



Indian Health Service

**National Indian Health Board
2013 Annual Consumer Conference
August 27, 2013**

Indian Health Service Update

by

Yvette Roubideaux, M.D., M.P.H.
Acting Director, Indian Health Service

Good morning. I am Dr. Yvette Roubideaux, Acting Director of the Indian Health Service (IHS). It's great to be here with you today at the National Indian Health Board's (NIHB) 30th Annual Consumer Conference.

Today I will provide an update on the work we're doing to change and improve the IHS, with an emphasis on how the Affordable Care Act (ACA) impacts our reform efforts. We're working hard, in partnership with Tribes and tribal organizations, to improve our ability to provide quality health care services to American Indian and Alaska Native people.

We need and appreciate the input and support of all of you as we work together to change and improve the IHS and to implement the ACA.

One question I hear frequently is "why should American Indians and Alaska Natives (AI/AN) care about the ACA, especially when they have IHS"? Well, first let me make it clear that that IHS is still available as a health care system that our patients can use for their care. It was made permanent with the permanent reauthorization of the Indian Health Care Improvement Act (IHCIA) in the ACA; therefore, IHS is here to stay and eligibility for IHS has not changed at all. The reason AI/ANs should care about the ACA is that it brings additional options for health coverage that represent an extension of the federal responsibility for health care. It means more choices and more health coverage options for individuals, including affordable insurance and the expanded eligibility for Medicaid.

And if our patients continue to receive care at IHS, that could potentially mean more resources through third-party billing, which could also mean more services for your local facility/community. So we hope all AI/ANs will explore their options in the Health Insurance Marketplaces beginning October 1 and find out what new benefits are available to them.

The ACA will definitely have an impact on the IHS budget. We know that the budget is a huge factor in our ability to provide the services our patients need. It's clear that a lack of adequate resources is a huge barrier to fully meeting the mission of the IHS. Many of the challenges and issues we struggle with at the IHS are related to the lack of resources.

The text is the basis of Dr. Roubideaux's oral remarks at the NIHB 2013 Annual Consumer Conference on August 27, 2013. It should be used with the understanding that some material may have been added or omitted during presentation.

So advocating for more funding has been a top priority. But in addition to our appropriated funding, IHS also depends on revenues from third-party resources, such as private insurance, Medicare, and Medicaid. This can amount to a significant part of our budget; in some facilities, almost half of their budget comes from third-party reimbursements. So if the ACA means potentially more resources for IHS, you can see how important those resources would be.

The third-party resources that the ACA may bring to the IHS are especially important since our budget from congressional appropriations is of more concern these days.

It seemed like we were on a roll prior to this year. We've received increases in the IHS budget each of the last 4 years. Overall, the IHS budget authority has increased 29% since fiscal year (FY) 2008. The IHS budget last year, in FY 2012, was \$4.3 billion.

Within this increase, there have been some significant targeted increases, including the 46% increase in Contract Health Service (CHS) funding, which has made a difference. Almost half of all federal CHS programs were able to fund more than Priority 1, or life or limb referrals.

For example, this increase in funds, along with concentrated efforts to improve their CHS program, resulted in an increase in orthopedic care for patients at the Shawnee Service Unit. In 2011, the deferred referrals for orthopedic care were more than the approved referrals. However, with the increased CHS funding in FY 2012, the number of CHS referrals increased, and the approved orthopedic referrals were much higher. So more resources do make a difference.

However, the FY 2013 budget this year is a different story. The final IHS FY 2013 budget authority is \$4.1 billion, which is lower than the FY 2012 budget of \$4.3 billion. The FY 2013 budget includes an increase of \$53 million for additional staffing for new health care facilities that have been constructed, which is great. But it also includes across-the-board rescission cuts of \$8 million and sequester cuts of \$220 million.

IHS is engaged in extensive implementation efforts to absorb the cuts associated with sequestration on the federal side. However, the impact is significant: reduced services, denied referrals, and a significant change in the way we're doing business. We're doing everything we can to protect the IHS mission to the greatest extent possible.

That's why we appreciate the President's budget proposal for FY 2014, which would get us back on track. However, the House and Senate have proposed their budgets, and with the continuing debate on the budget deficit, it looks like we might be headed for a continuing resolution starting October 1. It is unclear what our funding level would be at this time, which of course makes it very hard to plan ahead. We hope the budget will be resolved soon.

For FY 2015, the administration is working on its budget formulation process right now. And we anticipate starting our Area budget formulation process for FY 2016 in October. I encourage you to attend and take part in the discussion about budget priorities.

We value input during the tribal budget formulation process. At the annual Department of Health and Human Services (HHS) Tribal Budget and Policy Consultation, the Tribal Budget Formulation Workgroup presented their recommendations for the IHS budget and had a session with Secretary Sebelius to discuss their budget and policy priorities.

I am so grateful that HHS makes the IHS budget a priority. Even with all of this support for the IHS, it's still a difficult budget climate. So we have to do everything we can to maximize our revenues, whether they're from appropriated dollars or from third-party reimbursements. The ACA has the potential to help us on the revenue side of the budget.

Despite all this uncertainty about the budget, we also need to keep focused on our efforts to change and improve the IHS, guided by our four agency priorities. Our work on these priorities will also help us with implementation of the ACA.

Our first priority is to renew and strengthen our partnership with Tribes. The only way we're going to improve the health of our communities is to work in partnership with them.

Working to improve tribal consultation is an important part of this priority. We've done a lot to improve consultation at the national, Area, and local levels and use a variety of forums for consultation and listening. Many of our discussions are now focusing on the implementation of the ACA, including preparations for the Health Insurance Marketplaces.

I recently attended the inaugural meeting of the White House Council on Native American Affairs, which was recently established by Presidential Executive Order to convene federal agencies to better collaborate on tribal issues. The meeting was held in the Indian Treaty Room in the Eisenhower Executive Office Building at the White House and included several Cabinet Secretaries, including HHS Secretary Sebelius and Department of Interior Secretary Jewel, who serves as the Chair. This Council now will give attention to tribal priorities at the highest level of government. And in a listening session with Tribes before the meeting, health was one of those priorities, including help with implementation of the ACA.

Tribal consultation is a major activity for IHS because we need to understand the priorities and issues of the communities we serve. For instance, we recently held a Bemidji Area Listening Session at the Midwest Alliance of Sovereign Tribes meeting. I also meet with tribal organizations on a regular basis, such as the recent NIHB National Tribal Health Summit. Congratulations NIHB on a successful meeting!

We also hold individual meetings with Tribes, such as our recent Tribal Delegation Meeting with the Redding Rancheria at IHS headquarters.

Tribal consultation has been extremely important as we prepare for the ACA. The ACA always comes up as a topic in our discussions with Tribes; they tell us they want to make sure that our patients and our system can benefit from the new law as it is implemented.

We've conducted a number of tribal consultations in the past few years, and we've concluded or made decisions on many of these. I would like to highlight three of them today.

The first is the consultation since 2010 on improving the CHS program, which is how we pay for referrals for services in the private sector. We've consulted with Tribes on how to improve the referral process. One of those improvements has been making online CHS training available on the IHS website.

We've also made significant progress on gathering better data on CHS denials and deferrals. For FY 2012, the shortfall for CHS was \$973 million – almost a billion dollars of need beyond our current level of funding. That's why CHS is a priority in budget formulation, since this impacts all Tribes. We also recently heard a recommendation from the workgroup to keep the CHS funding distribution formula the same. The CHS workgroup has made some very key recommendations for improving our CHS business practices.

We appreciate the work of all those who are helping with this important effort.

The second consultation is on the Department of Veterans Affairs (VA)-IHS Memorandum of Understanding (MOU) that was signed in 2010, and the recently signed VA-IHS National Reimbursement Agreement.

Tribal consultation was critical to the completion of the final agreement, which includes the tribally-recommended all-inclusive rate for outpatient services provided to AI/AN veterans who are eligible for IHS and the VA.

We're actually making progress in improving coordination of care for veterans eligible for IHS and VA under the MOU, and can now bill the VA for direct care services provided to Native veterans. The initial 10 federal sites are now billing the VA and receiving payments from the VA! That's more dollars for services for everyone served by the facility.

We're implementing the billing process in all our other federal sites right now. I know that the tribal sites are also entering into agreements with the VA and receiving reimbursements. Let us know how it is going for you.

The third consultation I wanted to mention is on the subject of Contract Support Costs (CSC). IHS has been working since the Ramah decision on resolving past claims with a focus on settlement if possible. We are settling claims and making progress on our case management plan developed with tribal and federal lawyers for the Civilian Board of Contract Appeals. We have two options now – the traditional approach to settlement of claims, which involves exchanging information to reach agreement on the number for settlement, and the new alternative approach, where Tribes can opt to receive a one time, non-negotiable settlement offer from IHS. If they like it, we are done, and if not, then we can go the traditional route. We've already settled some cases, and have many in progress. I believe we're getting closer to agreement on the calculations that lead to settlement, so progress is being made.

The administration has also heard that Tribes do not like the proposed new appropriations language in the FY 2014 President's budget, and the administration is currently consulting on a more long-term option for CSC appropriations. The challenge is how to fund several top tribal budget priorities in a difficult fiscal climate. We're interested in hearing your ideas for a more long-term solution during the upcoming tribal budget formulation process.

Our second IHS priority is "to bring reform to the IHS." This priority has two parts – the first part involves the ACA and the IHClA. The second part is about internal IHS reform.

I will focus most of the discussion here on the ACA. The purpose of the ACA is to increase access to quality health coverage for all Americans, including our First Americans. I hope you already know that the benefits of the ACA for American Indians and Alaska Natives are significant. They can benefit from all the reforms, whether they have insurance now, want to purchase affordable insurance through the "Health Insurance Marketplaces," or can take advantage of the Medicaid expansion starting in 2014. Indian elders will benefit from how Medicare is being strengthened with more affordable prescriptions and free preventive services. We know that some states are not choosing to expand Medicaid, but we hope they change their minds soon. The expansion means that more low income adults can get health coverage.

And of course, we're thrilled that the IHClA, our authorizing legislation, was made permanent by the ACA. So IHS is here to stay.

The ACA is about options for health coverage in addition to access to the IHS health care system. Right now, about 23% of our patients have private insurance, usually as a part of their job or as a part of benefits from their Tribe. This means that when they come to us for a health care visit, we can bill their insurance, which means more resources at the local level for services for all patients.

The same is true for other coverage. About 38% of IHS patients are currently on Medicaid. With the ACA and Medicaid expansion, many more of our patients may be eligible for Medicaid since the qualifying income is being raised to 133% of poverty level, without any other conditions needed to qualify. Medicare and the VA account for a smaller portion – less than 10 percent – of the health coverage that our patients have, but they also bring in more resources.

However, a good proportion – approximately 30% – of our patients have no health coverage other than IHS. This is the group that may benefit the most from the ACA. In fact, we estimate that we could see up to an additional \$95 million in third-party collections in FY 2014, mostly from the Medicaid expansion. So making sure our patients understand their choices related to these new benefits is critical.

An important date is coming up soon – October 1, 2013 –that’s when enrollment begins for the ACA Health Insurance Marketplaces and the Medicaid Expansion. It’s especially important that everyone understand what new benefits are available now and in about 35 days from now.

The key thing that you need to know is that the Health Insurance Marketplaces, whether run by the state or the federal government, will be a way for individuals to purchase more affordable insurance if they are interested for any reason, such as not having employer-sponsored insurance. Or they can enroll in the Medicaid expansion in the Marketplaces where the state has decided to expand.

While enrollment starts on October 1, the coverage will start January 1, 2014. This means that starting on October 1, American Indians and Alaska Natives will have more choices related to health coverage. We want all AI/ANs to enroll just to see what benefits are available.

The ACA makes some important improvements to private insurance. Before the ACA, many AI/ANs could not afford to purchase insurance, with or without it being available as a part of a job, because the premiums were too high, or they could not afford the copays or deductibles when they used their insurance, or they may not have been able to get insurance due to a pre-existing condition.

Now, with the ACA, individuals can enroll in the Health Insurance Marketplaces and see what options are available to purchase insurance. With the new tax credits for premiums, and the new waivers of copays and deductibles for AI/ANs if they use IHS, many people might realize that health insurance is now very affordable, and estimates are that these costs will be much lower than anticipated. The benefits are also now better with the requirement around “essential health benefits,” and there will be no exclusions based on pre-existing conditions.

So it is important that all AI/ANs enroll starting October 1 in the state or federal Marketplace to see their options. They might be pleasantly surprised that they are newly eligible for Medicaid, or suddenly can afford health insurance. There is also a benefit that allows AI/ANs who are members of Tribes to enroll on a monthly, rather than just a yearly, basis. That helps if life circumstances change.

And if more people who go to IHS are covered by insurance, it helps stretch our limited CHS dollars and gives patients more choices around referred care.

Individuals can apply or enroll in the Marketplaces through a number of different ways – by phone or mail, online, or in person. They can submit an application to the Marketplace, which will determine their eligibility to purchase insurance and verify whether they qualify for premium tax credits or cost-sharing reductions so that they don’t have to pay copays or deductibles when they use their insurance. They can also determine if they are eligible for Medicaid. It’s important to encourage everyone to enroll to see the types of benefits for which they may be eligible.

There are special provisions for American Indians and Alaska Natives who are members of Tribes, as I mentioned before. They won’t have copays or deductibles if they go to the IHS, or anywhere if their income is below a certain level. Given the tax credits available, AI/ANs may be able to pay very little in premiums for insurance after they determine their eligibility. And they have the option to enroll on a monthly basis, not just once a year. So everyone should at least take a look at their individual eligibility.

There will also be a way during the Marketplace enrollment process that our patients can determine if they meet the exemption or can apply for a waiver from the mandate to have health coverage. This relates to the “definition of Indian” in the ACA.

You may have heard about the “definition of Indian” issues related to specific benefits of the ACA. First, let me make it clear that IHS eligibility is not affected by this and will remain the same. The definition of Indian in the ACA currently impacts two areas of benefits related to purchasing insurance – access to monthly enrollment and waivers for cost-sharing, or co-pays.

The challenge is that the ACA definitions of Indian are similar to the concept of “only members of Tribes,” which is a narrower definition than IHS eligibility, which includes members and descendants of Tribes. During tribal consultation on this issue, Tribes in general have said they want the definition of Indian in the law to be similar to IHS eligibility. However, since the definitions are in the law, it will take Congress to fix it. HHS has been giving technical assistance to Congress on this issue.

The definition of Indian issue also impacted who was exempt from the minimum responsibility payment if they didn't have health coverage.

The good news is that HHS recently announced that all AI/ANs who are eligible to receive services from IHS can apply for a hardship waiver to exempt them from the minimum responsibility payment under the ACA. Prior to this exemption, based on the specific definition of Indian in the ACA, only tribal members would have been exempt from the requirement to maintain minimum essential coverage under the law. Our tribal partners were essential in this policy in place, since this decision reflects the comments and feedback received from Indian Country.

While this is great news, we still need to work with Congress on corrections to the ACA definition of Indian for the monthly enrollment and cost-sharing waivers.

It's important for everyone to go to the Marketplace to determine the benefits available to them and to apply for the hardship waiver if they don't have health coverage but are eligible for IHS. While they're there, they may discover that they are eligible for more affordable coverage or are newly eligible for Medicaid.

So in addition to the normal eligibility rules, there are special benefits for AI/ANs who are members of Tribes and/or eligible for IHS.

Our patients are likely to need help with this because, as you can see, it's complicated. There will be people to help – there are various ways that groups or individuals can assist people during enrollment in general. There are organizations funded by the state or the federal government to assist individuals with enrollment, and there are individuals who, as a part of their job, will be available to help individuals with enrollment. They are likely to be in health care or community settings.

At IHS, we're working with our local IHS staff, including those in the business office, to help assist our patients. This is especially important because many of our patients who have used IHS their entire lives may not be familiar with insurance. They also may not realize that they are eligible for special benefits.

The Centers for Medicaid and Medicare Services (CMS) is making online training available for certified application counselors, and we hope to have at least one person in each of our federal facilities complete that 5-hour training.

Two weeks ago we focused on implementation of the ACA at our Annual Indian Health Partnerships Conference. This conference was focused on preparing for changes in business practices and getting front line staff in the business office and the CHS office ready to start assisting patients with enrollment starting on October 1.

Since the potential for the ACA to impact our bottom line is significant, IHS has developed a business planning template to help ensure our facilities have the opportunity to benefit from their patients' increased access to affordable health coverage, as this could mean more resources through third-party collections, and more services for everyone we serve. But we have to plan, because patients may get more coverage and then decide to go elsewhere for their care. And if they do, that's needed resources that are going elsewhere.

We're also working with the Qualified Health Plans (QHP) that will offer insurance for purchase in the Health Insurance Marketplaces in 2014; they have established networks and should

be working with our local sites that need to decide whether to contract with the QHPs. Section 206 of the IHCA indicates that our facilities should get the highest reimbursement rate.

The QHP Addendum for IHS/tribal/urban Indian health programs is now available to help explain the special authorities for working with these facilities.

We're also working on Contracting Guidance for Service Units if they enter into agreements with QHPs, and we will share this guidance when it's completed.

A major focus over the next few weeks to months is training for our staff, Tribes and patients on the ACA. We're working with HHS and the CMS Center for Consumer Information and Insurance Oversight on training for our staff. In addition, the national tribal organizations are helping us with outreach and awareness training. Our goal is that all staff will be able to respond to questions that patients have about the ACA, or will know where to refer the patients for further information.

And we have a number of other resources for training. For instance, our National Indian Outreach and Education initiative, which includes partners from all IHS Areas, has conducted over 330 ACA training sessions so far, and plan to do many more this year. They conducted all the ACA 101 training at our recent Indian Health Partnerships Conference and did a great job!

They're also developing helpful materials on the ACA, including a website. I encourage you to take a look at some of the helpful tools and information on this site at <http://tribalhealthcare.org>. They even have a video/PSA about the marketplaces for your waiting rooms. We appreciate all their help in getting information out to Indian Country on the ACA.

You can also go the <https://www.healthcare.gov/> website to learn more about your options related to the ACA. This is where anyone can go starting October 1 to see if they're eligible for the Medicaid expansion, or to compare rates for purchasing health insurance in their state. I encourage you to explore this site now and familiarize yourself with it so you can help our patients when enrollment starts. The Get Insurance tab will go "live" on October 1.

Those of you on the technical side can go to the website <http://marketplace.cms.gov> to get information on training and resources to help you learn more about the ACA. Some of you may be conducting trainings yourself, so you can get materials here. This is where you can get information on the certified application assisters training.

We're also working on internal reform efforts to change and improve the IHS, and to better prepare us to take advantage of the benefits of the ACA. Our internal reform efforts are focused on improving the way we do business and how we lead and manage our staff. In the interest of time, I won't cover this in detail today, but these reform efforts are important to showing our patients that we are improving our organization.

To improve the way we do business, we're working with HHS and our Area Directors to improve how we manage our budgets and to improve our financial management. And we're working to make our business practices more consistent and effective throughout the Indian healthcare system.

And we've been implementing improvements related to the corrective actions for the Senate Committee on Indian Affairs investigation.

To improve how we lead and manage staff, we're working on specific activities to make the hiring process more efficient and proactive and less time-consuming, and on other strategies to improve recruitment and retention, which are big issues at all of our sites. We're using the new HHS supervisory training for our managers, and improving our performance management process to praise top performing employees and to better hold accountable those employees who are not performing well. We're also working on improvements in pay systems and with an emphasis on customer service, ethics, professionalism, and performance management.

Our third priority is to improve the quality of and access to care. We've emphasized the importance of customer service, which is even more important now that the ACA is going to give our patients more choices. I tell our staff that even if you think you are providing the highest quality of care, patients won't see that if someone treats them poorly in the clinic. So we continue to work on customer service.

We're also working on a number of initiatives to help improve the quality of care and promote healthy Indian communities. One of the most important of these is our Improving Patient Care (IPC) program, which is our patient-centered medical home initiative that is designed to improve the coordination of care for patients. This is about making changes that will result in measurable improvements in patient-centered care.

The patient-centered medical home is a big focus of the changing health care system in the U.S. and the ACA. So if our sites get recognition as a "medical home," they might be able to get better reimbursements in the future.

We plan to expand this initiative throughout the entire IHS system – currently we have 127 sites. Many of these sites are doing really outstanding work, including reducing waiting times, improving no-show rates, and arranging the system so that patients can see the same providers each time they come to the clinic, which results in better coordination of care. This initiative is making the improvements that our patients have requested.

Many of our programs are seeing results. For example, the Fort Yuma Health Center has implemented ambulatory clinical care teams that have worked to reduce no-show rates from about 20% to 9%; thereby increasing the number of provider-to-patient opportunities. They've also formed patient-centered task teams to improve patient outcomes, including successfully lowering A1C levels in patients identified with very high levels.

Claremore Indian Hospital is also actively involved in the IPC collaborative. Their Family Medicine Clinic was the first department of focus, and they've improved access to care by reducing appointment availability delays from an average of 140 days to 1.5 days, and decreasing no-show rates from an average of 30% to 10% of scheduled appointments. They are also improving continuity of care by establishing Patient Care Teams so patients see the same providers over time.

So we hope all of our sites can make these types of improvements.

A few other initiatives are also helping us improve the quality of care. The better our services, the more patients will choose to stay with us when the Health Insurance Marketplaces make more options available to them. And this means more revenue for more services for our patients.

One of the most important of these programs is the Special Diabetes Program for Indians (SDPI). This program has shown that, in partnership with our communities, we can prevent and treat diabetes in Indian country with innovative and culturally appropriate activities. Our recent Report to Congress showed outcomes and improvements in diabetes care throughout our system. And our recent outcomes paper for the SDPI Diabetes Prevention Program show that these programs can reduce new cases of diabetes through lifestyle changes.

However, this program is authorized only through FY 2014 and will need to be reauthorized after that.

The case for continuing these programs is strong. I hope you've seen the dramatic in the rate of new cases of end stage renal disease, or ESRD, in AI/AN people with diabetes when compared with other racial and ethnic groups in the U.S. Between 1995 and 2006, the incident rate of ESRD in AI/AN people with diabetes fell by 28% – a greater decline than for any other racial or ethnic group.

All of this occurred while SDPI has been implemented. While we cannot say cause and effect, I believe these efforts are making a difference.

We're also focusing on behavioral health issues, which are a top tribal priority. We're making progress on our National Behavioral Health Strategic Plan and our National Suicide Prevention Plan. And the evaluation data from the Methamphetamine and Suicide Prevention and the Domestic Violence Prevention Initiatives are very promising. We will be discussing how to move forward with these initiatives in consultation with Tribes.

Our Healthy Weight for Life initiative unifies all our efforts to promote a healthy weight among AI/ANs. And our IHS Baby-Friendly Hospital Initiative is promoting breastfeeding to reduce childhood obesity. It's a part of the *Let's Move! in Indian Country* Initiative. We're also developing a new partnership with the Notah Begay III Foundation – more on that soon.

And we're working under an agreement with CMS to establish a new hospital consortium to work on improving quality and meeting accreditation requirements in our hospitals. We plan to establish a system-wide business approach to accreditation.

We're also implementing Meaningful Use with our Electronic Health Record, and are now receiving incentive payments throughout the system. This is a part of the ACA as well.

Our fourth priority is to make all our work transparent, accountable, fair, and inclusive. We've worked hard to improve transparency and communication about the work of the agency, and we're also emphasizing accountability and fairness, and inclusiveness in the way we do business and in our decision-making.

This priority is particularly important as the ACA is implemented. Our ability to show that we're improving and providing quality care will help encourage our patients to continue using our facilities, even if they take advantage of the health coverage options offered by the ACA. This could mean more third-party resources that will help improve access to services for everyone we serve.

Communicating our improvements will help. In terms of accountability, we're seeing that our efforts over the past few years are resulting in improvements in care at the overall national level.

When you look at national trends in Government Performance and Results Act measures over the past several years, you can see significant improvements in many of the measures, such as an increase in the percent of tobacco cessation intervention received, the percent screened for depression, and the percent screened for colorectal cancer.

So the increased funding we've received in the past few years, along with more accountability and a focus on improving the quality of care, is making a difference. And the potential for increased resources with the ACA means that these improvements will be able to continue. So that's why we need everyone to understand how to help patients enroll in the Health Insurance Marketplaces.

We just launched a new IHS website, and I hope you can take some time to look at the new format. We realized that our website needed to be more customer friendly for our patients, and not just focused on what our staff need. So one of the first things you see now on the website homepage is how to find health care.

The website also includes a link to my Director's blog. I use the Director's Blog on the IHS website to post brief updates on our activities and the latest IHS news, including updates on the ACA. This is one of many efforts to be more transparent about what we're doing as an agency.

I will close now by just saying once again how I appreciate all your support as we work to change and improve the IHS and to implement the ACA with all its potential benefits for the people we serve. We especially need your help in ensuring that all AI/ANs understand the new choices available to them with the ACA, and to encourage them to see what benefits they may be eligible for in the Health Insurance Marketplace starting October 1.

I appreciate your partnership as we work together to ensure that all AI/AN people get the health care they need and deserve.

Thank you.