WHEREAS Washington State Health Insurance Pool (“WSHIP”) has been established by act of the Washington Legislature for the purpose of providing health insurance coverage to all residents of the state of Washington who are denied health insurance, and to provide a mechanism to insure the availability of comprehensive coverage to persons unable to obtain such coverage on either an individual or group basis;

WHEREAS Section 1101 of the Patient Protection and Affordable Care Act (Public Law 111-148) (“PPACA”) establishes a temporary high risk pool program (“Federal Pool”) to provide health insurance coverage to currently uninsured individuals with pre-existing conditions; and directs the Secretary of Health and Human Services (the “Secretary”) to carry out the program directly or through contracts with states or private, non-profit entities;

WHEREAS the Secretary has written to the Governor and to the Insurance Commissioner of the state of Washington to request an expression of the state’s interest in participating in the Federal Pool and requested a response on the part of the state of Washington by April 30, 2010;

WHEREAS representatives of the Governor and the Insurance Commissioner have conferred with the Executive Director of WSHIP concerning possible arrangements that would facilitate establishment of the Federal Pool in the state of Washington consistent with the requirements of PPACA and the limitations of the resources of the state of Washington and WSHIP respectively;

WHEREAS the board of directors of WSHIP has determined that WSHIP assistance in establishing the Federal Pool in Washington has the potential to further the statutory purposes of WSHIP and be of benefit to the citizens of the state of Washington if WSHIP participation in the Federal Pool does not in any way impair or jeopardize the statutorily mandated operations of WSHIP;

WHEREAS pursuant to Chapter 48.41 RCW, the board of directors of WSHIP has the general powers and authority granted under the laws of the state of Washington to insurance companies and other health insurers licensed to provide health coverage, and pursuant to RCW 48.41.900, any part of Chapter 48.41 RCW that conflicts with federal requirements which are prescribed condition to the allocation of federal funds to the state of Washington is declared to be in operative, providing the board of directors with broad authority to act in this matter to achieve the purpose of WSHIP;

IT IS HEREBY RESOLVED:

1. **Indication of Interest.** The Officers of WSHIP and the Executive Director of WSHIP are authorized to furnish an indication of interest by WSHIP in the establishment of the Federal Pool
in Washington as generally described in these resolutions, and subject to the limiting conditions further described in these resolutions.

2. **WSHIP Requirements.** WSHIP can consider and indicate interest, on a non-binding basis, in a contract with the Department of Health and Human Services (“HHS”) directly or through the state of Washington whereby:

   (a) WSHIP would provide services to the Federal Pool to enable it to operate in the state of Washington in the manner that WSHIP operates the Washington high risk pool, including utilization of WSHIP current vendors and provider network;

   (b) Federal funding would provide reimbursement for providers, facilities and suppliers at rates equivalent to WSHIP reimbursement rates for the WSHIP pool;

   (c) As WSHIP does not have or have access to funding or assets to undertake risk or expenses in connection with the Federal Pool, the Federal Pool must be wholly funded by federal funds and the reasonable start-up and ongoing costs of administration of the Federal Pool incurred by WSHIP would be reimbursed from federal funds;

   (d) Federal Pool policies must be offered by the Federal Pool and not be or become an obligation of WSHIP or the state of Washington under any circumstances; the Federal Pool policies would contain provisions to the effect that the Federal Pool is dependent upon federal funds and that in the event federal funds are no longer available, coverage would terminate;

   (e) The Federal Pool must be separately managed and the assets of the Federal Pool and WSHIP must be segregated and not commingled; there would be no inter-pool loans;

   (f) WSHIP overhead and expenses, including vendor expenses, for the Federal Pool and the WSHIP pool would be allocated and accounted for in accordance with appropriate accounting methodologies and in a manner that can be audited by WSHIP auditors;

   (g) The Federal Pool in Washington would be available only to Washington residents;

   (h) The Federal Pool would be operated by WSHIP in compliance with PPACA and applicable federal regulations; and regulatory responsibility for the Federal Pool would reside with the Secretary and HHS;

   (i) WSHIP would continue to operate the WSHIP pool pursuant to the requirements of Washington state law.

3. **Development of Contract.** The Officers of WSHIP and the Executive Director are authorized and directed to engage in discussions with the Secretary and her representatives, with consultation and participation by the Governor and the Commissioner as they deem appropriate, to develop feasible terms of a contract with HHS as described in these resolutions, and to make further recommendations to the board of directors concerning possible WSHIP participation in the Federal Pool. Further, in the event WSHIP participation does not appear feasible, in particular, if participation by WSHIP in the Federal Pool will jeopardize operation of WSHIP statutorily mandated programs, or require WSHIP to incur expense which will not be reimbursed by the Federal Pool within a reasonable period of time, the Officers and Executive Director are authorized and directed to inform the Governor and the Commissioner, as well as any representatives of HHS engaged in discussions with WSHIP, of the inability of WSHIP to participate in the Federal Pool so that an alternative strategy may be pursued in Washington.
4. **Ad Hoc Committee.** The following individuals are appointed as an ad hoc committee of the board of directors to support and advise the Executive Director in the development of possible contract terms as authorized by these resolutions:

   Dorothy Graham, Board Chair, representing large employers  
   Matthew Damon, Board Vice Chair, representing consumers  
   Robert Kuecker, Secretary/ Treasurer, representing all member plans  
   Peter Cutler, Chair of the Marketing and Planning Committee, representing the Insurance Commissioner.

The committee shall have the authority to authorize expenses as appropriate up to $____ and otherwise shall not exercise the authority of the board of directors.
PROS & CONS
FOR WSHIP vs. ANOTHER ENTITY ADMINISTERING THE FEDERAL HIGH RISK POOL

WSHIP’s mission is to make coverage available to people who are rejected in the individual market

PROS

1. If WSHIP administers the federal program, consumers would have one place to go to learn what they qualify for and how the state and federal programs are different.

2. Federal consumers would get a program that is designed for and has experience with high-risk people.

3. WSHIP can very likely get the federal program going faster; therefore, some consumers who otherwise might have enrolled in WSHIP and had a six-month waiting period would get immediate coverage for their pre-existing conditions.

4. Because WSHIP can do it faster, those mentioned above would be subsidized by federal funds rather than Washington carriers and their customers.

5. WSHIP would be making the decision about what the pre-existing conditions are and to the extent they allow for more people to go into the federal pool instead of the individual market. This would tend to keep individual rates lower.

6. There is an expectation that WSHIP should express interest.

7. If WSHIP takes on the federal pool and does a good job, it will be seen in a positive light.

CONS

1. WSHIP assessments cannot be used to finance the federal program. Implementation will be delayed without a prompt guarantee that federal funds will be available and will cover all start-up and ongoing administrative costs in addition to all claim costs.

2. There is potential for additional burden to the Board, its officers and committees to the extent that things have to be done differently or because of increased enrollment; e.g. separate financials, more grievances, start-up work resulting in more meetings, more work at the meetings, more time needed in general.

3. There will be more work for WSHIP staff and contractors with limited ability to hire extra help due to aggressive timelines.

4. Administering the federal program could detract from WSHIP’s current efforts because of competition for scarce resources.

5. Potentially any number of different problems may arise due to the many unknowns (see questions).
Availability and Use of Federal Funds

1. How will states be reimbursed for their costs (i.e. medical claim, pharmacy claim and administrative costs) in excess of premium revenue? Is a funding formula modeled after SCHIP the only option under consideration? We have a concern that the variables used for that funding allocation may not equitably allocate funds for this program.

2. If HHS uses an allocation methodology rather than a system where pools are reimbursed for actual claims incurred, how would a pool with a smaller allocation be protected from the impact of catastrophic claims? It is easy to imagine a scenario where after having one or two major claims, the pool would have to shut down enrollment with few people covered. Under an allocation methodology, some states may also feel it’s necessary to hold back a significant portion of the allocation to maintain adequate reserves at the expense of serving more individuals. How does HHS envision managing the tension between the desire to serve as many people as possible, but to also maintain solvency for each individual pool? For example, would CMS be willing to create a mechanism for handling catastrophic claims outside the state allocation so that the state risk pools would be protected from this risk and cost?

3. Would HHS consider providing states with final guidelines on premiums and benefits such that each state could prepare an actuarial projection on the number of individuals it expects to enroll in the pool and the costs to insure those individuals? HHS could then review these projections and authorize each state to enroll a certain number of individuals and the state would be reimbursed for their actual costs in excess of premium to cover the approved number of enrollees. HHS would maintain a capital adequacy reserve for any catastrophic claims that occur within a states enrollment allocation, or for overall losses that exceed actuarial projections.

4. Is HHS willing to work with the high risk pools to structure the funding arrangement like an "Administrative Services Only" arrangement that is typical between Health Plans and Third Party Administrators where there is no financial responsibility for the State or for the existing high risk pool if there is a shortfall in the timing or the amount of federal funds? The use of the term "Administrative Services Only" agreement should give HHS terms of contract language that is already generally accepted in all states and with all types of administrators of health plans. It will provide context for a common understanding of the intent and the practices of the arrangement.
5. Since the pool may only be operational for 3 1/2 years and enrollment in each state will be dependent on a myriad of variables, would HHS consider evaluating its funding allocations under a timeframe that is shorter than two years into the program?

6. If federal funds become insufficient to support the program, our state intends to a) establish a waiting list and/or, if necessary, b) terminate coverage for individuals. Are there any prohibitions from doing so?

7. In terms of the available funding, we are concerned about the potential for unfunded liabilities (i.e. the pools have enrolled people and the funding runs out). Any guidance that could be provided on how the agreement will be structured between HHS and the states to ensure that states will not find themselves in a situation where they have incurred costs or have the risk of incurring costs beyond the available federal funding would be helpful.

8. If the money is insufficient for the creation and operation of the high risk pool, what will the federal government do, if anything, to assure that people currently in claim get those claims paid? What if an individual is in treatment and funding ceases, will the federal government commit to continue paying to allow the continuation of treatment?

9. Will HHS be setting requirements for how the pools should establish and maintain reserves?

10. Will there be “start up” monies available for states to support the administrative costs associated with implementation? Will we receive these funds prior to July 1, 2010? Or can we count on being reimbursed if we use our funds?

11. Does HHS expect to issue any guidelines or limitations for administrative costs under the pool? Given that many of the state pools will be operating both the state and the federal pools, it will be important to be able to allocate the time of the pool’s administrative staff between the two, as well of the time that its vendors (e.g. actuarial and legal) spend on the federal pool.

12. Similarly, if the state pool has an agreement with a third-party administrator or a pharmacy benefit manager that pays for services on a per-claim or a per-person basis it is assumed that those costs associated with the federal enrollees would be reimbursable costs under the federal program. Is that correct?

13. Will outreach and marketing be an allowable cost?
14. Can each state decide whether it wants to pay agent referral fees or will HHS issue uniform guidelines about this? Many of the states now pay a nominal fee.

**Eligibility**

1. In order for a state to successfully and expeditiously implement the federal pool so that it creates the least amount of confusion for applicants, some risk pools would like to use a single application form and enrollment process for both the state and the federal pool. The goal of this approach is to assign applicants to either pool based on the eligibility criteria they meet. Are there any prohibitions against doing this, i.e., must we use a completely separate application form for the federal form? (Note: Requiring a separate form would create confusion in the market because the general public would not know which pool to apply for and would make it difficult to move individuals into state pools if they did not meet the federal eligibility requirements.)

2. Will states be able to use the list of preexisting medical conditions it currently uses for establishing eligibility in the state pool to establish eligibility for the federal pool? Or is HHS planning to develop a comprehensive list of conditions to be consistent across the country?

3. Can a state use its existing mechanisms for determining eligibility based on pre-existing conditions, such as rejection for coverage, quote for coverage that's above our qualifying rate or offered coverage with an exclusionary rider?

4. Will states be provided with guidance concerning how to verify an applicant has not had creditable coverage within previous six months? How can we verify a negative? Is this simply an honor-system based model? Will there be penalties imposed for falsifying this information?

5. If an individual was rejected for individual insurance in the private sector due to a preexisting condition and the person applies for coverage in the temporary high risk pool but the pre-existing condition that the person provides is not specifically, but possibly could be related to, a qualifying condition as defined by HHS, will the rejection or the relationship of the conditions be construed as being enough for qualification? In other words will the qualifying conditions be literal and specific without consideration of co-morbidity?

6. Is HHS going to issue further guidance on specifically what prior coverage makes someone ineligible for the federal pool? It appears that the definition of "creditable" coverage in the Public Health Act is not limited to "comprehensive" coverage, which would make someone who has had a mini-
med or limited coverage plan ineligible for the pool? Also, it appears that someone eligible for Indian Health Services is ineligible.

U.S. Citizenship and Residency

1. What are the program requirements for documenting U.S. citizenship and will they be uniform across states? Must proof of citizenship be determined before an individual can enroll in the federal pool?

2. The current standard to prove citizenship or legal status for Medicaid was established federally and is consistent across the country. So, if citizen/legal status is required, are we to use the same mechanism as Medicaid or can we use a less stringent mechanism, such as I-9 type verification? Is there a different standard of proof for Native Americans?

3. Will applicants need to be residents of the state offering coverage to be eligible? Or, will out of state persons be eligible to enroll?

4. Can a state use the same state residency requirement for the federal pool that it uses for its existing state high risk pool? Is there any prohibition on doing so?

Termination of Coverage

1. State pools often impose a one year waiting period for re-instatement in the state pool for enrollees who voluntarily terminate their coverage. (There are some exceptions for individuals who terminate because they obtain group coverage which they lose within 12 months because the company goes out of business or drops employee coverage.) Can we impose the same restriction on enrollees who terminate their coverage in the federal pool to ensure that individuals do not jump in and out of the pool?

2. If an applicant states they have had no coverage for last six months and sometime after enrollment we learn that they did have coverage which was voluntarily or involuntarily terminated less than six months prior to enrollment, do we terminate coverage under the federal pool? Recind coverage? Assuming they are otherwise eligible, can we transfer them to our state pool and impose a pre-ex waiting period? Is there a penalty of some sort imposed on the individual? What are the repercussions on brokers who might have facilitated the application knowing they had prior coverage?

3. How will situations where an individual has applied for coverage and been enrolled but the administrator later determines that the individual was ineligible through no fault of their own or because of misrepresentation by the
individual, omission of information that would have made them ineligible, or clerical error, etc. be handled if claims were paid before the error was discovered? Will the pool need to reverse the claims, bill the former member and reimburse HHS?

**Benefit Plan Offerings**

1. How much flexibility will there be with benefit design? Can a state pool use its current pool benefit plans and simply modify them to exclude the six-month waiting period? Is this an acceptable strategy or will HHS be issuing specific requirements for the benefit packages? If guidelines will be issued, how soon can they be expected?

2. Are there any additional benefit requirements for the health insurance benefits under the federal pool besides excluding a pre-existing wait period? Are there any requirements for lifetime and aggregate annual limits? If so, please describe.

3. How many deductible plan options will each pool be expected to offer? Other than the out-of-pocket limit specified in the legislation, will there be any requirements on the level of deductible to be offered?

4. Can one or more of the plans being offered by a high deductible health plan to be used with an HSA account?

5. If the state pool currently offers a more generous benefit plan (or one with a higher actuarial value) than what might be defined by HHS, can we offer the same plan to enrollees under the federal pool? If so, is the state liable for a portion of the losses attributable to the more generous benefits?

**Premium Rates**

1. Outside of the rating for geography, family size, tobacco use, 4 to 1 age factor, and standard rate/standard population; does the Secretary anticipate any additional factors?

2. Does HHS expect that each pool will work with its actuary and existing market survey data to set rates that are equivalent to 100% of the standard risk rate for comparable plan? Will HHS be issuing any guidelines for these rate calculations and if so how soon will that be available?

3. What will be the definition of a standard market rate? Will it be new business rates or average rates for policies in force in the state?
4. Does HHS have any actuarial data that could be helpful to the states in estimating the potential costs of new enrollees?

5. Please confirm that state’s can offer statewide premium rates that vary only by age as long as the age rating does not exceed 4:1.

Payment of Premiums

1. Some state pools prohibit a third party public entity or health care provider from paying an enrollee premiums for the purpose of reducing their own financial loss or benefiting financially from the pool? Could this be permitted under the federal pool? Alternatively, some states allow for it. Would this also be permitted?

2. Will HHS develop any regulations to prohibit payment/reimbursement of premiums by government agencies? Most state risk pools prohibit such payment/reimbursement of premiums so that publicly funding insurance programs do not cede risk to state pools.

Payment of Claims

1. What requirements will HHS establish for provider payment rates under the pools?

2. Many pools are subject to prompt pay laws and are concerned about how to manage cash flow, particularly if a catastrophic claim if filed very early in the plan’s operations. How frequently will payments be available to states? Will the funding be available to states before a claim needs to be paid?

3. Will there be special drug discounts for the new pools? For example, has the Secretary considered using her authority to qualify the risk pools as 340(b) entities? Such a designation would help extend the $5 billion to cover more individuals and would improve the affordability of coverage for individuals in the existing state risk pools and HIPAA eligibles who cannot access the new federal pool.

Care/Disease Management

1. Some state pools have mandatory participation in disease management or care management programs for individuals with particular diseases or medical conditions. Are there any prohibitions on doing this under the federal pool?
2. Will costs associated with administering care and disease management programs be an allowable cost for the pools?

Maintenance of Effort

1. Please provide more detail on Maintenance of Effort. Could you please confirm that “state expended” refers to state revenues appropriates by state governments for the operation of the pool? A related question was whether this requirement could be waived for the first year of the program if a state legislature would not be in session in time to ratify an MOE requirement in the next 75+ days.

2. If a state enacted legislative changes in 2009 in order to reduce the costs to the program including the state’s contribution, the federal law seemingly does not allow for the state’s law to become effective in the sense that the state is mandated to continue a minimum contribution to the state’s pool. Has the federal government given any consideration to this type of issue?

3. In regard to the maintenance of effort, what if the money available to the state does not equal the amount required at 2009 level? What will be the consequence to the state, from the perspective of the federal government, if those levels are not met?

Communications

1. Will HHS be communicating to the public the requirements and guidelines they are creating? Will you provide the high risk pools with language to use, messages to convey about eligibility, benefits, premium costs, etc.

2. Will the federal government “advertise” the availability of the new pool? Will it require the state to engage in this campaign as well?

3. Will the materials provided to members (e.g. outlines of coverage and other policy documents) and marketing materials be subject to HHS approval?

Federal Pool

1. If a state opts not to contract with the federal government, what steps will the federal government take to create an operational pool within that state? Will the federal government develop the plans itself and be the administrator?

2. Will that network take into consideration rural areas versus urban areas and the availability of providers?

3. Will the federal government consider contracting independently with insurers to create a network?
4. Will the federal government consider pooling the states that do not contract with them into a larger pool to keep claims and costs contained?

5. Is the federal government prepared to take consumer complaints and calls regarding the administration of the newly created pool? If the federal government is assuming the responsibility of the newly created pool, will it forward complaints to the state? Who will have enforcement responsibility over the conduct of the pool and the plans therein?

6. What will the reimbursement rates be for the providers?

7. Has there been any consideration to running the program via Medicare or Medicaid offices if a state does not contract with the federal government?

**Anti-Dumping Provisions**

1. How will the “anti-dumping” provisions in the legislation be implemented? Will this be a federal or a state responsibility?

2. Will HHS issue regulations and define what “discourage” means for purposes of this section of the law? Under state law, insurers are mandated to inform insureds that the state’s high risk pool exists and is available. Would the issuing of this mandated notation on a letter be considered a violation of the federal law?

3. Will HHS interpret this section to be broad in the sense of enforcement against not only the insurer and/or employer but an insurance producer as well who acts as the agent of the company?

**Pool Governance**

1. Does HHS have requirements surrounding how the new pool is structured congruent with the existing pool? We anticipate keeping everything about both pools completely separate.

2. Will HHS have any requirements on the governance of the new pool if it is administered by the existing high risk pool? Can both be governed by the same Board of Directors?

3. Will a state’s current system of running the risk pools be allowed to continue or will there be additional oversight?

4. Will the federal government be willing to extend immunity to our board members in the same manner the state statutes extend it to them now when they are conducting the business of the board?
Miscellaneous

1. Is state implementation required as of July 1, 2010, or will the date established for implementation be a certain number of days following issuance of rules and regulations?

2. Will HHS extend the time available to implement the new high risk pool?

3. Will HHS be issuing guidelines, responding to questions as decisions are made or will there be one target date for issuance of guidelines and answers?

4. Will HHS be issuing guidance on grievance and appeal rights and the required processes? Will external review be a required component of the process?

5. Is HHS advocating for continued funding of the state run pools through the existing federal grant program?

6. Does the PPACA apply to current risk pools since they are not licensed and are quasi-governmental? Under the PHSA, which was amended by the PPACA, a health plan issuer is one who issues health plans and is licensed. High risk pools are generally not licensed.
Questions from NASCHIP Member States  
Submitted to HHS on April 14, 2010

Eligibility

1. Does HHS expect the pools to utilize eligibility from the date of opening of the pools (i.e. July 1, 2010)? This will avoid any retroactivity issues and will establish a date certain for pool eligibility forward.

2. If an existing high-risk pool has a lifetime maximum, what happens to those individuals who reach the maximum? They would no longer have coverage under the state pool, they would not be eligible for the new high risk pool because they were not uninsured for six months and they would not be able to obtain insurance in the private sector because of preexisting conditions until 2014.

3. Will HHS permit states to establish effective dates that are one or more days later than the date a completed application was submitted? Many states make the effective date the first of the month following completion of application. Will HHS allow this practice?

4. Will the pools need to confirm that applicants are ineligible for employer-sponsored group insurance or Medicaid; or is a good-faith affirmation or affidavit from the applicant stating he/she is not eligible sufficient? To obtain affirmation would require additional steps of fully screening for Medicaid and requiring documentation from the employer, neither of which are within the usual and customary procedures for most pools.

Benefits/Coverage

1. With regard to age rating, some pools cover a very small number of policyholders that have not qualified for Medicare – that are age 65 or older. They have historically utilized the last band rate for these policyholders. Do we have to maintain this “last band rate” or may we establish an additional rating for this population? If so, would such band rating need to fall within the 4:1 age ratio requirement?

2. Please define “total allowed costs” for the purpose of meeting the requirement that the issuer’s share of coverage is not less than 65 percent of such costs. Please also confirm that the members “share” (not to exceed 35 percent) does not include premium.

Implementation / Funding

1. Will the administration consider contracting directly with an existing independent non-profit high-risk pool if the governor elects to do nothing; or would the administration
consider a competing proposal from such an entity if the Governor elects to create a new program not affiliated with the existing high-risk pool?

2. When does HHS expect to give notice of funding to each state and when it does what level of budget detail does HHS expect to receive back from the state (e.g. projected enrollment, claims and administrative expense and premium rates) and under what timeframe?

3. How will administrative expenses and capital and surplus reserves be established in order to immediately pay claims?

4. Will audit costs be considered an allowable administrative expense?

5. Will Medical Management (utilization review, large case management, disease management) costs be an allowable administrative expense?

6. How does HHS plan to handle “catastrophic” claims and claims run out?

7. Will HHS be purchasing reinsurance or stop loss coverage for the pool? Will it expect states to purchase such coverage?

Maintenance of Effort

1. We interpret the “maintenance of effort” to mean an actual appropriation distributed to the pool during the 2009 fiscal year and would NOT include other funding mechanisms such as assessments from carriers (not a state appropriation) or premium tax credits (not a direct funding to the pool). Is this correct?

Miscellaneous

1. Cancellation of policies for non-payment of premium, after notice, has been governed by state statutes – does HHS anticipate utilization of the same standards (i.e. state law) or will one set of national non-payment standards be utilized for this group?

2. The state pool now issues a policy coverage document that shows the pool as the “insurer.” Would the coverage document/policy issued for the federal pool program show HHS as the “insurer?”
Federal High Risk Pool via WSHIP – Potential/Conditional 90 Day Implementation Scenario
(Independent upon HHS Secretary’s responses to questions, federal funds for development/start-up, OIC/State requirements, and availability of resources)

**April**
- **Planning & Decision-Making**
  - Gather information & send questions to HHS
  - Develop general approach & principles
  - Attend mid-April HHS call with contact person
  - State / OIC Direction
  - WSHIP Board Action
  - Federal funds for start-up
  - Planning meetings with administrator & vendors
  - Legal, financial & actuarial analysis/input
  - State submits intent by April 30

**May**
- **Application Preparation, Submission & Approval**
  - Design benefits
  - Determine SRR
  - Define pre-existing conditions criteria
  - Modify policy & enrollment materials
  - Develop administrative policies & procedures
  - Receive application by early-May
  - Prepare application
  - Obtain reviews/sign-offs
  - Submit application by end of May

**June**
- **Implementation**
  - Receive HHS approval by early June
  - Set up and test operational systems
  - Modify accounting systems & reports
  - Implement Customer Service training
  - Print policies and materials
  - Update website
  - Conduct education and outreach

**Dates**
- 90 days - March 23
- 60 days - April 22
- 30 days - May 22
- 0 days - June 21

**Key Dependencies**
1. HHS funding/contracting mechanism and proposed approach known and acceptable by 4/23
2. State direction / WSHIP Board action / federal start-up funds by 4/23
3. Actuarial work available to begin 4/26 and can be completed by 5/7
4. Legal work available to begin 4/26 and can be completed by 5/7
5. BMI and Medco can operationally set up plan within a 10-15 day period
6. HHS application is received by early-May
7. Limited review of contracts, forms and rates prior to application submission
8. Expedited review of application by key individuals prior to submission to HHS
9. HHS approval is received by early-June