GEORGETOWN UNIVERSITY
McCourt School of Public Policy
CENTER ON HEALTH INSURANCE REFORMS

No Good Options:

In the Wake of Marketplace Affordability Woes, Consumers Face Onslaught of Misleading Marketing of Limited Benefits Products

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Introduction

The year 2026 has been tough for consumers seeking coverage on the Affordable Care Act (ACA) marketplaces. Because of the expiration of enhanced premium tax credits (ePTCs) at the end of 2025, premiums for virtually all marketplace enrollees increased for 2026 coverage, with particularly sharp increases for older and middle-income consumers.[1] At the same time, federal actions have made it easier for consumers to enroll in products that are not subject to the ACA's coverage standards and consumer protections. A secret shopper study, conducted in May 2026 by researchers at the Center on Health Insurance Reforms (CHIR) at Georgetown University's McCourt School of Public Policy found that consumers frequently encountered aggressive and misleading marketing of limited benefit products that fail to provide protection from steep health care costs.

In this brief:

Background

Over the past year and a half, Congress and the Administration have taken a number of policy actions that undermine marketplace coverage and affordability. In July 2025, Congress passed H.R.1, a budget reconciliation law that made significant changes to both Medicaid and the marketplace, with anticipated massive coverage losses in both markets as a result.[2] The marketplace provisions included in H.R.1, combined with a series of policy changes made through federal rules, are already having a significant impact on marketplace enrollment, with more changes slated to go into effect in 2027.[3] Policy changes scheduled to take effect in 2027 or later include: a shortened annual open enrollment period, elimination of monthly special enrollment opportunities for low-income consumers, and additional income verification requirements, creating new administrative hurdles that could make it difficult for people to enroll in or keep marketplace coverage.[4]

In addition, Congress allowed enhanced premium tax credits (ePTCs)—which had been in place since 2021 and had made premiums cheaper for millions of marketplace enrollees—to expire at the end of 2025.[5] Expiration of the ePTCs also brought back the "subsidy cliff" for PTC eligibility, meaning that, once again, anyone with income over 400% of the Federal Poverty Level (FPL) is automatically ineligible for PTCs (with ePTCs, anyone who had a plan that cost 8.5% or more of their income could qualify for a subsidy rather than face an abrupt income threshold). As a result of these changes, most marketplace enrollees saw their premiums rise sharply in 2026, with subsidized consumers having to pay an estimated 114% more to keep the same plan in 2026.[6] Enrollment subsequently declined, with 41 states reporting enrollment declines and plan selections falling by 1.2 million people during the 2026 open enrollment period, the largest single-year drop since the marketplace was established. Because many people who initially selected a plan later failed to make premium payments and lost coverage, the true decline is likely even greater (an estimated additional 4.8 million fewer enrollees).[7]

As marketplace coverage has retracted, the federal government has also made it easier for consumers to enroll in non-ACA regulated plans. For example, the Trump administration has declined to enforce a 2024 rule limiting the duration of short-term limited-duration insurance (STLDI) plans to three months.[8] As people seek information about their coverage options in this landscape, many may encounter online advertisements for alternative products that

do not provide the same coverage and protections as required under the ACA. Products such as short-term plans, fixed indemnity insurance, and health care sharing ministries are often marketed as affordable substitutes for comprehensive coverage, but they frequently exclude essential services like prescription drugs, substance use disorder services, mental health, and maternity care, have pre-existing condition exclusions, and may charge higher premiums based on health status.[9] For example, fixed indemnity plans provide predetermined cash payments rather than covering the full cost of medical services and are intended to supplement income rather than serve as primary health insurance. As a result, people who enroll in these products may face substantial out-of-pocket costs when they need care or discover that services related to pre-existing conditions are excluded from coverage altogether.

Previous secret shopper studies conducted by CHIR researchers in 2019, 2021, and 2023 found that consumers shopping for health insurance on the private market face aggressive and misleading marketing of limited benefit products.[10] Numerous reports have similarly documented the aggressive marketing of short-term plans, fixed indemnity products, and other alternative coverage arrangements, finding that brokers and sales representatives frequently use misleading or deceptive tactics, including misrepresenting benefits and costs, concealing plan limitations, and pressuring consumers to enroll without providing or allowing customers to review written information.[11] This new secret shopper survey, conducted in May 2026, further builds on these previous findings. The survey found that consumers searching for coverage online were frequently routed towards products not regulated by the ACA. Sales representatives also provided misleading information about both limited benefit plans and marketplace coverage and exploited affordability concerns to discourage enrollment in comprehensive coverage.

Methodology

Researchers at Georgetown conducted a secret shopper study from May 23 through May 25, 2026. The study design was similar to designs used for the previous Georgetown secret shopper studies conducted in 2021 and 2023.[12] The team developed two profiles (see Table 1). Each profile lived in West Virginia and was eligible for a special enrollment period (SEP) that made them eligible for marketplace coverage outside of open enrollment.[13] Researchers chose West Virginia as a representative jurisdiction, with no prohibitions on the sale of most limited benefit products.

The different incomes of each profile meant that only "Dani" was eligible for subsidies to purchase marketplace coverage (she was eligible for both PTCs and cost-sharing reduction plans). Because she was eligible for a fairly significant PTC, Dani could purchase a silver-level plan for $184/month and a bronze plan was available for $0 per month.[14] "Jen's" income, however, made her ineligible for any federal assistance for marketplace coverage. The fact that Jen was much older than Dani also meant that she was subject to higher age-rated marketplace premiums.[15]

Table 1. Consumer Profiles

Dani	Jen
Livies in WV	Livies in WV
Eligible for SEP for marketplace	Eligible for SEP for marketplace
Income = 200% FPL	Income = 430% FPL
30 years old	55 years old
No pre-exhisting conditions	Type 2 diabetes
Household of one	Household of one

Georgetown researchers used Google to search for terms that consumers searching for coverage may enter ("cheap health insurance," "Obamacare plans," "ACA enroll," and "HealthCare.gov"). The team noted the first three websites that came up in each search, including sponsored sites, and entered information for the consumer profiles into each site. A researcher then fielded subsequent phone calls from representatives, speaking with 20 representatives in all, 10 as Dani and 10 as Jen.

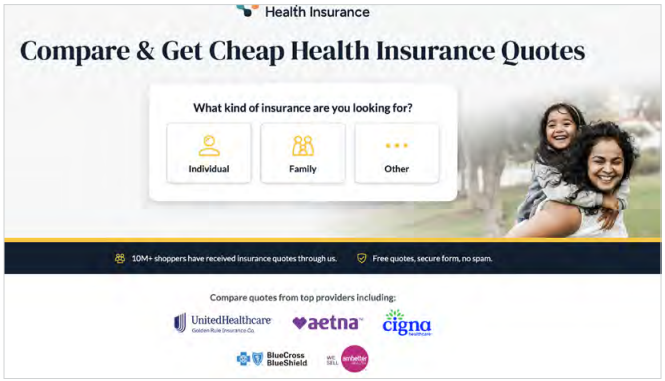
Findings

Online searches led consumers to "lead generators," who then handed off consumers to agents and brokers

Every single one of the websites that showed up on our Google searches were "lead generators," platforms designed to capture consumer contact information to then sell to other parties (in this case, agents and brokers). These lead generator sites often had misleading names that implied an affiliation with an official state or federal marketplace site, and most also included recognizable logos of major medical issuers.[16] By simply filling out basic demographic and contact information and indicating an interest in a health coverage quote, each consumer profile opened a floodgate of hundreds of solicitation calls and texts from any entity to whom the lead generator company sold the "lead."

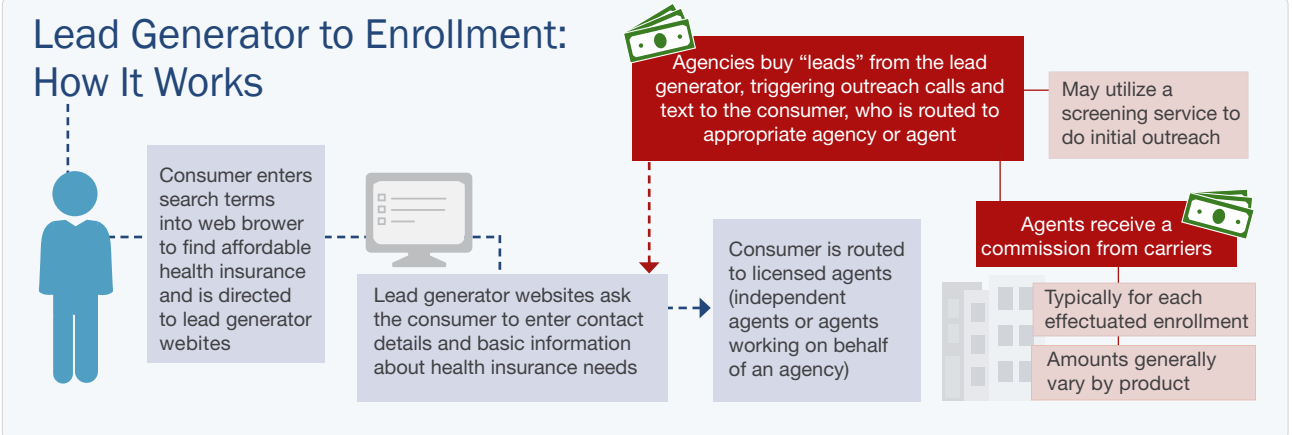
In our 20 calls, it was often difficult to tell what entity made initial contact with the consumer after information was entered into the lead generator website. In some cases, the sales representative calling the consumer identified themselves as calling from an entity that our research later identified as a lead generator. In other instances, the initial contact was made by someone who identified themselves as conducting "pre-qualification" or "screening" questions to identify the next step in the referral chain and later connected the consumer to a licensed agent or broker. These entities may also have been calling from lead generator companies, but it was difficult to verify this.

Example of "Lead Generator"



Screening questions included what type of coverage the consumer was looking for, whether the consumer had any pre-existing conditions, and household income. The person conducting the screening typically provided general information about the pathways available to the consumer (typically referring to "public market" and "private market" options), and the consumer was then transferred to a licensed agent or broker in West Virginia. In some cases, initial calls following entry of information into lead generator websites came directly from licensed agents and brokers. The various pathways to a licensed agent and broker may reflect differences in how each lead generator company operates and the types of screening services they provide in addition to selling consumer contact information.

Lead Generator to Enrollment: How It Works



A common marketing tactic was to describe the marketplace as a coverage option best suited for sick consumers, directing healthier consumers to non-ACA-regulated products

The vast majority of sales representatives described two different markets for health insurance coverage. Representatives used the term "public market" to refer to ACA-regulated marketplace plans and "private market" to refer to non-ACA regulated products, including short-term limited duration insurance (STLDI) and fixed indemnity plans. Despite confusing language about these two markets, both sell private insurance plans, but only the ACA marketplace, the so-called "public market," comes with federal assistance to afford those plans. The misleading messaging around these markets was remarkably uniform. The "public market" was almost always described as a market for sicker enrollees, with representatives urging both Dani and Jen to avoid that market if at all possible.

One representative stated plainly to Dani about marketplace coverage, "you don't want to be in that risk pool if you're healthy."

Another representative used a slightly different shorthand to distinguish the two markets saying that the so-called "public market" was only appropriate for low-income individuals, but that the "private market" was "based on health, not wealth." All but three sales representatives ultimately directed both Dani and Jen to non-ACA-regulated products, despite Dani being eligible for significant federal subsidies to purchase marketplace coverage and Jen having a pre-existing condition that could expose her to considerable financial risk in a non-ACA-regulated plan.

Consumers with income that makes them ineligible for ACA subsidies are faced with a no-win proposition, and sales representatives are exploiting this vulnerability

Nine out of the 10 representatives who spoke to Jen accurately provided information about her marketplace options. However, because Jen is just over income for PTC eligibility (following re-imposition of the 400% FPL eligibility cliff this year[17]) and is in a higher age-rating band, the options available to her for marketplace coverage came with a high price tag. Even a catastrophic plan had a $1,000 per month premium and a $9,000 or $10,000 deductible. Silver-level plans, which would have been more appropriate given Jen's health needs, had premiums closer to $1,500 per month with a deductible of $7,000.

> **"People are running for the hills, that's why we're here," according to one representative.**

Sales representatives were quick to point out to Jen how unaffordable these options were, recommending more affordable options available on the "private market" instead. A representative summed up why the "private market" options were gaining traction, saying "for [ACA] marketplace options, they're pulling back subsidies, you could end up paying $80 one year and $800 the next, not like locking in [the price] for private plans […] people are running for the hills, that's why we're here."

Sales representatives provided misleading and inaccurate information about limited benefit products

The information that representatives provided about limited benefit products was variable, and for the most part, did not include enough information to enable consumers to understand the risks of these options and make an informed choice. When describing limited benefit options, representatives rarely used specific product names (i.e., "fixed indemnity" or "short-term limited duration insurance"). This made it difficult to tell which products were being marketed, but information shared about features of these plans would indicate that all of the limited benefit options described were either fixed indemnity products or STLDI plans. Several representatives also refused to provide any written information about these limited benefit products until after a consumer had applied for coverage and provided a credit card number. Representatives who refused to send written information claimed that the limited benefit options they were selling were not publicly available and that rates and specific information were subject to hour-by-hour changes. Representatives claimed that if consumers did not make a decision before the call ended, their premium amounts could skyrocket.

We encountered numerous examples of blatantly misleading information with regard to limited benefit products that failed to accurately describe the limits of these products (see Table 2).

Table 2. Misleading Marketing Examples

Product[18]	Times Mentioned	Misleading Marketing Example
Limited Benefit Product A (fixed indemnity) with add-ons like critical illness and accident insurance	Eight times	"It all comes together to make it whole coverage." "How it's structured, it's a PPO and you get PPO pricing that reduces whatever the cost that your physician charges. Let's say you go to doctor and standard visit is $100, the PPO lowers it by up to 50-80% and then the plan applies [a] dollar amount. It's designed for you to pay nothing or as little as possible out of pocket. Compared to what we're looking at on the public market with a high deductible, you're never going to spend $10,000 in doctor's visits for a year of coverage based on how you've described your medical needs." "[The plan] pays $10 for generics and $40 for specialty. The discounts you get with the PPO network are applied to prescriptions as well, so you're pretty much paying a couple of dollars or nothing for prescriptions."
Limited Benefit Product B (fixed indemnity)	Two times	"The best part of this policy is that it comes with no deductible." "There is no deductible, no coinsurance, no copayment. As long as you don't need substance use, mental health, or maternity benefits, it's a no brainer."
Limited Benefit Product C (membership discount plan)	One time	"For every bill over $2,500, [the plan] will negotiate a bill and can knock off some. I don't recommend major medical for you."
Limited Benefit Plan D (provider network named but exact product not)	Three times	"This is better coverage and is more affordable than going through the marketplace … benefits include unlimited doctor visits and diagnostic visits as well as prescriptions, medical, surgical, hospital stays, inpatient, outpatient surgeries and procedures all with no deductible." "Very similar in terms of policy structure to how your employer plan operated."
Limited Benefit Plan E (hospital indemnity)	One time	"No upfront deductible, the moment you enter any medical facility, benefits kick in right away."
Limited Benefit Plan F (STLDI)	One time	"I'd put you on this plan at 364 days it's a little more [in premiums for that length of coverage], but you lock the rate in. But you can stay however long you want."

Most representatives mentioned three benefit categories completely excluded from coverage—inpatient substance use services, mental health services, and maternity care—and explained in broad terms that eligibility was based on medical underwriting, which "rewarded" consumers for being healthy. However, representatives often omitted information about pre-existing condition exclusions. For Jen, common pre-existing condition exclusions attached to fixed indemnity and STLDI products would likely exclude payment for claims resulting from Jen's Type 2 diabetes. For example, the fine print of one fixed indemnity product's description (which we found online as it was not sent to either Dani or Jen) had a lengthy description of exclusions, including a 12-month waiting period for coverage related to pre-existing conditions.[19] This waiting period was not described by any of the representatives marketing this option.

Representatives also used common insurance terms to describe products that were not at all structured like major medical insurance plans. For example, representatives described fixed indemnity products as having a national Preferred Provider Organization (PPO) network, allowing consumers to receive care anywhere in the country without a referral. Similarly, representatives described fixed indemnity products as having "first dollar coverage" and "no deductible, no coinsurance, or copayment." The absence of these insurance hallmarks is not because a consumer has found a unicorn product, it's because fixed indemnity products are not set up the same way as major medical plan designs.20 Fixed indemnity plans do not have traditional provider networks at all. Instead, the carrier sets an amount it will reimburse for certain services. The consumer pays the provider for the service and the plan reimburses the consumer. The reimbursement amount is fixed and goes directly to the consumer, and the amount is not correlated to the actual incurred costs. The consumer is then on the hook to pay the difference between that amount and what the provider charges. By contrast, under an ACA-regulated plan, the consumer's cost is fixed (e.g., $20 copay or 20% coinsurance), protecting the consumer from astronomical medical costs.

Several representatives marketed a fixed indemnity product that included additional add-ons and riders, such as a critical illness and accident coverage. One representative listed each component and declared "it all comes together to make it whole coverage." However, it is not at all clear that's true. Products that are patched together often have benefits structures that operate independently, with different rules for claims approval and coverage and different consumer financial protections.[21] This means that a consumer could hit a deductible or out-of-pocket maximum applied to one element of coverage, with a new set of financial protections and limits for another element of coverage.

Representatives claim that if consumers did not make a decision before the call ended, their premium amounts could skyrocket.

Information about prescription drug coverage was also confusing at best. Both Dani and Jen asked about prescription drug coverage and representatives indicated that the limited benefit plans all had a prescription drug benefit, with some products covering a percentage of the cost of certain drugs and some covering a fixed dollar amount. The brochure provided to the research team for Limited Benefit Plan A lists the prescription drug benefit as a set dollar amount: the plan will pay $10 for generic and $40 for brand-name drugs (regardless of the actual cost of the drug), with total annual plan payments capped at $800. One representative noted that the payment amount for prescription drugs was fairly low, but that the plan also "came with" CleverRx, a prescription discount service that negotiates lower prices with a number of pharmacies.[22] CleverRx is not a prescription benefit at all, it's a publicly available discount card. In response to questions about what would happen if Jen needed insulin or more expensive medications to treat her diabetes in the future, one representative offered to help find other assistance, saying "if you are ever prescribed insulin, just call me and I have programs to cover insulin and [GLP-1s], etc."

▶ Sales representatives provided misleading and inaccurate information about marketplace coverage

Sales representatives provided misleading, and in some cases blatantly false, information about the marketplace. Nearly half of all representatives did not indicate that either Dani or Jen would be eligible for marketplace coverage through an SEP. The misinformation about marketplace coverage was more pronounced for Dani than for Jen. Despite Dani being eligible for significant subsidies and an SEP, two sales representatives did not mention the marketplace at all to Dani. Another two inaccurately told Dani she was ineligible to apply for marketplace coverage because she was outside of the annual open enrollment period. And two additional brokers noted Dani was eligible for an SEP for marketplace coverage, but gave her inaccurate estimates about what her premium would be (one representative told Dani her marketplace premium would be $800 per month and provided no additional information about other options available or subsidy eligibility; in reality Dani would be eligible for marketplace premiums starting at $0).

Discussion

The results of the secret shopper study are consistent with our findings in 2019, 2021 and 2023. Agents and brokers capitalized on health system upheaval and intense affordability challenges, reeling in consumers with promises of affordable and comprehensive coverage options as an alternative to the marketplace. Just as we found in previous studies, sales representatives consistently pushed Dani and Jen to limited benefit plans, blatantly screening for whether they could pass underwriting and actively steering them away from marketplace coverage. This undercuts arguments that limited benefits products have no impact on the marketplace risk pool. Consumers that may have been better off in the marketplace—for example, because of the availability of subsidies to lower out-of-pocket costs and premiums—are being routed away from it. It also belies a common assumption and industry argument about fixed indemnity products that they are only marketed as a supplement to major medical coverage and not as stand-alone coverage.[23] It is clear from our findings that these products are not being marketed as supplements to major medical coverage, but as alternative options for consumers struggling with the costs of major medical plans.

Unscrupulous agent and broker behavior has been a longstanding challenge for state and federal insurance regulators. At the state level, investigations typically arise from authority given to insurance departments under state unfair trade practices statutes. In several instances, companies have been subject to fines for misleading or fraudulent marketing and have entered into multi-state settlement agreements. One of the carriers that came up in our study was subject to such a settlement in 2024.[24] While our study found that marketing techniques are still misleading, sales representatives marketing the products that were subject to the settlement agreement were far more likely to provide written information about the product and used less aggressive sales tactics, which may be the result of regulator enforcement. At the federal level, the Federal Trade Commission (FTC) has filed a number of investigations against lead generators and broker agencies for similar conduct, with a recent complaint filed in April 2026.[25]

These state and federal enforcement actions can help root out some bad actors, but it's a "whack-a-mole" approach rather than a systemic set of reforms. Companies subject to state or federal sanctions have simply reorganized themselves under different

business names and continued the same misleading marketing practices undeterred.[26] Systemic reforms, on the other hand, may be more promising. For example, 2024 updates to the National Association of Insurance Commissioners (NAIC) model law 880, the Unfair Trade Practices Act, provide more robust mechanisms for insurance regulators to protect consumers from misleading marketing.[27] The reforms to this model law placed health insurance lead generators under state regulatory authority, empowering regulators to not only monitor and enforce consumer protections with regard to producer activities, but to also regulate lead generators that use deceptive advertising to acquire health insurance leads. However, few states have adopted these amendments.[28]

Another approach state and federal regulators could take to protect consumers is to limit the sale of fixed indemnity and other excepted benefits products. In 2014, a federal regulation prohibited carriers from selling fixed indemnity products as stand-alone coverage.[29] However, this regulation was met with fierce industry resistance and was later struck down by a federal court.[30] Subsequent federal rulemaking omitted fixed indemnity products altogether.[31] Lack of federal action, however, is not a barrier to state action. States certainly have the authority to limit the sale of fixed indemnity products in their jurisdictions, though none have done so yet. States that have tackled the fixed indemnity market have instead focused their efforts on cracking down on deceptive marketing. For example, Colorado requires a prominent disclosure to be affixed to consumer-facing fixed indemnity plan documents.[32] But states have not gone so far as to prohibit sale of these products unless they are sold as a supplement to a consumer's major medical plan. State departments of insurance have also taken enforcement actions to help consumers harmed by the fraudulent or deceptive marketing of limited benefit products. For example, the New Hampshire Department of Insurance recently addressed misleading marketing by brokers that lured unwitting consumers into limited benefit benefits plans by opening up an SEP for affected consumers to enroll in marketplace coverage.[33]

And finally, reforms to how entities sell health insurance products will not have any impact on the availability and quality of what they are selling. States are rightly concerned about the growing health insurance affordability crisis, including the systematic weakening of affordability protections in the marketplaces. And a number of states have enacted policies aimed at keeping marketplace coverage affordable in their states.[34] The findings with regard to Jen's experience amplify the no-win situation many consumers now face, particularly following the expiration of ePTCs. The marketplace in Jen's state has become unaffordable for her. However, in Jen's case, despite the hard sell representatives made to convince her otherwise, a non-ACA limited benefit product is likely not the solution to her affordability challenges. Jen's chronic condition means that even if she is accepted for enrollment in an underwritten product, she faces pre-existing condition exclusions for needed care and exposure to any cost above the limited amount her plan will pay. For Jen and millions more like her, the policy solution likely to make the biggest difference is to ensure that comprehensive major medical plans remain affordable, not to continue to open up a Pandora's box of limited benefit products with low premiums and marketing promises that are too good to be true.

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The Center on Health Insurance Reforms (CHIR) is a research center within the Georgetown University's McCourt School of Public Policy, composed of a team of nationally recognized experts on private health insurance and health reform.

CHIR faculty and staff study health insurance underwriting, marketing, and products, as well as the complex and developing relationship between state and federal rules governing the health insurance marketplace. CHIR provides policy expertise and technical assistance to policymakers, regulators, and stakeholders seeking a reformed and sustainable insurance marketplace in which all consumers have access to affordable and adequate coverage.

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