ENROLLMENT AND RETENTION PATTERNS

AMONG HEALTHY FAMILY PARTICIPANTS

IN MENDOCINO COUNTY

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EXECUTIVE SUMMARY

Mendocino County's Children's Health Initiative is working to provide health insurance coverage for every child in the County. As part of this effort, the County is seeking ways to improve enrollment and retention in existing public programs, and to design and implement a new insurance product for children ineligible for Medi-Cal and Healthy Families. In order to help Mendocino County in those efforts, the California Institute for Rural Studies has conducted an analysis of enrollment and retention patterns among Healthy Families participants in the County, based on a survey of 310 current and former Healthy Families participants and an analysis of administrative data from the Managed Risk Medical Insurance Board (MRMIB). Key findings from this assessment include the following:

- While the majority of survey respondents felt the Healthy Families enrollment process was fairly easy, fewer felt the renewal process was as simple. This may in part be due to the fact that more families reported assistance with enrollment than renewal.
- The majority of children no longer enrolled in Healthy Families (20% of survey respondents) are currently insured, indicating that most disenrollment is due to unavoidable reasons such as changes in household income, shifts to employer-based insurance, ineligibility due to age, etc.
- Parents expressed high levels of satisfaction with Healthy Families. The overwhelming majority of respondents whose children are not currently enrolled in Healthy Families stated that they would re-enroll their children if they could.
- Cost does not appear to be a major barrier to participation in the Healthy Families program. Most parents felt that the Healthy Family premiums are affordable, and a number would even be willing to pay a higher premium.

- Many respondents would like to see an expansion of the Healthy Families program to others, including young adults, parents and other adults.
- Many survey respondent would like the income eligibility requirements to be relaxed as well, to include families with higher incomes.
- The vast majority of respondents felt that Healthy Families increased access to medical care for their children. Most parents take their children to regular, preventive medical exams, and reported that their children now have a medical home.
- While parents reported high levels of satisfaction with primary medical care, they were less satisfied with dental care, in terms of both access and quality of care.

This study is part of the growing body of literature demonstrating that the provision of health insurance coverage to children is an effective means of improving access to care. The findings also supports the hypothesis that access to health insurance encourages parents to utilize preventive services for their children.

INTRODUCTION

The Mendocino Children's Health Initiative (MCHI) is working to expand health insurance coverage so that no child in Mendocino County is uninsured. An important goal of the MCHI is to develop the infrastructure for active outreach, enrollment and retention of families in need of health insurance. Nonetheless, data from the Managed Risk Medical Insurance Board (MRMIB) indicate that Healthy Families disenrollment rates in Mendocino are extremely high. For example, 843 new children were enrolled in Healthy Families in 2004, while 830 children disenrolled during the same period, representing a net gain of only 13 children. MRMIB data for other counties indicate similarly high disenrollment rates. In light of this disconcerting trend, the California Institute for Rural Studies conducted an assessment designed to address the following program-related questions:

- How long do children in Mendocino County remain enrolled in the Healthy Families program, and what are re-enrollment rates?
- Which demographic, socioeconomic and insurance variables (e.g., annual income, monthly premiums, administrative procedures) are associated with disenrollment from the Healthy Families program?
- What are the barriers to retaining coverage, from the perspective of Healthy Families program beneficiaries?

We designed a study utilizing administrative and survey data to obtain the answers to those questions. Administrative data were obtained from MRMIB enrollment/disenrollment files for 1,675 families enrolled in the Healthy Family program between January 2004 and July 2005. A 37 question survey instrument was mailed to all 1,675 families as well. The survey included questions regarding experiences with the Healthy Families enrollment and renewal processes, and related issues such as access to care, quality of care, and cost of care. Surveys were completed by 310 families, representing 19% of all families enrolled during that period. Of the 310 completed surveys, 237 (77%) were in English, while 73 (24%) were in Spanish.[1] [2] (See Appendix A for more details regarding the research methodology.)

[1] Numbers total over 100% due to rounding.

In order to assess whether the survey findings were representative of the broader population of Healthy Families beneficiaries in Mendocino County, we conducted a non-response analysis, comparing key variables including ethnicity, age of children, family size, percent of federal poverty level, number of termination dates, and city of residence, for survey respondents and non-respondents. This analysis indicated that survey respondents were representative of all Healthy Families enrollees, with two exceptions:

- Survey respondents were enrolled in Healthy Families significantly longer than non-respondents (13.9 versus 11.6 months); and
- Survey respondents had participated in the Healthy Families program for a significantly longer time than non-respondents (2.7 vs. 2.5 years).

These differences suggest that some caution should be exercised in generalizing the survey findings to the larger population of Healthy Families participants.

Assessment Findings

Demographic Characteristics

Fifty-seven percent of survey respondents are White, 37% are Hispanic, and 6% represent other ethnicities, including African-American (0.3%), Asian/Pacific Islander (0.3%), Native American (0.3%), mixed race (3.2%) and other (1.6%). An additional six (1.9%) respondents did not indicate their ethnicity. Because of the small numbers of respondents that are not White or Hispanic, comparative analyses were conducted only for those two ethnic/racial groups.

The majority of respondents are employed or otherwise engaged in productive activities (e.g., students or retirees). Forty-four percent of respondents are employed full-time, 24% work part-time, 19% are homemakers, and only 3% are unemployed. Employment patterns vary

[2] The numbers of Spanish language surveys is less than the 37% of Hispanic respondents, because many families identified as Hispanic returned English surveys.

somewhat by ethnicity. Whereas 52% of White respondents reported full-time employment, that was the case for 39% of Hispanics.

The majority (54%) of respondents report some education beyond high school. One-third have attended some college or vocational/technical school, while one-fifth are college graduates. Conversely, 22% reported graduating high school, while 23% have an 11^{th} grade level education or less. Educational attainment varies by ethnicity as well, with Hispanics reporting significantly lower levels of educational attainment than Whites. For example, 58% of Hispanics have not completed high school, the case for only 3% of White respondents. Similarly, more than half of White respondents report some college or technical/vocational education, the case for only one-fifth of Hispanic respondents.

Survey respondents report a mean family size of four, while 20% have between five and seven family members. The mean family size for Hispanics is significantly larger than for Whites (4.2 versus 3.6).

More than half of all Healthy Families participants report incomes between 100 and 200 percent of the federal poverty level, while one in four are between 200 and 250 percent of FPL. Despite differences in both educational attainment and employment status, the survey findings reveal no significant differences between White and Hispanic respondents with respect to household income.

Healthy Families Enrollment and Retention Patterns

One of the concerns of Mendocino County's Children's Health Initiative is with respect to families leaving the program and not returning. Based on past termination dates, we determined that 325 families (19%) in the administrative dataset were entering the HF program for the first time, while the remaining 80% had been enrolled in the program one or more times

previously. Families in the administrative dataset were enrolled in Healthy Families an average of nearly 12 months (median 14 months), while survey respondents' reported a somewhat longer average enrollment period of nearly 14 months (median 17 months).[3]

We assessed the total amount of time[4] (non-consecutive months) in which families participated in the Healthy Families program. On average, families with multiple termination dates had been in and out of the Healthy Families program for nearly three years. As indicated in Table 1, nearly 23% had been enrolled in Healthy Families once in the past, 31% had been enrolled twice, another 20% had been enrolled three times and the remaining 7% had been enrolled four or five times in the past.

Table 1: Number of Previous Termination Dates in the Healthy Families Program

Number of Termination Dates	Frequency	Valid Percent	Cumulative Percent
0	325	19.4	19.4
1	382	22.8	42.2
2	525	31.3	73.6
3	332	19.8	93.4
4	102	6.1	99.5
5	9	.5	100.0
Total	1675	100.0	

Application and Renewal Process

Local Children's Health Initiatives (CHIs) often have a great deal of latitude in developing and implementing new health insurance products, and can design the application and renewal processes in ways they feel will encourage participation and retention. The Mendocino Children's Health Initiative was therefore interested in learning about participating families' experiences with enrollment and renewal processes.

[3] Because the dataset only included families enrolling between January 2004 and July 2005, the longest a family could have been enrolled for purposes of this analysis was 19 months.
[4] Total time = time from first termination date to most current enrollment date.

Application Process

Nearly 70% of all respondents felt the enrollment process was "as easy as it could be," 25% felt it was "somewhat more difficult than it needed to be," while 7% felt it was "much more difficult than it needed to be" (see Table 2). Over half (55%) of all survey respondents reported receiving assistance with their Healthy Families application. Significantly more Hispanics (83%) reported receiving assistance with the application process than Whites (32%). Nearly 95% of those receiving assistance reported that it was helpful.

Table 2: Ease of Enrollment in the Healthy Families Program

	Frequency	Percent	Cumulative Percent
About as easy as it could be	211	69.0	69.2
Somewhat more difficult than it needed to be	74	24.2	93.4
Much more difficult than it needed to be	20	6.5	100.0
Total	305	99.7	
Missing	1	.3	
Total	306	100.0	

Respondents reported waiting a range of one to 28 weeks to hear about their application status. Twenty-five percent were notified within two weeks of applying, 47% received notification between 2.5 and 4 weeks, while 17% were notified between five and eight weeks. Seven percent of respondents reported receiving notification about their status in the Healthy Families program over three months after submitting an application.

Respondents that did not find the enrollment process "as easy as it could be," commented that the application and renewal processes should be simplified, that the paperwork is "a bit daunting," that the they encountered difficulties in getting their paperwork to the right people, or had to send or fax their applications multiple times.

A number of families also reported billing difficulties with Healthy Families. Seventeen percent reported that they were told by Healthy Families that their premium payment was not

received, even though the family had sent it in. A number also reported errors with the billing system, for example, receiving a monthly bill even though they had prepaid for three months of coverage. Several families also commented that they had received notices that payment was due, despite the fact that their child was eligible for free coverage because s/he was Native American.

A number of families also reported difficulties obtaining accurate information from Healthy Families. Twenty percent reported problems getting information about eligibility and coverage, 15% reported receiving incorrect information about Healthy Families from someone that worked for the program, while nearly 16% of respondents said they had lost coverage because they did not receive the necessary renewal information. Twenty-two percent of respondents reported having to wait weeks or months to hear back from Healthy Families about enrollment and related issues.

Renewal Processes

Families are required to submit renewal documentation to Healthy Families once a year. Sixty-one percent of those renewing felt the renewal process was "about as easy as it could be," 23% felt that it was "somewhat more difficult than it needed to be," while 6% felt it was "much more difficult than it needed to be."

Whereas 55% of respondents reported receiving assistance with the original application process, only 20% received assistance with the renewal process. Spanish speakers were significantly more likely to report assistance than English speakers. Whereas 52% of those responding to the Spanish-language survey reported assistance with the renewal process, that was the case for only 11 of those responding to the survey in English.

Several families felt that mistakes in calculating their income were made during the renewal process, resulting in the disenrollment of their children. Additionally, several

respondents commented that the documentation required for renewals was burdensome, and that they got conflicting information from staff at Healthy Families about the renewal process. Several respondents also stated that it was difficult faxing documentation to Healthy Families. For example, several respondents reported that the faxes they sent were illegible, and that they received letters notifying them to resubmit materials. That however resulted in disenrollment, because Healthy Families claimed that they did not receive the required documentation on time.

Disenrollment Patterns

Twenty-three percent of survey respondents reported that they were not currently enrolled in Healthy Families. The principal reasons for non-renewal are "lack of eligibility due to increased income" (38%), "children switched to Medi-Cal" (23%), "private insurance through a job" (18%) and "children too old for Healthy Families" (16%),[5] reasons that are not directly related to the Healthy Families enrollment and renewal process per se.

Those reasons are however followed by factors more directly related to the enrollment and renewal processes, including "materials not received by Healthy Families" (10%), "overly complicated eligibility criteria for those with variable income" (7%), "inability to obtain background documentation" (6%) and "inability to pay the premium" (4%). Additionally, 8% of the sub-sample stated that the income guidelines and eligibility process were too complicated. Several respondents also commented that they encountered administrative difficulties during the renewal process and were denied coverage.

[5] Percentages total more than 100% because respondents could select up to three reasons for non-renewal.

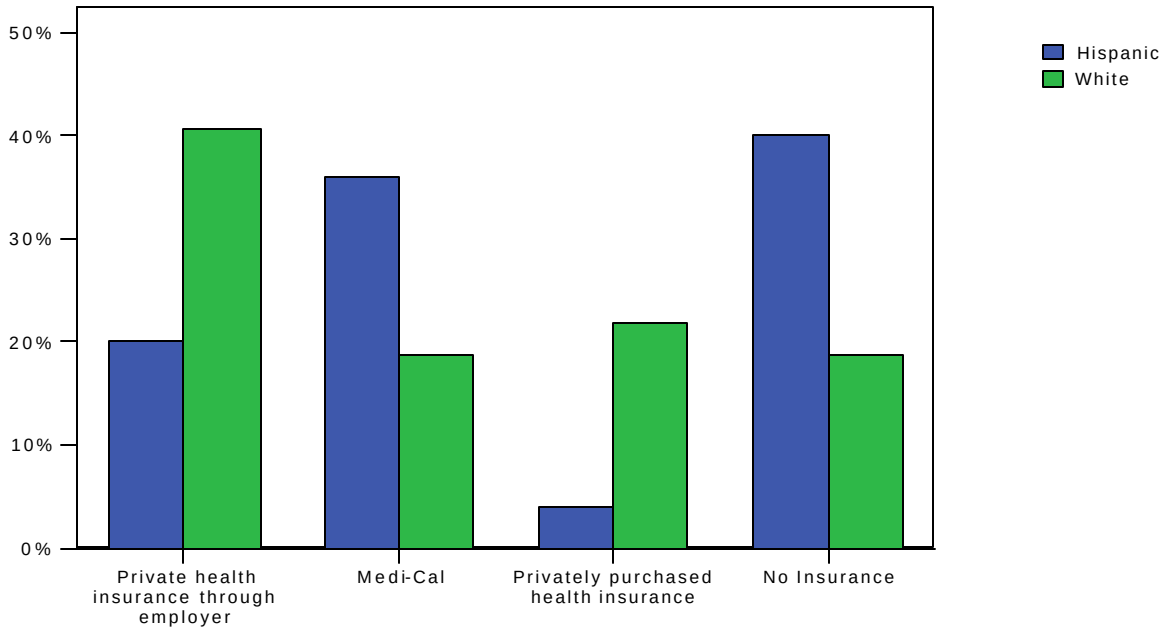
Table 3: Reasons for Non-Renewal in Healthy Families

Reason for Non-Renewal	Frequency	Percent
Income changed and no longer eligible	27	38.0
Children switched to Medi-Cal	16	22.5
Got private insurance through a job	13	18.3
Children too old for Healthy Families	11	15.5
Sent in renewal materials, but Healthy Families said did not receive them	7	9.9
Income variable and eligibility is too complicated	5	7.0
Couldn't get required background documentation	4	5.6
Unable to pay premium	3	4.2
Forgot to submit renewal paperwork	3	4.2
Physician not covered by Healthy Families	3	4.2
Forgot to pay premium	2	2.8
Never received renewal documents	2	2.8
Unaware had to renew	2	2.8
Didn't need services because child healthy	1	1.4
Other	8	11.3

Disenrollment in Healthy Families does not vary by ethnicity, and there was no significant difference in the percentage of Hispanics and Whites no longer enrolled in Healthy Families. While the survey did not ask about immigration status, no one cited concerns about citizenship or immigration issues as a reason for non-renewal in Healthy Families. No one stated a preference for bringing their child to a clinic with a sliding fee scale either. It speaks to the quality of the program that 82% of respondents not currently enrolled in Healthy Families said they would re-enroll their children in the program if they could.

The majority (69%) of children not currently enrolled in Healthy Families currently have some type of health insurance: 27% have employer-based health insurance, a further 27% have Medi-Cal, while 14% have privately purchased health insurance. Nonetheless, 31% of children no longer enrolled in Healthy Families are uninsured. Serious ethnic disparities exist in that regard, with 43% of unenrolled Hispanic children lacking insurance, compared with 19% of White children.

Chart 1: Health Insurance Status of Families Who Have Left Healthy Families



Cost: Premiums and Co-Pays

More than 90% of families believe that the monthly premiums and co-payments are "about the right amount." Five percent of Hispanic respondents felt the premiums were too high, compared with 1.5% of White respondents. Similarly, 7% of Whites felt premiums could be higher, while only 2% of Hispanics felt that way.

Eighty-eight percent of all respondents reported rarely or never having difficulty paying the premium, while 5% reported that paying the premium posed a financial difficulty. This varied by ethnicity, however, with 6% of Hispanics reporting difficulties paying their premium every month, compared with 1% of White respondents.

Several families commented that they would be willing to pay a higher premium for Healthy Families, consistent with anecdotal reports that cost does not pose a significant barrier to

Healthy Families enrollment. This finding may be particularly reassuring for CHIs across the state considering design options for new health insurance products such as Healthy Kids, since most family payment structures mirror those of Healthy Families.

More than 80% of respondents stated they were happy to pay the Healthy Families premium, because they felt good paying part of the cost of their children's health coverage. Similarly, the vast majority (86%) disagreed with the statement that "paying the premium is a waste of money, since my children are healthy and don't need medical care very often." Here too, Whites and Hispanics responded differently. Whereas only 5% of White respondents strongly or somewhat agreed with that statement, that was the case for over 21% Hispanic families.

Access to Care

The survey findings reveal that parents believe that health insurance increases access to care for their children and enables their children to have a medical home. Almost 90% of parents reported that having Healthy Families makes it easier to get health care services for their children. This varied by ethnicity, with 92% of Hispanics feeling that way, compared with 84% of White respondents.

More than half of all respondents reported taking their children to the doctor for regular check-ups. Here too, there were differences based on ethnicity; 68% of Hispanics reported taking their children for well-child check-ups, compared with 56% of Whites.

Ninety-eight percent of respondents report a regular source of care, and over 95% report that they have been able to continue seeing their regular provider under Healthy Families. Slightly over half (52%) of respondents report that their regular source of care is a doctor's office, while 46% report that it is a community clinic. The regular source of care varies by

ethnicity. Sixty-three percent of Hispanics report a community clinic as their regular source of care, while 36% reported a doctor's office. The numbers are virtually reversed for White respondents, 31% of whom use a clinic, while 67% visit a doctor's office as their regular source of care.

Quality of Care

The survey respondents reported high levels of satisfaction with the quality of care their children receive through Healthy Families. Almost 90% rated the quality of medical care as excellent or very good, while less than 2% felt it is fair or poor. Physical access to care is however an issue for some parents. Several noted that they needed to travel out of their area to get medical care, since there are very few providers in their region that accept Healthy Families insurance. Another respondent reported that she was billed when using the ER during her son's asthma attacks, since the physicians in the local emergency room are not contracted providers.

Almost 80% of respondents reported that the quality of prescription drug coverage was excellent or very good, while 8% felt it was fair or poor. Several commented that specific prescriptions, particularly allergy and asthma prevention medications, were not covered by their Healthy Families health plan.

Survey respondents were however much less satisfied with the quality of dental care and coverage through Healthy Families. Only 64% rated the dental care they received as very good or excellent, while 8% felt it was fair or poor. Dental coverage was in fact the most frequently addressed topic in the open-ended comments section of the survey. Parents reported a range of problems, including an insufficient dental provider network to meet the demand, inadequate quality of dental providers, unreasonably long waits to get an appointment (e.g. 5 months), long waiting room waits, and insufficient scope of covered services (e.g. tooth extractions and

orthodontia are not covered). These findings are also consistent with anecdotal evidence regarding dental coverage for families enrolled in government programs in other counties. Nonetheless, many county CHIs are exploring ways to improve access to dental services in their communities.

Nearly 13% of respondents felt their children were treated less well by a provider because of their Healthy Families insurance status. That did not vary by source of regular care, however it did vary by ethnicity. While nearly 20% of Hispanic respondents felt their children were treated less well because they were Healthy Families participants, that was reported by only 8% of Whites.

Expansion of Healthy Families to Other Populations

Overall, the majority of respondents are satisfied with the Healthy Families program and are grateful to have access to affordable and high quality health insurance for their children. Many respondents commented that they would like to see an expansion of the program, to include young adults, parents and other adults. A number of respondents would like eligibility to be expanded to include those with higher incomes, and suggested that premiums and co-pays could be higher for those with greater incomes.

IMPLICATIONS

The findings from this analysis offer a number of specific insights regarding the Healthy Families program in Mendocino County. First, families participate in the Healthy Families program for an average of three years.[6] Second, an analysis of MRMIB data indicate that only 20% of all families enrolled between January 2004 and July 2005 were new to Healthy Families,

[6] Unfortunately, the administrative data did not permit an analysis of the amount of time lapsed between enrollment and re-enrollment.

suggesting that aggregate disenrollment rates reported by MRMIB may overestimate turnover in Mendocino County.

The survey findings indicate that participating families are satisfied with the Healthy Families program, and that health insurance coverage is a valuable and important means of obtaining access to quality health care for their children. Nonetheless, the challenges identified by survey respondents shed important light on issues that must be considered in designing new locally managed health insurance programs. Parents appreciate a simple, clear application and enrollment process, and would prefer that the annual renewal process be as easy. It is noteworthy that significantly fewer families received assistance with the renewal process. Policies encouraging the use of assistors to help families with the renewal process could increase retention rates, while improving families' experience with the renewal process.

It is also clear that while the use of technology has improved enrollment and renewal processes, that can at times presents a barrier to families. For example, several respondents cited problems with faxes that were illegible or not directed to the appropriate person, at times resulting in a loss of coverage.

Perhaps one of the most interesting and useful findings from this assessment is that most families do not feel that the premiums and co-payments pose a financial burden. As noted, some even reported a willingness to pay higher premiums. This is helpful for program planning, as some local CHIs have opted to eliminate premium payments altogether.

One issue that is particularly relevant for program planning is the provider network. While families reported being fairly satisfied with access to medical providers in Mendocino County, several noted that they had to travel significant distances to see a provider. Also, this survey focused on access to primary care, and did not address whether families felt they had

sufficient access to specialists. Travel time and wait lists for specialty care is a problem for anyone enrolled in government programs, but poses an even greater challenge for those in rural areas.

CONCLUSIONS

The findings from this assessment demonstrate the value of asking families about their experiences with public insurance programs, in order to gain a better understanding of enrollment and retention patterns. The survey findings suggest that disenrollment rates reported by MRMIB may be vastly overestimated, and that the MRMIB reporting process does not accurately capture true disenrollment rates. A second significant finding is that cost does not appear to be a barrier to retention, which is particularly useful for counties designing new insurance programs to expand eligibility. A third key finding is that the provider network for Healthy Families is inadequate in Mendocino County, particularly with respect to dental care. It is likely that this is true for other rural counties, and possibly for all California counties. The implication of this finding is that counties need to work more closely with health plans, in order to encourage increased recruitment of medical and dental providers into the network. A recommendation should be made to MRMIB to devote more resources to working with health and dental plans, in order to expand provider networks. It is clear that county efforts to expand eligibility to a program similar to Healthy Families among children not eligible for existing public insurance programs will be greatly appreciated and utilized by families in Mendocino County.

Appendix A: Methodology

MRMIB Administrative Data

Two data sources were used to describe Healthy Families Beneficiaries in Mendocino County. The first source was administrative data files from MRMIB containing demographic, enrollment, disenrollment, and contact information for all Healthy Families enrollees in Mendocino County with an enrollment date between January 2004 and July 2005 (n=1,675 children). The administrative data was used to examine enrollment and disenrollment trends and to identify HF beneficiaries for the survey component. The January 2004-July 2005 time-frame was selected in the hope that it would result in a higher response rate than if older contact information were used. Variables in the dataset included:

- Healthy Families identification numbers
- Name of child
- Birth date of child
- Age of child
- Gender of child
- Ethnicity
- Address
- Enrollment dates (only dates between January 2004-July 2005)
- Family size
- Income as a percent of Federal Poverty Level
- Disenrollment dates (included all historical disenrollment dates)

Survey

A 37-question instrument was designed and piloted with individuals participating in Healthy Families in Yolo County. The survey instrument was revised based on the pilot tests, translated to Spanish and mailed to the parents of every child enrolled in Healthy Families during the period January 2004-July 2005 (n=1,675). Spanish and English surveys were sent to families that self-identified as Hispanic in the administrative database. A five dollar incentive in the form of a phone card was sent to those who responded to the survey. Reminder postcards were sent out

two weeks after the initial mailing. The initial response rate was 17% (n=289). In an effort to insure that people with limited literacy were included in the analysis, a telephone survey was conducted with a random sample of families for whom Spanish was the first language, bringing the total sample size to 310 (19% response rate). Survey data were entered directly into SPSS statistical software. The survey data were matched with MRMIB data using the Healthy Families identification number.

The data were analyzed using SPSS. The first analysis was a non-response analysis, which examined whether the survey respondents were representative of all survey recipients. Chi-square tests were used to assess differences in expected and observed values for categorical variables, while t-tests were used in the case of continuous variables, to examine differences in the means of respondents and non-respondents. Significant differences are reported at the p=<.05 level. The non-response analysis revealed that survey respondents are representative of all Healthy Families enrollees, with two exceptions: (1) families who responded to the survey were enrolled in Healthy Families significantly longer than those who did not respond (13.9 months versus 11.6 months), and (2) survey respondents had participated in the HF program for a significantly longer time (2.7 vs. 2.5 years).

The second analysis was descriptive and illustrated the results of the survey. Chi-square analyses were used to identify significant differences regarding perceptions of the application and re-enrollment processes, whether or not they had application assistance, and differences in perceptions of the quality of care based on health care setting (i.e. health clinic, doctors office, emergency room). No significant differences were found in that regard.

The third analysis examined survey respondents not currently enrolled in the Healthy Families program and the reasons for lack of enrollment.

Finally, a comparative analysis was completed to assess differences in responses between respondents that self-identified as Hispanic and White. Chi-square tests were used to assess differences in expected and observed values for categorical variables. T-tests were used to examine differences in the means of continuous variables. Significant differences are reported at the p=<.05 level.

Revised Methodology

The methodology used for this assessment differs from what we originally proposed, in a number of ways. Differences are primarily due to the difficulty of using particular data sources and obtaining certain types of data. First, we proposed to use application information collected by the Mendocino County Healthy Families/Medi-Cal Outreach and Support Alliance as our primary source of contact information. However, it became apparent that getting the application data from the Alliance would have required going to each of more than 20 sites to locate and photocopy the original applications. We then decided to use administrative enrollment/ disenrollment data from MRMIB as our source of contact data. By using MRMIB data, we were able to get recent contact information and match the survey data with administrative data, to obtain enrollment and disenrollment data for each respondent.

Second, we originally proposed to survey a sample of Healthy Families and Medi-Cal enrollees. Nonetheless, this study is limited to Healthy Families beneficiaries only. We were unable to obtain contact information for Medi-Cal beneficiaries from the Mendocino Department of Social Services, due to difficulties with the data files and the types of reports that the system is able to create. Ultimately, however, we believe that a survey of Healthy Families enrollees provides more useful information for the purposes of a CHI insurance expansion effort, since

most CHIs have modeled new insurance programs on Healthy Families, with respect to issues including scope of coverage, enrollment and renewal procedures, premiums and co-payments.