Health Insurer and Provider Perspectives in Idaho

Idaho Health Insurers Working Group

Presented by: Frances Lippitt, Analyst

September 15, 2026

Three questions we'll explore

What are the policy considerations?

Measurement
Claims process standardization

Where do insurers and providers agree?

12 Insurers
7 Healthcare Providers
2 Healthcare Provider Associations

What does the data show?

Workbook metrics are used to assess performance patterns.

LSO
Legislative Services Office

Policy considerations

1. Comparability

New reporting should use common definitions, common run-out rules, and common denominators; otherwise, comparisons may mislead.

2. Administrative burden

Both providers and insurers identify unnecessary variation as a cost. The policy question is which variation is clinically useful and which is avoidable.

3. Access guardrails

Any cost-control intervention should be evaluated for rural access, workforce, service lines, and continuity of care.

4. Market power

Consolidation, provider contracting, facility fees, site-of-care differences, and freestanding emergency models may require separate evidence-based review.

5. Pharmacy

Specialty drugs, infused medications, biosimilars, site of administration, and PBM/vendor oversight are repeatedly cited and should be measured distinctly.

6. Governance

Insurers broadly acknowledge responsibility for delegated functions, but legal duties and reporting obligations should be clear to patients and providers.

Where insurers and providers agree

POINTS OF AGREEMENT

- Administrative standards and electronic data exchange should improve.
- Medical-necessity denials should involve qualified human review.
- Cost-control should preserve access, quality, patient safety, and outcomes.
- Rural workforce shortages and specialty access gaps are central problems.
- Pharmacy and specialty drug spending are major cost drivers.
- Insurers remain accountable for vendor/delegated-function performance.

POINTS OF DISAGREEMENT / TENSION

- Are delayed claims mostly provider-submission defects or insurer process friction?
- Are rising premiums primarily provider price growth or broader system complexity?
- Should policy focus first on hospital prices/facility fees/consolidation or payer rules/denials/payment practices?
- How should network adequacy be measured: directories and time-distance, or actual service-line access and wait times?
- How much public reporting is enough before it becomes another administrative cost?

Opportunity: measurement and transparency

Create an annual Idaho health insurance performance data call and public dashboard.

- Route through DOI using defined metrics and common templates.
- Use claims run-out rules and publish caveats for low-credibility populations.
- Include claims denials, appeal rates, overturns, payment timeliness, accepted-but-unpaid aging, reprocessing/downcoding, provider complaints, prior authorization, and network access.
- Require methodology notes and denominator definitions.

RECOMMENDED DASHBOARD DOMAINS

- **Claims:** volume, initial denial, reasons, appeals, overturns
- **Payment:** clean-claim timeliness, aged unpaid claims, statutory interest
- **Utilization management:** PA volume, approval, denial, appeal, turnaround
- **Access:** appointment availability, time-distance, OON use, complaints
- **Cost:** premium, claims, admin, pharmacy, reserves, operating result

Opportunity: administrative simplification

1. Standardize prior authorization

Adopt uniform PA forms, attachment requirements, status fields, denial codes, response timelines, and continuity-of-care processes.

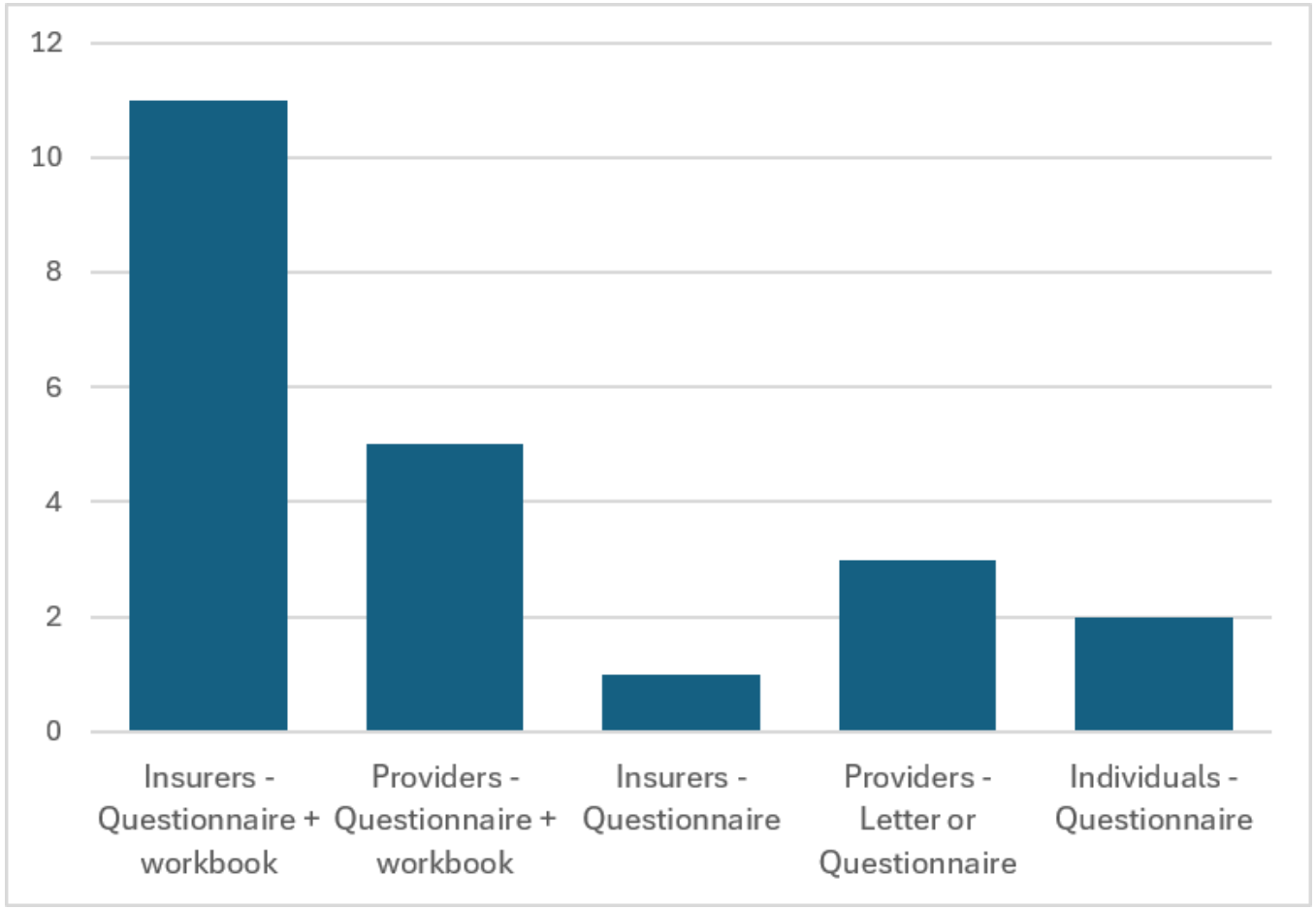
2. Reduce low-value PA

Require periodic review of services with high approval rates and low risk; consider gold-carding for high-performing providers and automatic removal when prospective review adds little value.

3. Pair insurer + provider metrics

Measure not only denials and turnaround times, but the administrative touchpoints created: resubmissions, requests for information, peer-to-peer, claim corrections, and appeals.

Respondents



Insurers

- Regence
- Blue Cross of Idaho
- Cigna
- Moda Health Plan
- Mountain Health COOP
- United Healthcare
- Select Health
- Pacific Source
- St Luke's Health Plan
- Molina Healthcare
- Aetna Life Insurance Company
- Aetna Health of Utah

Providers

- Madisonhealth
- Portneuf
- St Luke's
- Steele Memorial Medical Center
- Idaho Skin Institute
- CDA Spine and Brain
- Premier Eye Care of Eastern Idaho
- Idaho Medical Association
- Idaho Hospital Association

LSO
Legislative Services Office

Executive summary

Insurers' perspectives

- Prior authorization is a targeted tool.
- Most denials are not medical-necessity denials.
- Delays often originate with incomplete provider submissions.
- Premiums follow provider prices, pharmacy costs, utilization, workforce limits, and market dynamics.

Providers' perspectives

- Administrative burden from insurers' varied requirements for documentation, prior authorization, denial codes, appeals, reprocessing, and payment rules creates delays in care.
- Rural and independent providers are least able to absorb the burden.

What the data suggests

- Denial rates, clean-claim payment, and prior authorization metrics vary significantly by carrier.
- Provider data show high and rising payer workflow volume and narrowing operating margins.

Insurers' Responses & Data

12 respondents

11 data submissions

LSO
Legislative Services Office

Insurers' themes

Efforts to reduce administrative burden & maintain human clinical oversight

- Reviewing and reducing prior authorization lists for low-risk / high-approval services.
- Electronic prior authorization, portals, and real-time status tools are presented as the main path to lower burden.
- Automation is a tool for faster approvals.
- Human clinical review is reported for medical-necessity denials.

Access Barriers

- Provider shortages, rural geography, and specialty capacity are cited as major access barriers.

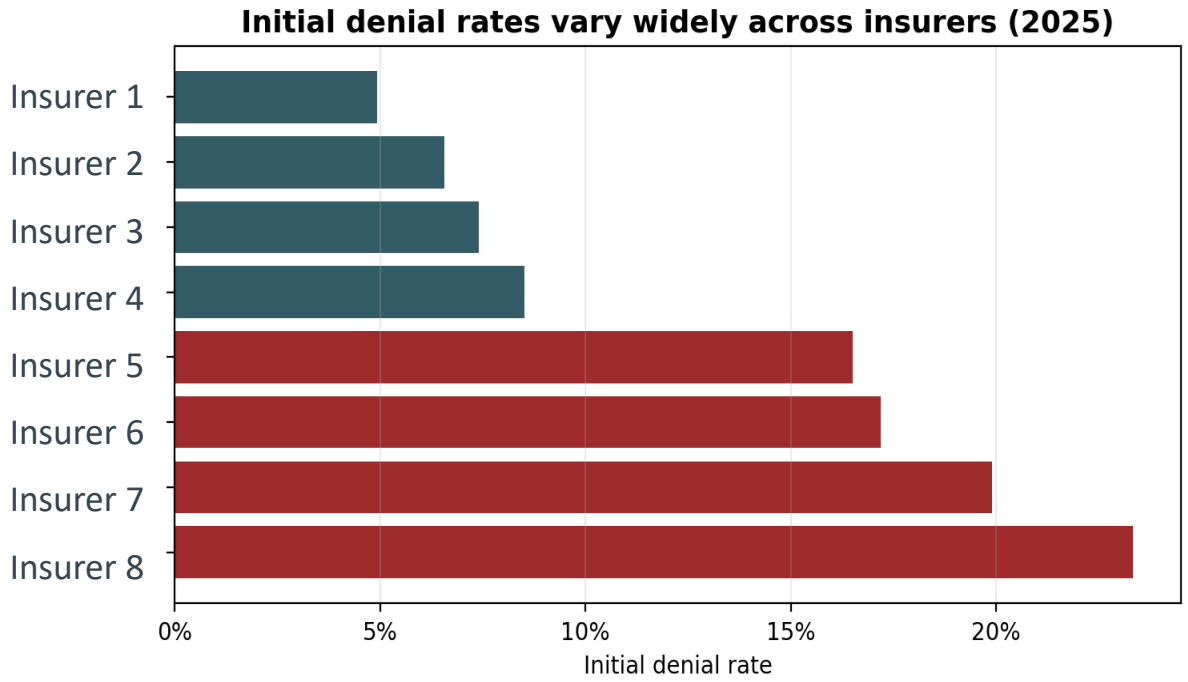
Premium Drivers

- Pharmacy, specialty drugs, provider unit prices, consolidation, utilization, and policy changes.

Insurer policy preference

Use existing DOI/federal reporting where possible; add new reporting only with consistent definitions, feasible timelines, and protection for confidential data.

Denial rates vary widely



Interpretation

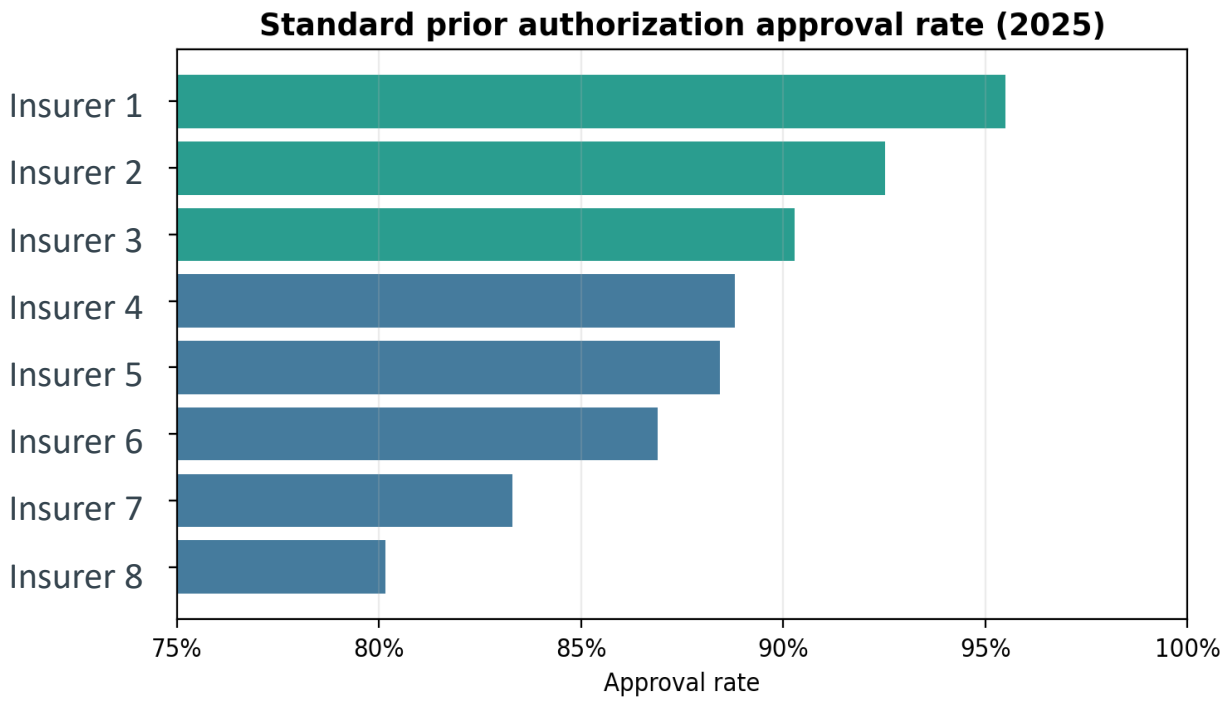
Variation may reflect real performance differences, but also different definitions, market mix, duplicate claims, benefit design, and claim-editing practices. This is exactly why standard definitions matter.

Questionnaire comparison

Insurers generally state that most delays are caused by incomplete, inaccurate, duplicate, or ineligible claims. Providers state that inconsistent payer rules and denial explanations create avoidable rework. The data show variation large enough to warrant a common reporting framework.

LSO
Legislative Services Office

Prior auth. approval is high, but not uniform



What supports insurer narratives

Several insurers report removing PA requirements, using electronic submission, and approving routine requests quickly. High approval rates support reducing or gold-carding low-risk, consistently approved services.

What supports provider concerns

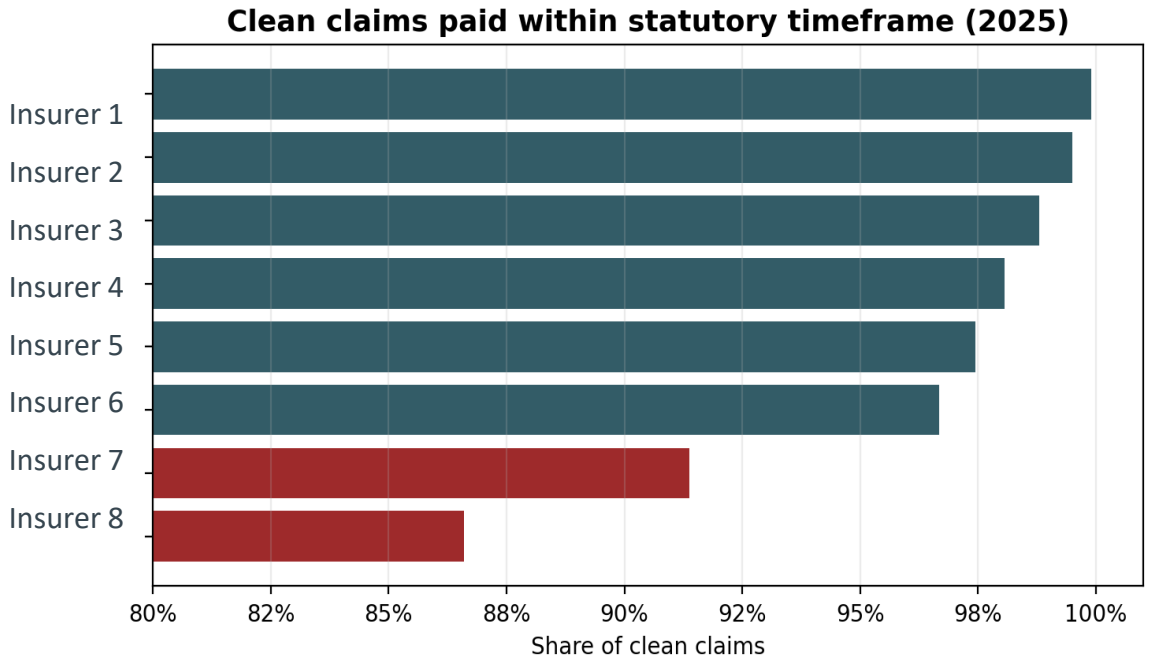
Even high approval rates can still create administrative cost when volume is large, rules vary by payer, documentation standards differ, and clinicians must delay or staff must follow up.

Practical policy signal

Prioritize service lines with high approval rates, low clinical risk, and high administrative volume for standardization, automation, or removal.

LSO
Legislative Services Office

Clean-claim payment performance varies



Data signal

2025 clean-claim payment within statutory timeframe ranges from the high 80s to 99.9% among reporting insurers. Some respondents report 2023–2024 disruptions or lower rates.

Questionnaire comparison

Insurers cite unclean claims, coding/eligibility/COB, duplicate submissions, and missing documentation. Providers cite inconsistent communication, misrouted claims, reprocessing, and denial-code variation.

Policy signal

A clean-claim metric is necessary but insufficient: pair it with accepted-but-unpaid aging, reprocessing/downcoding, appeal outcomes, and provider complaint resolution.

LSO
Legislative Services Office

Claims consume most premium

Carrier	Earned premium	Claims expense	As % of Premium
Blue Cross of Idaho	$1.66B	$1.60B	**96.6**
Regence	$751.6M	$657.2M	**87.4**
SelectHealth	$391.3M	$347.8M	**88.9**
PacificSource	$201.9M	$208.0M	**103.0**
St. Luke's HP	$74.6M	$61.2M	**82.0**
Mountain CO-OP	$73.9M	$67.9M	**91.9**
Moda	$20.9M	$22.6M	**108.3**
Molina	$7.3M	$6.7M	**91.4**

Caution

Market entry, enrollment shifts, risk adjustment, product mix, and reserve/accounting treatment can materially affect annual results.

LSO
Legislative Services Office

Providers' Responses & Data

9 respondents

5 data submissions

LSO
Legislative Services Office

Providers' themes

Administrative burden

Providers describe payer-specific rules for prior authorization, documentation, claim edits, denial explanations, appeals, and reprocessing. St. Luke's calls standardization the "greatest opportunity." Madisonhealth similarly requests standardized documentation and criteria.

Access and financial strain

Providers connect rising labor and supply costs, Medicaid reimbursement pressure, delayed/reduced reimbursement, acuity, and patient affordability to narrower margins and delayed care.

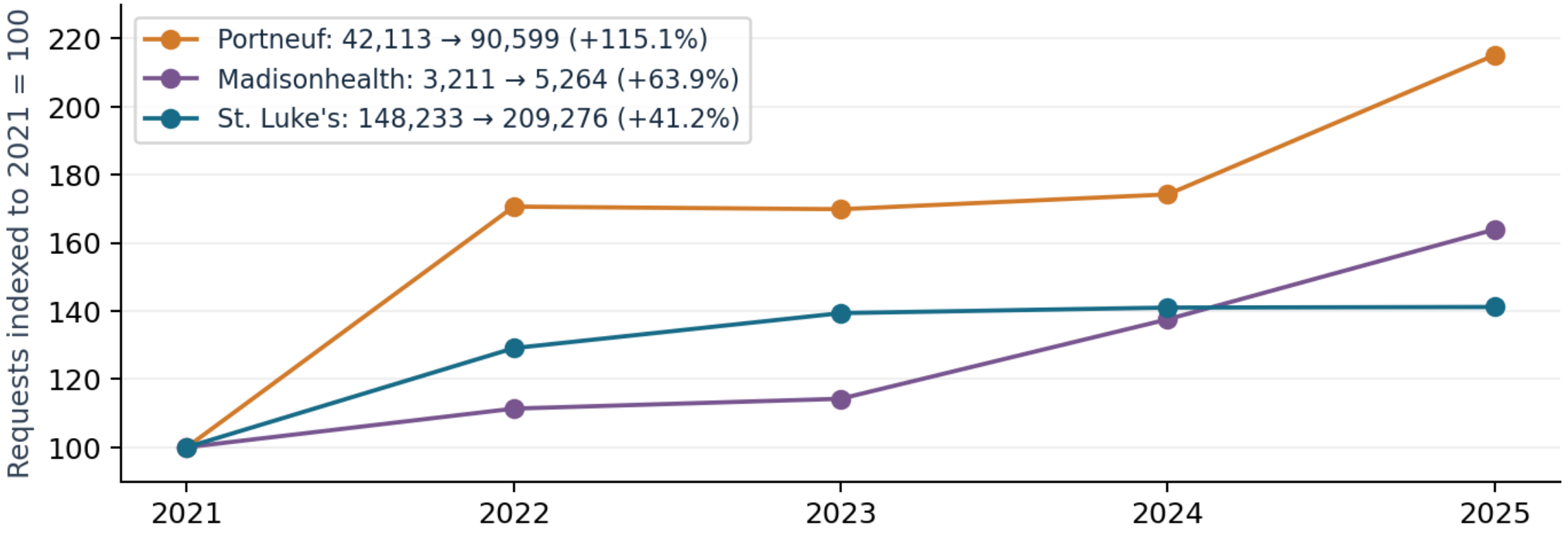
Network adequacy lens

Portneuf argues that network adequacy should be measured as meaningful access to comparable local care, not merely provider counts or distance standards.

Consolidation and rural nuance

Madisonhealth identifies both risks and benefits of consolidation; St. Luke's asks for clearer definitions and cautions against policies that undercut essential services.

Prior auth. volume appears substantial

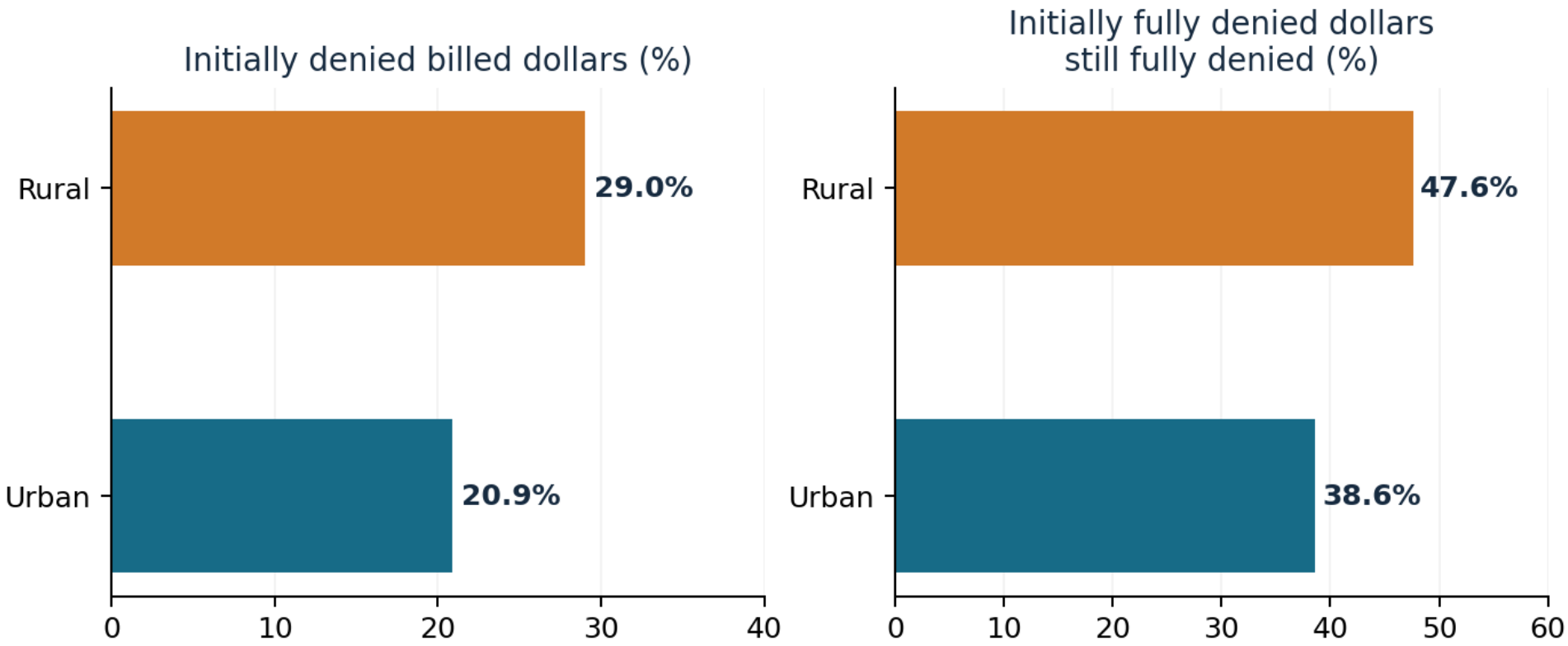


Policy signal

The working group would need more responses from providers and data preceding the pandemic to establish a trend.

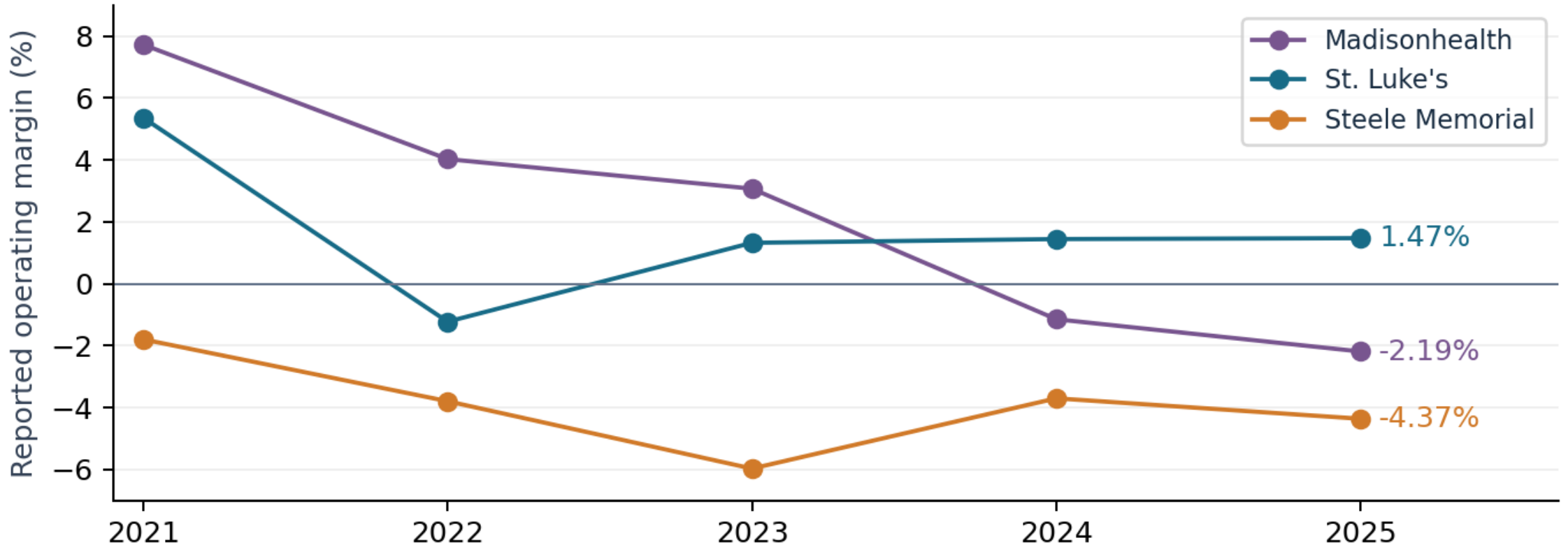
LSO
Legislative Services Office

Rural payment friction



LSO
Legislative Services Office

Margins are under pressure



Policy signal

Cost-control policy should explicitly test rural access, essential services, behavioral health, maternity, specialty care, and workforce effects before assuming savings are neutral.

LSO
Legislative Services Office

Opportunities

1. An annual data call would improve accountability and clarify policy opportunities.

Agree on a core data set for insurer performance, provider burden, and access, with definitions that can survive across years.

2. Process standardization across insurers would reduce administrative friction.

Prior authorization data elements, forms, attachments, denial codes, status transactions, and appeal pathways are near-term candidates for standardization.

LSO
Legislative Services Office

Appendix. Respondents & sources

Category	Questionnaire / narrative	Workbook used
Provider	Idaho Hospital Association	Aggregate hospital data
Provider	St. Lukes Health System, Madison Health	Yes
Provider	Portneuf, Steele Memorial Medical Center, Idaho Skin Institute, CDA Spine and Brain, Premier Eye Care of Eastern Idaho, Idaho Medical Association	No structured workbook
Insurer	Regence, Blue Cross of Idaho, SelectHealth, PacificSource, Moda, Mountain Health COOP, Molina, St. Luke's Health Plan, Cigna, Aetna Life Insurance Company, Aetna Health of Utah	Yes
Insurer	United Healthcare	Declined workbook
Individual	William Laude, Joshua Tolman	No

Appendix. Suggested minimum annual metric set

Domain	Minimum metrics
Claims	Total claims, clean claims, initial denials/rejections, denial reasons, duplicate claims, coding/eligibility/coverage categories
Appeals	Appeal rate, overturn rate, partial payment, median time to resolve, peer-to-peer volume
Prior authorization	Request volume, approval/denial rates, median and 90th percentile decision time, high-approval service list, continuity-of-care outcomes
Payment	Clean-claim payment timeliness, accepted-but-unpaid claims at 30/60/90/180 days, reprocessing, recoupments, statutory interest
Access	Appointment availability by specialty, time-distance, provider-to-member ratios, OON use, single-case agreements, access complaints
Cost	Premium, claims expense, admin expense, pharmacy/specialty Rx, reserves, operating results, total cost of care PMPM

Appendix. Individual Testimony

Joshua Tolman's testimony presents a perspective that healthcare affordability challenges are driven substantially by provider pricing and the setting in which care is delivered. He argues that Idaho insurers can play a constructive role in cost containment by creating incentives that steer patients toward lower-cost care settings, and he encourages the Working Group to closely examine hospital pricing, profitability, and market dynamics alongside insurer practices when evaluating healthcare costs in Idaho.

William Laude is alleging that Regence improperly handled a medication coverage denial and subsequent appeals process, and he is requesting documentation to determine whether the insurer followed its own review procedures before he pursues an external review.