January 12, 2015

Mr J.P. Wieske
Wisconsin Office of the Commissioner of Insurance
Chair, NAIC Network Adequacy Model Review (B) Subgroup
c/o National Association of Insurance Commissioners (NAIC)
444 North Capitol Street, NW, Suite 701
Washington, DC 20001

ATTN: Jolie Matthews, NAIC Sr Health and Life Policy Counsel

Dear Mr Wieske and Ms Matthews:

The American Academy of Pediatrics (AAP) is a nonprofit professional organization of 62,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults. The AAP appreciates the ongoing work the National Association of Insurance Commissioners (NAIC) Network Adequacy Model Review (B) Subgroup has conducted this past year related to the revision its Managed Care Plan Network Adequacy Model Act (hereafter “Model Act”), and applauds NAIC’s ongoing efforts to address the complex issue of network adequacy.

However, the Academy writes today to express significant concern with the November 2014 initial draft of the Model Act. Simply put, the Model Act as released would not create the proper framework to ensure that insurance plans offer an appropriate array of providers for children that would guarantee ongoing access to pediatricians, pediatric medical subspecialists and pediatric surgical specialists.

Children are a unique population, and the care they require is unique. Children and adults have significantly different patterns of illness, injury, and death, and children have distinct needs in regard to their anatomic, physiologic, developmental, and psychological characteristics.

The revision of the Model Act was undertaken in an effort to address narrow network plans proliferating in health insurance marketplaces. These narrow networks and the limitations on care they create can have significant and lasting impacts on the health care children receive and their growth and healthy development throughout their lives.

The steps taken by NAIC to address network adequacy through this Model Act are very significant and being watched by countless law- and policymakers across the country. States rely on the NAIC to provide expert consensus of appropriate state
regulatory oversight of insurance, and the US Department of Health and Human Services (HHS) has even stated in its November 2014 Notice of Benefit and Payment Parameters for 2016 proposed rule that HHS will continue its “reasonable access standard” for measuring network adequacy adopted in its 2015 Letter to Issuers in the Federally-facilitated Marketplaces, but that the agency will otherwise await the outcome of the NAIC’s work on this issue before proposing future changes on the subject. All of which is to say, this Model Act is likely to have a profound impact on insurance plan networks across the country.

The AAP believes the initial draft of the Model Act would do little to positively affect change to narrow networks; instead it lays out options for states to consider when examining the issue. If the Model Act is to have an impact on solidifying access to care and ensuring networks are truly adequate, it must be strengthened in several important areas.

In particular, the Academy raises the following overarching concerns (with specific line-thru Model Act recommendations following):

1. **The Model Act as drafted would not ensure that plans are overseen by the state Insurance Commissioner or other state agency with regulatory authority.**
   
   Allowing issuers to submit or file access plans demonstrating network adequacy without substantive review and meaningful approval by a state Insurance Commissioner or other state authority does not ensure that there is an appropriate review of a given plan’s network. Access plans must be required to be submitted to, and reviewed by, the Insurance Commissioner or other appropriate state authority. Further, a Model Act Drafting Note indicates that states may want to consider accreditation as a supplemental measure of network adequacy. The AAP believes that accreditation should never substitute for state regulatory oversight of network adequacy; accreditation of network adequacy should only be supplemental in nature.

2. **The Model Act does not require use of quantitative methods to demonstrate network adequacy.**
   
   While the Model Act cannot prescribe the exact quantitative measures to be used to measure network adequacy in every state, this should not preclude states from being required to quantify network adequacy. Quantitative measures such as those found in Section 5, including maximum time and distance standards, maximum wait times, minimum provider/enrollee ratios, in-network/out-of-network ratios and the like are instrumental in documenting network adequacy. The most fitting measures for each state or region must be required to be used for adequate documentation.

3. **The Model Act does not appropriately ensure children access to pediatricians, pediatric medical subspecialists and pediatric surgical specialists.**
   
   Again, health care for children is unique, and access to an adult physician or specialist must not substitute for care by pediatricians or pediatric specialists when measuring network
adequacy. As currently drafted, the Model Act would simply not ensure that the unique needs of children are adequately addressed.

In instances where care provided by a pediatrician, pediatric medical subspecialist or pediatric surgical specialist is not readily available, network adequacy standards documenting access to appropriate pediatricians, pediatric medical subspecialists and/or pediatric surgical specialists must include specialty or subspecialty care provided in a geographic region beyond the normal confines of an existing plan network area, which might even include care in another state. Similarly, children’s hospitals, including those in areas beyond an existing plan network area where one is not readily available, must be included in network.

It has been argued that networks can be established with procedures to provide out-of-network care at in-network rates in specialized cases, in lieu of building an adequate network. However such an “as needed” model should never be the norm; pediatricians and pediatric specialists and subspecialists must be included in networks as they are built.

In summary, the above issues must be addressed if the Model Act is to ensure children receive the medically necessary care they need. Coupled with recent research calling into question the appropriateness of state essential health benefit (EHB) packages for children (http://content.healthaffairs.org/content/33/12/2136.abstract), weak network adequacy standards and oversight will do nothing to further the goal of providing all children with the right care, in the right setting, at the right time.

It is with this goal in mind that the AAP offers the following strike-through recommendations to the November 12, 2014 Model Act. Academy edits are found below in green:

Section 3 – Definitions

Drafting Note: States that regulate Medicaid managed care plans may wish to broaden this definition to list other types of facilities, such as end-stage renal facilities, hospice, and home health agencies.

K. “Health care provider” or “provider” means a health care professional, a pharmacy, or a facility.

Comment: The AAP recommends removal of the above Drafting Note, as Medicaid enrollees are a unique population and the Model Act is drafted with private health plans in mind. In addition, the AAP opposes inclusion of “pharmacy” in a definition of “health care provider,” unless it is specified that “pharmacy” is included in this definition for the purpose of
provision of prescription drugs. Without such a clarification, the Model Act is unnecessarily inviting debate over the scope of practice of pharmacists, which is outside the purpose of the model legislation.

Section 4 – Applicability and Scope

Drafting Note: States may wish to consider accreditation by a nationally recognized private accrediting entity, with established and maintained standards that, at a minimum, are substantially similar to or exceed the standards required under this Act, as evidence of meeting some or all of this Act’s requirements. However, accreditation should not be used as a substitute for state regulatory oversight nor should accreditation be considered a delegation of state regulatory authority in determining network adequacy. States should consider accreditation as an additional regulatory tool in determining compliance with the standards required under this Act. Under such an approach, the accrediting entity should make available to the state its current standards to demonstrate that the entity’s standards meet or exceed the state’s requirements. The private accrediting entity shall file or provide the state with documentation that a managed care network plan has been accredited by the entity. A state may deem a health carrier accredited by the private accrediting entity with standards that meet or exceed the state’s requirements would then be deemed to have met as meeting the requirements of the relevant sections of this Act where comparable standards exist, except that accreditation should never exempt a health carrier from submitting for prior approval or filing, as appropriate, an access plan as required by Section 5 of this Act. States should periodically review a health carrier’s private certification and eligibility for deemed compliance.

Comment: As stated previously, the AAP opposes any step that would supplant state Insurance Commissioner review and approval of a given plan’s network adequacy. While accreditation can supplement this state review, it should not substitute for it. The above recommended deletion addresses this concern.

Section 5 – Network Adequacy

A. A health carrier providing a managed-care network plan shall maintain a network that includes a comprehensive range of primary, specialty, and subspecialty providers and, with respect to children, pediatricians, pediatric medical subspecialists and pediatric surgical specialists and that is sufficient in numbers and types of providers to assure that all services to covered persons will be accessible without unreasonable travel or delay. In the case of emergency services, covered persons shall have access twenty-four (24) hours per day, seven (7) days per week. A health carrier providing a tiered network
plan shall ensure that all covered services are accessible through a provider in the lowest tier as measured by required cost sharing, without unreasonable travel or delay.

Comment: The above recommended edits to the Model Act distinguish that access to care includes access to all of primary, specialty and subspecialty care, and with respect to children, pediatric primary, specialty and subspecialty care. The final sentence is added to indicate that network adequacy standards must apply to all plans, independent of any tiered status.

B. Sufficiency shall be determined by the Insurance Commissioner in accordance with the requirements of this section, and may be established by reference to any reasonable criteria used by the carrier, including but not limited to:

1. Provider-covered person ratios by specialty;
2. Primary care provider-covered person ratios;
3. Geographic accessibility;
4. Geographic population dispersion;
5. Waiting times for visits with participating providers;
6. Hours of operation;
7. New health care service delivery system options, such as telemedicine or telehealth; and
8. The volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.

1) Maximum travel time and distance standards to access a full time equivalent primary care physician, specialist or subspecialist, facility, and other health care providers. Such a standard shall take into consideration the provider’s ability to accept new patients, the wait time to see the provider and hours of availability, the ability of the provider to admit the patient to an in-network hospital, and the quality measures used to include the provider in-network.

2) Minimum ratio of providers to covered persons for primary care physician, specialist and subspecialist services, and other health care providers. With respect to children and with a focus on children with special health care needs (CSHCN), a health carrier must maintain a network of pediatricians as well as a complete range of pediatric medical subspecialists and pediatric surgical specialists in a given geographic area so
that every child has and can maintain access to his/her medical home in a timely manner.

3) Minimum number of full time equivalent physicians and healthcare providers needed in a network to meet the needs of patients with limited English proficiency, diverse cultural and ethnic backgrounds, and with physical and mental disabilities.

4) Maximum time and distance standards in miles to access full time equivalent diagnostic and ancillary services.

5) Maximum time and distance standards in miles to access general hospital services with emergency care.

(C) The Department shall consider the following factors in the access standards identified in Section 5(B): (1) In instances where care provided by a pediatrician, pediatric medical subspecialist or pediatric surgical specialist is not readily available, network adequacy standards documenting access to appropriate pediatricians, pediatric medical subspecialists and/or pediatric surgical specialists will need to include pediatric specialty or subspecialty care provided in a geographic region beyond the normal confines of an existing plan network area. For example, in some areas of the country, access to pediatric specialty and subspecialty care might require travel to a neighboring or nearby state. As such, network adequacy measures must document the availability and coverage of non-emergency transport in such cases.

(2) Telehealth care may provide opportunities to meet the needs of enrollees, particularly in underserved areas. Network adequacy standards documenting access to care can include care provided via telehealth technologies, but should be balanced with safety, quality, licensing and certification standards, and must take place within the context of or in support of a medical home.

(D) The Department shall conduct or review available periodic patient and family surveys to help inform its monitoring of network adequacy and shall make the results publicly available.

(E)(1) In any case where the health carrier has an insufficient number or type of participating provider to provide a covered benefit, the health carrier shall have a process to ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers an in-network level of benefits from a non-participating provider, or shall make other arrangements acceptable to the commissioner when:

(a) The health carrier has a sufficient network, but has determined that it does not have a type of participating provider available to provide the covered benefit to the
covered person or does not have a participating provider available to provide the service without unreasonable travel or delay; or

(b) The health carrier has an insufficient number or type of participating provider available to provide the covered benefit to the covered person.

(2) The health carrier shall specify the process a covered person may use to request access to obtain a covered benefit from a non-participating out-of-network provider as provided in Paragraph (1) when:

(a) The covered person is diagnosed with a condition or disease that requires specialized health care services or medical services; and
(b) The health carrier:

(i) Does not have a network provider of the required specialty or subspecialty with the professional training and expertise to treat or provide health care services for the condition or disease; or

(ii) Cannot provide reasonable access to a network provider with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay.

(3) The health carrier shall treat the services the covered person receives from a non-network provider pursuant to Paragraph (2) as if the services were provided by a network provider.

(a) The process described in E(1) and E(2) of this section must ensure that requests to obtain a covered benefit from a non-participating provider or covered person are addressed in a timely fashion. At a minimum, the process must ensure that the covered person and the requesting provider are notified of a decision to approve or decline the request is made within seven (7) calendar days of receipt of the request. However, if the requesting provider indicates that the covered person’s life, health or ability to regain or maintain optimal function could be seriously jeopardized, the carrier must notify the covered person and the requesting physician of the approval or denial within 24 hours of receipt, and denials of such requests shall be subject to expedited carrier review and, if necessary, external review.

(b) The carrier shall have a system in place that documents all requests to obtain a covered benefit from a nonparticipating provider. This documentation must include a log subject to review at the discretion of the commissioner, to be updated on no less than a monthly basis. The log shall list:

(i) all such requests;
(ii) the name of the covered person involved;
(iii) the name and address of the provider making the request;
(iv) whether the request or was approved or denied;
(v) the date of approval or denial; and
(vi) the relevant authorization number, if the request was approved.

(4) Nothing in this section prevents a covered person from exercising the rights and remedies available under applicable state or federal law relating to internal and external claims grievance and appeals processes, including in instances where a covered person’s request to access an out-of-network provider using the alternate process is denied by the carrier.

(5) The health carrier shall ensure that these processes are documented and made publically available.

DEF. (2)(1) The health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity access of participating providers to the business or personal residence of covered persons. In determining whether a the health carrier has complied with this provision, the commissioner shall give due consideration to the relative availability of health care providers in the service area under consideration.

(3)(2) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, financial capability and legal authority of its participating providers to furnish all contracted covered benefits to covered persons.

Drafting Note: States should be aware that it is intended that the process for accessing out-of-network providers established in this subsection be used as infrequently as possible and that it cannot be used by carriers as a substitute for maintaining an adequate network for all covered services. States must monitor how often the alternate process is being used as a potential indicator of an inadequate network.

G. A health carrier shall ensure that all essential community providers are included in network plans, especially children’s hospitals.

Option 1. Prior Approval of Access Plan

(1) Beginning [insert effective date], a health carrier shall file with submit to the commissioner for approval prior to or at the time it files a newly offered network plan, in a manner and form defined by rule of the commissioner, an access plan meeting the requirements of this Act for each of the managed care network plans the carrier offers in this state.

Drafting Note: States will establish different requirements for the access plan. Option 1 of Paragraph (1) above requires a health carrier to submit the access plan to the insurance commissioner for prior approval. Some states may prefer that a health carrier file the access plan with the insurance commissioner, but not require that the insurance commissioner take any action on the plan. This is Option 2 of Paragraph (1) below. Some states may also specify an agency other than the insurance department as the appropriate agency to receive or approve access plans.
Option 2. — Filing of Access Plan

(1) Beginning [insert effective date], a health carrier shall file with the commissioner, in a manner and form defined by rule of the commissioner, an access plan meeting the requirements of this Act for each of the network plans the carrier offers in this state.

Drafting Note: States will establish different requirements for the access plan. Option 2 of Paragraph (1) above requires a health carrier to file the access plan with the insurance commissioner, but does not require the commissioner to take action on the plan. Some states may want require the commissioner’s approval of access plans, which is in Option 1 of Paragraph (1). Other states may prefer that a health carrier not file the access plan with the insurance commissioner but, instead maintain the plan on-file at the health carrier’s place of business and make it accessible to the commissioner and others specified by the commissioner. Some states may also specify an agency other than the insurance department as the appropriate agency to receive or approve access plans.

Drafting Note: States may want to consider defining “material change for purposes of Paragraph (3) above.

“Material change” is a change in the composition of a health carrier’s provider network or a change in the size or demographic characteristics of the population enrolled with the health carrier that renders the health carrier’s network non-compliant with one or more of the network adequacy standards set forth at Section 5 of this Act or rules adopted pursuant to that section.

(3) The access plan shall describe or contain at least the following:

... 

(12) The health carrier’s system for appropriately informing providers of their network status on any plan in which they are included in-network. Issuers must inform physicians of the marketplace networks to which they are added;

Comment: The AAP makes the above recommended edits to indicate that quantitative measures of network adequacy must be created and overseen by the Insurance Commissioner. Moreover the list of sample quantitative measures has been expanded upon to provide additional details and considerations for states to implement such measures. In
addition, the AAP advocates that health plans must include all essential community providers in a geographic area, with a specific emphasis on inclusion of children’s hospitals.

As noted above, the AAP does not agree with a requirement less than submission of an access plan to the Insurance Commissioner for meaningful review and approval using appropriate measures of network adequacy. We therefore have deleted Option 2, above.

We have removed the Drafting Note suggesting a state definition of “material change” and instead added a comprehensive definition of the term, to ensure that plans must take action to update access plans when a change occurs that renders the plan out of compliance with an existing standard of network adequacy.

Finally the AAP adds further measures that must be included in access plans, including details of access to pediatric services, and the manner in which providers will be notified of network status.

**Section 6. Requirements for Health Carriers and Participating Providers**

A health carrier offering a managed-care network plan shall satisfy all the requirements contained in this section.

...

**B. A health carrier shall appropriately inform providers of their network status on any plan in which they are included in-network.**

...

**L. (1)(a) A health carrier and participating provider shall provide at least sixty (60) days written notice to each other before terminating the contract without cause.**

*Drafting Note: In addition to without cause contract terminations, with respect to tiered network plans, states may want to consider the implications that consumers may face, including continuity of care and financial implications, when a participating provider is reassigned in the middle of a policy or contract year to another tier with higher cost-sharing requirements.*

(b) The health carrier shall make a good faith effort to provide written notice of a termination within fifteen (15) working thirty (30) days of receipt or issuance of a notice of termination to all covered persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause.

(c) Where a contract termination involves a primary care professional, all covered persons who are patients of that primary care professional shall also be notified. Within five (5) working days of the date that the provider either gives or receives notice of termination,
the provider shall supply the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier.

(2)(a) (i) For purposes of this paragraph, “active treatment” means regular visits with a provider to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment or modify a treatment protocol.

(ii) “Active treatment” does not include routine monitoring for a chronic condition (e.g., monitoring chronic asthma, not for an acute phase of the condition). “Acute condition” means a medical condition involving a sudden onset of symptoms that requires prompt medical attention and that has limited duration.

(iii) “Terminal illness” means an incurable or irreversible condition that has a high probability of causing death within one year or less.

(iv) “Special circumstance” means a condition in which the treating physician or health care provider believes that discontinuing care by the treating physician or provider could cause harm to the covered person. Examples of a covered person who has a special circumstance include a covered person with a disability, a mental health condition, or a substance use disorder; acute condition or life-threatening disease or a covered person who is past the 24th week of pregnancy; or a person who has prior authorization for a procedure or surgery by a provider who subsequently leaves the network.

(b) Whenever a provider’s contract is terminated without cause, the health carrier shall allow affected covered persons with acute or chronic medical conditions in active treatment to continue such treatment until it is completed or for up to ninety (90) days, whichever is less.

(c) In the event that a provider’s contract is terminated without cause and the provider treats pregnant covered persons, the health carrier shall allow affected covered persons in their second or third trimester of pregnancy to continue care with the provider through the postpartum period.

(d) In the event that a provider’s contract is terminated without cause and the provider treats covered persons with terminal illnesses, the health carrier shall allow affected covered persons to continue care with the provider for the duration of their illness.

(e) In the event that a provider’s contract is terminated without cause and the treating physicians or health care provider identifies a special circumstance with respect to the covered person, the health carrier shall allow the covered person to continue care with the provider until the course of treatment ends or until the effective date of new health benefit plan coverage, whichever is less.
(f) In the event that a treating physician or health care provider identifies a patient with an acute or chronic medical condition in active treatment or a special circumstance who enrolls in new health benefit plan coverage for which the treating provider is not a participating provider, the health carrier shall allow the covered person to continue care with the treating provider until the course of treatment ends or for up to 90 days, whichever is less.

(c) A health carrier shall agree to extend its obligation to reimburse the treating physician or provider for ongoing treatment at the in-network rate for the duration of time specified for one of the conditions under paragraph 2 if:

The health carrier agrees that a condition for which ongoing treatment is being provided is a special circumstance; and

(ii) The contract termination was not “for cause.”

(d) Except as provided in Subparagraph (e) of this paragraph, the health carrier’s obligation to reimburse the treating physician or provider for ongoing treatment of a covered person ends the earlier of:

(i) The next plan renewal date; or

(ii) The course of treatment ends.

(e) If the covered person is past the 24th week of pregnancy at the time of termination, the health carrier’s obligation to reimburse the treating physician or provider extends through delivery of child and applies to immediate postpartum care and a follow-up check-up within the 6-week period after delivery.

Comment: The AAP strongly recommends the above edits to ensure that providers are appropriately informed of those plans to which they are included in-network. Further the AAP recommends that treatment continues when a physician and network end their contractual relationship in those circumstances where it is of benefit to the child. The above edits reflecting these recommendations are particularly important for children with special health care needs (CSHCN).

Section 7. Disclosure and Notice Requirements

A. A health carrier for each of its network plans shall develop a written disclosure or notice to be provided to covered persons at the time of pre-certification, if applicable, for a covered benefit to be provided at an in-network hospital that there is the possibility that the covered person could be treated by a provider that is not in the same network as the hospital. Such disclosure shall include whether a health care provider
scheduled to provide the service is an in-network provider, a description of the methodology used by the carrier to reimburse for out-of-network services, if applicable, and the amount that the covered person would be required to pay for out-of-network services.

B. For non-emergency services, as a requirement of its provider contract with a health carrier, a hospital shall develop a written disclosure or notice to be provided to a covered person of the carrier within ten (10) days of an appointment for in-patient or outpatient services at the hospital or at the time of a non-emergency admission at the hospital that confirms that the hospital is a participating provider of the covered person’s network plan and informs the covered person that a physician or other provider who may provide services to the covered person while at the hospital may not be a participating provider in the same network as the hospital. Such disclosure shall include an estimate of the approximate charges that may be billed to the covered person for services provided by a non-participating provider.

Comment: If families are penalized financially for not receiving care from in-network providers, adherence to plan rules is based on complete transparency as to which providers are considered in-network. The above AAP recommended changes reflect requirements to ensure families know the network status of providers from whom they are receiving care.

Section 8. Provider Directories

A. (1) A health carrier shall post online a current provider directory for each of its network plans with the information and search functions, as described in Subsection C. In making a directory available online, the carrier shall do so in a manner that:

(a) Makes clear which providers are included in-network in a given health plan; and

(b) Does not require a covered person or prospective covered person to log in or enter a policy number in order to access the applicable provider directory.

(2) The health carrier shall update each network plan provider directory at least monthly and it shall be offered in a manner to accommodate individuals with limited-English language proficiency or disabilities.

(3) A health carrier shall provide a print copy of a current provider directory with the information described in Subsection B upon request of a covered person or a prospective covered person.

(4) For each network plan, a health carrier shall include in plain language, as clearly as possible, in both the online and print directory, the following general information:
(a) The type of plan (i.e. HMO, PPO, EPO, etc.) and whether there is coverage for services provided by out-of-network providers;

(b) The methodology used, if any, for determining the payment amount for out-of-network services and the covered person’s liability for additional costs;

(c) The breadth of the network;

(d) The standards or criteria used for including or tiering a participating provider and the cost-sharing and out-of-pocket limit differentials that may result from using a non-participating provider or a provider in a tier other than the lowest cost-sharing tier;

(e) The carrier’s process for allowing covered persons to use out-of-network providers with in-network cost-sharing in situations where a suitable in-network provider is not available on a timely basis; and

(f) The email address and phone number that covered persons or the public can use solely to directly notify the plan when provider directory information is inaccurate.

B. The health carrier shall make available in print the following provider directory information for each network plan:

(1) For health care professionals:

(a) Name;

(b) Gender;

(c) Contact information;

(d) Specialty; and

(e) Network tier to which the professional is assigned, if applicable; and

(f) Whether accepting new patients.

(2) For hospitals:

(a) Hospital name;

(b) Hospital location and telephone number; and

(c) Hospital accreditation status; and

(d) Network tier to which the hospital is assigned, if applicable.
(3) *Except hospitals, other facilities by type:*

*(a)* Facility name;

*(b)* Facility type;

*(c)* Procedures performed; *and*

*(d)* Network tier to which the facility is assigned, if applicable; *and*

*(e)* Facility location and telephone number.

...

**D. In any instance in which a covered person receives covered benefits from a non-participating provider due to a material inaccuracy in the provider directory indicating that the provider is a participating provider, the carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from a participating provider.**

Comment: The above recommended edits would ensure that families receive additional and meaningful information when viewing a provider directory to determine whether a given network will meet family needs. This information is vitally important for families to be able to make informed decisions about the plans they choose and the care they receive.

In closing, the AAP appreciates NAIC efforts to move toward accurate documentation of appropriate networks of providers for children. We thank you for the opportunity to provide comment on this important issue and look forward to the strengthening of the standards found in this Model Act to ensure that children are able to obtain real, meaningful access to care across the country. Should you have questions on our comments, please contact Dan Walter, Sr Policy & Government Affairs Analyst, at dwalter@aap.org or 847-434-4086 or Wendy Chill, Government Affairs Analyst at wchill@aap.org or 847-434-7797.

Sincerely,

Sandra G. Hassink MD, FAAP
AAP President

SH/dw