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SB 334
Health Insurance – Coverage for Mental Health Benefits and Substance Use Disorder Benefits – Treatment Criteria
Finance
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Support

Last year, our 17 year-old son, who had been diagnosed with a substance use disorder as well as anxiety and depression, overdosed on a cocktail of Benadryl and Zzzquill. He was admitted to the Emergency Department where he remained in a hallucinogenic psychotic state for over 48 hours. Then he was sent to Sheppard Pratt, where he stayed for two weeks. The treating clinicians at Sheppard Pratt said that our son required a long-term residential treatment program to address his co-occurring mental health and substance use disorder. In fact, the social worker and psychiatrist said that he needed long-term inpatient treatment or was at risk for another overdose or death. While we were looking for such a program and had reached out to our insurance provider for help identifying a facility, we were abruptly told by Sheppard Pratt that our insurer only would cover his stay until that night – we had to come get him. We knew that he was not safe to come home, despite what our insurer said, but we had not yet found a residential treatment facility for him to transfer to. I spent 10 ½ hours on the phone the next day pleading with both our insurer and Sheppard Pratt to keep him longer; we were finally approved for three more days.

Although we had reached out to our insurer for help identifying an appropriate facility, they provided none. I searched through our insurer's website and found no in-network Maryland residential treatment centers for youth. I myself had to start searching on the insurer's web site state by state to try to find an appropriate provider for my son. No luck. Finally, through the SAMHSA web site, I found a residential treatment center in Pennsylvania that provided co-occurring mental health and substance use treatment for teens – Gateway.

Gateway had a 28 day program, and this is what the Sheppard Pratt clinicians had recommended that he receive at the very least. Our insurer, however, would only approve 3-5 days of residential treatment at a time. Then, after our son was there 12 days, our insurer denied continued coverage. Despite what the treating clinician at Gateway said, our insurer's clinician had determined that inpatient treatment was no longer medically necessary. Gateway told us that we would need to give them our credit card number or he would be released immediately. I fought with the insurance company for two hours and got nowhere. Finally, after I obtained the phone number (with tremendous difficulty) for our insurer's physician who had denied continued care and pled with him, our son was approved for five more days. Then our insurer approved three more days because of a snow storm. In the end our son was released after just 20 days of treatment, with no arrangements in place for him to transition to an intensive outpatient program.

We felt strongly that throughout this process our insurer was in violation of insurance parity requirements. They would not deny coverage for a somatic condition after a clinician said, for example,

that an individual required a number of chemotherapy treatments. They would not abruptly terminate treatment because **their** clinician determined that the individual no longer needed chemotherapy treatment, despite what the treating physician said. They would not re-determine medical necessity criteria every three days. They would have an adequate provider network.

Currently our son is living in active addiction. We have not had contact with him for months.

For these reasons I urge you to pass SB 334.