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Dr. Nicole: Hello, and welcome to Bold Conversations, an immune deficiency foundation podcast series aimed at advancing knowledge and understanding of HealthEquity. I'm your host, doctor Nicole Rochester, the immune deficiency foundations medical advisor for HealthEquity and the founder and CEO of your GPS doc, LLC. Welcome back to both conversations. You all, we are in season three, and I'm super excited to bring another amazing guest to this podcast series.
Our guest today is Jalisa Clark. She is a research fellow at the center on health insurance reforms at Georgetown University's McCourt School of Public Policy. Her research includes state measures to improve health equity, federal reforms on health insurance and monitoring state innovation waivers. And I'm gonna have her tell us a little bit more about herself and her work, but, Jalisa, thank you so much for being with us today on the podcast.

Jalisa Clark: Thank you so much for having me. This really is an honor. And in my day to day life, when I tell people I work in health insurance research, they I can see them starting to fall asleep, so I have appreciate to have a platform that wants to talk more about health insurance and other that there is to it.

Dr. Nicole: That's awesome. Well, why don't we start there? Because I'll be even honest with you. I had not known previously that this was a whole research area, so tell us about your background and what led to your research interest in health insurance reform? So, yeah, so

Jalisa Clark: my my my master's degree is in public is a master's in public health, with a specific concentration in health policy and management, and this can look for for people for a lot of people in different this is a little different for a lot of different people. So some people go to work in the hospital system. Some people want to do general public health, so think about, like, you know, campaigns for vaccination. A lot of people go into policy, and my interest was in policy specific health policy systems, so healthcare systems in the U. S. And basically what a boils down often here is insurance. So who is who is paying for your health coverage? How much do they pay? Who is covered? How much of your health care is is covered?
And I think my my big interest in that drew from at the time was, I think this is twenty seventeen. The big conversation, the big topic was Medicare for All. And there was we saw in this country in a way that we haven't seen in a while the people wanting the government to pay more for healthcare. People being upset with their insurance feeling like they're paying for a product and that product was not delivering. And so when you have these

conversations for Medicare for all, you're like, what does that look like?
How much is gonna how much is gonna be paid? How who's gonna be covered in this? Like, where where what are the networks gonna look like? And so that's where I kinda got interested in. And still those are the same questions that are being asked today.
So what services are being covered? How how much do these services be covered? And what what do the processes look like? Is it before deductible? Is it after deductible?
Do we need bigger networks? Tiniar networks? And basically all the kind of the nitty gritty.
And and what is and what does what benefit design works best for people? Because you want an assurance that people want to use.
Oh, yeah.

Dr. Nicole: Absolutely. As you were talking about, like, deductibles and co pays and things, I wouldn't reminded, you know, in in my work in health advocacy, I do a lot of education around just basics of health insurance. And as I'm sure you know, so many people are not aware or familiar with the terms, and and they they don't understand the benefits. And even if this is regardless of education, there's just so much lack of information, I think, and a lack of knowledge with regard to how health insurance works. In preparation for this conversation with Ejalisa, I did a little research just looking back on the history of health insurance, and I thought it might be helpful for us to share a little bit about that history with the listeners because, you know, for those of us who were maybe born in the last thirty, forty, fifty, sixty years, we may not have a full understanding of how health insurance came into play.
Like you said, we're we're familiar with some of the recent reforms or attempts at reform. But as I reminded myself of the history, it was very fascinating to learn that at least according to what I read and you can correct me if I'm wrong that health insurance really kind of originated in with the military. And with the marine hospital fund appearing like this in the late seventeen hundreds that there was a marine hospital fund that was financed due a tax on the pay of maritime sailors. And then we started to have, in eighteen fifty, the Franklin health assurance company of Massachusetts, which was kind of the introduction of accident, insurance. And then there's kind of this slow, steady progression of from accident insurance to finally, you know, hospital insurance or insurance that actually pays for medical expenses And then that moving to, like, Blue Cross and kind of the introduction of of Blue Cross.
And then that ultimately moving into employer sponsored plans, which I think wasn't until after World War two. And then, of course, the big addition of Medicare and Medicaid in nineteen sixty five, but just this idea that originally, you know, there was a time in our history in America where people were paying all of the cost of their medical care out of pocket, you know, fee for service, and I guess paying it how they could. And, of course, that created a

situation early on where there were inequities with who could afford to pay and who could not afford to pay. And then even now that we have the employer based insurance, what I have seen in my work is that there are still a lot of inequities and that who has, you know, quote unquote, good employer insurance varies. There are people who will work and even work full time.
Who either don't have coverage or don't have appropriate coverage. But what what based on your extensive work, your experience, your research, what would you add to that history about health insurance in in a way that making me provide some context for how we got where we got now.

Jalisa Clark: No, I think that's I think there was a great background, a great history, and I'll I'll jump in right here. You're talking about employer sponsored insurance. And I think what is really really hard is I've been to that we need to remember is that the landscape of insurance today looks drastically different because of the Affordable Care Act. Okay? So the Affordable Care Act instituted so many wide sweeping changes to the landscape of insurance today.
So there is, you know, it allowed young people to stay on their parents' insurance until twenty six. I mean, I think in the first year, there was like a one to three million deduction in uninsured uninsured uninsured people who are uninsured because of raising that young adult availability to stay on your your parents' insurance. Then, of course, there are the preexisting conditions, which

Dr. Nicole: I can talk

Jalisa Clark: a little bit later, but basically, insurers were allowed to flat out deny if you've had a preexisting condition. And I think, actually, one of the things that I find myself doing because I work in insurance as I'll throw out a term, preexisting condition literally means that at some point in your life within the that you had been diagnosed or you were seen for a medical issue. So and I mean, that stays with you. If you go to the doctor, the doctor says, oh, your blood pressure is high and that's in your medical records, you now have a preexisting condition, which is high blood pressure. And based on that, for the rest of your life, insurers were able to charge you more for coverage or flat out denying you for coverage. So that's what so it's a it's a it's a crazy landscape there. And then, tying to employer sponsored insurance, the ACA made it so that if you are an employer who had fifty or more full time employees you had to provide insurance to those workers. And that's and it has to be affordable, so it has to be around I think today is, like, the premiums can't be more than nine percent of of their wages, and it has to have a certain amount of coverage available. So those are those are three huge changes that don't even have to do with the actual setting up of healthcare dot gov in the actual marketplaces where people can buy individual plans.

And what I think is really interesting that we as the United States cannot seem to get away from is the kind of in-depth the general inequity is a part of employer sponsored insurance. So as you were saying, you know, the modern health insurance system, it it stems from companies meaning to provide a benefit to workers that wasn't more pay. And so that's where insurance comes from. So is that not directly money in your pocket, but they're like, we can provide you this benefit. It stems from providing coverage to able body wipe men workers and typically working union jobs. So this excludes insurance coverage for those who are unable to work This typically is building off of looking at industries where women aren't working.

And then there are also racial and ethnic divides. And what's really interesting is that when we if we look just back into the and the ninety. So this is a study that's looking at nineteen ninety nine, this is before the ACA, and they found that there were disparities among full time working adults who are less less likely to have employers sponsored insurers by race and ethnicity. So they looked at union workers. And ninety one percent of white union workers had employees, bonds with insurance, compared to eighty six percent of black union workers.

And that's something that you have to think about is, like, how are we in these you're in a union and we're seeing disparities. And then, of course, when you look at nonunion workers, there's even greater disparities in employer sponsored insurance. So in nineteen ninety nine, seventy five percent of white nonunion workers had health insurance through their employer compared to only fifty two percent of Hispanic nonunion workers. When I was talking about the importance of the ACA requiring employers with fifty or more full time employees, the importance of offering them coverage. You saw that in nineteen ninety nine, where they looked at employers that had a hundred to a thousand workers.

And they found that in those those large firms, eighty four percent of white workers had employers sponsored insurance compared to only sixty eight percent of black workers that had employers sponsored insurance and sixty one percent of Hispanic workers. So there are there are disparities abound in the employer sponsored insurance. And that's why I think conversations where when we ask what kind of healthcare system can we build that is more or more inclusive to race and ethnicity, more inclusive to those who whose disability doesn't allow them to be a full time worker. What what does that look like? And in the meantime, what kind of what kind of insurance can I buy, not from employer?

Ideally, you want a marketplace, you know, an ACA plan and what ACA plan will be affordable, what ACA plan can I understand? Can I get my most get the most benefit from, and that fits my needs? So that is looking at if you already have a doctor, you wanna plan that Harry has your doctor, including the network, depending on where you live. If you have a hospital that you prefer to go to, looking for a plan that has Med Hospital in network.

Dr. Nicole: Well, thank you, Jalisa. That was phenomenal. As you were talking, it was just reminding me of all of the protections that we have as a result of the Affordable Care Act and and also just, you know, there are a lot of critics as I'm sure you're aware of of the AACA. And as with many things, there's often a lack of recognition You know, there's this misconception that only certain people benefit from certain laws. And these were wide sweeping reforms in the insurance industry.
And I wanna point out on a personal note, as someone who owns her own business, I when I left medicine and started working for myself, I had to get a plan. And all those protections that you mentioned have benefited me and my family. My ability to purchase health insurance for myself without, you know, regard for, like you said, preexisting conditions, not only in myself, but in family members. I have young adult children, both of which at various times have been on my health insurance. So the ability to keep your young adult child on your insurance up until age twenty six, all of those things are are so incredibly important. You look like you wanna say so?

Jalisa Clark: Yeah. No. It's it's incredibly important. And with the new administration, you have to look back at what they did in the past and wonder if they're gonna try that again. And in twenty seventeen, there's a big push to repeal the ACA.
And the Center for American Progress, they did a study that had an estimate saying, like, what would happen, if the ACA is repealed and specifically what would happen to the cost of insurance premiums if that preexisting conditions, so that that protections keep protections that allow the prohibiting insurers for raising your premiums because of your health conditions goes away. How much would that cost? And so what they did is they took a they looked at a four year old person. They did this based in twenty twenty the the study is in twenty seventeen, I'm pretty sure. And they they cast it forward to twenty twenty six. And they say that the base premium, they estimate is six thousand a year. Right? So that's they're saying that's the base premium with protections. And then what they do is they look at other conditions and they try to estimate how much more? What would be the surcharge?
Because up for your premiums based on your conditions. And this isn't an issue. This isn't something like, oh, this would only impact those are low income. This is not something that would only impact low income and middle income families. This is the range that this of it would affect every single person in America.
So one of the things that they one of the things that they estimated that if you had breast cancer, in the past or current, your premiums would increase. So on top of this six thousand would be twenty eight thousand dollars for the year. Twenty eight thousand dollars for the year. If you have asthma, if you have asthma, you know, something that people have their entire lives, your your premium would be four thousand dollars extra. So

on top of the six thousand, ten thousand dollars for one per when one person's forty years old with asthma, major depression.
And mental health is an is an issue we're constantly dealing with in the United States. That'd be an extra eight thousand dollars. So, like, these are these are this is expensive. It doesn't You know, people do not have the money to just pay fourteen thousand dollars a year in your insurance premiums because you have struggle with a mental health disorder. These are the prep protections of the ACA.
This is how big they are, how wide sweeping they are, and something that I that Yes. You're right. The ACA does not get enough credit for specifically the preexisting conditions and how much money is is saving Americans. When premiums go up, the result isn't that people pay them. Right?
I know you said that, like, if fourteen thousand dollars and you're you're not you're not paying that because you're you're just not buying insurance. And so then you're uninsured. And so currently, the US is at a historical low for the uninsured rate. So I think it's like twenty million. I think that's about eight percent of people are uninsured right now.
That's that's so low. And the the number one reason why people continue to to be uninsured is because their sensitive price And this is prices with the ACA in place. This is prices where there are subsidies available on the insurance marketplace. I think, oh, I I I think was it last year, they were touting that four out of five people who purchased insurance on the marketplace were able to get coverage for less than ten dollars a month.

Dr. Nicole: So, like, there's a lot of financial assistance right now for for insurance. Jalisa, as you were talking about these protections and the forecasts for what will happen to our premiums in the United States if indeed these protections go away, I couldn't help, but think about the primary immunodeficiency community. And, you know, these are lifelong conditions, many of which require very expensive medications and infusions and I can't even imagine the cost that members of this community will be faced with if we if the ACA is repealed and they are now subject to these these additional costs related to their preexisting conditions. Like, this is untenable.

Jalisa Clark: It's hard to imagine that things could be worse than they are right now because, I mean, The problem is today, the reason why people are so frustrated is because insurance right now doesn't provide enough coverage. And what's really interesting is that people are adding this word underinsured into the conversation. So there's uninsured, which is a straight up note, there's no other provider paying for health coverage, and then there's underinsured. And so these are people who have insurance coverage, whether through their employer, whether through the marketplace, Medicare, and came, but are still struggling to access care because the out of pocket costs are too high. Their deductibles are too high, so they are having too front you know, the the cost into the thousands before

their insurer steps in or or where they can access, you know, get it into copay or or call insurance.
This is a major problem. And it's a huge issue for those with chronic conditions, those who have to access these treatments, have to get x rays, have to get tests and laptops, lab tests and diagnostics, each of these all these costs add up and it comes it is paid by the patient into thousands once again before the insurer steps in. One of the one of the ways that we're trying reversing on this was one of the big things in the Biden administration to kind of combat is was standardized plans. So standardized plans, these are found in the marketplaces, so the healthcare dot gov, as well as the different states that run their own exchanges. We call those state based marketplaces, SBM's, And what standardized plans are is it's a set of cross sharing standards.
So for every insurer, whether it be Cigna or Blue Cross Blue Shield or Kaiser, they have to have the same exact cost sharing for each plan by their by their metal tiers of bronze, silver, gold platinum with it getting more generous as the metal tiers go up. And so the way that this looks is that whether you're getting purchasing from Cigna, whether you're purchasing from Blue Cross Blue Shield, you know that if you buy this, you know, let's say, silver tier plan, you're gonna have you're gonna have a ten dollar copay. For your generic drugs. And then it's going to be maybe perhaps a forty dollar co pay for X rays. And so with that set in stone knowing that this is going to be the same across issuers then you can look at other things that the the plans offer and make your decision based off that.
Once again, whether your doctor's in planner, whether you just had a good experience, you know, gone customer service from this plan and allows you to it takes with something standardized. It allows you to look at other things that impact your health care and make your decision based off that. What's really interesting and what we're seeing a lot in standardized plans are co pays before the deductible. Just for a reminder, deductible is how much you have to pay before your insurer kicks in. So let's say you have a four thousand dollar deductible and you would have a twenty dollar co pay for outpatient, specialized care physician visits.
So you would have to pay four thousand dollars in medical care before your insurer says, okay, now you just have to pay that twenty dollars to see this out outpatient physician, which I mean, that's insane. It feels it feels like madness. You're telling me I have to spend four thousand dollars before I just have to pay twenty dollars to see my doctor. It it it feels like a rip off and then it feels why people are it's done it. You can understand why people are frustrated with your insurance.
So what we're seeing is this trend and then standardized plans of putting more co pays before the deductible. So you're seeing okay. Your deductible is four thousand But for this outpatient service, we're gonna allow that you can just you just have to pay twenty dollars, that twenty dollar co pay for this service before and you don't have to reach the deductible.

What what that does, it'll it makes it more affordable for people to show to the doctor's office. It makes it it makes people fine.
They're like, fine. If I if I know that I'm just if I'm from the start, from the moment I'm covered, I just have to pay twenty dollars to see to see this, you know, specialized care physician, I'll go. And and so that's one of the that's one of the great things about our standardized plans. And that's one of the ways of working insurance. So so that you've people who who are insured don't feel like they're uninsured.
They feel like they're still getting some benefit from the start without me ending their deductible.

Dr. Nicole: Thank you for explaining that and as you were talking, it sounds like well, one, I will say, I have noticed that myself because again, I continue to purchase my insurance through the ACA. And so I have definitely noticed each year that there are more co pays that are covered before my deductible, which has made me very happy as as a healthcare consumer. But as you were talking, Jalisa, I feel like this is also a measure going back to kind of the equity conversation that improves or or facilitates equity within the health insurance space. Because when you have a situation where your deductible is your deductible four thousand dollars as your example, there are some people who will be able to afford that thousand dollar deductible, although it might be a sacrifice. And there are other people who just absolutely cannot.
And so if we look at, you know, health and equities, if we look at marginalized populations, if we look at black and brown people or people with physical or mental disabilities, people who have historically have income and equity gaps. And all of these things that we can understand are people that maybe don't have a trust fund or, you know, money that was passed on to them from their wealthy parents. You you can see how that's a situation where you have this have and have not, where somebody can afford this four thousand dollar deductible and someone else is making the decision between going to the doctor or paying their rent or, you know, putting food on the table for their children, which we know a real conversations even now in the US. So in addition to these standardized plans, what other ways have have states addressed insurance and equities?

Jalisa Clark: Yeah. So I one way to see that is that states are kind of building on standardized plans. And one thing that we we can see from states and state based marketplaces so that are designing their own is that people enrolling in the marketplace they are buying into these plans. They're with an option of having a standardized plans or a nonstandard plan, we're seeing that they're buying a standardized plan. So Washington State, their standardized plan is called the Cascade Care.
And their last open enrollment, seventy three percent of people who enrolled through Washington, the marketplace purchased a standardized plan. So seventy three percent

That's huge. That's a great success for Washington. One of the things that Washington is trying to do, but they're trying to be mindful of affordability. So really kinda looking at once again, looking at the services, pre deductible and deciding, what are page what are people using the most?
And won't be most beneficial for them to address. You can you've also found that in Connecticut. So Connecticut, one of the things that they've reached and looked at and they're getting nice plans is looking at lab costs and really trying to lower the cost sharing for lab tests and and services with services for patients with keeping in mind and really prioritizing those with chronic conditions. Now, DC, they're super interesting. And I would I can yeah.
I give them credit with really elevating what was being called equity based design. So equity based design is looking at current healthcare conditions where the outcome There's a disparity in the outcome by race and ethnicity. So one of the examples of this is diabetes. Diabetes is an issue that all of America is dealing with. Why black, Hispanic, It's just a it's a it's a chronic condition that many Americans have, but when looking at the data, DC found that it was black Americans who have in the worst outcomes from diabetes.
And so what they did is they want to build they wanted to increase access to healthcare by lowering cost sharing in their standardized plans. So when the first thing they did was they required in their standardized plans for everyone everyone was enrolled in this plan and has type two diabetes, zero cost sharing. So zero dollars for a preferred brand insulin, some select non insulin injections. They also added with an unlimited primary care office visits, a nutritional counseling visits, they had an annual retinal and diabetic foot exams. They basically sat down with experts in diabetes care and said what would a person need for a year to manage their diabetes?
And they took took all those services, took those medications, and put it before the deductible. And lower lower cost sharing for most, but also then made zero. So that's huge. And then DC didn't stop there. So then they added they saw in the youth population that young African American children were really struggling with mental health.
And they set a five dollar co pay before the deductible for outpatient mental health visits. And then in this new year, so coming in plan year twenty twenty five, they also added services and drugs related to cardiovascular disease. Also, another disease with disparities in outcomes by recent ethnicity. What's interesting that that needs to be noted, this is all under the umbrella of equity based design, but it applies to every person in that plan with these conditions. And I think one of that's what's so kind of important about America is like, yes, it varies in a severity and in a prevalence by race and ethnicity.
But these are conditions that we all have, and these are conditions that all Americans are struggling with. Diabetes is a huge conversation and And that's why you saw with the Biden administration, the limiting insulin for thirty five dollars in Medicare. You could call that

equity based design. Right? The it was sure diabetes was impacting dog Medicare population, but I'm sure the studies will show that there is disparities in outcomes by race and ethnicity.
So that's what this equity based design approach is, and it's very interesting because and ask the question, what would my what would I want my insurance to cover if I had this or if I were if I had this condition and I could design it, what would I want?

Dr. Nicole: You explained that so well, and and I wanna just highlight what you already highlighted, but I just wanna put a, like, a double line under it, highlighter for everybody listening because it's this idea of equity, which is really, you know, the core purpose of this podcast series is to really educate our listeners about equity. And to help everyone understand that when when we make these equity based designs, when we put when we end implement things whether it's policies or systems or even laws to help an individual or a group who's historically has been marginalized, everybody wins. And so as you were talking, I was reminded of an example that I have used in some of my presentations. So I'm reminded of legislation and and I don't know the year, but that mandated access just with regards to like sidewalks and curves and ramps and how there was a time where there were no cutouts. There were no rants.
So you'd had to step up from the street to the curb from the curb to the street. And as a result of legislation and and making things assessable to those with physical disabilities, you know, originally meant for wheelchairs. It it it benefited everyone as someone who now my kids are adults. But when my kids were young, babies and I had a stroller, I regularly would look for that opening in the curve so that I could roll their stroller, you know, over that ramp. It even ramps to give you access to buildings.
And there are so many other uses if you're traveling and you're pulling lots of luggage, you know, being able to just be able to find that opening and pull your luggage up on that ramp. So I use that example just as a very practical case where we can hopefully see that when we when there are laws that are implemented, when there are policies that are centering individuals with maybe a specific need, we number one, the rest of us don't lose. Like, it's not like they gain, we lose, but also we gain too because many times these these interventions end up helping all of us. You know, I don't have diabetes. Thankfully, I don't have any chronic conditions at the time of this recording.
And I am able to benefit from all of those those things that you mentioned. I'm able to benefit from having copays that kick in before my deductible. So I just really wanted to highlight that because we know that, you know, sometimes there is rhetoric around this idea that equity means that somebody's losing, and and it really is a a win win.

Jalisa Clark: No. It's such a win win. And if we could talk about costs, right? Hospital costs are one of the biggest drivers for your insurance premium. So I guess when when we as a

collective spend more money and more time at the hospital, our premiums go up.
So but also, there's also the cost of life. Right? So you want people to be able to go to the doctor. You're going to be able to manage their conditions. So that they can stay alive, but also want them to have a better quality of life.
And that requires people being able to manage their conditions. You know, like, not feeling of death, so they have to wait more time to see a doctor because of the cost of it. Not having to split medications or for deciding to go without a test for a month. We want people to be able to manage their conditions safely and efficiently, and that it saves everyone money at the end. What's really interesting is that HSS, they have this, like they propose this idea that will allow insurers to design non standardized plans, but plans tailored for specific conditions.
If they could demonstrate that the way that they could design their plan would save those in that in those with that kind of condition, twenty five percent or more in their cost sharing. I think this stems from one insurer Oscar Health, which had designed a insurer's plan around diabetes in which they would limit they lowered the cost sharing for diabetic foot exams as well as wellness programs and and health coaching. As much as I do like this idea, we one of the things and that you kind of mentioned it is that we everyone needs access to care. So we really kind of have to work on the fundamentals of health insurance, which is everyone feeling it so they can go to the doctor before we can tailor these kind of specific programs where at the end of

Dr. Nicole: the

Jalisa Clark: day, you know, someone could purchase that specific insurance and it doesn't cover the other things that they need. So in a standardized plan when we're adding these benefits, you still have access to a primary care office. You still have, you know, a set cost sharing for an visit. When the plan is not standardized and it has a name like, you know, something like diabetes. You may click on it thinking that it covers everything that you need, but it may be missing on other areas because just because you have a chronic condition doesn't mean that there can't be another unexpected condition that arises that year.
So we wanna make sure that people are getting tailored insurance, but also being protected in general for any other health insurance or issue that may arise.

Dr. Nicole: That's a really good point. A really good point. Somebody opportunities for education and, you know, health literacy as it relates to insurance. With regard as you as you talk about these standardized plans and these plans that are tailored around conditions, you know, people with primary immunodeficiency have rare conditions. And so it makes sense to me that there are plans that are being tailored around diabetes or around

heart disease.
But for the person listening who maybe they or their family member, or the loved one is managing a rare disease like a primary immuno deficiency. Do you see any opportunities for health insurance reform in that area?

Jalisa Clark: I can't I I can't really speak to our health insurance reform. I mean, there are there are some basic things like as we we were talking about earlier about make you know, in Congress making sure that we keep in premium subsidies. Issues like that, keeping the ACA in place. I think on an individual level when picking out insurance, for people with chronic conditions, I think maybe perhaps one of the number one things to look at is the network. And making sure that your doctor is in your network.
And honestly, there's the US has a long ways to go there. Provider directories are not readily available when they are. They're not up to date. It can be really hard if you're shopping for an insurance to know what which insurer covers your doctor. And sometimes the only reliable way is to ask to call every single one of your doctors and ask them whether they take this insurer, whether they take this plan, and that's one that's very timely for the person making the call, but it's also the doctor's office is don't have the time and ask someone who's done this myself, feel like they do not have time for me, and I'm all busy answering my questions.
So, yeah, I think that is I think that's one of the main issues. One of the surprises that patients can face when they go to a doctor that they've been seeing their entire, you know, for the past couple of years and they find out for this one year that this doctor is no longer in that. We're no longer covered and their co pays gone up. Every state has a Department of Insurance, and that Department of Insurance is supposed to help you fight an insurance claim denial. That's what they're there for.
And I feel like a lot of times people, you know, they'll get as a nile back from the insurer and feel like that's where the buck ends. They can try to appeal it with insurer. You can go to your department of insurer. That's what they're there for. And I've actually there's an organization.
It's the NAIC. It's the National Association of Insurance Commissioners. I've been to a lot of their national meetings. They constantly are trying the thing. How can we get the word out to people?
How can we get the word out to constituents that we are here? This is a you know, I'll I'll I'll hunt them right now. Your state has department of insurance. Whether it be your employer sponsored insurance, whether it be a private insurer, you should go to them if you're if you run into a problem, specifically, especially if it's a service or medication that you've had covered before and it's being denied now. Even if not, talk to your Department of Insurance. Because if they if not, they can steer you in the right direction and tell you the the next

course of action. I will say once again, it's tough because that takes time. And when you are sick, you don't have time and you definitely don't have energy. And I mean, sometimes this process can go on for weeks So if it's also if it's urgent, then, you know, that really puts it's it's not the resource that you need, but I would definitely encourage people to reach out to their states department of insurance.

Dr. Nicole: Now, you just taught me something, Jalisa, because I'm not aware, I wasn't aware that every state has that. So that's very useful information. This has been incredible. I have learned a lot about health insurance and about reform and equity based design. I'm sure the listeners have as well.
Is there anything that you wanna leave us with? Any closing thought regarding this work or your research before we say goodbye?

Jalisa Clark: I think all I will say is that insurance really brings everyone together. Everyone needs to be in the risk pool. Everyone needs to be contribute when we all when we contribute our premiums, It goes to the person in need then and then down the road, we could be the person in need. It's such a communal aspect. And so when we're when we're having these kind of conversations nationally, I think it's just a one thing to focus on is that it doesn't matter your economics.
So your status, it doesn't matter your race ethnicity, your gender, your gender orientation. When you are sick, you need health coverage. And health insurance is one of the best ways that we can make sure that everyone is covered and able to financially access the healthcare that they need. So, yes, I just wanted to continue to be health for health insurance to be a national conversation And I want it to be a topic where we can all agree upon that the system that we have now as though much better than it was before prior to the ACA, there are so many opportunities to strengthen it and so many ways that we can make healthcare more affordable.

Dr. Nicole: Wow. Thank you so much, Jalisa. I really appreciate you being on the show and sharing all of this information with our audience. Is there a way that people can contact you? If you have I don't know if you're on social media or if they wanted to read the articles that you've written about this topic.

Jalisa Clark: Yes. So if you Google, my name is Felisa Clark, also with Georgetown University Center on Health Insurance Reforms. We're a research center within the with Georgetown University that writes on every aspect of private insurance. And I will tell you that there's it is actually ridiculous how many things that that go on in private insurance that impact our premiums and deductibles and our networks. So there's an array of information there.
You can also follow me on Blue Sky. I've made the jump at jalisa j a l I s a health to reach

out. And if feel free free free to email me with your insurance questions. I do it for my family all the time. I'm as someone who has been in this field for years, I still struggled my own insurance and getting my with my walking to, you know, walking out of eye exam and finding that something wasn't covered.
I'd tell you the system is not easy to navigate, so feel free to reach out with me. Read out to me if you have any questions.

Dr. Nicole: Thank you so much, Jalisa. And you all thank you for listening. We have lots more exciting guests and so much information for you in season three d, so I will see you next time.