**Addressing Low-Value Insurance Products with Improved Consumer Information: The Case of Ancillary Health Products**

The sale of financial services products is rife with information asymmetry favoring sellers and leads to the marketing of insurance products offering low value to consumers. Exemplifying this problem is the current market for ancillary health insurance products such as short-term health insurance and supplemental insurance. One policy option for regulators is to mandate a robust regime of disclosures and labeling, described here as comparative disclosures. This article reviews comparative disclosure regulations previously implemented in the U.S. and proposals for reforms. It then outlines a possible policy solution for the lack of value in ancillary health insurance products: expanding consumer information to facilitate shopping.

Consumers shopping for insurance face market conditions ranging from positive to abusive. In some lines of insurance, such as automobile, competitive markets have arisen more or less organically, with insurers advertising on price and standardized products making it possible for motivated consumers to shop for a good deal. In the case of individual major medical insurance, a regulatory scheme prescribing "managed competition" has structured the market so consumers can easily comparison shop. But in other areas, insurance is offered under circumstances that discourage comparison shopping or—worse still—permitting "reverse competition" in which side payments to intermediaries inflate costs. The result is products of low value that do little to enhance consumer welfare.

This article reviews and synthesizes literature on problems faced by consumers in navigating insurance markets. It then lays out a framework for regulators to assist consumers by restructuring the shopping experience. The focus here is on how a light regulatory touch can be applied to stimulate competition.

The Affordable Care Act (ACA) overhauled the individual market for health insurance. The ACA's so-called "three-legged stool" of market reforms consisted of guaranteed issue of insurance without exclusion of pre-existing conditions; premium subsidies for low- and middle-

income consumers; and mechanisms to spur consumers into the new individual market's single risk pool, most notably the mandate to have comprehensive coverage. Often overlooked is a critical fourth market reform: the ACA's regime to facilitate comparison shopping and promote competition among health plans.

The ACA established a system of state insurance exchanges and a four-tiered menu of coverage options, often referred to as "metal levels" for the use of precious metals in their nomenclature. The ACA's requirement of coverage of "essential health benefits," coupled with plan designs pegged to actuarial values at each metal level, permits consumers to compare competing plans of similar generosity. Comparison is further facilitated by the display of plans side-by-side on insurance exchanges' websites.

Since the advent of the Trump presidency in 2017, much of the conflict surrounding the ACA has centered on non-comprehensive health insurance products that remain unregulated by federal law. Chief among these has been the "short-term, limited duration insurance" (STLDI) category of products (Appleby, 2018). Another category, "supplemental" or limited benefit products, rides alongside STLDI as a product type regulated by state insurance commissioners. I will refer to these products by the catchall phrase, ancillary health insurance.

Backers of the ACA have viewed these categories of products as problematic because they can lure price-conscious consumers away from ACA exchange plans, undermining the ACA's single, broad risk pool. But with the National Association of Insurance Commissioners in the midst of revising its model law regulating STDLI and supplemental products,[1] it is an

[1] Model 171, Model Regulation To Implement The Accident And Sickness Insurance Minimum Standards Model Act, April 1999.

appropriate time to look at the markets for these products as such, apart from the impact they have on the ACA risk pool. As this article will demonstrate, these categories of insurance products are problematic in that they currently deliver poor value to their enrollees. This problem of low value could be addressed with tools similar to those deployed in the ACA's underappreciated fourth market reform; that is, a regulatory regime that permits consumers to shop intelligently among different offerings, forcing vendors to compete on price and deliver value for the premium dollar.

## I. Information Asymmetry Problems for Insurance Consumers and Associated Policy Considerations

### A. Information Asymmetry Generally

Information asymmetry is usually cited as one of four types of market failures giving rise to a need for government action. Information asymmetry, negative externalities, and monopoly are three generally thought of as consumer protection problems requiring regulatory interventions.[2] Information asymmetry can be defined as an "unequal repartition of information between two agents, which allows an opportunistic behavior of the best-informed agent" (Bougherara and Grolleau, 2005).

In the context of insurance, however, information asymmetry was traditionally thought of as an imbalance favoring consumers over sellers: a consumer presumably has intimate knowledge of his own risk factors and likelihood of making a claim, leading to adverse selection (Einav & Finkelstein, 2011).

[2] A fourth, public goods, is closely related to the concept of merit goods which will be discussed later.

In fact, information failure is likely a bigger problem for insurance consumers. In this era of big data, insurers have access to numerous sources of information about an individual's risk factors, and as the drafter of the contract, the insurer can deploy exclusions to negate others. But consumers remain vulnerable to pitches for low-value products in a number of particularly opaque lines of insurance.

In the context of financial services products, Lumpkin (2010) lists six categories of information problems faced by consumers: product complexity; long duration; unknown quality; opaque pricing; complex disclosures; and financial illiteracy. Lumpkin observes that the fact that consumers "cannot readily discern the quality of financial products… makes them vulnerable to misconduct on the part of financial service providers [including] conflicts of interest [or] outright fraud."

Ippolito (1986) notes that "if it is difficult for consumers to assess the quality of goods sold by individual sellers in a market, there is an opportunity for sellers of low-quality goods to attempt to pass their goods off as high quality goods," driving sellers of high quality goods from the market.

### B. Sources of Consumer Vulnerabilities Specific to Low-Value Insurance Products

1. Frustrated expectations

Daniel Schwarcz (2007) cataloged a number of problems consumers face that are specific to insurance products. Their unifying theme: it is too easy for consumers to face outcomes that don't comport with their reasonable expectation of the product. Schwarcz notes that "insurance policies are contracts of adhesion, which sophisticated insurers unilaterally draft and offer to uninformed consumers on a take-it-or-leave it basis." As such, insurers are in a position to draft

contract language excluding coverage that, given the overall context of the transaction, consumers reasonably expect.

Schwarcz wrote in the context of litigation that challenges the letter of these policies and asks judges to alter their provisions to conform with consumer expectations. As Schwarcz pointed out, courts in only a handful of states permit judges to do so, and the topic of this Article is regulation *ex ante* of the marketing of insurance products. Applied in this setting, the reasonable expectations doctrine can be a starting point for state regulators to analyze the market for, the marketing of, design of, and parameters governing an insurance product. The regulator can ask, looking at the product and the context of its sale to consumers as a whole, are consumers likely receiving their reasonable expectations? For Schwarcz the question in evaluating the "need for legal intervention—whether via the judiciary or state regulators—is whether, and in what ways, existing market mechanisms fail to ensure efficient insurance policy terms." (Schwarcz, 2007) The inquiry should be made with regard to both consumers who make a claim and consumers who let a policy lapse without making a claim, for the rate at which claims are paid is an element of value even for consumers who do not suffer a loss.

Schwarcz notes that "The actual market mechanisms by which… insurance consumers become 'informed' about policy terms have virtually nothing to do with insureds reading policy terms." (Schwarcz, 2007) Rather, consumers are more likely to rely on general descriptions of coverage by an insurer or agents; the reputation of the insurer; or other intermediaries. "Even if insureds wanted to learn directly about the scope of potential coverage… insureds generally do not receive the policy itself until after they have agreed to purchase their insurance." (Schwarcz, 2007) Further, consumers seek products within the confines of bounded rationality, "only

capable of incorporating a limited number of considerations into their purchasing decision." (Schwarcz, 2007)

Schwarcz observes that when insurers use exploitive terms in drafting policies, "the negative effects on social welfare are often significantly larger" than in other form contracts. Given that stakes are high for a consumer with large medical bills, and that "insurers are more efficient bearers of risk," health-related insurance products merit special regulatory scrutiny.

2. Strategic Underperformance

Russell Korobkin (1999), writing about managed care before adoption of the ACA, used game theory to explain why health insurers were incentivized to strategically underperform in approving or paying for consumers' care. His analysis no longer applies to the standard health insurance market, but it does apply to short-term and supplemental products. Moreover, the analysis illustrates how market problems can be addressed by the ACA's approach to market reforms.

The likelihood of a consumer securing a satisfactory bargain can vary based upon whether a search good or experience good is being purchased. A search good is an item the quality and utility of which can be readily ascertained; for instance, a consumer can immediately judge whether a pair of reading glasses achieve the necessary outcome, at a good price, during a trip or trips to a drugstore. In contrast, an experience good (which often is in fact a service) must be experienced after a purchase before the consumer can evaluate the bargain; (Nelson, 1970) for example, joint replacement surgery. Insurance is an experience good because the consumer can only determine its value after a loss is suffered and a claim is disposed of.

Korobkin observes that while sellers are highly incentivized to offer value in a market for search goods, they are less so in markets for experience goods. However, when an experience good is purchased frequently and there is likelihood of repeat business from a consumer, the seller has an incentive to develop a reputation for quality and customer service: "Once the seller establishes such a reputation it can serve as a bonding mechanism that permits the seller to credibly commit to providing a high-quality product or service… When these incentives operate effectively, the unregulated market can provide buyers with a choice between high-quality/high-price sellers on the one hand, and low-quality/low-price sellers on the other. This choice permits each individual buyer to allocate the efficient amount of resources to the product." (Korobkin, 1999)

A problem can arise in the health insurance context because of a "complete or near absence of incentives to cultivate repeat business and build a reputation for quality." The "unusual nature" of health products "distorts sellers' usual incentive to cultivate repeat business":

> Although most sellers of goods and services desire repeat patronage from all of their customers, [insurers] would prefer not to retain a portion of their customers from one year to the next. In any given year, the sickest approximately two percent of Americans consume approximately forty-one percent of the nation's health care resources, and just ten percent of the population uses seventy percent of all health care provided. Because of this reality, an [insurer] that is able to avoid enrolling the sickest portion of the population stands to be extremely profitable. (Korobkin, 1999)

When a consumer makes a claim for an accident or injury, she reveals herself as a less desirable customer. In the market for short-term health insurance, the insurer can decline to cover the customer after the term expires. In the case of short-term and supplemental products, a

consumer whose claim is denied will want to drop the coverage, a situation that the insurer will likely find pleasing.

**C. The problem of opportunism.**

Oliver Williamson postulated the concept of opportunism as the strongest form of self-interest seeking within a market economy. Opportunism is "self-interest seeking with guile" encompassing sellers' "incomplete or distorted disclosure of information" and "calculated efforts to mislead, distort, disguise, obfuscate, or otherwise confuse." (Williamson, 1985) Put another way, consumers are "vulnerable to calculated efforts by others to mislead, renege, cheat or otherwise take advantage of the vulnerabilities of their trading partners" (Richman & Macher, 2008). Opportunism results in a bargain that is unfair to consumers in the sense that too much money is spent on a product or service, or money is committed that would have been better spent elsewhere. In an opportunistic transaction, the surplus goes mostly to the seller, leaving little or no gain for the buyer.

From the consumer advocate's perspective, there are two ways for a firm to make money: by adding value or through opportunism. The financial services firm that adds value addresses a need of households in an efficient manner, disciplined by a competitive market and empowered consumers, by providing credit, or protection from risk, on attractive terms. Consumer advocates assume that most insurance products add value, which is why we work to make them accessible to more customers.

But because of the information problems inventoried in Sections IA and IB above, financial services products are uniquely prone to opportunism. Sometimes a firm whose products unquestionably add value may pursue opportunistic strategies alongside provision of valuable services; and sometimes a business that originally provided high-value services may devolve into

an opportunistic pursuit. A major concern is that it may be easier, and more profitable, for a firm to pursue an opportunistic model than a value-added model, as competition will force a value-adding businesses to pay more attention to customer service and satisfaction, and likely have smaller margins. A further concern is opportunistic models attracting and displacing capital that would otherwise be invested in value-adding endeavors.

The challenge for regulators is to identify opportunistic products and strategies and prudently use their authority to curb them. Laws including the Federal Trade Commission Act, the state Unfair and Deceptive Acts and Practices laws that parallel the FTC Act, provide remedies against opportunistic conduct that falls short of common-law fraud. In the insurance sphere, insurance commissioners' authority to approve rates or forms,[3] or catchall authority to prohibit unfair and deceptive acts in the insurance business,[4] are checks against insurer opportunism.

### D. Shortcomings of government regulation

The counterargument to calls for state regulatory responses to market failures was best articulated by Wolf (1993) in his theory of non-market failures: "Just as some types of incentives encourage market failure, so too incentives influencing particular non-market organizations may lead to behavior and outcomes that diverge from ones that are socially preferable."

The non-market failure identified by Wolf most relevant to insurance regulation is what Wolf labelled "derived externalities"—side effects of regulation that distort economic activity in perverse ways. By definition, restrictions on the type of insurance that may be sold reduce

[3] For example, Florida Statutes §627.410; Mass. General Laws c.175 §108.

[4] For example, Nev. Rev. Stat. § 686a.170(1); Cal. Ins. Code § 790.06(A); Ky. Rev. Stat. Ann. § 304.12-130(1); Mont. Code Ann. § 33-18-1003(1); N.C. Gen. Stat. § 58-63-40(A).

consumer choices in the marketplace (Miller, 2020) even for consumers sophisticated enough to understand the pitfalls of the prohibited product.

A further concern is that regulatory standards can "cause people to exit the market for the regulated insurance product. These people may either substitute toward unregulated forms of insurance or drop coverage altogether" (Finkelstein, 2002). Finkelstein estimated that NAIC's adoption of minimum standards for Medicare supplemental policies reduced Medigap coverage by 25 percent among seniors newly eligible for Medicare.

"A common problem with state control is the excessive power accumulated by incumbent providers of services, who use their leverage to prevent potential competitors from disrupting the status quo" (Capretta, 2020). Miller (2020) argues that the ACA's regulation of individual health insurance led to "the six leading health insurers by market share increase[ing] their percentage from about 30 percent market share in 2015 (one year after the ACA's insurance exchanges were launched) to just over 50 percent in 2019."

With regard to ancillary products, regulators must weigh the assessed loss of consumer welfare resulting from information asymmetries in the current market against the potential for lost consumer welfare resulting from reduced product availability and reduced competition.

### E. Economics of low value products

Dueling economic perspectives are available to analyze regulation of low-value insurance products. A report issued by the Trump Administration's Council of Economic Advisors (CEA) in February 2019, *Deregulating Health Insurance Markets: Value to Market Participants*, purports to demonstrate the value to consumers of substituting loosely-regulated products for

major medical insurance. Its analysis highlights certain respects in which comprehensive health coverage lacks utility for healthy or risk-tolerant consumers.

> Providing insurance to those who value it most highly nets large social benefits. Insuring more and more of the population nets progressively smaller social benefits, because the coverage still costs society but is directed at enrollees who do not value the coverage as highly. When insuring even more of the population requires providing insurance to enrollees who value the insurance at less than what it costs society, on net the social benefits become negative. [Diagrammatically] this is captured by the downward-sloping net marginal social benefits (MSB) schedule, which shows that as enrollment increases, the net social benefits decline and eventually become negative.

After setting forth assumptions about consumers who shift from ACA-compliant individual coverage to short-term, limited duration insurance (STLDI) coverage, and the latter product's lower price, CEA assessed that by "removing the combined effects of the renewability restrictions, the limited term, and the administrative and hassle costs," the Trump-era regulation easing sales of STLDI permitted consumers switching from ACA-compliant individual coverage to STLDI coverage enjoyed a consumer surplus of $609, aggregated across an estimated 1.3 million enrollees who shift, resulting in $5.3 billion in welfare gains.

The CEA analysis relies on two premises. First, it disregards any merit good analysis of the ACA's promotion of universally available comprehensive health insurance. A merit good adds positive externalities to the individual's consumption (Musgrave, 1959) —in the case of health insurance these may include reduced premiums due to broad contributions to the pool, fewer medical bill-related insolvencies and therefore fewer debts written off, and better

population health—thereby increasing the marginal social benefit beyond the individual's welfare.

Ignoring this element results in an analysis is that proves too much, as there are many merit good financing programs that build cost into the purchase of a product or maintenance of an asset to promote a collective benefit. For example, a catalytic converter or other emissions control devices required for an automobile must be purchased by consumers who value clean air as well as by those who are indifferent to pollution. Zoning laws requiring that structures retain wood clapboard exteriors to maintain a community's historic character add costs for unsophisticated homeowners who would be satisfied with cheap, low-maintenance vinyl siding. The list goes on ad nauseum—iodization of salt purchased by consumers who are not vulnerable to iodine deficiencies; fluoridation of community water supplies for those who would opt out; mandatory athletic fees added to college tuition for sports fans and non-fans alike; funding mass transit through gasoline taxes; etc.

But the biggest hole in this critique of merit good financing is, of course, public education being paid for by property taxes. A childless household must shoulder the same tax burden as a household with multiple school-age children. An analysis that disregards positive externalities could conclude that public education produces a negative net social benefit, and that Americans ought to be able to opt of out of financing it like they can with health insurance.

Inasmuch as many workers are voluntarily relinquishing cash compensation equivalent to the cost of employer-sponsored health insurance, (Lucia & Jacobs, 2020) the suggestion that the ACA represents some sort of uniquely or particularly oppressive merit good financing scheme is unpersuasive. The only unique characteristics of the ACA are the lingering political controversy surrounding it and the ability of individuals to bypass it. (Cohn, 2020)

Second, the CEA analysis does not acknowledge any loss of utility attributable to information asymmetry favoring sellers of alternative products. Vining and Weimer (1988) demonstrated the inefficiency caused by information asymmetry favoring sellers. The consumer surplus resulting from consumption of a product is lower when demand for a product is "uninformed" because a greater quantity is demanded and a higher price is paid than would be the case if consumers have perfect information about its quality. The increased spending represents a deadweight loss in consumer surplus.

CEA (2019) disregards information asymmetry differences between ACA-compliant insurance sold in an environment approaching perfect information balance and the STDLI market. The consumer knows that competing ACA products are uniform in their distribution of benefits (if not in the precise combination of benefits) enabling apples-to-apples price comparison. The products' reliability can be attested to through accreditation and star ratings issued by the National Committee for Quality Assurance.

As discussed in Section III below, we can infer that there is a high degree of uninformed demand for short-term products, such that we can assume a substantial loss of consumer surplus in this market, possibly equaling or exceeding any savings to ostensibly healthy consumers purchasing them.

## II. Disclosures, Labeling and Other Regulations to Promote Comparison Shopping

### A. Cautionary disclosures

Currently, ancillary health products are subject to a regime of what I will refer to as cautionary disclosures, which primarily advise consumers of the products' limitations vis a vis comprehensive health insurance. Such disclosures are necessary, but by no means sufficient,

because they do not promote competition and value. This section attempts to synthesize and taxonomize policy options related to disclosures and labeling of products.

1. Disclosures of products' attributes and shortcomings

The current NAIC model (National Association of Insurance Commissioners, 1999) requires this language:

> Read Your [policy] [certificate] [Outline of Coverage] Carefully—This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR [POLICY] [CERTIFICATE] CAREFULLY!
>
> "Notice to Buyer: This is a limited benefit health [policy][certificate]. This [policy][certificate] provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses."

In addition, a U.S. Department of Health and Human Services rule requires fixed indemnity application materials to include a notice that prominently states: "This is a supplement to health insurance and is not a substitute for major medical coverage. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes."[5]

2. Conflict of interest warnings

[5] 45 C.F.R. § 148.220(b)(4)(iv).

A conflict-of-interest disclosure may be appropriate when a service provider earns financial gain upon closing a sale that is significant enough to disincentivize a full and accurate representation of the commodity's suitability for a given consumer.

In September, 2021, in order to "ensure transparency of agent and broker compensation when purchasing individual health insurance coverage or short-term, limited-duration insurance," HHS proposed a new regulation at 45 CFR 148.410(c) requiring that health insurance issuers offering such products "disclose to a potential or existing policyholder the amount of direct and indirect compensation provided to an agent or broker associated with enrolling the policyholder … to include the commission schedule used to determine the compensation owed to an agent or broker as part of the appointment contract between the agent or broker and the health insurance issuer offering individual health insurance coverage or short-term, limited-duration insurance, as well as the structure for compensation not captured on the commission schedule." The agency said that disclosure of commissions would help consumers "understand the compensation that their insurance agent or broker would receive and make informed purchasing decisions."

As with other cautionary disclosures, the consumer is spurred to think twice about completing the sale, but the disclosure in itself does not promote competition.

### B. Critique of traditional disclosures

While it is appropriate to require such disclosures for products that have questionable utility and that may in fact be harmful, these disclosures by themselves are inadequate protections for consumers. In general, problems with disclosures include consumers' bounded rationality, low financial literacy, and the fact that, despite the language quoted above, people typically do not read contracts. In an analysis of recently implemented insurance disclosure

requirements in Germany, Schwarzbach & Weston (2016) report that "Studies showed that the disclosures, though timely and containing important information about the insurance coverage, did not facilitate consumer understanding, primarily because the information and format were not standardized." They concluded:

> Carefully constructed disclosures can improve consumer understanding of some limitations and options, and may prompt the consumer to ask for advice.... Research [shows] that "nudges" and default opt-outs have been useful, but are incomplete solutions to improve consumer decisions and welfare. Disclosures lacking such careful construction will likely accomplish more to insulate the insurer and the agent rather than motivate them to provide better products and service.
>
> But better consumer decisions do not necessarily follow from increased information unless the information is perfectly conveyed in the right way at the right time. The real goal of better consumer decisions is consumer welfare, which requires more than disclosures, whose value remains limited.

Researchers for the European Commission (2017) conducted a comprehensive study of consumer decisionmaking in insurance purchases, including interviews with regulators, consumer focus groups, and behavioral experiments. They concluded that while disclosures should be improved, the regulatory regime must go beyond provision of information to "Facilitate consumers' decision-making in insurance purchases" by, inter alia, "ensur[ing] that consumers are given the opportunity to reflect on and modify their choices throughout the purchasing process – for example, by introducing guidelines or standards that allow sufficient opportunities for consumers to pause and reconsider their choices;" making consumers "aware of the availability of alternative offers during the purchasing process;" harmonizing definitions and

contract formats to facilitate "comparison of different products on the market;" and "Establishing standards for price comparison websites" to ensure that they "are transparent, comprehensive, show costs clearly, and enable complex comparisons."

### C. Comparative disclosures

Such an alternative regime might be called one of comparative disclosures—disclosures permitting easy comparison of products, thereby promoting competition on price and quality. This regime assists consumers in shopping by giving experience goods attributes of search goods so the consumer can better exercise choice. Comparative disclosures encompass two categories. Fair labeling standards regulate the use of commonly understood terms to ensure that the product conforms with consumers' pre-existing expectations of everyday products. Augmented disclosures facilitate comparison of infrequently purchased products that pose greater danger of confusion or inability to discern value.

1. Fair labeling requirements

A longstanding example of a fair labeling regime is the identity standard provision of the Food Drug and Cosmetic Act, enacted in 1938, which permits, when necessary to "promote honesty and fair dealing in the interest of consumers," the FDA to promulgate regulations "establishing for any food, under its common or usual name so far as practicable, a reasonable definition and standard of identity."[6]

Some three decades later, Congress adopted the Fair Packaging and Labeling Act,[7] permitting regulations "necessary to prevent the deception of consumers or to facilitate value comparisons as to any consumer commodity," including definition of "standards for

6 21 U.S. Code § 341
7 15 U.S. Code § 1451 et seq.

characterization of the size of a package" and requirement that the label on a package "bear the common or usual name of such consumer commodity."

2. Augmented disclosures to promote comparability

A classic example of an augmented disclosure regime exists for mortgage loans. Congress enacted the Truth in Lending Act[8] (TILA) and Real Estate Settlement Practices Act[9] (RESPA) which together transformed what had been an experience good into a search good, facilitating consumer shopping for interest rates and closing costs.

The Truth in Lending Act addressed a lack of transparency in credit pricing: "camouflage" of the true cost of credit with "extraneous fees that should have been included in the interest rate. This camouflage rendered meaningless and deceptive any interest rate quoted." (National Consumer Law Center, 2012) TILA's Annual Percentage Rate, or APR requirement counteracts this problem. "Just as the consumer is told the price of milk per quart and the price of gasoline per gallon, so must the buyer of credit be told the 'unit price.' The APR is the unit price of credit." The APR precludes "non-standardized methods of computing interest that result in an apples-to-oranges comparisons of rates… The APR is a simplifying heuristic that allows borrowers to decide between options that are otherwise overwhelmingly complex." The consumer need not know how the APR is calculated; like watt numbering on a lightbulb, it is not the underlying measurement that is important, only the value relative to other similar products.

RESPA requires mortgage lenders to give consumers a good faith estimate of closing costs, so consumers can shop among lenders offering lower (or no) additional fees at closing. (Congressional Research Service, 2012) Some lenders absorb closing costs rather than separately

[8] 15 U.S.C. 1601 et. seq.
[9] 12 U.S.C. 2601 et seq.

bill them, and thus bypass the disclosure requirement. But more frequently, lenders or mortgage brokers charge what are known as "junk fees"—fees representing service costs that in many analogous contexts are considered part of a business' overhead. Such fees can include inevitable third party costs, such a recording a document at the courthouse; fees paid to third-party vendors such as title insurers that are selected by the lender; or fanciful "fees" breaking out overhead costs as separate charges, that simply add to the lender's profit. In any event, they increase costs to the consumer, permitting sellers to charge more than the price they advertise, and thus need to be subjected to competitive forces through disclosure.

Another augmented disclosure is found on the Monroney Sticker, which federal law requires be affixed to new cars.[10] It permits consumers to compare different models and different options, and to compare prices different dealers ask for identical models, incentivizing dealers to charge no more that the manufacturer's suggested retail price inscribed on those stickers. The sticker removes some experience good attributes such as gas mileage from automobile shopping and, together with quality advice from intermediaries such as *Consumer Reports*, makes cars largely a search good.

Note that these regulatory regimes stop far short of commanding underlying prices or attributes of products. They simply facilitate comparisons and competition among whatever products the sellers bring to market. In the health insurance sphere, such regulations have received bipartisan, consensus support.

Various pre-ACA market-driven proposals to replace employer-sponsored health insurance with individually purchased insurance contained labeling requirements to facilitate

[10] Automobile Information Disclosure Act of 1958, 15 U.S.C. §§ 1231 et. seq.

shopping. The Heritage Foundation plan authored by Stuart Butler (1989) would have included "a classification system for insurance, under which certain types of coverage would be required to receive a certain classification… [to] make comparisons between policies easier for potential buyers [and] help stimulate the market for such insurance." A similar, bipartisan, effort, the Healthy Americans Act, introduced by Senators Wyden and Bennett and co-sponsored by 11 Republican senators,[11] would have required each state to designate a State agency as a "Health Help Agency" to promulgate "standardized, unbiased information" on plans and supplemental health insurance options; "develop standardized language" for plan terms and conditions and "require participating health insurance issuers to use such language in plan information documents;" "provide prospective enrollees with a comparative document" describing all plans in which the individual may enroll; and "publish information that includes loss ratios, outcome data regarding wellness programs, disease detection and chronic care management programs categorized by health insurance issuer, and other data as the HHA determines appropriate." These early efforts to empower consumers as purchasers of health insurance offer guidance to regulators in fostering competitive and transparent markets for health products.

3. Competition admonition

A competition admonition is a mandatory disclosure, by a seller, of the availability of competing sellers and offers prior to the competition of a transaction. It encourages consumers to consider alternative offers before making a purchase, thereby promoting competition based upon price and quality.

[11] S. 391, 111th Congress, 1st Session (2009)

One such admonition requirement applies to real estate brokers and attorneys when they refer a client to an affiliated title insurer for settlement services. Pursuant to a rule promulgated by HUD under the Real Estate Settlement Practices Act, a self-referring party in real estate must make the following disclosure in writing:

> This is to give you notice that (referring party) has a business relationship with [settlement services provider(s)]. Because of this relationship, this referral may provide [referring party] a financial or other benefit. Set forth below is the estimated charge or range of charges for the settlement services listed. You are NOT required to use the listed provider(s) as a condition for [settlement of you loan on] [or] [purchase, sale, or refinance of] the subject property. THERE ARE FREQUENTLY OTHER SETTLEMENT SERVICE PROVIDERS AVAILABLE WITH SIMILAR SERVICES. YOU ARE FREE TO SHOP AROUND TO DETERMINE THAT YOU ARE RECEIVING THE BES SERVICES AND THE BEST RATE FOR THESE SERVICES.[12]

Another such admonition familiar to Medicare beneficiaries is made pursuant to the Medicare Imaging Disclosure Sunshine Act.[13] This law requires that when a physician self-refers for advanced imaging, the referring physician must inform the patient in writing that the patient may obtain the services elsewhere and provide the patient with a written list of other suppliers

This disclosure has been criticized as a conflict-of-interest disclosure clothed as a competition admonition, inasmuch as Medicare sets uniform prices, and meaningful information about imaging quality is not yet available—its true purpose is to spur the patient to inquire

[12] 24 C.F.R. § 3500. 1, et seq. (2008). Id. at § 3500 App. D.
[13] 42 U.S.C. 1395nn(b)(2)(B)

whether the scan is necessary. Nevertheless, it represents a helpful example of both types of disclosure.

Another well-known example relates to electric power providers in states that have deregulated electricity markets. In Pennsylvania, language appears on monthly electric bills informing consumers that they can shop among electricity providers on a price competition website.

The third Part of this article proposes options for comparative disclosures to improve consumers' ability to shop for ancillary health products and promote a more competitive market.

## III. Applying the Framework to Ancillary Health Products

Ancillary health products are sold under suboptimal purchasing circumstances—in the absence of consumer shopping activities. Under Katz & Shapiro's (1986) Simple Model of Consumer Shopping Behavior, shopping consists of two components: "(1) obtaining information about the prices and qualities of the available products; and (2) obtaining any sorts of deals that require special activities on the part of the consumer, such as clipping coupons and bargaining." In the information gathering phase, "consumers will balance the credibility and costliness of alternative information sources. Some sources, such as visits to several stores, will provide particularly reliable or accurate information, but may be too costly for consumers to rely on extensively." Consumers "need both price and quality information."

The problem in markets for ancillary health products is the lack of any meaningful information gathering. Short-term health insurance is often sold in the context of phone solicitations by brokers. While in theory, aggregator websites enable consumers to view competing options, as described in Section A.1.b below, broker- or lead generator-operated

websites are of no real use in evaluating coverage or value. In the case of supplemental products, they are most often purchased from the broker serving the consumer's employer, and the sale is closed in the workplace conference room, during annual open enrollment. As the broker sells just a single company's products, the consumer is unlikely to attempt comparison shopping. And in both cases, no information is available on the product's quality.

### A. Problems in the market for ancillary health products

1. "Short-term" products

The exclusion of short-term limited duration insurance from the ACA's definition of major medical insurance and other reforms spurred the marketing of relatively cheap products labeled "short term health insurance." In fact, it appears that many of the products may be excluded from ACA coverage requirements not because of their duration but because they pledge to pay a fixed indemnity upon occurrence of a medical event. As such, regulatory efforts to restrict these products' duration will not address two major problems described below: the advantage to sellers from marketing products as "short-term *health insurance*," which implies a generosity on a par with ordinary health insurance; and the advantage to sellers of truncating their legal responsibilities after short intervals by re-setting exclusions of emergent health conditions as "pre-existing" with regard to a new term.

a. Low value to consumers

A year-long investigation by the House Energy and Commerce Committee (2020) catalogued numerous problems in the short-term insurance market, including:

- Insurers subjecting consumers to a post-claims review process to determine whether the claim may have arisen from a pre-existing condition or a health condition that should have been disclosed by the applicant in the plan application; with insurers sometimes refusing to pay even for medical claims not due to pre-existing conditions or subject to any of the plan's exclusions and limitations, in which case claims were processed only after the consumers retained attorneys or filed complaints with state regulators.
- Insurers rescinding policies if they determine that the enrollee had an undisclosed prior health condition or risk factors, leaving enrollees uninsured and with large medical bills.
- Significant limitations on payments for doctor's fees, hospitalization, emergency services, and prescription drugs, such as maximums of $500 per policy period for physician fees, $1,000 per day for hospitalization, $500 per visit for emergency services, and $2,500 per surgery for surgeon services, leaving substantial medical costs for consumers to pay.
- Across the eight companies responding to the Committee's subpoenas, an average of 48 percent of premium dollars paid out for health care claims.
- An average broker commission rate for STLDI plans of 23 percent, many times the 2 percent commission rate for ACA-compliant plans.
- Abuses by a firm whose "operation and business structure incentivizes third-party agents and brokers to actively target vulnerable consumers seeking comprehensive health coverage and deceive them into purchasing STLDI plans, in addition to limited benefit indemnity plans, life insurance plans, and medical discount plans" that resulted in "thousands of consumer complaints" reviewed by the Committee.

Reporting by ProPublica (Deam, 2021) independently replicated several of these findings.

b. Diagnosing the market failures

The following analysis reports on a review of short-term health product descriptions found on the eHealth and Agile websites, conducted by the author for a presentation before the NAIC's Consumer Liaison Committee in August 2019. The review sought to determine the sufficiency, clarity, and quality of information available to a consumer attempting to comparison shop among short-term health insurance products, and to communicate the consequences of purchasing on these products relative to common expectations of "health insurance." While one suspects that a rather small proportion of short-term product sales are made on these websites, and that the sites function primarily to generate leads, researchers have found them to be the most readily accessible source of information about the products and how they are portrayed to consumers.

(i) Inadequate information, presented too confusingly, for consumers to understand exactly what they are buying.

These websites are structured as aggregators of products. Both are formatted quite similarly, displaying search results with companies' logos as one might see airlines and flights displayed on the Orbitz or Expedia websites. But the insurance sites have less specificity, less uniformity, and more ambiguity than travel websites. Unlike Orbitz or similar sites they superficially resemble, they are not conducive to comparing prices or attributes of the products.

Both the websites and brochures to which they link lean heavily on the use of shorthand, undefined phrases. Clauses that are typically used as modifiers, such as "out-of-pocket," sometime have no noun following them to clarify their meaning (e.g., "Out-of-pocket maximum/limit" is the phrase used in the healthcare.gov glossary).

Each website uses a matrix to display various product attributes but there is no uniformity across entries. For example, one website's display has two columns with no headings at the top. In the 2nd column, across from "Prescription Drug Coverage" the display describes what is paid for; across from Hospital Services Coverage the display says "20 percent after deductible," presumably referring to the part that is *not* paid for. The lack of uniformity—and in particular, the lack of identifiably similar benefit packages—prevents comparison shopping.

Under the heading of "Plan Type," "PPO" (which consumers would understand to mean Preferred Provider Organization) is sometimes used to describe indemnity products. Perhaps of greater concern is that the sites do not explain the dynamics of an indemnity policy, which will often leave a remaining balance between providers' charges and a "usual, customary, and reasonable" payment tendered by the insurer. When the insurer does not contract with providers as under a PPO, and when the insurer's relationship with the consumer will end with the term of the policy, insurers may feel less inhibited in setting an unrealistically low payment amount.

Some product descriptions inflate the policy's value. Product L (I have kept the names of companies anonymous) is advertised as having a $750,000 policy limit. The shopper seeing that number will surely think that it offers a lot of protection, and could believe, as is true with auto insurance, that higher policy limits provide greater protection. But given its fixed-dollar benefit schedule and its 3-month term it appears unlikely that this policy has paid anyone more than a few thousand dollars. It would seem the maximum this could policy could pay out is far lower than advertised. If a consumer entered the hospital the first day a policy was in effect and stayed for 90 days, the payout, limited to $800/day, would be around $72,000—leaving an unpaid hospital bill in the neighborhood of the advertised "limit." Because spending during a cancer episode is spread across a period far exceeding 3 months, even the payout for cancer would be

unlikely to exceed $100,000, nor more than a third of the total cancer episode cost. A key reason these insurers can expect low losses, and offer seemingly low prices, is the truncation of their responsibilities at the 90-day or 180-day mark.

(ii) Inadequate communication of limited benefit design and its consequences

The aggregator websites did not display the full plan descriptions/certificates, nor were they made available after I requested them through the websites' communication features. None of the plan descriptions for products I reviewed were publicly posted on the NAIC's System for Electronic Rate and Form Filing (SERFF) for the state in which they were being sold. But it appears from the scant publicly-available details of these products that many, if not most, are low-value products that won't pay out the benefits consumers need and expect in a time of crisis, and will pay amounts that are disproportionately low in relation to their premium. The products described here were those displayed as available to a 50 year-old non-smoking male in Philadelphia PA. I focused on my inquiry on products priced below $200/month.

Products in the $100-200/month range tend to be indemnity-type products that pay fixed amounts for needed services. A plan from company L, priced at $128.43/month, has a benefit of $1,000/day for hospitalization. However, the average hospital day charge in the US is $5,220/day and the average inpatient length of stay is about 5 days. If the purchaser of this product goes to the hospital for 5 days he can expect a bill for $26,000. This product has a $5,000 deductible and 20% coinsurance. The maximum payout for the hospital stay is 5 x $800 or $4,000; but because that number is below the deductible, the consumer gets nothing.

Pre-existing condition exclusions in these products represent a limitation of unknown, but likely severe, scope. They typically exclude coverage not only for illnesses resulting from conditions for which the consumer received medical treatment, diagnosis, care or advice over the past five years

but also "conditions that produced any symptoms which would have caused a reasonable person to seek diagnosis, care or treatment" within that five-year period.

History has shown that insurers can sometime be aggressive in denying claims related to heart attacks, strokes, and even conditions more tenuously related to the cardiovascular system when the consumer has a history of high blood pressure[14]—and 54.5 percent of adults aged 40 to 59 have hypertension (Ostchega et al, 2020).

Many products include limitations for the most common conditions likely to escape any pre-existing condition exclusion. One finds products carving out from coverage the incidence of gallbladder removal, kidney stones, appendicitis, knee injuries, and joint or tendon surgery. Such incidents share two traits: first, they come without warning or prior symptoms, thereby avoiding the pre-existing existing condition exclusion; and second, they are the most common operating room procedures for the non-elderly population (Fingar et al, 2014).

Plan L lists those among five "conditions or procedures… limited to the specified amounts shown in the Schedule of Benefits." That schedule is not included in the document containing that limitation, nor is it available on SERFF where the Pennsylvania Insurance Department posts policy forms.

However, we can get some idea of what limited amounts might be paid from a document posted by a competing insurer, Plan S, which limits benefits for kidney stones to $1,500 and appendectomy to $2,500. An appendectomy costs, on average, $13,910. Meanwhile, another paragraph in the Plan L document states that the 3-month policy offers no coverage, "during the first 6 months after the

[14] See, e.g., *Meyer V. Unum Life Insurance Company*, United States District Court, D. Kansas, 96 F.Supp.3d 1234 (2015).

Certificate Effective Date," of cholecystectomy, which is gallbladder removal. The average cost of this procedure is $12,600.

I was able to find certificates for Product N and Product L on SERFF/Texas. While the plan language includes boilerplate language not uncommon in ACA or employer plans, there are also some major exceptions. In addition to fixed indemnity schedules, lists of exclusions include "injury resulting from intoxication" and "hazardous activity." These would seem to warrant upfront disclosures, especially if younger consumers are purchasing the products. We do not know how often these exclusions are invoked. Another major element of plan language relates to pre-authorization requirements; we do not know anything about how pre-authorization is implemented nor how often abatements for failing to notify are invoked.

Product E purports to pay "Charges for organ or tissue transplants including all expenses related to the transplant before the transplant is performed, for the procurement of the donor organ or tissue, the hospital expenses of the donor, and for follow-up care…" Yet it is difficult to imagine circumstances in which the predicate organ failure would not be excluded as a pre-existing condition. While in theory a person could suffer kidney failure with no warning and arrange a transplant from a living donor within the 3-month policy term, Product E excludes any coverage of kidney disease.

In sum, these products are likely to lead to frustration of the expectations a purchaser would have upon suffering an illness. Even the products' most ardent defenders concede a need for "enhanced information disclosure" to protect consumers (Blase & Badger, 2020).

2. Supplemental products

A review of loss ratio data in the NAIC's Experience Reports indicates that supplemental products return scant, and declining, compensation to consumers. Loss ratios for Accidental Death and Dismemberment (AD&D) insurance in both the group and individual markets have averaged about 40%. Moreover, a downward trend is evident across several categories of products. For instance, while AD&D in the individual market had a loss ratio of 40.94% in 2017, by 2019 it had dropped to 37.93%.

For Specified Disease, in the group market loss ratios had dropped from 68.64% in 2009 to 42.56% in 2017. For 2019, the loss ratio was 40.76%. In the individual market, Specified Disease has dropped from 69.6% in 2009 to 61.5% in 2019.

"Other Medical" is the category that includes Hospitalization Insurance. Loss ratios have dropped from 66.58% in 2009 to 45.45% in 2019.

When loss ratios drop below 50%, the principal purpose of the product is no longer spreading risk and compensating consumers, but perpetuation of sales for their own sake.

The Models 170 and 171 revision process has adduced little insight into why these markets deliver far less value to consumers than they did when earlier model law language was adopted. Is it because insurers now know who to sell or not to sell to? Or has restrictive plan language been added so fewer claims need to be paid? It is possible that claims have dropped organically due to greater safety or better preventive care. But that would beg the question of why fewer accidents and illnesses have not led to lower premiums, as one would expect in a competitive market. These issues need to be explored in depth by regulators.

### B. Reforming Disclosures to Facilitate Product Comparisons

As NAIC deliberates on revisions to the Model Regulation that governs short-term and other limited benefit health products, regulators should consider steps toward a comprehensive disclosure regime that promotes vigorous competition among these products, as well as between these products and major medical insurance. Such a regime would bring about a structured market—"putting structure around [consumer] choices," prodding insurers "to keep prices competitive and innovate to provide more value" (Capretta, 2021).

Elements to be considered for such a framework would include:

- Improving cautionary disclosures
- Disseminating information on product quality
- Fair labeling standards
- Development and disclosure of a unit price permitting comparisons
- Admonitions to consumers of competing offers and a price comparison website
- Commission disclosures
- Required display of uniform label

1. Improving cautionary disclosures

The current cautionary disclosures need to give greater detail on the implications of relying on a limited benefit product. These details should include the consequences of pre-existing condition exclusions re-setting after the term expires, the scale of the shortfall remaining when an indemnity amount is less than provider charges, and other key coverage differences between a limited benefit product and ACA-compliant health insurance. One approach to the latter two items might be to require posting of a list of the most common surgical procedures performed on Americans in the consumer's age group, showing the average provider charges, whether the

product covers the procedure, and the average amount the insurer has paid out for such procedures.

2. Disseminating information on product quality

States should require short-term insurers to submit to accreditation by the National Committee for Quality Assurance or similar entity. NCQA scrutinizes insurers' practices and conducts the Consumer Assessment of Health Plans Survey of enrollees. Accreditation would generate publicly-reported information on companies' customer satisfaction and oversight of their pre-authorization requirements. States should also issue report cards, similar to those disseminated by California's Department of Managed Health Care, showing rates of claim denials and consumer complaints for each company.

3. Fair labeling standards

A set of fair labeling standards would impose a modicum of uniformity and clarity to inform the shopping experience. Health insurance is already confusing to consumers. Focus groups of consumers have shown that the concept of insurance that lacks ACA protections adds to this confusion (Kleimann Communication Group, 2019).

Labeling standards should prohibit descriptions found on the aggregator websites that create inflated impressions of the products' protections:

- Consumers generally understand a PPO to connote agreement by providers to accept a negotiated sum and refrain from balance billing.[15] The model

[15] *Kartell v. Blue Shield of Massachusetts, Inc.*, United States Court of Appeals for the First Circuit, 749 F.2d 922 (1984).

regulation should prohibit use of the term PPO unless there is an adequate network of providers who have agreed to accept a sum negotiated with the insurer as satisfaction in full of the patient's obligation.

- Some policies are advertised as offering "36 months of coverage" when fine print—visible only when an icon is clicked—indicates that three policies of 12-month duration are being offered. Because the pre-existing condition exclusion re-sets after 12 months, it cannot be accurately said that these products offer 36 months of coverage. The model regulation should prohibit numerical representations of coverage terms unless there is continuous coverage without re-setting of exclusions.
- Some insurers are advertising an out-of-pocket maximum that does not account for the deductible, while others do. This situation is confusing, makes comparison shopping difficult, and invites a race-to-the-bottom. The model regulation should prescribe uniform definitions and verbiage for describing out-of-pocket maximums and deductibles.
- Consumers' expectations, from their experience with life and P&C products, is that policy limits are a meaningful gauge of a product's value. It appears that insurers are exploiting this dynamic by advertising policy limits more with an eye to puffing up the apparent value of a product than with limiting the insurer's liability. The model regulation should prohibit numerical representations of coverage limits unless the limit would truncate coverage otherwise permitted in actuarially expected claims. In addition, policies with

coverage limits should be required to state a median or range of actual or predicted payouts.

- The model regulation should prescribe uniformity in how prices are quoted, advertised, or displayed on aggregator websites. For example, the US Department of Transportation requires Orbitz and others to display bottom-line fares inclusive of "fees."

Regulators should scrutinize the nomenclature used to describe products to ensure consumers understand limited benefit structures.

The phrase "Short-Term Health Insurance" is in most cases a misnomer, because the duration is only one difference, often dwarfed by other differences. "Short Term Limited Benefit" is a better descriptor of products that fail to meet consumers' reasonable expectations of what constitutes "health insurance," even when the product is medically underwritten and has a pre-existing condition exclusion. Regulators should not let the form—in this case, a legal term of art used in 42 USC §300gg-91(b)(5)—eclipse substance. While it is convenient for regulators and advocates to use this legal term in discussing policy, it does not follow that the term is helpful to consumers—the legal term for an unmarried woman is "spinster" but that term is seldom used outside the legal context. In this case, it is self-serving for insurers to use a legal term that happens to connote more generous coverage than they are actually selling.

The Model Regulation should set some minimal standard of comprehensiveness to be met if products are to be marketed as "Short-Term Health Insurance." The phrase "health insurance" should be reserved for products with coverage that healthy buyers reasonably expect that phrase to connote. An appropriate standard would be equivalence to an ACA "Bronze" plan, i.e. an

actuarial value of 60% of "essential health benefits." Note that this recommendation is not the same as recommending substantive minimum standards for the sale of products.

Similarly, the phrase "critical illness" will have a much different connotation to consumers than the meaning it has in the market for supplemental products, where it simply means a collection of specified diseases. Products marketed with use of this phrase should also meet a minimum standard of covered illnesses that conforms with consumers' expectation of what constitutes a critical illness.

To be sure, many of the circumstances described above are arguably in violation of existing legal prohibitions on deceptive practices, and may be better candidates for enforcement action than for new rulemaking. But it could be worthwhile for Model 171 to explicitly restate the illegality of such practices.

4. Development and disclosure of a unit price and uniform coverage examples permitting comparisons

Capretta (2021) argues that to promote competition, a light regulatory touch is necessary to "take the complexity and risk out of the consumer decision-making process through standardizing what is being provided." One option in the insurance sphere is "strict standardization—with exactly the same deductible and cost-sharing [to] allow consumers to focus solely on the premium differences among the competing plans." Less strict options would instead require disclosure of some indicator of value, analogous to how the APR permits a per-unit comparison interest rates. Ideally it should be an indicator that shows value not only among similar products but relative to ACA products. Two easily ascertainable indicia of ACA products' value are the actuarial value/metal level, and the mandatory loss ratio floors.

It might be possible to create an actuarial value equivalent for short-term health insurance, but it would be difficult for supplementary products such as specified disease. The simplest value indicator to determine and disclose would be loss ratios.

At least two current statutory provisions mandate loss ratio disclosures for major medical insurance. It goes without saying that disclosures are far more warranted for limited-benefit products for which there is no mandated loss ratio floor, but these statutes demonstrate that loss ratio disclosures at the point of sale have been successfully implemented.

> **Connecticut: Sec. 38a-477c. Disclosure of medical loss ratio with each health insurance application.** An insurer or health care center shall include a written notice with each application for individual or group health insurance coverage that discloses such insurer's or health care center's medical loss ratio, as defined in subsection (b) of section 38a-478l, as reported in the last Consumer Report Card on Health Insurance Carriers in Connecticut, to an applicant at the time of application for coverage.

> **District of Columbia: § 31–3311.03. Loss ratio disclosure.** Policies, certificates, and marketing materials shall prominently display medical loss ratio disclosure, as defined by rule.

Another option would be to create a classification scheme under which products would have uniform labeling requirements based on their levels of protection, e.g., MiniMed One, MiniMed two, etc.

Because there is no explicit regulation of coverage examples, we find insurers are including unrealistic depictions of the costs of medical care in order to overstate the value of their products. For instance, one seller of a hospitalization-only product, which pays a $4,500

benefit, indicates that the hospital facility fee for hernia surgery is $5,784. One large hospital system in Pennsylvania which has a cost-lookup feature on its website states its price for hernia surgery—exclusive of professional fees—at $16,200. The insurer's coverage example thus understates the buyer's out-of-pocket costs by at least $10,000.

Regulators should consider requiring uniform coverage examples for representative illness episodes.

5. Admonitions to consumers of competing offers and a price comparison website

Sellers should be required to post their prices on a price comparison website approved by regulators, and when making offers of coverage, to inform prospective buyers that they may shop for other offers on that website.

6. Commission disclosures

Sellers of supplemental products should also be required to disclose commissions.

7. Required display of uniform label

All of the foregoing standards could be enforced by requiring a uniform display along the lines of the Monroney Sticker or the Summary of Benefits and Coverage required for comprehensive health insurance under the Affordable Care Act.

**Conclusion**

This paper argues that a structured set of disclosures and admonitions could give consumers purchasing ancillary health products information and prompts to reflect on and modify choices to find products offering the most value. While there is no guarantee that all

consumers would use these tools to comparison shop, a seller or sellers wishing to appeal to the segment of "smart shoppers" could respond to these interventions and at least make higher-value products available.

As Brenda Cude (2005) has noted, when regulators consider whether information disclosure is an appropriate regulatory response, one question they must answer is whether a market is sufficiently competitive to permit consumers to use their knowledge to gain leverage. The evidence reviewed here suggests not; but a comprehensive, well-structured framework of disclosures could create a competitive dynamic among insurers, promoting value and increasing consumer welfare.

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