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December 22, 2025

The Honorable Bill Ferguson
President, Senate of Maryland
State House, H-107
Annapolis Maryland 21401

The Honorable Joseline Pena-Melnyk
Speaker, Maryland House of Delegates
State House, H-101
Annapolis Maryland 21401

Re: Report required by HB 1292/Ch. 648(2), 2025 (MSAR # 16476) – Health Insurance Provider Directory Updates

Dear President Ferguson and Speaker Pena-Melnyk:

Pursuant to HB 1292/Ch. 648(2), 2025 (MSAR # 16476), and in accordance with § 2–1257 of the State Government Article of the Annotated Code of Maryland; the Maryland Insurance Administration (MIA) shall report on any changes to regulations related to the accuracy of provider directories. Please find the responsive report attached.

Five printed copies of this report will be mailed to the DLS library for its records.

Should you have any questions regarding this report, please do not hesitate to contact me or my Associate Commissioner of External Affairs and Policy Initiatives, Jamie Sexton, at Jamie.Sexton@Maryland.gov.

Sincerely,

Marie Grant
Insurance Commissioner

cc: Sarah T. Albert, Department of Legislative Services (5 copies)

Health Insurance Provider Directory Updates

2025 Report

HB 1292/Ch. 648(2), 2025

Marie Grant
Commissioner

December 22, 2025

For further information concerning this document, please contact:

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This document is available in alternative format upon request
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The Administration's website address: insurance.maryland.gov

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Executive Summary

Insurance companies generally provide better benefits for seeing in-network providers, and publish lists of their in-network providers for members' use. It has been a problem that these directories are not accurate or up to date. This creates difficulties for members in finding providers who are in-network. Over the years, as detailed below, laws have been passed to address this issue.

Chapter 648 of the Laws of 2025 amended provisions of §§ 15-112 and 15-112.3 of the Insurance Article related to provider directories. *See* 2025 Maryland Laws Ch. 648 (H.B. 1292) ("AN ACT concerning Health Insurance—Provider Directory—Required Updates") (the "Act"). Section 2 of the Act directed the Insurance Commissioner to report to the General Assembly ("Report") on any changes to regulations related to the accuracy of provider directories:

> SECTION 2. AND BE IT FURTHER ENACTED, That, on or before January 1, 2026, the Insurance Commissioner shall report to the General Assembly, in accordance with § 2–1257 of the State Government Article, on any changes to regulations related to the accuracy of provider directories.

The Maryland Insurance Administration ("MIA" or "Administration") has not yet changed the regulations, but has taken steps to investigate possible changes. These steps include a public meeting, where stakeholders had the opportunity to share their comments, both during the meeting and through written submissions afterward. Stakeholder comments will be addressed more fully below. Comments were submitted by health care providers and by carriers. In this Report, the terms "Carrier" and "Provider" are used as they are defined in § 15-112(a)(5) and (15):

> (5)(i) "Carrier" means:
> 1. an insurer;
> 2. a nonprofit health service plan;
> 3. a health maintenance organization;
> 4. a dental plan organization; or
> 5. any other person that provides health benefit plans subject to regulation by the State.
> (ii) "Carrier" includes an entity that arranges a provider panel for a carrier.
> * * * * *
> (15) "Provider" means a health care practitioner or group of health care practitioners licensed, certified, or otherwise authorized by law to provide health care services.

The MIA is planning to propose regulations to strengthen provider directory requirements in Maryland. These will include requirements related to the current statutory provisions regarding a periodic review of a reasonable sample of the provider directory by the carrier.

Introduction

Provider directories are an important tool for members of health plans to access in-network care. "Provider directory" is also a defined term in § 15-112(a)(16) as follows:

> (16) "Provider directory" means a list of a carrier's participating providers and participating health care facilities.

It is important that members be able to rely on the accuracy of provider directories in order to quickly find a provider who will take their insurance. Instead, there are frequent reports that provider directories are not accurate.[1] Consumers may spend time trying to make appointments with providers listed in provider directories, only to find that a phone number does not work or the provider no longer takes their insurance.

There have been legislative attempts at the state and federal level to address this situation. In Maryland, as indicated above, the primary statute regarding provider directories is § 15-112 of the Insurance Article. Problems persist despite these laws.

Carriers[2] state that health care providers fail to update their information timely. Health care providers indicate that there are administrative burdens to comply with carriers' requests for data verification. These positions will be addressed in greater detail below.

The MIA held a public meeting, solicited comments from stakeholders, and reviewed regulations in other states. As a result, the MIA is considering proposing regulations to clarify what a review of a reasonable sample size of the directory should entail.

Legislative Background

Maryland has had various amendments to § 15-112 of the Insurance Article that were intended to improve the accuracy of provider directory listings.

Chapter 597 of the Laws of 2006 added requirements that carriers verify whether providers were accepting new patients at the time of credentialing and recredentialing, and update the information, and that carriers update provider information within 15 working days after receipt of written notification from a participating provider of a change in their information. *See* 2006 Maryland Laws Ch. 597 (H.B. 1003).

Chapter 309 of the Laws of 2016 added the requirement that a carrier must have a customer service phone number, email, or other electronic means for a member or prospective

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[1] *See, e.g*. Haeder and Zhu, American Journal of Managed Care, Persistence of Provider Directory Inaccuracies After the No Surprises Act, November 7, 2024; Assessing the Persistence of Provider Directory Inaccuracies in Pennsylvania, https://www.pa.gov/content/dam/copapwp-pagov/en/insurance/documents/public-hearings-outreach-spcl-proj/network-adequacy/provider-directory-inaccuracies-report-extended.pdf.

[2] Carriers include health maintenance organizations, nonprofit health service plans, and insurance companies.

member to notify the carrier of inaccurate information in the provider directory, and that the carrier must investigate and take corrective action, if needed, within 45 working days. Another provision required carriers to periodically review at least a reasonable sample size of the provider network directory for accuracy or contact providers in the directory who had not submitted a claim in the last 6 months to determine if the providers intended to remain in the network. The new law laid out data elements to be included in a directory listing. Another provision required carriers to update the information provided on the internet at least every 15 days. *See* 2016 Maryland Laws Ch. 309 (H.B. 1318).

Chapter 648 of the Laws of 2025 changed "network directory" to "provider directory" and changed the requirement to update internet directories every 15 days to every 2 working days, except for dental carriers. This made the Maryland requirements more similar to federal requirements. *See* 2025 Maryland Laws Ch. 648 (H.B. 1292).

The federal Consolidated Appropriations Act of 2021 included the No Surprises Act, which had a provision regarding provider directories. *See, e.g.,* Public Law 116-260, Division BB, Section 109; *et inter alia,* 42 USCA § 300gg-115 ("Protecting patients and improving the accuracy of provider directory information"); 42 U.S.C.A. § 300gg-111; 26 U.S.C.A. § 9816, I.R.C. § 9816. The No Surprises Act required carriers to establish a process to verify and update the provider directory information no less often than every 90 days and remove providers for whom information cannot be verified. If a provider updates information, the carrier must update information within 2 working days. The No Surprises Act also requires providers to have processes to ensure that they update provider directory information when the contract begins or ends, or when there are material changes to the information. The No Surprises Act states in pertinent part:

> (2) Verification process
> The verification process described in this paragraph is, with respect to a group health plan or a health insurance issuer offering group or individual health insurance coverage, a process--
>
> (A) under which, not less frequently than once every 90 days, such plan or such issuer (as applicable) verifies and updates the provider directory information included on the database described in paragraph (4) of such plan or issuer of each health care provider and health care facility included in such database;
>
> (B) that establishes a procedure for the removal of such a provider or facility with respect to which such plan or issuer has been unable to verify such information during a period specified by the plan or issuer; and
>
> (C) that provides for the update of such database within 2 business days of such plan or issuer receiving from such a provider or facility information pursuant to section 300gg-139 of this title.

42 USCA § 300gg-115(a)(2).

Public Meeting and Comments

On June 25, 2025, the MIA held a public meeting on the topic of provider directories. The record was held open for comments until July 9, 2025. The MIA asked the following questions in advance of the meeting:

1. The federal No Surprises Act has provisions regarding provider network directories. The Administration has authority to enforce the No Surprises Act. How should Maryland law be updated to be clearly consistent with the federal law, and prevent confusion as to the requirements? Is there consensus that the No Surprises Act requires a review of the entire provider network directory every 90 days?

2. Section 15-112(p)(3) requires carriers to "periodically review" their directories. If the Administration were to define this term through regulation, what is the appropriate frequency to require periodic reviews of provider directories, if not the 90 days specified in the No Surprises Act?

3. Section 15-112(p)(3) also uses the term "reasonable sample size." If the Administration were to define this term by regulation, what is a reasonable sample size to expect to be used when conducting a review of a provider directory?

4. What are the minimum required processes that should be undertaken as part of a provider directory review? For example: contact the provider's office, verify with the Board of Physicians, etc. What sources or processes are currently being used to collect and update provider information in directories?

5. Do carriers currently differentiate between a "meaningful error" and a "non-meaningful error" in a provider directory? For example, having directory information which lists the street address incorrectly versus listing the street address correctly, but the suite incorrectly. If not, is it reasonable to make the differentiation?

6. Should carriers be required to report to the Commissioner network directory inaccuracies discovered during their review, date of discovery, and the date of correcting discovered inaccuracies?

7. Should carriers be required to consider the number of received complaints related to inaccuracies in provider directories, and the result of those complaints in conducting their review of a provider directory?

8. In reviewing the information submitted to the Commissioner pursuant to § 15-112(p)(4), should the Administration conduct additional verification of the accuracy of the provider directory, and should there be a threshold that suggests noncompliance with the requirements of § 15-112(p)(3)?

9. If a carrier is unable to reach a provider to verify their contact information, what steps are currently being taken to verify the provider's information is accurate? What additional

steps, if any, are reasonable to expect to be taken? Should the provider information be presumed to be accurate, and remain in the provider directory, or presumed to be inaccurate and removed from the provider directory?

10. What mechanisms are in place to address changes in practice locations, specialties, or acceptance of new patients?

11. How are duplicate records for the same provider currently handled?

12. Should certain provider types, such as hospitals, be exempt from, or have different, periodic review requirements for provider directories? Please explain.

13. If an inaccuracy is discovered (through any method) and not corrected in a certain time period, what would be an appropriate penalty/range of penalties to impose?

14. Are carriers currently collecting data regarding the frequency of out-of-network providers being treated as in-network due to the requirements under the No Surprises Act?

The MIA received comments from health care providers asking that all carriers be required to use the Council for Affordable Quality Healthcare ("CAQH") system for verification of provider information.[3] The CAQH system requires attestation of accuracy every 120 days. Their Directory Management system may be reached using this link: https://www.caqh.org/solutions/provider-data/directory-management. Using this system would reduce administrative burden on providers as compared to interacting with each carrier every 90 days. CareFirst BlueCross BlueShield also expressed support for using the CAQH system to verify information, but noted that providers could use their portal to update information. The MIA will be unable to designate the CAQH as a central verification system for reasons explained in the "Next Steps" section below unless Maryland law is changed.

At the public meeting, carrier representatives indicated that they put effort into verification, but providers do not respond. Carriers do not want to remove providers who do not respond from their networks, because they want a robust network. There were also concerns that large provider groups provide inaccurate information for the practitioners within the group.

Other States

The MIA reviewed the laws regarding provider directories of other states, primarily Illinois (*see, e.g.,* 215 ILCS 124/25 "Network transparency"), Colorado (*see, e.g.,* C.R.S.A. § 10-16-146 "Periodic updates to provider directory"), and Massachusetts (*see, e.g.*, M.G.L.A. 176O § 28 "Provider directories; contents; audits; print copies; customer service contact information; accommodations; accuracy; updates"). These states set requirements for the audits by carriers of their provider directories. They included time frames and percentages for the audits, for example, no less frequently than quarterly, the carrier must audit 20% of the directory

[3] https://www.caqh.org/.

and update the directory based on the findings. These other states also had requirements for document retention and reporting to the Commissioner of audit results.

Massachusetts had more specific requirements for behavioral health providers and their listings than for medical and surgical providers. (*see* 211 CMR § 52.15(20)).

Next Steps

The MIA will post draft regulations for comment. The regulations will provide minimum standards for a periodic review of at least a reasonable sample size of its network directory for accuracy. It should be noted that § 15-112(p) of the Insurance Article allows a carrier to comply either through a periodic review of a reasonable sample size, or by contacting providers in the directory who have not submitted a claim in the past 6 months.

The MIA considered the requests from providers to designate CAQH as a central verification system. Section 15-112.3 of the Insurance Article allows the Commissioner to designate a multi-carrier common online provider directory information system, from which carriers would be required to accept provider information updates. This system had to meet these standards:

(1) the system is available to providers nationally;

(2) the system is available to providers at no charge;

(3) the system allows providers to:

(i) attest online to the accuracy of their information; and

(ii) 1. correct any inaccurate information; and

2. attest to the correction; and

(4) the nonprofit alliance has a well–established mechanism for outreach to providers.

§ 15-112.3(b).

CAQH is no longer a nonprofit, and so does not meet these standards. The MIA is not able to designate CAQH as the multi-carrier common online provider directory information system. However, the MIA will consider whether there are ways to address the concerns of providers in regulations.

The MIA will continue to work with stakeholders to improve the accuracy of provider directories. Draft regulations will be posted for comment, and all comments considered before moving forward with the process.