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**SB 484 - Health Insurance – Provider Panels – Coverage for Nonparticipating Providers
SUPPORT**

My 14-year old daughter is diagnosed with depression and anxiety in addition to her autism diagnosis. In January of 2018, after witnessing a school fight and enduring several months of frustration for not having proper supports in place, she began refusing school and eventually refused to leave her room. She did not return to school for 9 months. School refusal triggered self-harming behavior, refusing to eat and social isolation. She required 24-hour care. I took a leave of absence from work and my husband dropped his work hours in half. My two of other children began struggle in school and at home.

After 4 months of intensive outpatient treatment with no improvement, she was admitted to John Hopkin for failure to thrive. When they were finally ready to discharge her, I was hopeful that things would start to get better. Instead, we have faced a never-ending series of battles with our insurance, CareFirst, to get my daughter the mental health care in our community that she needs.

When my daughter was discharged, the hospital recommended that she receive residential treatment. However, there was not a single residential treatment facility in CareFirst's network in Maryland that would accept a child with co-occurring diagnoses of mental health and developmental disorders. Because we had no access to the level of care my daughter needed, Maryland does not have residential placement for children with a dual diagnosis, the psychiatrist suggested a day program. But the only day program that would accept my daughter is in Baltimore, and I live in Salisbury with two other children. There was no way we could drive over 100 miles twice a day, a 4.5-hour round trip, and keep our jobs and take care of our family. Without any other options, my daughter was discharged from the hospital with only her outpatient care team in place. We had to accept a lower level of care than what our daughter's providers said she needed. I never questioned coverage as we could not find placement. **There are no residential treatment centers in MD for dual diagnoses. No one ever told me I had a right to get approval to go out of network.**

Getting an outpatient care team in place was hard enough for us, living in Salisbury. **There is only one pediatric psychiatrist within an hour of my home. He is out-of-network with CareFirst.** The closest in-network pediatric psychiatrist is three hours away. We worked with CareFirst to get a single case agreement, so that our daughter could see the provider who is only an hour away at the in-network cost. **While we managed to get this agreement in place so that CareFirst would cover the services my daughter needed, it was never implemented.** CareFirst never paid the psychiatrist. But my daughter needed the care. We have been paying out-of-pocket to see him for four years, even though CareFirst knows that they do not have an adequate network for this specialty, for children like my daughter.

Returning to outpatient treatment after the hospitalization wasn't enough though. My daughter's psychiatrist told us that she needed a higher level of care, just as the doctors at the hospital had said. With no other choice, we found a residential program in Connecticut, where our daughter has been for

the past year and a half. Of course, CareFirst denied coverage of the program because it was out-of-network, even though there were no in-network facilities available. **We are paying \$150,000 a year to get our daughter the care she needs, care that should be covered under the insurance we already pay for, and care that everyone agrees is medically necessary.** It has been an incredible financial strain on my family. It is not fair that the children in our community who need the most help, the ones with multiple diagnoses and disorders, are the ones that our insurance companies and our state fails.

Additionally, my daughter needed cognitive and psychological testing while she was in her residential placement. This claim has been under appeal for 9 months as the provider was in Connecticut. We were told they had no in-network providers in Connecticut. This is a \$6,500 bill we paid, **even though CareFirst should have told us we had a right to go out-of-network when there were no in-network providers within a reasonable time or distance.**

We know that this does not happen for children with medical diagnoses. Insurance companies have adequate networks of specialists for other conditions, or else they cover the cost of going out-of-network. They do not let single case agreements fall through the cracks. They would not tell the family of a child whose doctors said she needs 24-hour supervision that outpatient care is enough because they could not find a facility. Those families would not be paying \$150,000 a year for the care their child has a right to receive through her insurance. We know our insurance company is in violation of parity requirements and network adequacy standards, and Maryland is letting it happen. It's time for our state to step up and close the gaps in these laws to protect the most vulnerable residents in our community.

My hope in sharing our story is to help bring change for everyone not just myself. For these reasons, and for my daughter, I urge you to report favorably on SB 484.