

MARKET WATCH

Florida's Medicaid Reform: Informed Consumer Choice?

After Florida implemented reforms, a sizable minority of recipients were not even aware that they were enrolled in a reform plan, and many did not understand how their plan worked.

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ABSTRACT: Florida is among the first states to implement Medicaid reform using a competitive consumer choice model. Using data from a 2006–07 Kaiser Family Foundation survey of Medicaid recipients newly enrolled in Florida's reform program, we examine how well they understood the changes taking place and their experiences in selecting a health plan. We find important gaps in people's understanding of major components of the reform: About 30 percent were not aware that they were enrolled in reform, and more than half had trouble understanding plan information. These problems were not particular to any group but instead were experienced broadly across the full Medicaid population. [*Health Affairs* 27, no. 6 (2008): w523–w532 (published online 14 October 2008; 10.1377/hlthaff.27.6.w523)]

MEDICAID PROVIDES health coverage to more than forty-five million children and adults in low-income families, and fourteen million elderly people and people with disabilities. Until recently, Medicaid recipients within a state typically had access to the same set of benefits. Recent federal changes, however, move Medicaid in a new direction by allowing states to offer different benefit packages to different Medicaid recipients and to emphasize consumer choice and personal responsibility. Recently, several states (Florida, Idaho, Kentucky, and West Virginia) have adopted elements of benefit

variation or consumer choice, or both, in their Medicaid programs, and others are considering such changes.¹

The central rationale behind allowing benefit variation and offering choice is that health plans will compete to serve Medicaid populations, creating a competitive, consumer-driven system of care. Proponents argue that incorporating private-market principles will make Medicaid more efficient and control program spending and that expanding enrollees' choices will promote personal responsibility while improving satisfaction with care.

However, others raise concerns regarding

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how these strategies will affect vulnerable groups such as Medicaid recipients. For example, the success of consumer-choice models is determined in large part by a state's ability to accurately adjust premiums to reflect expected health care use—a particular challenge for Medicaid populations, given their characteristics and health care needs.² Failing to set premiums accurately can lead to market instability and potential access problems for recipients, among other things.

One of the core issues in assessing consumer-choice models is the degree to which individuals have the ability to make informed choices among different plans, which is central to the success of a competitive model. Informed choice presumes that key information on enrolling in and using a plan are communicated in a way that is easily

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accessible. It also presumes that sound plan information (for example, information on provider networks and prescription drug formularies) is readily available. Equally important, people must be able to use the information to make the complicated decisions required to ensure that they select a plan that meets their needs and preferences. Previous studies, however, indicate that understanding and acting on health care information is a problem for nearly half of the general population.³ Making sound decisions may be an even greater challenge for Medicaid populations, as research indicates that advanced age, limited formal education, and poor health status—characteristics common among program recipients—are associated with poorer health literacy.⁴

In this paper we present findings from a 2006/07 Kaiser Family Foundation survey of Florida Medicaid recipients who were enrolled in the state's Section 1115 waiver demonstration program, called Medicaid Reform. Implemented in July 2006, the demonstration introduced a consumer-choice model in which Florida calculates a risk-adjusted premium for various groups of recipients (children, parents,

aged and disabled adults). Enrollees select from among state-approved private health plans that offer varied provider networks, benefit packages, and cost-sharing levels. Plans are then paid risk-adjusted premiums for those who enroll. In addition, enrollees can “opt out” of Medicaid and instead use funds to help cover premiums for private insurance.

The survey covered several topics, but this paper focuses on how well Florida Medicaid enrollees understood the many changes that

were taking place in the program and their experiences in selecting a plan.

Florida's Medicaid Reform

In October 2005, the Centers for Medicare and Medicaid Services (CMS) approved Florida's waiver, enabling the state to make fundamental changes to its Medicaid

program, including converting from a “defined-benefit” program, in which a recipient is guaranteed specified benefits, to a “defined-contribution” program, in which, based on a person-specific, state-assigned, risk-adjusted premium, an enrollee is required to select from among preapproved health plans available at that premium level. Florida has several goals for the waiver, including improving the Medicaid delivery system, creating a competitive Medicaid market that emphasizes enrollees' involvement, and making program costs predictable and sustainable.⁵

The demonstration began 1 July 2006 in two pilot counties: Broward (Ft. Lauderdale) and Duval (Jacksonville), which include about 220,000 recipients—approximately 9 percent of Florida's Medicaid population.⁶ The target population was enrolled in the demonstration over a seven-month period, from September 2006 to April 2007.⁷ Over that period, the state sent a series of letters about reform to Medicaid enrollees, including one that informed them that they needed to select a health plan or that a plan would be assigned to them. Those who did not choose a plan within thirty

days were assigned a plan by the state.

Prior to reform, statewide, only a third of Medicaid recipients were enrolled in a capitated managed care plan.⁸ The extent of managed care enrollment before the demonstration, however, varied from a virtual absence in some counties to as much as 80 percent in others.⁹ Medicaid enrollment in capitated managed care in the two initial pilot counties (Broward and Duval) was, respectively, 59 percent and 50 percent.¹⁰

Under reform, participating plans are now allowed to offer different benefit packages and impose different levels of cost sharing for nonpregnant adult enrollees, subject to state approval. Although plans must include all mandatory Medicaid benefits and most optional benefits, services can vary in amount, duration, and scope.¹¹ For example, two of the three plans in Duval County and four of the nine plans in Broward County impose a limit on the number of prescription drugs paid for or an annual dollar limit on drug spending.¹² At the same time, plans can provide new services beyond those previously covered by Florida Medicaid.

As a result, enrollees are newly required to consider differences in benefit packages when making a choice of plans. They must also consider other plan differences such as preferred drug lists, provider networks, and prior authorization requirements. Florida implemented choice counselor services to assist enrollees in making these choices. The state contracted with a private vendor to maintain a call center that offers a toll-free number by which recipients can get help in the enrollment process, as well as providing face-to-face and group sessions to assist them.

Beyond these changes, the waiver has several other features, including a new annual maximum benefit limit for nonpregnant adults, beyond which enrollees are responsible for their health care costs; a new opt-out program, in which enrollees can choose to apply their premium to the purchase of private insurance; and a new “enhanced benefits” program that awards credits to enrollees for engaging in healthy behavior, as defined by the state.

Study Data And Methods

■ **Data.** Data are from a Kaiser Family Foundation telephone survey of Florida Medicaid recipients fielded in the two demonstration pilot counties—Broward and Duval—between November 2006 and March 2007. The survey sample was identified through Florida Medicaid enrollment records. In each county, the sample was selected to be representative of the Medicaid caseload that was enrolled in the demonstration by 1 November 2006. In addition, because there was concern that disabled enrollees were particularly vulnerable to changes, we included an oversample of disabled adults who receive Supplemental Security Income (SSI).¹³

The sample was drawn from those enrolled in the demonstration who were continuously on Medicaid during January–June 2006, using a stratified random sample based on county and enrollee group. Before the survey was conducted, letters were mailed to potential respondents (or, for children in the sample, their parent or guardian) describing the survey and seeking their participation. The University of Florida Survey Research Center conducted the interviews in English and Spanish using computer-assisted telephone interviewing. A \$10 gift card was offered to those who completed the survey.

For adults in the sample, information was sought directly from the Medicaid recipient whenever possible. Given the nature of the population, however, some were not able to complete the survey, especially among the SSI subsample, which includes people with mental retardation and developmental disabilities, among other health conditions. Overall, 8 percent of adults in the sample relied on a proxy respondent.¹⁴

The overall response rate for the survey was 21 percent.¹⁵ About half of the nonresponse was because the sample member could not be located, generally because of an inability to locate a valid telephone number.¹⁶ Once a person was located, the cooperation rate was 60 percent. We used Florida Medicaid administrative data to compare the characteristics of

survey respondents with those of nonrespondents. We found only limited differences.¹⁷ All of the analyses are weighted to adjust for the complex design of the survey and for survey nonresponse. The weights are poststratified so that the characteristics of the survey sample match the characteristics of the total Medicaid population in terms of age, sex, race/ethnicity, and length of Medicaid enrollment. The final sample size totaled 1,848 people.

■ **Methods.** We used both descriptive and multivariate methods to conduct the analyses. We first examined recipients' awareness of Florida's Medicaid Reform and their experiences in selecting a health plan. We report this information for the overall caseload and the adult SSI caseload in the two counties. To identify whether particular subgroups of Medicaid enrollees had different experiences, we estimated multivariate models.

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Study Results

As noted above, the study sample consists of Medicaid recipients who were reported by the state to have been enrolled in a Medicaid Reform plan prior to the start of our survey. Yet about 30 percent of the enrollees across the overall Medicaid caseloads and the adult SSI caseloads in each of the counties were not aware that they were enrolled in Medicaid Reform (Exhibit 1). Of those enrollees, 71–77 percent reported that they had not yet been told by the state that they needed to choose a plan under the waiver, which suggests that the enrollees either did not receive, did not read, or did not understand the letter from the state on the transition process for reform. As noted, those who did not select a plan were assigned one by the state.

Among those who were aware that they were enrolled in Medicaid Reform, the majority picked a new plan or stayed in their previous plan. Only a small share (less than 3 percent across the four groups) reported that they

had opted out of Medicaid for private coverage.¹⁸ The remaining enrollees reported that they were assigned a plan by the state. For the overall sample, it appears that 43–49 percent of enrollees were assigned a plan by the state.

■ **Limited awareness of components of reform.** Enrollees reported a limited understanding of the major changes being implemented under Florida's Medicaid Reform. Roughly 30 percent of adult SSI enrollees and 20 percent of the overall caseload in both

counties were not aware that they had a choice of health plans under the waiver. An even greater proportion did not understand that plans could vary benefits and benefit levels. This was particularly true among SSI enrollees, among whom more than 35 percent reported not knowing that such differences could exist. Also, more than half of the enrollees in all four groups were not aware of

the availability of choice counseling to help with the plan selection process or of enhanced benefit accounts, and more than 60 percent were not aware of the opt-out option.

■ **Difficulty understanding health plan information.** Apart from basic features of the demonstration, among enrollees who were aware that they needed to select a plan or had thought about selecting a plan, few knew specifically how many plans were available to them (Exhibit 2). Across the four groups, nearly half underestimated the number of available plans, and about a third indicated that they did not know the number of plans available to them altogether. Further, more than half of each group reported that it was difficult to understand the available plan information, and a similar share said that they had difficulty picking a plan. The majority of respondents were also worried about making a bad health plan choice.

Although many reported that it was very easy or easy to get information about the various plan options, sizable minorities reported

EXHIBIT 1
Enrollees' Awareness Of Enrollment In Florida Medicaid Waiver And Changes
Associated With The Waiver, 2006–07

	Broward County (%)		Duval County (%)	
	Overall caseload (n = 938)	Adult SSI caseload (n = 537)	Overall caseload (n = 910)	Adult SSI caseload (n = 507)
Reported to be enrolled in Medicaid Reform by the state	100.0	100.0	100.0	100.0
Aware of being enrolled in Medicaid Reform				
Yes	61.5	59.3	67.8	61.9
No	30.9	28.7	27.6	29.5
Missing	7.6	12.0	4.6	8.6
Of those who were aware of being enrolled				
Picked a new plan or stayed in previous plan	77.6	69.6	71.0	67.2
Opted out of Medicaid for private coverage	3.1	2.2	4.3	2.1
Assigned a plan by the state	19.3	28.2	24.8	30.7
Of those who were NOT aware of being enrolled				
Reported that they had not yet been told that they needed to choose a plan	71.3	72.9	77.2	75.9
Reported that they had not yet made a decision about a plan	28.7	27.1	22.8	24.1
Share of enrollees who reported being assigned a plan by the state or who appear to have been assigned a plan by the state, given that they are not aware of enrollment	42.8	45.4	44.4	48.5
Not aware that Medicaid Reform includes the following elements				
Choice among different health plans	20.2	28.4	20.3	28.3
Plans may have different levels of benefits or new benefits	32.7	38.5	30.3	36.2
Availability of opt-out options	65.5	68.9	63.0	66.9
Availability of choice counseling services	51.5	52.0	54.0	54.5
Enhanced benefit accounts	57.7	56.5	58.0	57.3

SOURCE: Kaiser Family Foundation Survey of Florida Medicaid Beneficiaries, 2006–2007.

NOTES: Responses are missing for less than 5 percent of the samples, unless otherwise noted. SSI is Supplemental Security Income.

otherwise. This was especially true in Broward County, where 41 percent of adult SSI recipients and 33 percent of the overall caseload said that it was not too easy or not at all easy to get plan information. Moreover, about a fifth of respondents reported that they had unsuccessfully tried to get help in finding information.

■ **Few differences across Medicaid recipients.** To assess whether particular Medicaid recipients had a lower awareness of reform or faced more difficulty in obtaining help with plan selection, we conducted multivariate analyses (not shown). We considered a range of personal and health care characteristics and

examined several outcomes: measures of the awareness of plan choice, the different levels of plan benefits and choice counseling, and reported difficulty in understanding plan information or picking a plan. We found that enrollees' awareness of and experiences with Medicaid Reform were, by and large, comparable across groups, which indicates that a limited level of awareness and difficulty in getting help were broadly observed in the overall population.

■ **Financially and medically vulnerable population.** The personal circumstances of enrollees as well as their health and medical needs put them at risk if components of the

EXHIBIT 2 Plan Selection Processes And Help In Making Selection, Florida Medicaid Reform Plan, 2006–07

	Broward County (%)		Duval County (%)	
	Overall caseload (n = 764)	Adult SSI caseload (n = 443)	Overall caseload (n = 732)	Adult SSI caseload (n = 409)
Aware of the availability of plans under Medicaid Reform ^a				
Did not know number of available plans	37.9	34.7	29.8	28.5
Estimated close to the number of plans ($\pm 20\%$)	2.9	10.3	12.0	12.9
Thought more plans were available ($>20\%$)	2.4	3.6	4.0	2.1
Thought fewer plans were available ($<20\%$)	51.7	43.0	51.7	49.8
Missing	5.2	8.4	2.5	6.6
Respondent's assessment of health plan choices ^b				
Hard to understand information about plans	56.3	65.6	54.1	66.3
Hard to pick a plan	62.3	63.1	56.4	68.6
Plans all have about the same benefits	55.3	44.4	45.6	54.7
Plans all have about the same out-of-pocket costs	43.5	41.6	40.4	42.1
Ease of getting to see a specialist is about the same across plans	49.3	48.0	51.1	52.8
Worry about making a bad choice	71.1	69.3	60.3	70.6
Doesn't matter which health plan	21.2	25.9	16.4	27.9
Any missing	4.8	4.2	2.0	5.5
Ease of obtaining information about available plans				
Very easy	31.1	22.1	38.6	29.4
Somewhat easy	26.7	24.9	28.8	28.8
Not too easy	20.9	19.2	17.2	15.7
Not at all easy	12.1	21.9	10.0	16.4
Missing	9.2	11.9	5.3	9.8
Received help finding information about plans				
Yes	44.3	43.2	49.1	51.1
No, tried but unable to get help	21.5	25.8	18.4	19.8
No, did not try to get help	29.6	23.0	29.7	24.0
Missing	4.5	8.0	2.8	5.1

SOURCE: Kaiser Family Foundation Survey of Florida Medicaid Beneficiaries, 2006–2007.

NOTES: Responses are missing for less than 5 percent of the samples, unless otherwise noted. The sample in this exhibit is limited to people who reported that they were told they needed to select a plan, those who had volunteered to enroll in a plan, and those who had thought about plan selection before the interview. SSI is Supplemental Security Income.

^aWe defined the respondent's estimate as being close to correct number if it was within ± 20 percent of the correct number of available plans in the county. "More plans" was defined as at least 20 percent more than the correct number of plans, whereas "fewer plans" was defined as at least 20 percent fewer than the correct number of plans.

^bThis measure is based on the respondent's reporting that he or she agrees or strongly agrees with the statement. Those who reported that they don't know whether they agree were included in the "do not agree" category. Additionally, 2.6 percent of the population had missing values for this sequence because they had missing information from previous questions that were used to define the sample of people asked these questions. These people are excluded from the estimates.

demonstration do not go according to plan. For example, by qualifying for Medicaid, respondents were low-income.¹⁹ In addition, about 35–50 percent in each group reported having trouble paying bills in the past year (Exhibit 3). Thus, if people selected a health plan with a benefit package that was not well suited to their health needs, most would have limited or no means to purchase care on their

own.

Perhaps even more important, the results show that many in the affected population have major health care needs. One-fifth of the overall caseload and about 60 percent of the adult SSI samples reported being in fair or poor health. Additionally, roughly a third of the overall caseload and four-fifths of adult SSI samples reported a chronic or ongoing health

**EXHIBIT 3
Demographic And Socioeconomic Characteristics Of The Adult Sample Member Or Parent Of The Child Sample Member, Florida Medicaid Reform Plan, 2006-07**

	Broward County (%)		Duval County (%)	
	Overall caseload (n = 938)	Adult SSI caseload (n = 537)	Overall caseload (n = 910)	Adult SSI caseload (n = 507)
Family income relative to poverty in 2006				
Less than 50%	25.1	30.6	34.3	34.4
50-99%	28.7	28.1	25.3	28.4
100-199%	17.3	6.5	15.0	7.7
200-299%	7.7	4.9	7.1	3.9
300% or more	5.9	7.7	6.7	3.3
Missing	15.3	22.2	11.5	22.4
Family had problems paying rent, mortgage, or utility bills between January and June 2006	49.6	41.6	42.2	34.4
Sample adult or parent frequently has difficulty reading or understanding				
A newspaper	11.1	19.9	10.5	22.9
Directions for taking medicine	7.8	16.9	7.7	14.9
Forms or letters from doctors or health plans	10.3	20.2	8.0	18.0
Numbers in a table or chart	10.5	17.9	6.8	15.3
Has one or more literacy problems ^a	21.0	36.7	19.0	35.0
Highest educational attainment of sample adult or parent				
Less than high school	22.7	38.9	29.3	46.2
High school graduate or equivalent	38.5	32.6	38.8	30.8
Some college	26.5	20.2	25.5	18.1
College graduate	12.4	8.3	6.5	4.9
Overall health status				
Very good or excellent	58.5	15.5	59.2	14.0
Good	22.1	21.9	20.1	26.1
Fair or poor	19.4	62.6	20.7	60.0
Any chronic or ongoing health condition	35.8	82.3	37.5	79.7
Source of health limitations or difficulties				
Physical health	14.2	62.9	16.2	64.6
Mental retardation/developmental disabilities	8.8	30.0	9.0	31.0
Mental health	11.2	44.9	10.8	40.9
Confusion or memory problems	10.0	40.9	10.4	36.7
Told by health care professional had				
Hypertension	10.3	55.6	10.9	46.9
Diabetes	3.7	25.9	5.3	24.3
Asthma	17.7	25.0	25.5	27.3
Uses any special equipment ^b	5.6	29.3	8.6	32.1

SOURCE: Kaiser Family Foundation Survey of Florida Medicaid Beneficiaries, 2006-2007.

NOTES: Missing values less than 5 percent unless otherwise noted. SSI is Supplemental Security Income.

^a "One or more literacy problems" indicates that respondent reported having difficulty all of the time or most of the time with any of the activities listed.

^b Asked of or about sample persons age two and older.

condition. Although the bulk of health limitations or difficulties stem from physical conditions, about 11-45 percent reported mental health problems. About a third of the SSI sam-

ples reported using special equipment.

Given their limited incomes and poor health status, it is important for enrollees to select a plan that can meet their health care

needs. Survey findings on literacy, however, suggest that many may find it challenging to choose a plan. Between 20 percent and 37 percent acknowledged having a literacy problem. This was especially evident among the SSI group, with about 35 percent reporting having trouble with at least one of the literacy activities (Exhibit 3). Moreover, the level of formal education was low, again particularly among the SSI enrollees, of whom roughly 40–45 percent had not completed high school.

Discussion

This paper provides insights into how enrollees in Florida's first two pilot counties for its Medicaid Reform demonstration fared in the early stages of program implementation. Overall, the results reveal sizable gaps in enrollees' understanding of major components of the reform: almost one in three were not even aware that they were enrolled in reform. Further, the majority of enrollees found it hard to understand plan information and to pick a plan, and a sizable minority reported difficulty obtaining plan information. Limited awareness and lack of understanding of Medicaid Reform were found to be pervasive problems in both pilot counties.

The study relied on a survey of Florida Medicaid recipients. One potential limitation to the study is the low survey response rate, driven largely by poor-quality contact information in the Florida Medicaid administrative files. As noted above, poststratification weights were used to ensure that the final survey sample was representative of the overall Florida Medicaid caseload.

Given what past research shows about the low level of health literacy in the United States, it is not surprising that we found enrollees struggling to make choices under Medicaid Reform. The demonstration demands that enrollees assume several new roles: they now must seek information about the re-

form and participating plans, read and review plan materials, weigh the costs and benefits of the different (and sometimes subtle) options, determine which one best meets their health needs, and, finally, act on their choices and enroll in a plan. At the same time, enrollees need to understand what it means to be enrolled in a health plan and how to access care within the plan.

These activities require a level of fluency beyond reading skills, including the ability to understand numbers; the ability to assess, compare, and synthesize information; and conceptual knowledge of health and health care.²⁰ Research has shown that these are challenging for the general U.S. population, and likely even more challenging for Medicaid populations. In the survey sample, for example, sizable shares reported having one or more literacy problems, and many had not finished high school. Findings

“Florida has acknowledged that health literacy has been a challenging part of the demonstration during its first year and has taken steps to address the problem.”

thus suggest that when consumer-choice programs are implemented, policymakers need to pay particular attention to health literacy and may need to consider providing more-intensive supports for some groups or even exempting certain people altogether.

Florida has acknowledged that health literacy has been a challenging part of the demonstration during its first year and has taken some steps to address the problem.²¹ Among others, five months into the transition, the state created a Special Needs Unit, in which choice counselors help educate medically complex enrollees and their families on how to access health care. Florida has also increased efforts to locate Medicaid recipients who did not enroll within the thirty-day choice period. Other research on the program has reported problems with information available to enrollees on plans' preferred drug lists, prior authorization procedures, and provider networks.²² Despite these steps taken by the state, at this point it is unclear how effective the

measures are.²³

As the demonstration continues, it will be important to evaluate enrollees' experiences under the program. Continued monitoring will allow greater insight into whether the gaps in people's knowledge and challenges with plan choice stem from the inevitable disruption of implementing a major programmatic change or whether there are more systemic problems associated with the program's design. Further, the findings on enrollees' lack of understanding about the changes occurring under reform suggest that careful monitoring is essential.

THE SUCCESS OF consumer-choice models such as that being tested by Florida's Medicaid Reform demonstration hinges on the ability to translate complicated health care information for consumers, and then help consumers use that information to make informed health care decisions. Without a well-informed consumer, a fundamental piece of the competitive model is missing, potentially jeopardizing hoped-for efficiencies and cost savings. Further, if recipients are enrolled in health plans that do not meet their health care needs, they are at risk for having problems obtaining needed care, which could have major health consequences.

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NOTES

1. J. Solomon, *The Illusion of Choice: Vulnerable Beneficiaries Being Placed in Scaled-Back "Benchmark" Benefit Packages* (Washington: Center on Budget and Policy Priorities, September 2006).
2. S.M. Payne et al., "Comparison of Risk-Adjustment Systems for the Medicaid-Eligible Disabled Population," *Medical Care* 38, no. 4 (2000): 422-432.
3. Institute of Medicine, *Health Literacy: A Prescription to End Confusion* (Washington: National Academies Press, April 2004).
4. J.H. Hibbard et al., "Is the Informed-Choice Policy Approach Appropriate for Medicare Beneficiaries?" *Health Affairs* 20, no. 3 (2001): 199-203.
5. Florida Agency for Health Care Administration, *Florida Medicaid Reform: Application for 1115 Research and Demonstration Waiver*, 30 August 2005, http://ahca.myflorida.com/Medicaid/medicaid_reform/waiver/pdfs/medicaid_reform_waiver_final_101905.pdf (accessed 1 October 2008).
6. Three additional counties (Baker, Clay, and Nassau) came under the demonstration in July 2007.
7. Florida AHCA, *Florida Medicaid Reform, Year 1, Draft Annual Report, July 1, 2006-June 30, 2007*, October 2007, http://ahca.myflorida.com/Medicaid/medicaid_reform/pdf/medicaid_reform_draft_annual_report_year_one_10-1-07.pdf (accessed 10 September 2008).
8. Statehealthfacts.org, "Florida: Medicaid Managed Care Enrollment: Comprehensive Plans, PCCM and Those Not in Comprehensive Plans, as of June 30, 2006" (as of 1 October 2008, these data were no longer available online).
9. Florida AHCA, "MediPass Report: June 2006," http://ahca.myflorida.com/Medicaid/MediPass/xls/0606_enr.xls (accessed 10 September 2008).
10. Ibid.
11. To participate in Medicaid and receive federal matching funds, states are required to provide program enrollees with certain services such as physician, inpatient care, and nursing facility services. These are referred to as mandatory benefits. At their discretion, states can offer certain optional benefits such as prescription drugs and dental services.
12. J. Hoadley and J. Alker, "Uncertain Access to Needed Drugs: Florida's Medicaid Reform Creates Challenges for Patients" (Jacksonville, Fla.: Jessie Ball Dupont Fund, July 2007).
13. SSI is a federal program that provides cash assistance to low-income aged, blind, and disabled people.
14. We selected proxy respondents who were

- knowledgeable about the health care experiences of the sample member, including those who participated in health care decisions. In 85 percent of the cases where a proxy respondent answered on behalf of an adult sample member, the proxy either made health care decisions for the sample individual or helped the sample individual make decisions about his or her health care.
15. This response rate is the number of completed interviews divided by the number of eligible sample members (American Association for Public Opinion Research RR2). The response rate, although low, reflects the general downward trend in response rates for telephone surveys occurring nationally in the United States. See, for example, R. Curtin, S. Presser, and E. Singer, "Changes in Telephone Survey Nonresponse over the Past Quarter Century," *Public Opinion Quarterly* 69, no. 1 (2005): 87–98. For example, the 2005 California Health Interview Survey reported an adult sample member response rate of 27 percent: California Health Interview Survey, *Response Rates*, CHIS 2005 Methodology Series, Report Four, April 2007, <http://www.chis.ucla.edu/pdf/CHIS2005.method4.pdf> (accessed 10 September 2008). The median response rate for the 2006 Behavioral Risk Factor Surveillance System (BRFSS) was 35 percent, with nine states in the 20s: BRFSS, 2006 *Behavioral Risk Factor Surveillance System, Summary Data Quality Report*, 3 May 2007, <ftp://ftp.cdc.gov/pub/Data/Brfss/2006SummaryDataQualityReport.pdf> (accessed 10 September 2008). Response rate is just one element to consider in assessing the reliability of survey estimates. Lower response levels in surveys are not, in and of themselves, an indicator of survey quality. See R.M. Groves, "Nonresponse Rates and Nonresponse Bias in Household Surveys," *Public Opinion Quarterly* 70, no. 5(2006): 646–675.
 16. We used a variety of methods to attempt to locate telephone numbers for sample members, including a telephone reverse-match look-up service and matches against additional state administrative data sources. Poor contact information is a common problem in surveys that rely on Medicaid administrative data, which has led some studies to exclude program enrollees with missing contact information. Although this leads to a higher response rate, the resulting study population is based on a nonrepresentative sample of Medicaid enrollees.
 17. In keeping with many surveys, younger adults, males, and nonwhite adults were somewhat less likely than others to respond to the survey.
 18. Although quite small, these reported figures are higher than indicated by state administrative data, which showed that just fourteen enrollees had opted out as of 30 June 2007. C.H. Lemak et al., "Medicaid Reform: Organizational Analysis" (Tallahassee: Department of Health Services Research, University of Florida, July 2007).
 19. Although the income of surveyed enrollees is low, given Florida's Medicaid eligibility standards it might have been expected to be lower than reported by respondents. This anomaly is likely due to reliance on a single income question in the survey that asked only about family income over the prior calendar year rather than the detailed questions on the family's current monthly income and spending that are used in determining Medicaid eligibility.
 20. IOM, *Health Literacy*; and E. Peters et al., "Numeracy Skill and the Communication, Comprehension, and Use of Risk-Benefit Information," *Health Affairs* 26, no. 3 (2007): 741–748.
 21. Florida AHCA, *Florida Medicaid Reform*; and Office of Program Policy Analysis and Government Accountability, "Medicaid Reform: Choice Counseling Goal Met, But Some Beneficiaries Experience Difficulties Selecting a Health Plan That Best Meets Their Needs," Report no. 08-46, July 2008, <http://www.oppaga.state.fl.us/reports/pdf/0846rpt.pdf> (accessed 1 October 2008).
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 23. Florida AHCA, *Florida Medicaid Reform, Quarterly Progress Report, April 1, 2008–June 30, 2008*, http://www.fdhc.state.fl.us/Medicaid/medicaid_reform/pdf/reform_qtrly_report_q4_year2_apr08-jun08.pdf (accessed 1 October 2008).