2026

National Trends Surrounding Health Insurer Performance and Idaho's Recent Legislation and Data Needs

IDAHO HEALTH INSURERS WORKING GROUP

LSO

Legislative Services Office

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EXECUTIVE SUMMARY

The following report is a collection of recent findings relevant to the health insurance industry. Focus has been given to findings related to the Idaho Health Insurers Working Group's charge:

> Study the performance of health insurers in Idaho, but not limited to their rates of claim denial and yield on expected reimbursement to providers, delays in treatment caused by prior authorization decisions and related practices, and the amount insurers owe to providers in accepted but unpaid claims; Study the effect of poor health insurer performance on the health of Idahoans; and Make recommendations to the Legislature on policy solutions to poor health insurer performance.

The request for this report was to identify national trends surrounding the industry and it should operate as background context, as specific data or findings may not be applicable to Idaho. Data sources and findings are indicated when possible

The report is broken down into the following categories, and brief descriptions of the findings are included:

1. National Trends for Claims Denials, Prior Authorization, and Delays in Payment.
    a. Claim denials and prior authorization denials/requirements appear to be increasing. Moreover, hospitals report increasing delays in receiving payment.

2. Effects of Poor Insurer Performance on Health Outcomes.
    a. Denied claims, prior authorization, and poor insurer performance may lead to adverse actions including treatment delays, denial of care, and increased administrative burdens for patients and providers.

3. Funding Models of State Employee Health Plans (SEHP).
    a. There are three main models for SEHPs. Idaho uses a hybrid model and is one of three states that do not have at least one self-funded plan.

4. Policy Decisions and Legislation Enacted in Other States.
    a. Other states have enacted legislation relevant to the working group's charge in areas such as prior authorization reform, appeal rights and other transparency initiatives, artificial intelligence utilization review, provider contracting, copay accumulators, step therapy, and prompt payment..

5. Updates: Federal Rules and the Health Insurer Industry.
    a. CMS published Final Rule CMS-0057-F in January 2024 and certain insurers were required to provide data on prior authorization practices. Moreover, leaders of the health insurance industry pledged to CMS to improve performance and data are being collected.

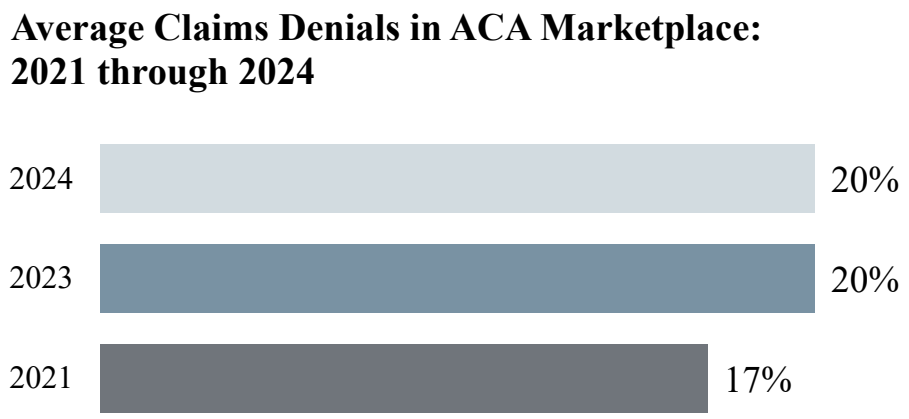
The remainder of the report contains the following Idaho specific information:

6. 2026 Insurance and Health Care Legislation Summaries.
7. Idaho Data Needs.

NATIONAL TRENDS FOR CLAIMS DENIALS, PRIOR AUTHORIZATION, AND DELAYS IN PAYMENT

DENIAL RATES FOR CLAIMS ARE INCREASING, BUT DATA ARE LIMITED

Data compiled by the Kaiser Family Foundation (KFF),[1] suggests that the number of denied claims has increased slightly in qualified health plans sold on the federal marketplace since 2021. The data does not include employer plans, Medicare, Medicaid, or state-based marketplaces; Idaho operates a state-based marketplace. Although limited in scope, the data represents the most recent analysis available for denial rates we could find, and it contains the most comprehensive data set that provides a semi-national picture. After analyzing hundreds of millions of claims in 2021, 2023, and 2024, KFF estimates ACA marketplace insurers denied the following percentages of claims on average:



Source: Kaiser Family Foundation publications 2021 through 2026

In 2024, the claims denial rates varied by insurer and by state and ranged from 3% to 36%.

Rising claim denial rates have also been reported by the Experian Health survey and the American Hospital Association (AHA). The Experian Health survey found that in 2025, 41% of providers faced denial rates of 10% or higher and that the figure has grown each year since at least 2022. The AHA found that claims denials increased an average of 20% from 2022 to 2023 for commercial claims and nearly 56% for Medicare Advantage claims.

[1] Kaiser Family Foundation (KFF) is an endowed national nonprofit organization that provides health policy analysis, polling, and journalism. www.kff.org

Reasons for Claims Denials by Administrative Category

KFF analyzed national denial reasons for claims denied among healthcare.gov plans from 2021 through 2024. The denial reasons are largely administrative by nature and may provide context for the working group. The nine categories analyzed, along with the estimated share of total claims as a percentage, are included below in Table 1.

Table 1: Reasons for Claims Denials Among HealthCare.gov Plans by Percentage: 2021 through 2024

Denial Reason	*Share of 2021* Denied Claims*	*Share of 2023 Denied Claims*	*Share of 2024 Denied Claims*
Other Reason not listed	76.5%	34%	36%
Administrative reason	-	21%	25%
Services excluded	13.5%	14%	13%
Enrollee Benefit Limit Reached	-	11%	5%
Lack of referral or PA	8%	9%	9%
Member not covered	-	5%	7%
Not medically necessary (no BH)	0.3%	5%	5%
Not medically necessary (BH)	1.7%	1%	<1%
Investigational, experimental, or cosmetic procedure	-	<1%	<1%

Source: KFF analysis of CMS Transparency in Coverage Data for years 2024, 2023, and 2021. Numbers may not match because of rounding.BH refers to behavioral health.
** KFF analysis of 2021 had fewer categories than 2023 or 2024.*

Prior Authorization Practices, Denials, and Costs

Like claims, prior authorizations can also be denied by health insurers. According to researchers writing in the Health Affairs Scholar, prior authorization is defined and characterized as,

> "…the process by which payers determine the medical necessity of specific procedures before allowing clinicians to provide the service, is estimated to account for $35 billion of US health care administrative spending…From the payer perspective, the primary goal of PA is to flag newer and better treatments for patients, improve the quality of care, and prevent excess and unnecessary utilization and spending, thereby improving the overall cost–quality balance of care."

In 2024, the American Medical Association (AMA) found that physicians complete 40 prior authorizations a week and that they spend 13 hours doing so.

In 2026, KFF analyzed data released by insurers as described in CMS-0057-F (this rule is examined in this report on page 12). From the newly provided data, KFF reported in 2025, Medicare Advantage insurers denied 12% of standard prior authorization requests, Medicaid managed care insurers denied 14%, and ACA Marketplace insurers denied 18%.

Evidence of Clinical Services Denied

During LSO's review of the literature, we found evidence to suggest that certain claims for clinical services, or prior authorization for those services, were denied at higher rates than others or exhibited issues after review.

- **Skilled Nursing Facility (SNF) Admission:** The Federal Department of Health and Human Services Office of Inspector General found that in 2024, of the 19 Medicare Advantage Organizations (MAO) that were reviewed, they denied around 12% of requests for SNF. However, when the denials were appealed, and 18% were, MAOs overturned 95% of the claims.

- **Long-term Care Hospitals (LTCH) and Inpatient Rehabilitation Facilities (IRF):** The Federal Department of Health and Human Services Office of Inspector General found that in 2024, of the 19 MAOs that were reviewed, they denied around 65% of requests for LTCH and 54% of IRF. However, when the denials were appealed, MAOs overturned 36% of LTCH and 43% of IRF denials on average.

- **Chemistry Studies:** Researchers from the University of Pennsylvania and CVS Health studied claims of Medicare Advantage beneficiaries. They found that chemistry studies represented about 57% of denied services and 29% of the denied spending share for services denied under Medicare's medical necessity rules. Under Medicare Advantage insurer rules for medical necessity, chemistry studies were 19% of the denied services and 11% of the denied spending share.

- **Post-Acute Care:** In 2024, the Federal Permanent Subcommittee on Investigations (PSI) found that Medicare Advantage insurers are intentionally using prior authorization to boost profits by targeting costly yet critical stays in post-acute care facilities. The PSI found that denial rates for post-acute care were substantially higher than those for other prior-authorization requests and that they increased for the three largest MAOs from 2019 to 2022.

Trends Surrounding Appeals for Denials

Evidence surrounding denial appeals is disjointed according to the plan type and whether the claim is denied or prior authorization is denied; however, evidence suggests that most denials are not appealed. Analysis by third parties further suggests that appeals are often successful when initiated and that rates of overturned denials may be rising.

In 2024, looking at qualified health plans sold on the federal marketplace, KFF researchers estimated that less than 1% of claim denials were appealed. They further estimated that 66% of the denied claims were upheld.

Looking at Medicare Advantage insurers in 2024, KFF estimated that denied prior authorization requests were appealed 11.5% of the time. However, they found that about 80.7% of appeals were partially or fully overturned.

The Commonwealth Fund surveyed over 4,500 individuals with private insurance in 2025 and found[2] that 47% of individuals reported not appealing a claim denial and 47% did not appeal prior authorization denials. The top cited reasons for not appealing a claim denial were:

- 56% of individuals were not sure they had the right;
- 55% did not think it would make a difference; and
- 34% weren't sure who to contact.

According to the survey, "Among those who challenged prior authorization denials, 30 % said that their insurer approved the recommended medical care, and a quarter received approval for a different type of care. But in one-third of appealed cases, the insurer continued to deny the care." Those who appealed a claim denial were successful 33% of the time.

In 2026, researchers with the University of Chicago examined over 50,000 closed cases in New York State. They found that around 46.7% of appeals that reached the state's third level of appeal with independent physicians were overturned, suggesting that persistence and independent review may lead to more overturned decisions. Overall, the researchers found that overturned denials increased from 38% in 2019 to 52.5% in 2025 even as the volume of appeals has more than doubled.

Delays in Payment for Providers

The data we found regarding delayed payment to providers was limited to a survey completed by the AHA. Between 2021 and 2022, the AHA surveyed 304 respondents representing 772 hospitals. The survey compilers found that 50% of health systems reported more than $100 million in accounts receivable for claims older than six months. In total, the hospitals responded that there were $6.4 billion in delayed or unpaid claims that were six months or older. Thirty-five percent of hospitals reported $50 million or more in foregone payments because of denied claims.

[2] The Commonwealth Fund is a private foundation that supports independent research on health care issues. https://www.commonwealthfund.org/

EFFECTS OF POOR INSURER PERFORMANCE ON HEALTH OUTCOMES

Denied claims, prior authorization, and poor insurer performance may lead to adverse actions including treatment delays, denial of care, and increased administrative burdens for patients and providers. In exceptional circumstances, physicians have reported serious adverse health events. It is outside the scope of this request; however, research assessing the impact of prior authorization on care utilization and spending should be kept in mind.

Denials and Delays in Treatment

According to survey data from the Commonwealth Fund and KFF, individuals reported significant delays for care and adverse effects from claims denials and prior authorization denials. Forty-one percent of the 2025 Commonwealth Fund survey respondents who experienced a prior authorization denial reported a delay in care and 28% reported worsening health problems. Respondents also indicated that denials raised anxiety and 45% said that claim denials led to medical debt.

KFF's 2026 poll found that 66% of respondents found delays and denials by health insurers to be a major problem and that 47% responded that they experienced their health insurance company denying or delaying care. Moreover, among those denied, delayed, or who had altered care, 26% indicated it had a major effect on their physical health, 33% a major effect on their finances, and 34% on their mental or emotional health.

Prior Authorization Practices and Health Outcomes

The AMA completed a survey in 2025 of about 1,000 physicians. The survey results suggested that 95% of physicians associated care delays with prior authorization issues and 79% reported that prior authorization issues can lead to abandoning a recommended treatment. Moreover, 26% of physicians indicated that prior authorization issues led to a serious adverse event for one of their patients.

In a 2025 review of the harmful effects of prior authorization practices in the American Journal of Medicine, researchers found that prior authorization requirements were associated with, "disease exacerbation, preventable hospitalization, prolonged hospital stay, and lower rates of disease-free survival" across a number of medical specialties.

Delays in Accessing Pharmaceuticals

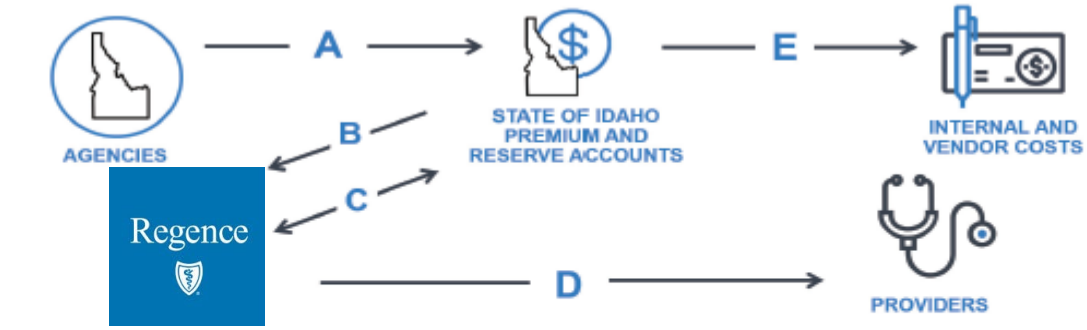
In 2026, researchers from the Johns Hopkins Bloomberg School of Public Health found that prior authorization practices can lead to delays in ultimately approved prescription medications. The researchers further found that patients with multiple disease conditions had lower approval rates.

FUNDING MODELS OF STATE EMPLOYEE HEALTH PLANS

State employee health plans (SEHPs) are available to public employees in all 50 states, though who can enroll varies. Three different funding models exist throughout the states: the hybrid funding model, the fully insured funding model, and the self-funded model. The National Conference of State Legislatures (NCSL) and the Georgetown University Center on Health Insurance Reforms report that all but three states, Idaho, North Dakota, and Wisconsin, offer at least one self-funded plan.

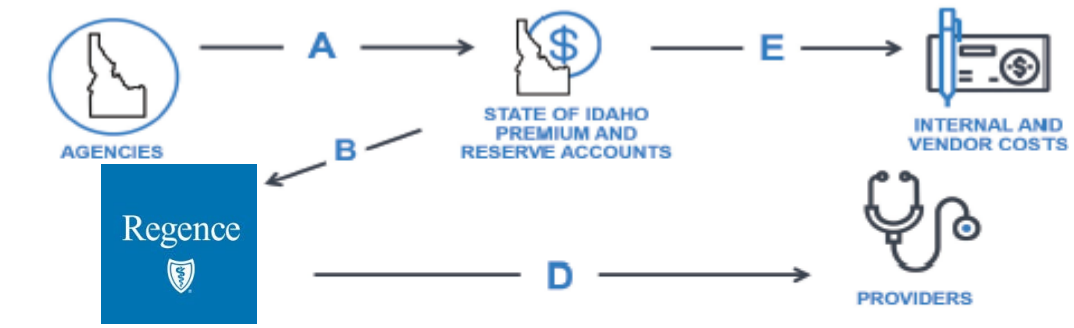
Idaho currently operates a hybrid funding model. More information on the models from the December 2020, State Health Plan Working Group Report produced by the Group Insurance Advisory Committee and Milliman is included below. The models have been updated to include the current carrier.

HYBRID SEHP FUNDING MODEL



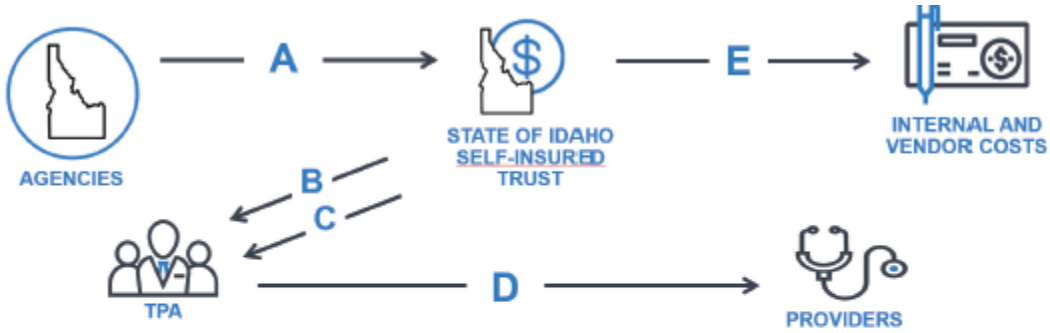
A. State and employee funding
B. Carrier premiums
C. Carrier claim settlement
D. Provider payments
E. Management costs

FULLY INSURED SEHP FUNDING MODEL



A. State and employee funding
B. Carrier premiums
C. [no settlement]
D. Provider payments
E. Management costs

SELF-FUNDED SEHP MODEL



A. State and employee funding
B. TPA administrative fee
C. TPA claim transfer
D. Provider payments
E. Management costs

POLICY DECISIONS AND LEGISLATION ENACTED IN OTHER STATES

Other states have also enacted legislation related to health insurers that may be relevant for the committee to consider. The contents or themes indicated in the following subsections are not an exhaustive list and do not necessarily include laws enacted, or bills introduced, to loosen restrictions in these areas. It should be noted that amending legislation in these areas to require more utilization management practices may be a strategy to pursue lower costs.

The major themes of legislation we identified were: Prior Authorization Reform, Appeal Rights and Other Transparency Initiatives, Artificial Intelligence Utilization Review, Provider Contracting, Copay Accumulators, Step Therapy, and Prompt Payment.

Appendix 1 includes a table of least 4 other states that have recently convened working groups or committees to study health insurance related issues similar to the charge of the Idaho Health Insurers Working Group, and it provides links to any materials produced or recordings of meetings

Prior Authorization Reform

According to the Georgetown Center on Health Insurance Reforms, 17 states have enacted legislation in the following summarized categories related to prior authorization since 2025.

- **Clinical criteria**: Prior authorization standards must be peer-reviewed and evidence-based (1 state: Alaska).
- **Provider review:** Requires a physician/specialist with relevant experience to conduct the review (5 states: Arizona, Indiana, Montana, Nebraska, North Dakota).
- **Prohibition on prior authorization:** Bans revocation, modification, or prior authorization for certain services like emergency or preventative care (11 states: Arkansas, Colorado, Indiana, Montana, Nebraska, North Dakota, Oregon, Rhode Island, Texas, Virginia, West Virginia).
- **Decision-maker**: Denials must be reviewed by a provider without financial incentives (1 state: Delaware).

Moreover, according to NCSL, "at least 10 states, have instituted "**gold card**" exemptions from prior authorization processes for providers with a specified rate of approvals for previous prior authorization requests, allowing them to provide certain services or prescription drugs without first receiving health plan approval."

Appeal Rights and Other Transparency Initiatives

According to NSCL, states like Maine, Colorado, Maryland, and Alaska have aimed to increase transparency for enrollees and ensure they are aware of their rights to appeal. NCSL has reported,

> Maine required insurers to report a wide range of data on prior authorization, including the number of requests approved after appeal. Colorado required health insurers to post readily accessible information about the appeals process for prior authorization denials on their public-facing websites. Maryland also recently updated its law regarding the prior authorization grievance process for denials, requiring insurers to include a dedicated contact number for grievance decisions in notices to enrollees. A portion of Alaska's prior authorization reform legislation required that for each claim denial, an insurer must provide both the individual and provider a statement of the person's right to appeal and instructions on how to file an appeal, including "a clear explanation of the appeals process, the appeal timeline and the direct telephone number and electronic and physical mailing addresses for appeals."

According to the Georgetown Center on Health Insurance Reforms, at least 15 states have enacted legislation regarding transparency, disclosure, reporting or other process reforms related to prior authorization since 2025.

Artificial Intelligence Utilization Review

According to KFF, at least nine states have passed state laws on AI and prior authorization and claims review as of April 2026. KFF identified the following major themes in enacted legislation:

- Human review of claim denials required.
- AI tools must take individual clinical circumstances into account.
- Disclosure of AI use.
- Review of AI tool outcomes.
- Limits on the use of patient data to protect privacy.
- AI tools must be open to inspection, including the underlying algorithms.
- AI protections against bias and discrimination.

The nine states are: Maryland, Alabama, Texas, Indiana, Illinois, Nebraska, Utah, Oregon, and California.

Provider Contracting

The National Academy for State Health Policy has drafted model legislation to address anticompetitive measures from large, consolidated health providers. The legislation addresses all-or-nothing clauses, anti-tiering or anti-steering clauses, gag clauses, and most-favored-nation clauses in health plan contracting. LSO's research suggests that at least three states, Connecticut, Texas, and Nevada, have enacted laws since 2021 that address some of these clauses in health plan contracts.

COPAY ACCUMULATORS

According to NCSL, "As of 2025, laws in at least 25 states, the District of Columbia and Puerto Rico address the use of copay adjustment programs by insurers or Pharmacy benefit managers by requiring any payment or discount made by or on behalf of the patient be applied to a consumer's annual out-of-pocket cost-sharing requirement."

STEP THERAPY

Step therapy refers to the practice of requiring patients to use lower-cost drugs at the beginning and advancing to more expensive options if treatment is not working. According to KFF, as of 2019, 24 states had statutory limits on prior authorization or step therapy requirements on certain drugs or drug classes in some scenarios.

PROMPT PAYMENT

LSO identified at least seven states, Arizona, Arkansas, California, Connecticut, Mississippi, Vermont, and Wyoming, that added or amended laws surrounding prompt payment of claims since 2024. Payment deadlines range from seven days to at least 30. Interest rates range from 12% to 18% although some states appear to only include pharmacy payments.

Our limited review of Idaho Code identified laws in the following areas: prior authorization, appeal rights and other transparency initiatives, and prompt payment. A review of how Idaho Code might be amended in these areas can be provided at the request of the working group.

UPDATES: FEDERAL RULES AND THE HEALTH INSURER INDUSTRY

The Centers for Medicare & Medicaid Services (CMS) published the CMS Interoperability and Prior Authorization Final Rule CMS-0057-F in early 2024. The rule requires impacted payers in the following: Medicare Advantage organizations, state Medicaid and Children's Health Insurance Program Fee-for-Service programs, Medicaid managed care plans, CHIP managed care entities, and Qualified Health Plan issuers on the Federally Facilitated Exchanges to implement certain provisions regarding prior authorization decision timeframes, the provision of denial reasons, and the reporting of prior authorization metrics. The compliance date started January 1, 2026

Moreover, in June 2025, the Secretary of Health and Human Services, Robert F. Kennedy Jr., and the Administrator of the Centers for Medicare & Medicaid Services, Dr. Oz, met with leaders of the health insurer industry. According to CMS, the participating health insurers voluntarily pledged to:

- Standardize electronic prior authorization submissions…
- Reduce the volume of medical services subject to prior authorization by January 1, 2026.
- Honor existing authorizations during insurance transitions to ensure continuity of care.
- Enhance transparency and communication around authorization decisions and appeals.
- Expand real-time responses to minimize delays in care with real-time approvals for most requests by 2027.
- Ensure medical professionals review all clinical denials.

According to a KFF article written in July 2026, implementation of the pledge has produced mixed results.

2026 INSURANCE AND HEALTH CARE LEGISLATION SUMMARIES

Bill Number	Became law?	Chapter	Brief summary
H 645	Yes	Ch. 106	Created portable benefit accounts for independent contractors. Allowable portable benefits include health insurance.
H 648	Yes	Ch. 259	Requires health benefit plans to apply comparable cost-sharing requirements to oral anticancer medications and other cancer treatments. It applies to plans issued or renewed beginning January 1, 2027.
H 788aas	Yes	Ch.226	Allows for certain providers to be exempt from Medicaid prior authorization requirements if they act as a qualified preceptor. Limited to 100 eligible practitioners from each of the three qualifying categories.
H 929	Yes	Ch. 275	Prohibits a health carrier from preventing a covered person from paying a provider's discounted cash price without submitting a claim to the carrier.
H 931	Yes	Ch. 274	Trailer bill to H 645. It conditionally amended the Portable Benefit Plan Act by removing an unused Department of Insurance definition.
S 1362	Yes	Ch. 330	Appropriated public-school funding based partly on participation in the state health plan. The funds help offset employee health, vision, and dental benefit costs.
S 1435	Yes	Ch. 271	Extended the deadline for submitting Idaho's comprehensive Medicaid managed-care proposal to the federal government to July 1, 2027. It also continues existing managed-care arrangements until replaced and requires implementation reporting.
H 529	No		Would have prohibited health carriers from preventing an insured person from paying a provider's discounted cash price without submitting an insurance claim. The proposal was later enacted through H 929.
H 530	No		Would have established cost-sharing parity between orally administered anticancer drugs and other cancer treatments. A revised version became law through H 648.
H 611	No		Would have established deadlines, electronic submission procedures, appeals, continuity protections, reporting requirements, and enforcement provisions for insurer prior authorization. H 841 was a later version.

H 713	No	Would have required payments made by or on behalf of an enrollee to count toward applicable deductibles, copayments, coinsurance, and annual cost-sharing limits.
H 725	No	Would have allowed cities to obtain group insurance and health-care-service coverage through the Department of Administration.
H 818	No	Would have required specified individual, group, managed-care, and exchange plans to cover fertility-preservation services before certain cancer treatments.
H 829	No	Would have revised prompt-payment deadlines, interest, penalties, contracting rules, civil remedies, and transparency requirements for health insurers and managed-care organizations.
H 841	No	Later version of the prior-authorization proposal. It included electronic interface requirements and revised utilization review, continuity, appeal, and reporting provisions.
H 844	No	Would have revised renewability, discontinuation, guaranteed-issue alternatives, and other market requirements for enhanced short-term health plans.
H 945	No	Would have established an AI Medical Services Act and required insurance-related guidance on reimbursement, network credentialing, and coverage of licensed AI medical-service providers.
S 1319	No	Would have regulated out-of-network emergency billing and allowed self-funded health plans to elect participation in the statutory framework.
S 1367	No	Would have imposed pharmacy reimbursement floors, annual dispensing-fee adjustments, and additional requirements on pharmacy benefit managers, plan sponsors, and third-party payers.

IDAHO DATA NEEDS

The working group partnered with the Department of Insurance to request data from insurance carriers offering fully insured qualified health products in the individual, small group, and large group markets. Requests were sent to

- Aetna Life Insurance Company
- Asuris Northwest Health
- Blue Cross of Idaho Health Services, Inc.
- Cigna Health and Life Insurance Company
- Moda Health Plan, Inc
- Montana Health Cooperative
- PacificSource Health Plans
- Regence BlueCross BlueShield of Oregon
- Regence BlueCross BlueShield of Utah
- Regence BlueShield
- Regence BlueShield of Idaho, Inc.
- SelectHealth, Inc.
- St Luke's Health Plan Inc.
- State Farm Mutual Automobile Insurance Company
- UnitedHealthcare Insurance Company
- Molina Healthcare

Requested Data from Insurers: 2021-2025

ID	Ref	Data Element Requested	Idaho Code Reference	Basis	Unit
		Claims & Denials [14-1329]			
1	85	Total Idaho claims volume	41-1329	Annual	count
2	85	Initial denial rate (all Idaho claims)	41-1329	Annual	%
3	85	Definition of "denial" used by respondent	41-1329	n/a	text
4	86	Denials by reason: administrative or technical	41-1329	Annual	%
5	86	Denials by reason: lack of medical necessity	41-1329	Annual	%
6	86	Denials by reason: missing information	41-1329	Annual	%
7	86	Denials by reason: eligibility or coverage	41-1329	Annual	%
8	86	Denials by reason: coding or billing	41-1329	Annual	%

Requested Data from Insurers: 2021-2025					
ID	**Ref**	**Data Element Requested**	**Idaho Code Reference**	**Basis**	**Unit**
9	86	Denials by reason: other	41-1329	Annual	%
10	87	Appeal rate (share of denials appealed)	41-1329	Annual	%
11	87	Overturn rate on appeal	41-1329	Annual	%
12	87	Partially paid on appeal	41-1329	Annual	%
13	87	Upheld on appeal	41-1329	Annual	%
		Prior Authorization [41-3930]			
14	90	Prior-authorization request volume	41-3930	Annual	count
15	90	PA approval rate: urgent	41-3930	Annual	%
16	90	PA approval rate: standard	41-3930	Annual	%
17	90	PA denial rate: urgent	41-3930	Annual	%
18	90	PA denial rate: standard	41-3930	Annual	%
19	90	PA appeal rate	41-3930	Annual	%
20	90	PA overturn rate	41-3930	Annual	%
21	91	Median decision time: urgent (from complete request)	41-3930	Annual	hrs/days
22	91	90th-percentile decision time: urgent	41-3930	Annual	hrs/days
23	91	Median decision time: standard	41-3930	Annual	days
24	91	90th-percentile decision time: standard	41-3930	Annual	days
25	127	Peer-to-peer review volume	41-3930	Annual	count
26	72	% of PA-denied services later approved (resubmit/P2P/appeal)	41-3930	Annual	%
27	72	Median time to eventual approval	41-3930	Annual	days
		Payment Timeliness and Aging [41-5602, 41-5603, 41-5605]			
28	93	% clean claims paid within statutory timeframe	41-5602	Annual	%

Requested Data from Insurers: 2021-2025					
ID	**Ref**	**Data Element Requested**	**Idaho Code Reference**	**Basis**	**Unit**
29	93	Median payment time (from receipt of clean claim)	41-5602	Annual	days
30	73	Accepted/payable claims unpaid at 30 days (from original submission)	41-5603	Year-end	count / $
31	73	Accepted/payable claims unpaid at 60 days	41-5603	Year-end	count / $
32	73	Accepted/payable claims unpaid at 90 days	41-5603	Year-end	count / $
33	73	Accepted/payable claims unpaid at 180 days	41-5603	Year-end	count / $
34	73	Accepted/payable claims unpaid at 365 days	41-5603	Year-end	count / $
35	73	Statutory interest owed	41-5603	Annual	$
36	73	Statutory interest actually paid	41-5603	Annual	$
37	24	Claims unpaid under 41-5605 exceptions: count and dollar value	41-5605	Year-end	count / $
38	128	Recoupments from providers	41-5602	Annual	$
		Complaints [41-3918, 41-1330]			
39	101	Member complaints by category (attach breakdown by category)	41-3918	Annual	count
40	101	Median complaint resolution time	41-3918	Annual	days
41	31	Prompt-payment complaints received	41-5606	Annual	count
		Financial [41-335]			
42	102	Idaho earned premium	41-335	Annual	$
43	102	Idaho claims expense	41-335	Annual	$
44	102	Idaho administrative expense	41-335	Annual	$
45	102	Idaho operating results	41-335	Annual	$
46	103	Premium growth attribution (utilization/prices/pharma/admin/reserves/taxes/margin)	41-335	Annual	% attach
		Fraud [41-290]			
47	42	Suspected fraudulent claims identified	41-290	Annual	count

Requested Data from Insurers: 2021-2025					
ID	**Ref**	**Data Element Requested**	**Idaho Code Reference**	**Basis**	**Unit**
48	14	Fraudulent claims referred to the Department of Insurance	41-290	Annual	count
49	15	% of delayed/denied claims represented by suspected fraud	41-290	Annual	%
50	16	Providers removed/suspended for substantiated fraud	41-290	Annual	count

The working group sent data requests to providers based on contact information provided by the Idaho Hospital Association (IHA) via email to CEOs and government relations officers. IHA sent an email to their members letting them know to expect a request for information from the committee and encouraged them to take the opportunity to share their stories with the working group.

Requested Data from Providers: 2021-2025					
ID	**Ref**	**Data Element Requested**	**Idaho Code Reference**	**Basis**	**Unit**
		Claims and Revenue Cycle [41-5602, 41-1329 — provider vantage]			
51	117	Submitted claims rejected/denied initially (all payers)	41-1329	Annual	%
52	134	Rejection/denial rate by payer (attach by-payer schedule)	41-1329	Annual	% attach
53	118	Claims requiring correction, resubmission, appeal, or peer-to-peer	41-5602	Annual	count
54	119	Dollars in disputed, approved, or otherwise unpaid claims (by category)	41-5603	Year-end	$
55	135	Accounts receivable and unpaid claims by status and age (attach aging)	41-5603	Year-end	$ attach
56	114	% of disputed claims from own documentation/coding/eligibility/billing	41-5602	Annual	%
		Prior-Authorization Experience [41-3930]			
57	111	Prior-authorization requests submitted	41-3930	Annual	count
58	111	Approval/denial/appeal/overturn rates by insurer (attach)	41-3930	Annual	% attach
59	112	Median treatment delay from authorization/coverage review	41-3930	Annual	days
60	112	90th-percentile treatment delay	41-3930	Annual	days
61	113	De-identified representative delay cases (attach)	41-3930	n/a	attach

Requested Data from Providers: 2021-2025					
ID	**Ref**	**Data Element Requested**	**Idaho Code Reference**	**Basis**	**Unit**
		Prices, Charges, and Access [committee examining; no governing insurance-code provision]			
62	106	Commercial price trend, most common services (attach)	no provision	Annual	% attach
63	132	Net revenue trend, common services; site-of-care and facility-fee info	no provision	Annual	$ attach
64	107	Facility-fee occurrences and patient-notification practice	no provision	n/a	narrative
65	120	Administrative FTE attributable to payer requirements	no provision	Annual	FTE
66	120	Clinician time attributable to payer administration	no provision	Annual	hrs
67	122	Financially vulnerable services or locations (with supporting data)	no provision	n/a	narrative
68	123	Services reduced/consolidated/discontinued and travel/access effect	no provision	Annual	narrative
		Financial and Governance [committee examining; no governing insurance-code provision]			
69	125	Operating margin	no provision	Annual	%
70	125	Reserves, debt, executive compensation, charity care (attach)	no provision	Annual	$ attach
71	137	Quality, access, workforce, service-line, charity-care data (attach)	no provision	Annual	attach

The working group sent requests related to the state employee group insurance plan to the Office of Group Insurance in the Department of Administration.

Requested Data from State Employee Group Insurance Plan: 2021-2025					
ID	**Ref**	**Data Element Requested**	**Idaho Code Reference**	**Basis**	**Unit**
		State Employee Plan Performance			
72	7	Initial claim-denial rate, state employee plan	41-1329 / 67-5761	Annual	%
73	8	Appeals: % of appealed denials ultimately approved	41-1329	Annual	%
74	8	Appeals: average duration to resolution	41-1329	Annual	days
75	8	Appeals: most common reasons for reversal	41-1329	n/a	narrative

Requested Data from State Employee Group Insurance Plan: 2021-2025					
ID	Ref	Data Element Requested	Idaho Code Reference	Basis	Unit
76	8	Appeals: % that remain denied	41-1329	Annual	%
77	10	Denial reason breakdown (six categories; attach)	41-1329	Annual	% attach
78	9	Comparison to Blue Cross of Idaho and other insurers (attach)	67-5762	Annual	attach
79	11	State employees/dependents forced out of network or required to travel	41-3915	Annual	count
80	12	State employees with delayed or interrupted care from disruptions	41-3915	Annual	count
81	13	Additional costs incurred by plan, employees, and providers	67-5769	Annual	$

The working group sent requests related to the regulation of health insurance carriers to the Department of Insurance.

Requested Data from Department of Insurance: 2021-2025					
ID	Ref	Data Element Requested	Idaho Code Reference	Basis	Unit
		Examinations and Inquiries [41-219, 41-247]			
82	32	Most recent examination date for each authorized health insurer (attach list by insurer)	41-219	n/a	date/attach
83	37	Director-initiated inquiries commenced	41-247	Annual	count
84	36	Date the Director last initiated an inquiry	41-247	n/a	date
		Prompt-Payment Enforcement [41-5606]			
85	31	Prompt-payment complaints received	41-5606	Annual	count
86	31	Complaints resulting in corrective action, interest, penalty, or enforcement	41-5606	Annual	count
		Fraud Reports and Referrals [41-290, 41-295]			
87	42	Reports of allegedly fraudulent provider claims received from insurers	41-290	Annual	count
88	43	Reports substantiated	41-295	Annual	count
89	17	Fraud referrals resulting in a finding that fraud occurred	41-295	Annual	count
90	44	Penalties, network, licensing, civil, or criminal actions resulting (attach)	41-295	Annual	count attach

Requested Data from Department of Insurance: 2021-2025					
ID	**Ref**	**Data Element Requested**	**Idaho Code Reference**	**Basis**	**Unit**
91	45	Substantiated cases vs. total claims delayed/denied on fraud basis (attach)	41-290	Annual	count attach
		Third-Party Vendor Complaints and Actions [41-910]			
92	51	Complaints involving a third-party administrator	41-910	Annual	count
93	51	Complaints involving a pharmacy benefit manager	41-910	Annual	count
94	51	Complaints involving a utilization-management company	41-910	Annual	count
95	51	Complaints involving a prior-authorization vendor	41-910	Annual	count
96	51	Complaints involving another subcontractor	41-910	Annual	count
97	52	Investigations or enforcement actions against these entities	41-910	Annual	count

APPENDIX 1: RELATED WORKING GROUPS IN OTHER STATES (2024 THROUGH 2026)

State	*Year*	*Committee/Agency*	*Enabling Legislation*	*Materials*
Maryland	2025	Workgroup to Study the Rise in Adverse Decisions in the State Health Care System	HB 995/SB 776	Link
Mississippi	2025	Study Committee on the Matter of Certification of Health Benefit Plans and Health Insurance Issuers	SB 2401	Link Link
Hawaii	2025	State Health Planning and Development Agency: Prior Authorization Report 2025	HB 250	Link
Rhode Island	2024	HealthSource RI: Marketplace Coverage Affordability Work Group	H 8332Aaa S 3086Aaa	Link