participants this question because they were so confused by the previous questions. Of the remaining six participants who were asked, three easily answered the question correctly. Two understood that coinsurance was part of the calculation but reversed the percentage, choosing 70% instead of 30%, thus underscoring their lack of understanding. The third person thought that since the deductible was met, then he would no longer have to pay any costs because “copays are not included in the out-of-pocket maximum.”

Table 1. Three Questions about Costs

Question 1 If you have not met your \$5,000 deductible and a doctor's visit is \$200, how much do you pay when you go to the doctor?			
Concept to understand	Concepts understood	Some concept understood	Concepts not understood
<ul style="list-style-type: none"> ▪ Deductible must be met ▪ Must pay full cost 	<ol style="list-style-type: none"> 1. Participant 01 with no health condition 2. Participant 02 with chronic condition 3. Participant 02 with no health condition 4. Participant 03 with chronic condition 5. Participant 03 with no health condition 6. Participant 05 with chronic condition 	<ol style="list-style-type: none"> 4. 	<ol style="list-style-type: none"> 1. Participant 01 with chronic condition (deductible) 2. Participant 04 with chronic condition (deductible) 3. Participant 04 with no health condition (deductible)
Question 2 You wake up with back pain and need to go to the emergency room where you're given an exam and a muscle relaxant. You have paid \$3,000 of your \$5,000 deductible and the emergency room bills you \$2,400. How much do you pay? How much does your plan pay?			
Concept to understand	Concepts understood	Some concept understood	Concepts not understood
<ul style="list-style-type: none"> ▪ Deductible must be met ▪ \$250 ER copay ▪ 30% coinsurance 	<ul style="list-style-type: none"> ▪ Participant 02 with chronic condition 	<ol style="list-style-type: none"> 1. Participant 01 with no health condition (ER copay) 2. Participant 02 with no health condition (coinsurance) 3. Participant 03 with chronic condition (ER copay) 4. Participant 04 with chronic condition (ER copay) 5. Participant 05 with chronic condition (ER copay) 	<ol style="list-style-type: none"> 1. Participant 01 with chronic condition (wrong coinsurance %; ER copay) 2. Participant 03 with no health condition (deductible, ER copay, coinsurance) 3. Participant 04 with no health condition (deductible; ER copay)

Question 3 You've had a really, bad year and have now paid your \$5,000 deductible. You again go to the doctor for a \$200 office visit. How much do you pay?

Concept to understand	Concepts understood	Some concept understood	Concepts not understood
<ul style="list-style-type: none"> ▪ Deductible must be met ▪ 30% coinsurance. 	<ol style="list-style-type: none"> 1. Participant 01 with no health condition 2. Participant 02 with chronic condition 3. Participant 03 with chronic condition <p>Did not ask</p> <p>Participant 04 with no health condition</p> <p>Participant 05 with chronic condition</p>	<ol style="list-style-type: none"> 1. Participant 01 with chronic condition (reverses coinsurance %) 2. Participant 02 with no health condition (reverses the coinsurance %) 3. Participant 03 with no health condition (coinsurance) 	<ol style="list-style-type: none"> 1. Participant 04 with chronic condition (misunderstands out-of-pocket max)

Findings: Can consumers understand the trade-off of affordability versus coverage?

Most participants found the low premium appealing.

From the team, we received calculations of premium cost based on the participant profiles for both the short-term health insurance plan and for unsubsidized individual coverage under an ACA plan. When we told participants the cost of the short-term plan, nearly all participants felt that the price was affordable. They said they could pay the monthly premiums associated with these plans. Most of them understood that it was important to have insurance--just in case, but cost was their driving factor.

A few more sophisticated participants coupled their assessment of the “reasonable” price to a recognition of the limits of the coverage and that the price was fine if this was the plan you had to have. Others expressed a similar sentiment as “you pay for what you get.” But the undercurrent, even with these participants, was that “some” insurance is better than no insurance.

One participant, who had understood very little during the interview, understood his pocketbook extremely well. He wanted to drive the cost down even more, surmising that the

Value Select plan was probably less expensive than the Plus Select because of its position on the page.

I think so. It has been a while since I paid but that does seem reasonable to me.

Participant 04 with chronic condition

I mean, yes it does seem reasonable if you know, if this is you know the coverage that you have to have. Participant 04 with chronic condition

You don't get a lot, so it's [the premium] not as high. You pay for what you get basically. [it's a reasonable price], for what you're getting. Participant 03 with no health condition

Because the price is okay. It's giving me the options for the different deductibles and coinsurance. And it's only for six months. It's a max of six months . . . I probably wouldn't use it. But it does give you the choice of it. You also need some insurance in the terms of, what if something does happen? We've all had . . . just people all of a sudden call you and say they have something and had no idea last week. So . . . I would never be without insurance. Let's put it that way. It would not be a wise choice. Participant 01 with no health condition

\$69 a month? For \$600,000? Yes, it would sound reasonable to me . . . Give the age that I am it does to me, yes. As of now. Maybe if I was a little bit older, maybe I would have chose Plus Elite A or something like that. But as of now, I would maybe have chose the least [expensive]. I mean I'm in good health and stuff like that, but just want to have insurance I would – yes, I probably choose it. Maybe I don't even choose that. I probably would choose this one right here . . . If this is only \$69, then this one right here that would be even cheaper than that. Got to be like \$39 or something. As long as I've got insurance, you know. Participant 04 with no health condition

Many found the more comprehensive plan also appealing and would have preferred it.

Most participants were interested in a plan that would have more coverage and at least lower deductibles. Some participants had chronic health needs or were looking for pregnancy coverage or dental or prescription benefits, so more comprehensive coverage was of great interest.

Yes, because I don't really like anything that excludes preexisting conditions. Participant 02 with no health condition

I would take a look at it. I would consider it, but I'd still want to see what hospitals, the doctors, and the rating on the insurance company itself. Participant 02 with chronic condition

Yes, that would make a lot more sense because then you'd have coverage, emergency room or doctors, because you need to go to your primary doctor to get your prescriptions refilled and stuff. So, then that would be of more value to me. Participant 03 with chronic condition

Yeah, I would because everybody gets sick, everybody needs doctors, we all need medicine and I wouldn't have to pay out of pocket. Participant 03 with no health condition

Many thought the ACA premium for the more comprehensive plan was out of reach for an individual's coverage.

When we gave participants the cost of an unsubsidized individual ACA premium, most reacted very quickly that the cost was too high. **We were not, however, able to calculate subsidies that people might receive for families, so the cost might have been inflated for many participants.** Of the nine participants, four may be eligible for a premium tax credit subsidy based on their household income.

It's way too much. I don't have a job, or I'm in between jobs, or . . . there's a reason why I don't have the insurance as it is, and it's probably a financial reason. So that would be . . . that's like another car. I would choose this one [short-term] over the other one. Again, I'm healthy . . . I'm not going to pay \$500. Participant 01 with no health condition

Couldn't afford it [comprehensive coverage]. Participant 04 with chronic condition

I mean I should be able to afford it because I'm saving more out of pocket, but that's high, that is really high [for a single person]. Participant 03 with no health condition

Even though the [the second price] had less restrictions? Still, I think that would price me out of the picture. Participant 03 with chronic condition

That [more comprehensive plan] does sound appealing for those reasons . . . Then I wouldn't be able to afford this, the higher priced premium . . . I have looked at the ACA plans but I couldn't afford those either. Participant 04 with chronic condition

On the other hand, some said that they would pay more in order to have more comprehensive coverage for a family.

At least two participants understood the trade-off of cost and coverage. Interestingly, both of these participants may be eligible for subsidies based on their household income. Nearly everyone understood the benefit of increased coverage, but only a few could afford the cost. One participant considered that the higher deductible on the short-term plan would offset her higher premium on the more comprehensive plan along with the fact that she would have more coverage for services that she thought she would need, such as prescriptions. She saw this as a tradeoff of costs—higher premiums for the ACA plan versus much higher out-of-pocket costs for the short-term plan. To her, the premium cost of the ACA plan was worthwhile because she would have the security of better coverage for herself and a young child.

I think I would look at my other options first in terms of having a more comprehensive coverage even at a much higher cost than I would to consider this. If I was not able to get more comprehensive coverage even at a much higher cost, I would then consider something like this. Participant 02 with no health condition

I would be more interested in that, because I'm not coming out of pocket every month, because like you said if I get sick, if I have a bad year I don't have to come that much out of pocket. I would have a lower deductible, I would have a lower payment and I wouldn't have to worry about all those restrictions. I would have access to everything, so I would be more interested in that because I'm saving money . . . because with the same deal with not so many restrictions, that's not bad . . . I would [take the tradeoff of a higher payment] because everybody gets sick, everybody needs doctors, we all need medicine, and I wouldn't have to pay out of pocket." Participant 03 with no health condition

Conclusion

Overall, participants struggled with the brochure on short-term health plans. We think this occurred for several reasons: experience, lack of knowledge, innumeracy, and lack of resources. The federally required disclosure on the first page of the brochure did little to reduce this confusion, since few participants even noticed it.

One of the primary reasons for participants' lack of understanding about the short-term policies appears to be that they have been shaped by their experience and expectations of the market since the passage of the Affordable Care Act. They expect to find health insurance plans that do not exclude coverage for pre-existing conditions. They expect to have a basic level of coverage for services such as pregnancy, prescription medications, and mental health care. As a result, they come to the reading of a new plan with a pre-existing psychological anchor and frame, and

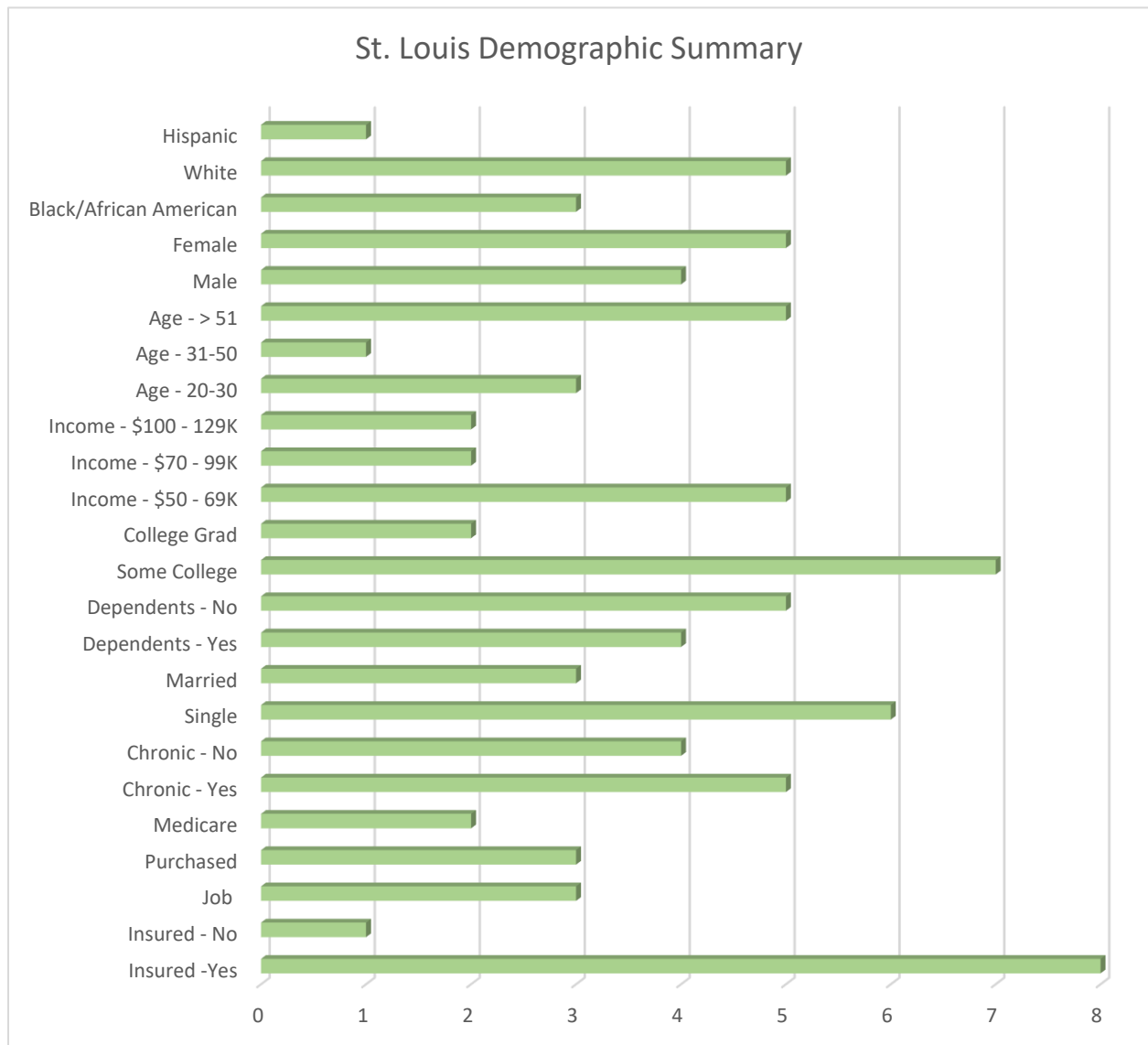
they read expecting to find the same things that their experience tells them will be there. They do not read for difference or dissonance. For many of the participants in this study, it took them quite some time before they understood that they were not dealing with a plan that was similar to what they were expecting. Then they had to reset their expectations. Some participants never had this realization, even over the course of a full hour focused on the brochure. As a result, many misunderstood even the basic concept of the short-term plan.

It is not new information that consumers struggle with insurance terminology. In this study, “coinsurance” baffled nearly all participants, both to define it and then to apply it in the scenario problems we gave them. Other terms were also difficult for participants. The only term most did not struggle with was “deductible” because they were familiar with it in a different context—automobile insurance.

In part because of their lack of familiarity with the terminology, participants struggled with the three scenario applications we gave them. They were not able to apply all concepts successfully except in the simplest problem. It seems unlikely that had we given them even more complicated situations, they would be able to calculate what their true out-of-pocket costs could be.

Nearly all participants could see the value of a more comprehensive plan, and some recognized the tradeoff between higher premiums and lower out-of-pocket costs. However, many simply did not have the financial resources to pay for a comprehensive plan without financial assistance.

Appendix A: Demographics



Appendix B: About Kleimann Communication Group

Since 1997, Kleimann Communication Group, a woman-owned small business, has been a national leader in the development of award-winning, plain language forms, disclosures, consumer tools, and education materials to help consumers understand complex topics and make informed decisions. We specialize in projects involving both design and testing and in solving unusually complex or challenging communication problems with multiple stakeholders and complex legal/regulatory requirements and constraints. Our iterative design/test process uses a human-centered methodology and results in products that address consumer, industry, and statutory needs in sophisticated and innovative ways.

Kleimann's principals are frequently speakers in issues of financial literacy and the use of plain language. For example, in June 2018, Dr. Susan Kleimann spoke at the Securities and Exchange Commission Investor Advisory Committee on the topic of "Effective Disclosure and Design."

We have completed major redesign and testing projects with national impact:

- The model Financial Privacy Disclosure for Board of Governors of the Federal Reserve System, Federal Deposit Insurance Corporation, Federal Trade Commission, National Credit Union Administration, Office of the Comptroller General, Securities and Exchange Commission
- The Loan Estimate (English and Spanish) to replace the Good Faith Estimate for the Consumer Financial Protection Bureau
- The Closing Disclosure (English and Spanish) to replace the HUD-1 for the Consumer Financial Protection Bureau
- The Health Insurance Portability and Accountability Act (HIPAA) notice to adapt it to the Affordable Care Act requirements for the Department of Health and Human Services
- The Uniform Residential Loan Application (English and Spanish) for Fannie Mae and Freddie Mac