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Please stand by for realtime captions.

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Good afternoon. My name is Ava, training and education coordinator. I would like to welcome you all to December 2013 practice call title affordable care act, opportunities to reduce Medicare disparities. Let's go through a few housekeeping matters really quick. All lines will be muted during the call. The Q&A session will begin after the training portion of the call. Participants are encouraged to use the WebEx chat. If you miss anything, don't worry. We will post the slides and transcript on the website. Leslie, these are member to complete our valuation at the end of the call. With that, we will be led into introductions.

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Good afternoon to you while. We are having a little bit of white here in the East Coast but we know you all have suffered to the cold already. We are hoping this topic will warm things up. We are having a return visit with the moderator for our panel back in April for minority health month. We had so many questions about the affordable care act and it is such a well-designed law in terms of trying to deal with some of the health disparities, that we have asked her to come back and talk about things today.

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I'm going to introduce her, but we also have two members who were get QIOs. -- Potter and March from Kentucky and they are going to also talk a little bit about what is happening with the affordable care act in their states.

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We are going to realize that this does not specifically change things for our target population of Medicare individuals, but it will have impact in the future because so many more people will have had insurance. At the same time we recognize that there are some other things going on related to the act itself. With that, I would like to introduce rigidity this who is the associate -- Regina Davis. She's the director of the public health policy and practice Institute and she oversees a broad portfolio activities ranging from continuing education to global health. She has 20 years of experience managing disease prevention initiatives and addressing areas such as reproductive health, obesity prevention, health policy, and sustaining capacity in public health. She has a PhD in maternal and child health from the University of Maryland. Her and pH from George Washington and a BS in biology. As you may know, one of the three main goal areas for the American public health Association is held equity and she is having that effort. With that I'm going to turn the slides over to her.

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Thank you for joining us today. Let me say it's an honor to be here and speak to you while. I always enjoy coming together with colleagues to share and engage and make critical connections needed to advance public health.

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Today I'm going to talk about the affordable care act and the implementation progress or lack thereof. Also some of the challenges to implementation.

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[ Indiscernible - low volume ] for bridging long-standing disparities in the health care system.

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The patient protection and affordable care act which is called the affordable care act, ACA, or Obamacare on March 23, 2010, together with the education and reconciliation act represents the most significant overhaul of the US healthcare system since the passage of Medicare and Medicaid. It was enacted with the goal of increasing ability of health insurance, lowering the uninsured rate, and reducing the cost of healthcare for individuals and government. My presentation is going to draw upon the policy analysis of a couple of organizations doing some work in this area. We have been studying the affordable care act since shortly after the passage of the law and the health Institute has been monitoring the provision of the last cup of years.

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There are 60 provisions that are intended to advance health equity and that is directly by supporting and actions specific to diversity, language, access, or my probably by potentially affecting large numbers of linguistically diverse populations.

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First, there are several provisions aimed at improving recording requirements so no later than the end of this year, all federally funded grants and surveys such as the US Census Bureau are required to collect and report data on things like race, ethnicity, language, and other demographic characteristics which are identified as appropriate by the -- for reducing health disparities.

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They are also authorized to lead efforts to analyze data and monitor trends and the persistent stresses data mechanisms in federal state Medicaid programs in the children's health insurance program.

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There are also numerous reports that have underscored the importance in increasing diversity to reduce health disparities. We all know concordance between race and ethnicity has long been recognized as a strategy for improving the quality of care here they authorized and expand programs to improve diversity in fields like primary care, dentistry, and mental health as well as increase forgiveness opportunities for healthcare providers agree to work in communities that have a high need for health professionals.

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Have an emphasis on outrage on basically an academically diverse communities -- CL a S. These CLAS standards are a set of principles for healthcare organization serving diverse population. There are specific standards that have actual relevance for public health and prevention such as responsiveness to cultural and linguistic needs and the use of trained personnel in employing strategies for communication.

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-- And additionally authorizes HRSA to establish grants which is an explicit requirement of the program that the grantees must include information and education about and -- to healthcare populations.

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I know you all have seen reports that same certain populations are less likely to receive pain care management so this is definitely an issue of importance. Reauthorize the healthcare opportunity

program which supports individuals from disadvantaged backgrounds to graduate health professions program and finally the healthcare law -- by spending authority to award funding to colleges [ Indiscernible - low volume ]

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Studies had shown that persons of color are more likely to report -- to report experiencing poor quality and and this disparity is pronounced among individuals whose primary language is not English. The ACA attempts to try to address that and allocates five years of support to system development and dissemination of models that are culturally competent and also to create training and education curriculum. Support is also provided for cultural competence training for primary care providers, home care aide people working with persons with disabilities. The affordable care act elevates the office of the secretary and this is good because it extended their authority in terms of quantitative agreements but in addition, the affordable care act offer -- authorizes the individual minority health to keep federal agencies [ Indiscernible - low volume ]

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We know that research will not -- we enhance the development of the evidence base to reduce disparities and promote the national Center on minority health and health disparities to Institute status which gives it the authority to plan and coordinate and evaluate all disparity research within the national Institute of health. It also increases funding to the centers of excellence and supports collaborative research on corporate competence.

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It gives special attention to pain treatment of postpartum depression research which is a condition that affects African-American and Hispanic women, and the ACA creates the patient centered outcome research Institute to examine health disparities through comparative effective research. You conduct and synthesize systematic research and compare it within different strategies for an effort health conditions.

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The ACA also includes numerous provisions and education initiatives that offer opportunities to prevent premature death, disability, chronic disease. The law enhances the previously established maternal and child health home visitation program which is designed to make families to a variety of services beyond healthcare such as early childhood education, programs to prevent child abuse as well as education programs related to parenting skills.

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We also authorized an oral health education campaign to the CDC and the emphasis is on racial - racial ethnicity is because we see high rates

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The stress the importance of these which will also include pregnant women and the elderly racial and ethnic minorities include language that specifically says that services must be provided in a linguistically appropriate manner.

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I did want to note that Grace to all 50 states for the dental programs and improved data collection for oral health had been authorized but have not been funded.

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In addition to that the oral health campaign which focuses on health disparities has not seen any appropriations so here we are saying some of the unintended consequences of what is happening despite our best intentions.

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They also mandate drug labeling standards to improve patient decision-making and help meet the needs of the 7 million US adults with literacy and \$24 million with limited English proficiency. Additionally, support for decision aids and education programs that empower individuals to take responsibility for things such as STD prevention is also provided. We also make reauthorization of the health care improvement act on it as well as authorizing new programs within the health services such as long-term care or -- care to increase services available to American Indians and Alaska natives. Individuals like age in place so this is an effort to try to address those issues. In addition their efforts to reduce preventative illness as well as training Alaska native healthcare providers through what is called the community health representative program. We know that health insurance marketplace reform hold a promise to substantially reduce disparities and insurance that is, efforts are doesn't -- definitely necessary to ensure that they are linguistically isolated and take full advantage of the benefits for which there eligible. The ACA provides support for outreach efforts targeting low income populations. The ACA puts forth a mandate for nondiscrimination. It requires the outrage for the new national state health insurance to be quizzically appropriate and also requires [ Indiscernible - low volume ] and a summary of the benefits that are culturally and that was the appropriate and we'll specify that -- with limited proficiency be provided in a timely manner at no cost to the individual websites and other systems established by the state -- enrollment activities accessible to persons for whom English is not their first language.

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[ Indiscernible - low volume ]

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The health insurance reform for expanding access to health insurance is one of the general provisions of implications for minorities. Now I will talk about the more general provisions and about half of 50 million US residents are racial and ethnic minorities.

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One important provision is of course expansion of income eligibility for Medicaid but also requires employers with 50 or more employees to pay a penalty where we see a premium tax credit for purchasing their own coverage.

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Larger players are mandated to [ Indiscernible - low volume ] and small employees and average annual wages of less than 50,000 will be provided a tax credit. These policies have the potential to expand coverage for large -- and especially given over 90% of minority on firms have fewer than -- that is a great thing that we can now offer coverage to them.

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Optics changes are required to offer at least two multistate plans separately from the federal employee health benefit program and to ensure affordability of coverage and finally the affordable care act provides immediate access -- assistance would have been uninsured by creating state-sponsored high-risk insurance pools and providing subsidized premiums.

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This one shows how Medicaid covers expansion under the affordable care act and will dramatically reduce insurance rates among all of the ethnic groups. According to the Congressional Budget Office by 2019 there will be 22 million newly insured individuals and how these individuals will be ensured through programs such as advocate. The other half will be insured through the health insurance exchanges. There is debate about expansions but 15 million would be eligible and 45% or 6.8 million will be racially and ethnically diverse from other ethnic

groups. Unfortunately, as of November 22, 26 states including the District of Columbia, 26 are moving forward and 25 are not. We are talking about a couple million of who would lose out from this expansion and these are states with large minority populations so they are being disproportionately impacted.

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Moving on with general provisions, most of you know that having an insurance card is not enough to ensure access to timely high-quality healthcare and in fact we see in many communities of color, they are characterized by being medically underserved or disenfranchised communities. We offer number of provisions to try to address this by expanding funding for community health centers that I want to note that 10 million will only be served by 2015 as opposed to the estimated 20 million that would have been served at the federal A discretionary funding. The law expands resources to provide oral and behavioral services and additionally the law expands funding for the national health services core. The law has authorized health centers, health clinics, and community health teams. It seeks to create a medical option for Medicaid enrollees with chronic conditions. We are seeing a frequent concentration of services in these areas but the new law also provides for funding that can of eluate innovative models for emergency care systems so they are trying things such as regionalization of emergency care to try to get some of these issues, particularly in those world populations. Something like this could significantly expand access to care but some of those diverse communities as well as historically diverse areas with limited resources and capacity.

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There are also a number of provisions intended to print -- improve quality of care. The ACA authorizes the Secretary. to create a national strategy for quality improvement that will improve the delivery of healthcare services, patient outcomes, population health overall. In addition, the agency for healthcare quality [ Indiscernible - low volume ] and awarding grants and contracts to improve and update quality measures

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It also includes support for Medicare and Medicaid pilot demonstration programs to align payments of quality rather than -- of care and finally the law authorizes the creation of a new office within CMS to improve care coordination for dual eligible. This could potentially improve continuity of care but upon -- for approximately 1.2 million elderly African-Americans were dual beneficiaries of Medicare and Medicaid.

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The law includes a number of provisions to try to get a cost-containment. The ACA considerably reduces Medicare and Medicaid to share hospital payments and the law supports access to drug rebate programs which could potentially improve compliance with physician recommended regimens. It also [ Indiscernible - low volume ] -- for interoperable systems of enrollment, provides grants to state and local government for implementing information technology for enrollment, access policies to reduce fraudulent claims and waste in public programs. In addition, the portable care act authorizes \$25 million in funding for demonstration projects that reduce childhood obesity and targets ethnically diverse and low income children. We first saw this described in 2009 children's health insurance program reauthorization act but it is good that we are seeing this in the affordable care act.

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Also working with that -- increase non-surround breast cancer. This is called the education and awareness earning act and provides funding for breast cancer campaign for young women's of

these are women under the age of 40 and the goal is to improve knowledge of health among women of all backgrounds who have -- such as familial racial and ethnic backgrounds.

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It helps participants understand good habits and the availability of health resources for women with breast cancer and evidence-based strategies among other things. The education campaign is intended to include national media campaigns and will include billboards, television, radio, print ads, and other mediums. The CDC is working with the secretary to undertake education campaign targeting positions of health nationals so they can also be involved with educating their patients particularly around counseling for those with family history. We do see certain populations that suffer from disproportionately more in terms of deaths from breast cancer and providing counseling around long-term survivorship in other areas. The affordable care act mandates the creation of the national diabetes prevention program and this is to support community-based initiatives. This contract -- this includes proper training and outreach for intervention instruction as well as for monitoring of valuation. The law does not include explicit language related to diverse populations but it specifies that the program be tailored to adults at high risk for diabetes and as we know, this includes populations such as American Indians and Alaska natives.

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Moving on to other public health initiatives, the affordable care act enhances the personal responsibility and this offers support for abstinence and contraception learning education to prevent pregnancy and STDs among minority groups that are particularly at risk. Of course the ACA establishes the prevention and public health fund so this authorizes, the secretary enhancement funds beginning it is clear 2010 two programs for prevention and wellness and public health activities. These activities must be intended to improve health and control healthcare costs. Just a little bit -- was primarily spent on infrastructure

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-- Community health program or reach program and national prevention programs. In fiscal year 2013, funding was reduced across all categories would represent significant reduction in the critical programs and services prevention. Immunization, mental health as well as home equity. [ Indiscernible - low volume ] over nine years beginning in fiscal year 2013 and a decline that sequestration increased by 51 million as of April 2013, 453 million was used to supplement insurance involvement activities for the marketplace and these and natural production; to question whether public health prevention fund will be able to achieve the initial goal of significantly reducing rates of chronic disease and controlling healthcare costs.

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We will authorize the prevention and promotion of public health Council which is a federal interagency group established by the president. Is charged with coordinating federal efforts and health promotion, prevention and wellness, developing prevention strategies and making recommendations to the president and Congress regarding federal health priorities. In June 2011 the prevention Council was comprised of about 17 federal agencies and they released a national strategy that emphasizes optimal health but should not only come from medical care received in hospitals or clinics should also be addressed through improvements in clean air and water and safe recreation areas and workplaces. We are seeing the holistic approach to addressing health. The ACA also -- task force with developing topic areas for new interventions as well as making recommendations to address health to consider the specific population and age groups as well as the social economic and physical things that can have broad effects on health. The task forces are

product -- required to report gaps of research and provide recommendations on an annual basis and they also review the health effects at least every five years and using health impact assessment.

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The ACA rewards grants being a resource of funding for prevention of public health in these are state and local government agencies as well as a few community-based organizations to reduce rates of chronic disease and health disparities through community level prevention program. The activities are really intended to focus on community improvement strategies such as ensuring healthier school environments and improving access to safe foods and encouraging healthy food options at restaurant. -- Underlying the racial and ethnic disparities.

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If this -- it specifies that no less than 20% of the grants be awarded to recipients in world areas. The law authorizes funds as necessary for this provision for 2010 to 2014 and lists as possible activities, things such as prioritizing strategies to reduce ethnic disparities and adjust special population needs including all age groups.

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I spent a lot of time talking about various provisions. There are roughly 60 or 50 to be exact and now I will talk about the progress of what these have been over the last three years. If we take a look at this, we will see that I have tried to group these into five categories to make this a little more manageable but you will see where they are are some interesting find the and I definitely have to credit health Institute in Texas because they have been great and monitoring a lot of these provisions.

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The first one I think is interesting is the focus related to the health equity and affordable care act which has been on workforce diversity.

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There are 19 provisions that specifically address cultural competence he and other areas as well, but I think that is a wonderful thing in terms of preparing us for all of the people that will be receiving insurance. In terms of progress, nearly half of the provisions with major implications for racial -- racial and ethnic communities have been authorized in the past three years. They have either received near full appropriations and federal governments has come forth and has been established. We are talking about the first two columns but now I want to dig down a little deeper and the not so good news is about 30% of provisions have seen some progress and many of these do not receive sustainable funding for the funding was significantly reduced. It is really unfortunate is that one forth the provisions have not seen any progress in terms of funding or other actions.

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To give you an example of some of the provisions in all the various categories, with regard to those that received full or near full funding or final regulations or rules have been issued or have successfully established new offices that are operating, those include many of the cultural and service requirements particularly with regard to the exchanges. There are final regulations issued around that and support for the primary care workforce, the CMS innovation centers, the release of the data collection centers for disability status allows us to track where we are in terms of addressing health outcomes in and visiting programs and the grant for the prep programs.

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Many of these are funded through mandatory dollars. In terms of the provisions that have received considerably less funding than was authorized by the ACA or have not -- have only -- issues are established offices task force that are generally underfunded, and or not operational, this is many of the minority health professions programs which really saw steep cuts in funding. One example is the healthcare opportunity program which I talked about in this is really a vital pipeline that has seen some money but declining support. Now going into 2014 it is going to go to zero. So these are things that we need to keep our eye on. Many of the health centers, the Indian health care improvement act which was also reauthorize, left with little to no funding. We are also seeing -- community transportation -- transformation grants are seeing a decline in the centers for excellence has not received nearly the funding that it was intended. In terms of those problems that were not funded, or have not seen an effect -- federal regulation, there has been a delay in the dish payment cuts. These have been postponed by one year that is not -- secondly a good thing potentially because it will allow more time to review the impact of -- affordable care unless the feds, but something that will reduce the adverse unintended consequences. We know we have to address this populations. I talked about the lack of funding but there has also been low funding

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With regards to ramping up the primary care workforce we saw that a lot of efforts with their and ensuring that they have the capacity. We know there's going to be a great influx of patients and generally speaking, both generally but also in terms of seeing that among racial and back -- ethnic minority groups. We have to ask if this is enough and if we are ready. We already know we have a shortage and providers so this is something that we really need to consider. We are seeing that it is an area that is definitely getting some support, but there is -- and continued support for national health services program. There has also been a redistribution of unused residency spots to underserved how professional shortage areas. We are definitely seeing some support their but we know there was some discretionary funding setbacks and we just have to keep moving forward. There is expansion and support coming through for the health centers and a lot of investment in payment and innovation many which are addressing and reaching out to diverse populations. As you can see, the provisions related to health equity advancements and health disparities have made it into law. There is progress in terms of implementation and declining funding in many cases. Good news, not so good news, and unfortunate news. Unfortunately a lot of the provisions related to health equity fall into discretionary funding category and are not currently funded were underfunded.

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We just want to give you a two-minute warning.

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These are some of the challenges. Despite whatever happens we know that health professionals have to continue to be providers and for the undocumented, they will have to deal with insurance volatility as income fluctuates, they're going to be moving back and forth in terms of coverage. They may not have any kind of coverage. What we are hearing is that this is a challenge because they have to deal with continuity of care and also administrative challenges. There are also challenges related to funding and sustainability. While new funding are a promising start, health disparities and budget cuts to the prevention of public health and sequestration continue to challenge programs funded for the affordable care act. Local and state health parts have smaller budgets and are really struggling to fulfill required duties and objectives.

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We talked about the health care improvement act and they have existing efforts which will continue but they made not be able to fulfill their potential because of limited funding and appropriations. Data collection and evaluation have presented long-term challenges so we just kind of have to continue to address that there is a limited timeframe usually to address these sort of and prevents, so it is difficult for us to contribute to that evidence base because things like obesity and diabetes can have challenges. Certainties around the rollout of the marketplaces and opposition to the law in general, in many states we are seeing that dashes some of the efforts are not supported and some are really difficult to advance health equity. What that looks like it states that are not expanding, these will fall through the cracks and nearly 60% of those Americans that fall below the expansion limit reside in those states that are not expanding. We have a high number of diverse populations that are not going to be served to the states that are not expanding. We can't forget about those undocumented immigrants who will remain off the table. Of course continued misinformation around the law, there is confusion amongst people who do not know what to do as well as the issues that we have to contend with.

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Despite all of this there are definitely some windows of opportunity that are emerging because of the long. It is clear that equity is embedded as part of the long so we have to deal whatever we can to support the implementation. There is quite a bit of correction as well as provisions to encourage collaboration. The national prevention strategy and the counselor to try to address this approach and increase the focus on the community level which resents an opportunity to reduce fragmentation of funding and would receive the direct funding, to break down that effect that we've seen does a lot more flexibility in terms of targeting goals for improved health. Provisions in the law

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-- The points to the lot in terms of community based initiatives and 50% of the grants have to target African-Americans and Latinos populations. Finally, this is what providers have already faced, they're going to have to play more significant [ Indiscernible - low volume ] which is really an opportunity to educate individuals about their health.

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As you can see the affordable care act has created -- for breaking new ground but we have to continue along this path. Why would you ask that we need to do that? We are rapidly becoming a diverse nation and half of all babies born are nonwhite. 40% of young people are people of color and by 2014, one out of two people in the United States will be a person of color. There are states with minority populations greater than 50% and nine -- those of drug the list by 2020. When trying to convey is that soon there will not be a majority population. The health of our nation will really determine the overall health status for us. We cannot continue to allow disparities and allow subpopulations to be sicker than others. If the human argument is not good enough, think about the economic consequences of for our country. We lost over \$200 billion over a four-year period as people were too sick to go to work or for lost wages or lost business productivity.

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They will be supporting us in retirement so there's no question that there are communities that are going to benefit from the implementation of the affordable care act, but we need to continue to focus on policy to ensure that these communities are able to benefit from the law and that these gaps do not widen and we do not is the products we've made so far.

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Thank you for your time. I look forward to your comments and questions at the end of the webinar.

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Next we will have Rick Potter from the health services advisory group of California and I'm going to go ahead and pass the ball to you.

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Would you like to give me a time limit?

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If you could keep it under 5 min. please.

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Okay, good afternoon everyone. With all of that great stuff -- great stuff, I look at it in two steps. The first thing we want to talk about is that you have to get people and world to begin with. Once they are enrolled, just getting unrolled won't enough. That you have to make sure the care is reduced so it -- for care and diversity. Let's start first with how California is doing in terms of enrollment. -- On the time this was taken,

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This recovery teleprinter marketplace. It got off to a great start in getting people and world. There are 5.3 million uninsured Californians that are eligible so we have a long way to go. Of that, -- [ Indiscernible - low volume ] but didn't because of cost may be more enticed to do this. It -- in terms of who unrolled, we saw from one of the last slides that you have California were people identify themselves as white are the minority of the population. We have 40% identified as white and 50% of Latinas making up almost 30%, Asians, almost 6%.

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In terms of how we are enrolling, we will do that will make it to the slide after that. Let's take a look at terms of enrollment. The 35 to 64-year-olds are overrepresented. That is only 39% of the population but there is 79% of the enrollees that we have so far. If you are looking at it from, those other people are getting care, then we have a better opportunity to get some preventative services and looking a lot better when we put them into Medicare. When we take a look at enrollment, it is getting unrolled and keeping them unrolled. Is if the -- continues to be the majority of whose unrolling, the premiums going forward can be increasing which make it to the point of people dropping off.

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In terms of the language that we have of people and rolling, this is a little discouraging because for those that have enrolled, 85% identify as English-speaking even though that is 56% of the population and Spanish speakers at 3%, California representation is 29%. There will be a lot of work they're going to get materials out there to bridge that gap.

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By region, we really just want to say we are getting more urban and regional areas that we need to do. Challenges and impact, as dollars maybe going up based on the mix of people that stay in the exchanges.

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As you know, President. Obama asked states to go ahead and change those plans which are ones that did not meet the basic requirements, they were eliminated. California was one that didn't. So we have a 1.1 million policyholder that have lost their insurance have to come back, so we have to make up for those that will not have those plans.

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In the interest of time, there is another challenge that we have you're not penalized for signing up for insurance as it is with other populations. We have to look at incentives for them to enroll. In terms of opportunity, people editor eligible, 39% of applicants. Why that is important is that the cow -- Medical is going to manage care in the world areas of the state they will have most of their population enrolled in the managed-care program. They are held accountable for performance measures in terms of preventative types of outcomes like immunization rates. If we get people into these Medi-Cal plans you have the state taking a look at the type of care being delivered and in particular, they don't look at health care of the plant level, they go by Levels of this gas survey type of information to get better data at a more detailed type of level which will allow us to make changes seeing the type of care that is delivered.

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What I'm going to do is finish here because I am running late.

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I know we're going to be running out of time. I want to mention this for Medicare beneficiaries, the ACA to allow improved access for preventative services, mammograms, prostate exams, etc. That help to lower Medicare premiums which are Dr. visits and other things. They actually decreased in the premium for 2012, I think it was under \$100 which was \$700 lower than projected and the monthly programs and premiums was also lower than what is being projected. Additionally, doughnut hole coverage which referred to in place and subscriptions with people for -- for people with out-of-pocket cost, it is being eliminated it will be completely gone by 2020. Because of the discounts offered under this, about \$900 in savings for each beneficiary in California is accruing.

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I will bring this back to you.

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Our next speaker is Margie.

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Thank you, I appreciate that. I will click along and get us going here. I'm going to talk about the success of rollouts of health insurance exchange. The approach and methodology that was used in was very linear and I think the timeline up so you can get an idea of how the state went about creating this. In terms of disparities there was a very conscious decision to get to the basics and be very aware of the demographics of our state. This was written at a six grade level for example. They have also hired -- to assist folks with choosing the right, helping them navigate the website so they can sign up. Our exchange is fully supported by the governor of the state of Kentucky who actually wrote an edit in the New York Times editorial. I have those links at the end of the presentation if you would like to read some of these articles. As of five December, approximately 100,000 in -- -- are uninsured it was successfully launched on October 1 and the 28th of the month, 26,000 Kentucky natives had enrolled and 20,000 to start the application process. The impact that we are seeing is the statewide worker and we share successes. This is made up of the QIO and the governor's office health information, the candidates for Health and Human Services, Kentucky fried information exchange and both the regional extension centers, we put a story in here about one of the enrollees who was struggling and did not have health insurance, he was struggling to get on about which plan she needed, I have the full impact storage and as far as talking about how ACA SX beneficiaries, our coverage, the average savings are \$928 and that comes out to 1.8 and that comes out to \$1.8 million and for the entire state of Kentucky.

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Here are the resources where in particular the last one is a conglomeration of interviews with folks who have enrolled and experiences with connectors and why this has been more successful in the state of Kentucky. If you have any questions, feel free to contact me. And I'm going to turn it back over to you, a that.

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Now we are going to open the line for questions and you can go ahead and handle that.

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Are you there?

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We do have a question that came to the chat room and the question is, how is the a PHA supporting [ Indiscernible - low volume ]

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And actually just coverage for several decades -- and ethics to care [ Indiscernible - low volume ] the guiding principles, that is how all of our programs, they also got our advocacy work, it is that we have -- are consistently invited to the White House and try to provide input on various conversations and make sure that public health have a place at the table and always weighing in at the various points when funding appropriation periods, under attack.

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Thank you. Did we have any more questions?

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There are no more questions in the chat.

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Participants can queue by pressing one followed by the four.

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We have no when the queue.

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First the -- will launch for groups in January 2014 with topics ranging from behavioral health, community engagement, and please contact the names that you see up there if you're interested in those groups.

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The NCC is excited to share your success stories on the website so if you have any shortest is there -- share please e-mail me. Also about the CMS websites, these will be updating to include a virtual training page. So please be on the lookout for this new format for all virtual training materials. This is to keep current on anything that -- does, please sign up for our list. If anyone has any more questions, please feel free to use the session and we will open office hours next week. Thank you everyone for joining us and these are never developed the evaluation at the end of the call.

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This concludes today's conference call. We thank you for your participation and we ask that you please disconnect your lines. Have a great day, everyone.

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[ event concluded ]