Commercial Health Insurer Performance in Idaho

Idaho Health Insurers Working Group Report | 2021-2025

Commercial health insurer submitted data[1] and Market Conduct Annual Statements

$3.28B	13.5%	1-13.1 days	7 of 9
2025 earned premium reported across 11 insurer submissions	2025 volume-weighted submitted initial denial rate	2025 range in 90th-percentile standard PA decision time	insurers reporting negative operating results in Idaho in 2025

BACKGROUND

The Idaho Health Insurers Working Group was established to study the performance of commercial health insurance in Idaho. The working group solicited information including financial data and claims payment metrics from insurers, healthcare providers, and the public through a questionnaire and data request.

The Department of Insurance requested responses from mid- and large-market commercial health insurers on behalf of the working group (Appendix A). Responses were requested from carriers that offer "fully insured" qualified health products in the individual, small group, and large group markets.

Provider responses were requested from member hospitals and health systems of the Idaho Hospital Association.

EXECUTIVE BRIEFING

- **Claim denials increased.** The weighted denial rate among insurers submitting data rose from 9.1% in 2021 to 13.5% in 2025. Idaho's statewide rate rose from 11% to 15%. Insurer rates ranged from 4.9% to 23.3%.
- **Most insurers paid claims on time, but results varied.** Eight of 10 insurers paid at least 96% of clean claims within the legal time limit. Results ranged from 86.6% to 99.9%. Insurers reported about $890,000 in interest payments for late claims in 2025.

[1] **Trade secrets.** For every data element identified as trade secret, all individual insurer identities are redacted in this brief and replaced with chart-specific "Insurer 1," "Insurer 2," etc. Labels intentionally do not carry across figures. For data elements not designated as trade secret, insurer names are shown.

- **Prior authorization approval rates were similar, but decision times varied.** Standard approval rates ranged from about 83% to 96%. The time to decide 90% of standard requests ranged from 1 to 13.1 days. After an initial denial, the median time to approval ranged from 1 to 23 days.
- **Most reporting insurers lost money in 2025. Seven of nine reported a loss.** The median operating margin fell from 1.3% in 2021 to negative 3.9% in 2025. The share of premium spent on claims rose from 85.4% to 91.4%.
- **Insurers did not report data the same way.** They used different units, definitions, and time periods. Idaho should set one reporting standard before it ranks insurers or applies penalties.

Bottom line for policymakers: The strongest accountability opportunity is a paired insurer-provider measurement framework that isolates price, utilization, administrative friction, payment performance, and access/quality - and then assigns remediation to the party that controls the driver.

1. MARKET SHARE AND FINANCIAL TRENDS

The 11 submissions reported approximately $3.28 billion in 2025 Idaho earned premium. This represents 45% of the $7.3B total premium reported to the National Association of Insurance Commissioners for Idaho's accident and health insurance market.

The data show substantial differences in carrier scale, so absolute counts are not to be interpreted as performance measures without normalization. The data also show a material shift in financial pressure: most carriers reporting operating results were negative in 2024-2025.

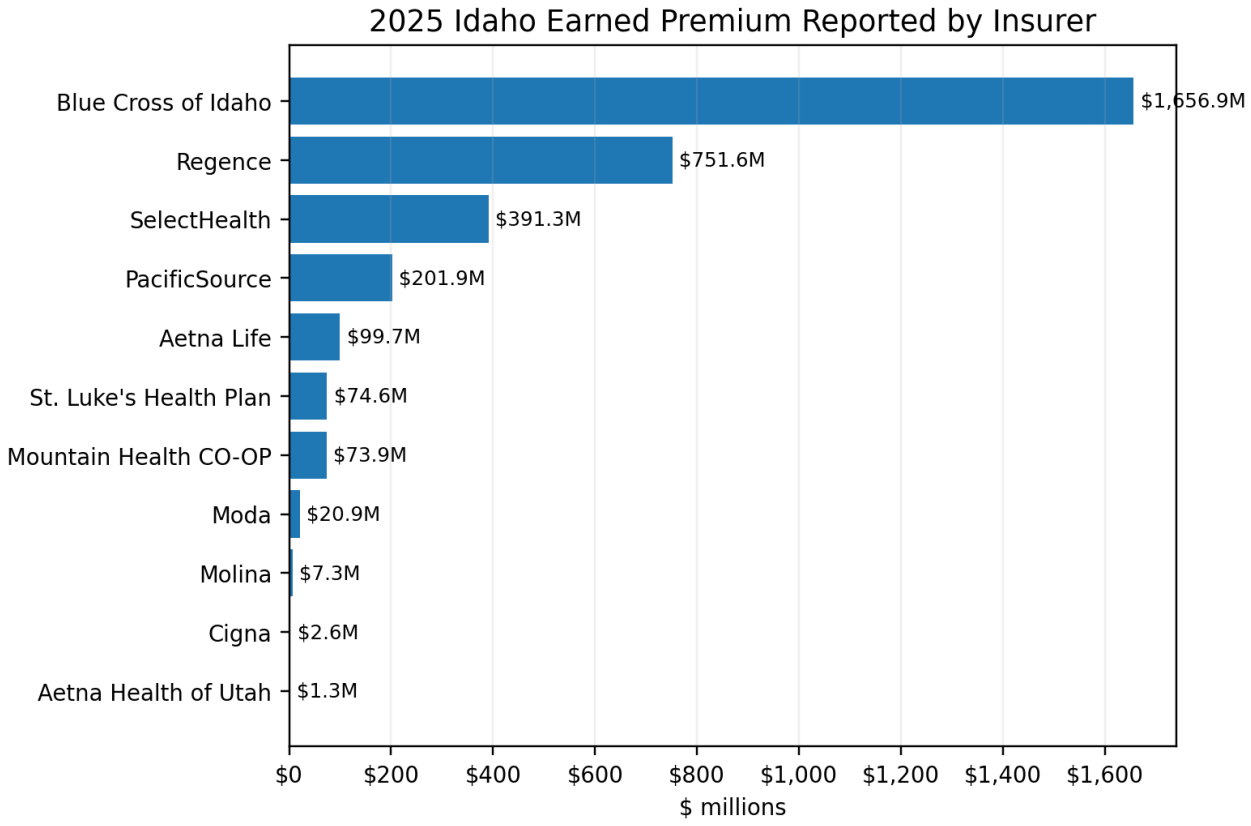


Figure 1. 2025 earned premium reported in the insurer submissions. This is submitted premium, not a validated market-share estimate.

Source/notes: Insurer workbooks, "Idaho earned premium," Ref. 102. Aetna legal entities are shown separately because they submitted separate workbooks.

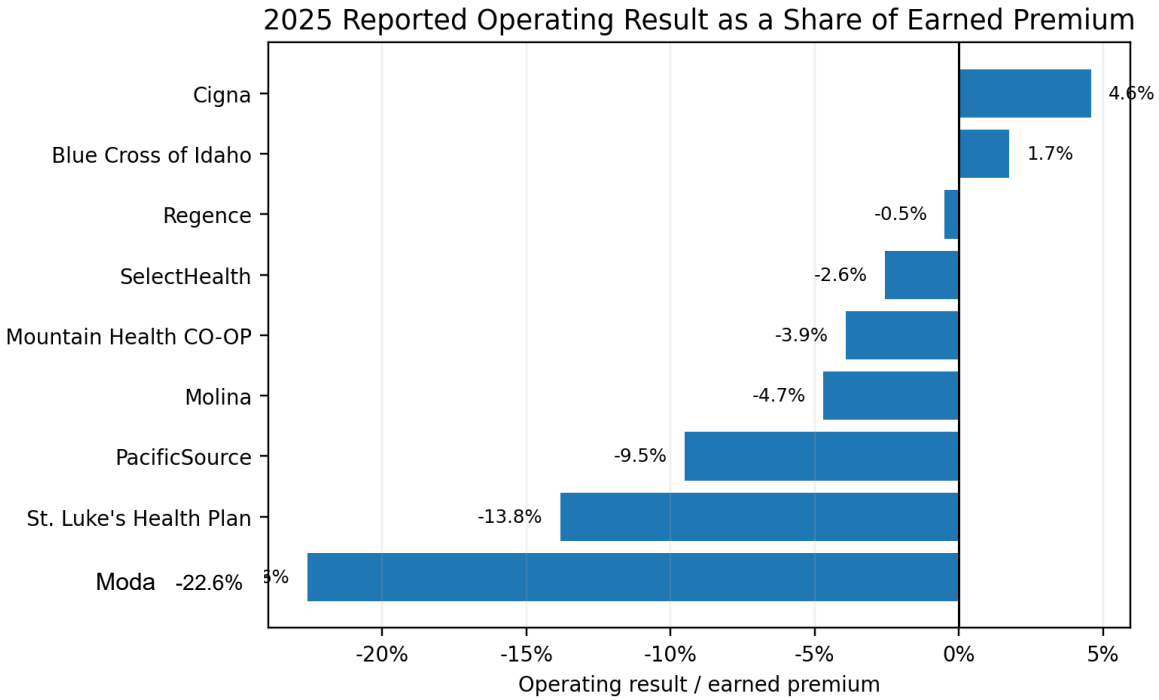


Figure 2. Operating result divided by earned premium. Seven of nine reporting insurers were negative in 2025.

Source/notes: Derived from public Ref. 102 fields: Idaho operating results / Idaho earned premium. These statutory/reporting lines do not necessarily reconcile to a statutory medical loss ratio or comprehensive profitability measure.

Financial trend indicators

Indicator	2021	2025	Interpretation
Median claims expense / earned premium	85.4%	91.4%	A larger share of premium went to claims.
Median administrative expense / earned premium	12.1%	14.8%	Administrative expense share also increased.
Median operating result / earned premium	+1.3%	-3.9%	Reported operating performance deteriorated.
Carriers with negative operating result	1 of 6	7 of 9	Losses became more widespread.

The financial data do not support a simple conclusion that insurer margin alone is the principal cost driver. A cost-containment strategy should separately measure medical unit prices, utilization, pharmacy trend, and administrative expense. Current submissions identifying drivers of premium growth are too inconsistent to do this reliably across carriers.

2. CLAIMS DENIALS AND PAYMENT DELAYS

Denial rates rose across submitting insurers and variation among insurers has increased. Because designated claims-volume and denial-rate elements were identified as trade secret, insurer identities are redacted for individual comparisons.

In Figure 3 below, the light blue shading identifies the insurer interquartile range, or the middle 50% of initial claim denial rates reported. The expansion of that distribution since 2023 points to increasing variability among insurer practices for initial denial.

The blue unweighted insurer median does not account for a carrier's size, while the orange volume-weighted submitted rate accounts for carriers' claims volume to provide a clearer representation of the market level trends in the denial rate.

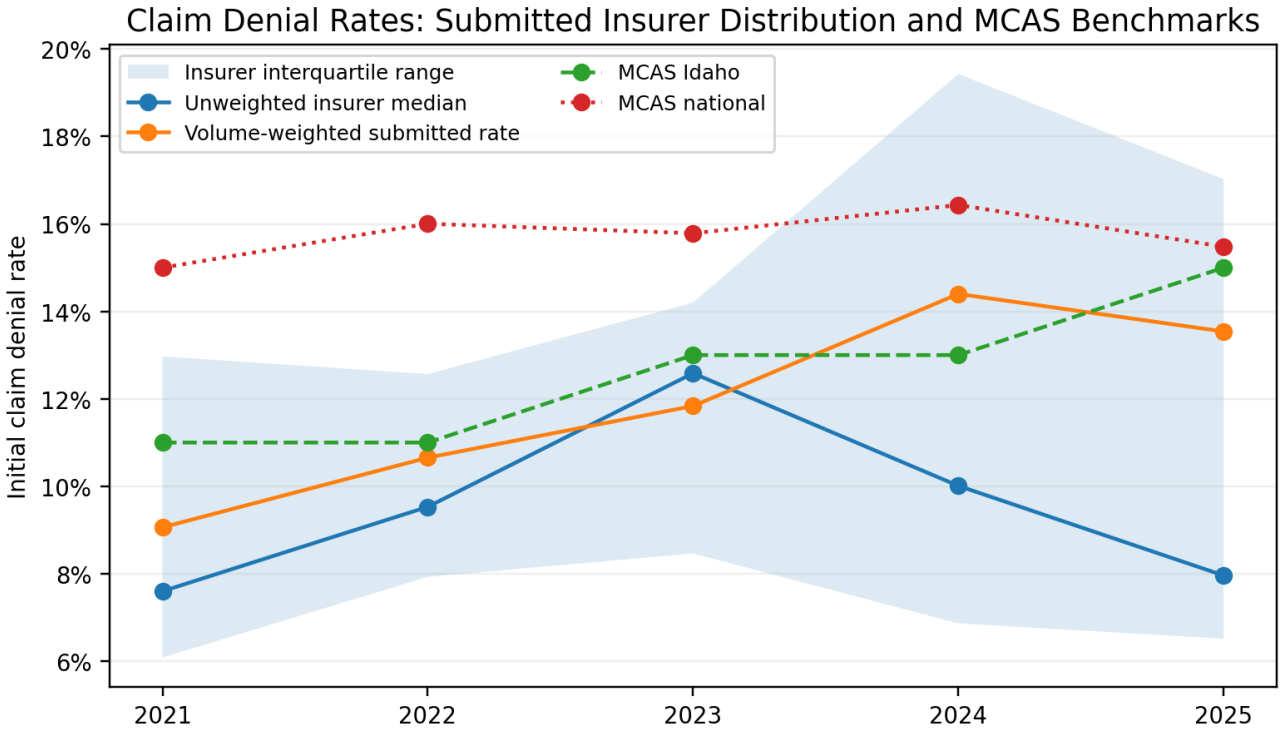


Figure 3. Insurer submission distribution and volume-weighted rate compared with Idaho and national MCAS denial rates.

Source/notes: Insurer Ref. 85 data; MCAS State Ratio Distribution Reports for Idaho and National, 2021-2025. The insurer-submission weighted rate uses submitted claim volume as the weight; scope and definitions may differ from MCAS.

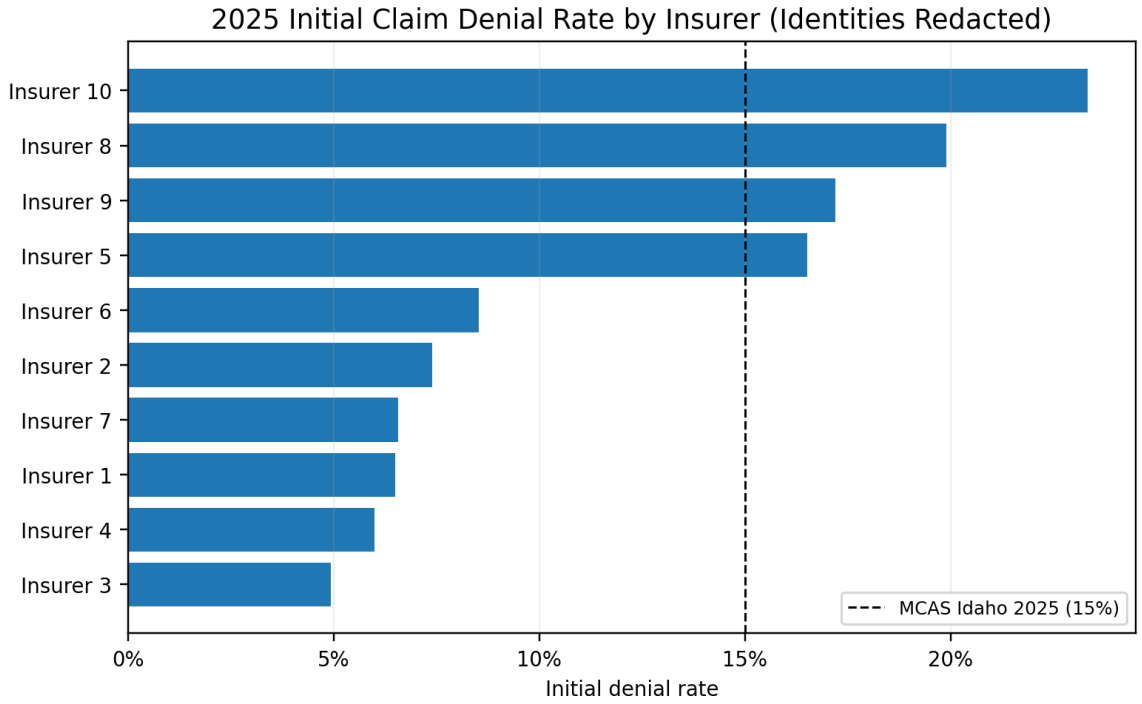


Figure 4. 2025 initial denial rates by insurer, with identities redacted. Cross-insurer range: 4.9% to 23.3%; median: 8.0%.

Source/notes: Insurer Ref. 85. “Insurer” labels are chart-specific and intentionally cannot be matched to other confidential figures.

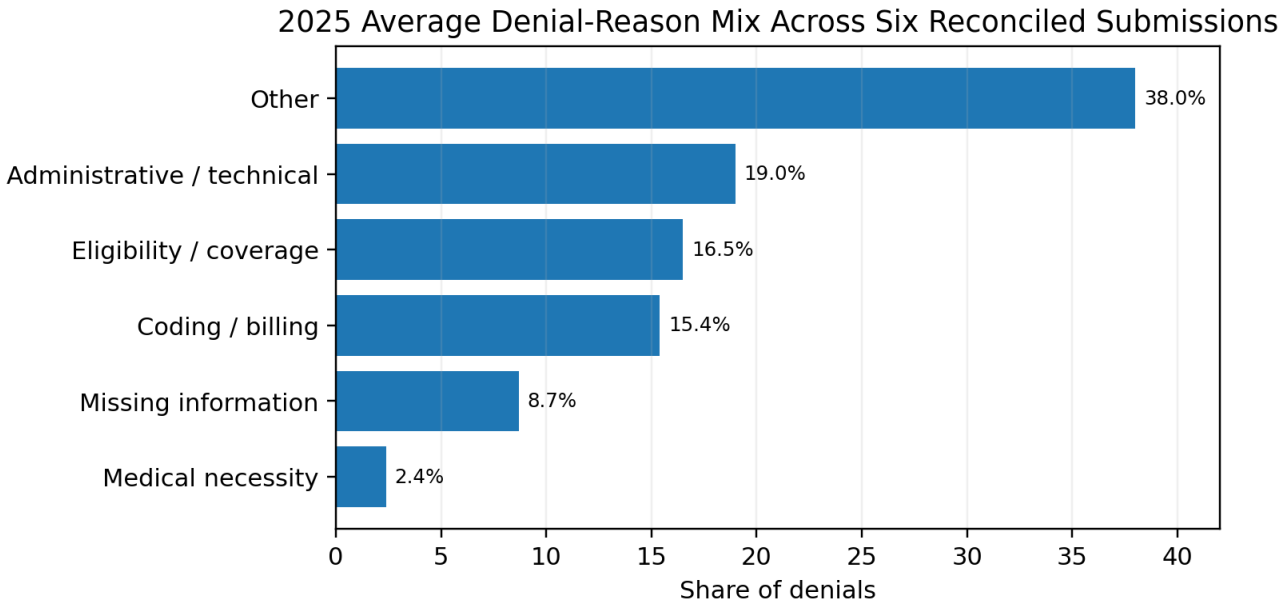


Figure 5. Average denial-reason mix across six submissions whose 2025 reason categories were complete and reconciled to approximately 100% of denials.

Source/notes: Derived from confidential Ref. 86 data after normalizing each carrier to a share-of-denials basis. Two submissions with incomplete categories and two with non-reconciling totals were excluded. “Other” remains the largest average category, limiting root-cause accountability.

Only about 2.4% of denials were due to lack of medical need. About 60% involved administration, missing information, eligibility, coding, or billing. Insurer rules and provider submissions may both play a role. Better processes could reduce many denials without weakening clinical review.

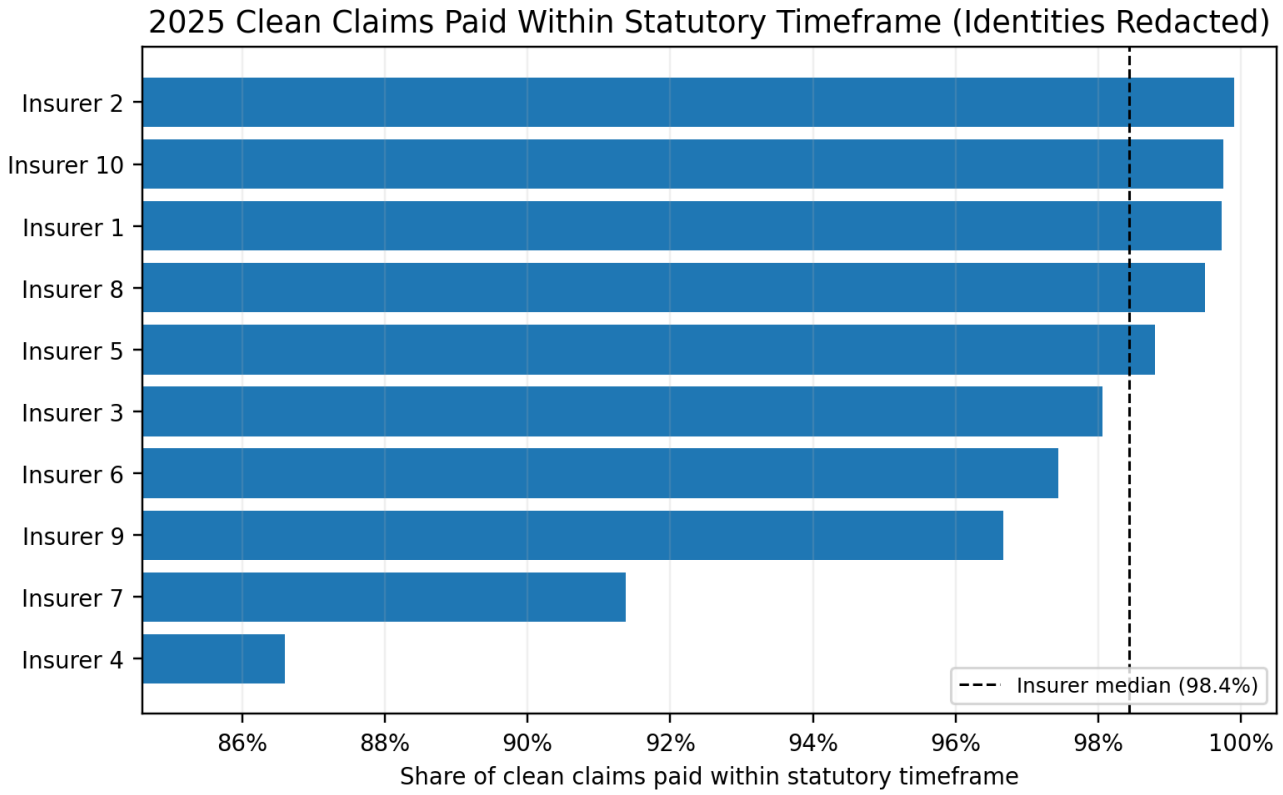


Figure 6. 2025 clean-claim payment performance.

Source/notes: Insurer Ref. 93. Eight of ten usable submissions were at or above 96%; the range was 86.6%-99.9%.

The Department of Insurance received seven prompt-payment complaints in 2025, with three resulting in corrective action, interest, penalty, or enforcement. The insurer submissions simultaneously show sizable differences in statutory interest actually paid, indicating that complaint counts alone do not capture the full amount of payment friction.

3. PRIOR AUTHORIZATION RESULTS AND SPEED

Prior authorization standards offer a chance to reduce paperwork while protecting care. Approval rates were fairly close, but decision times varied widely.

Prior authorization reform can target avoidable delays without requiring weaker clinical standards. In addition, public reporting requirements could pair approval rate with 90th-percentile decision time, appeal/overturn rate, share later approved after denial, and time to eventual approval. High delay or reversal rates should trigger a review of the insurer's or provider's process.

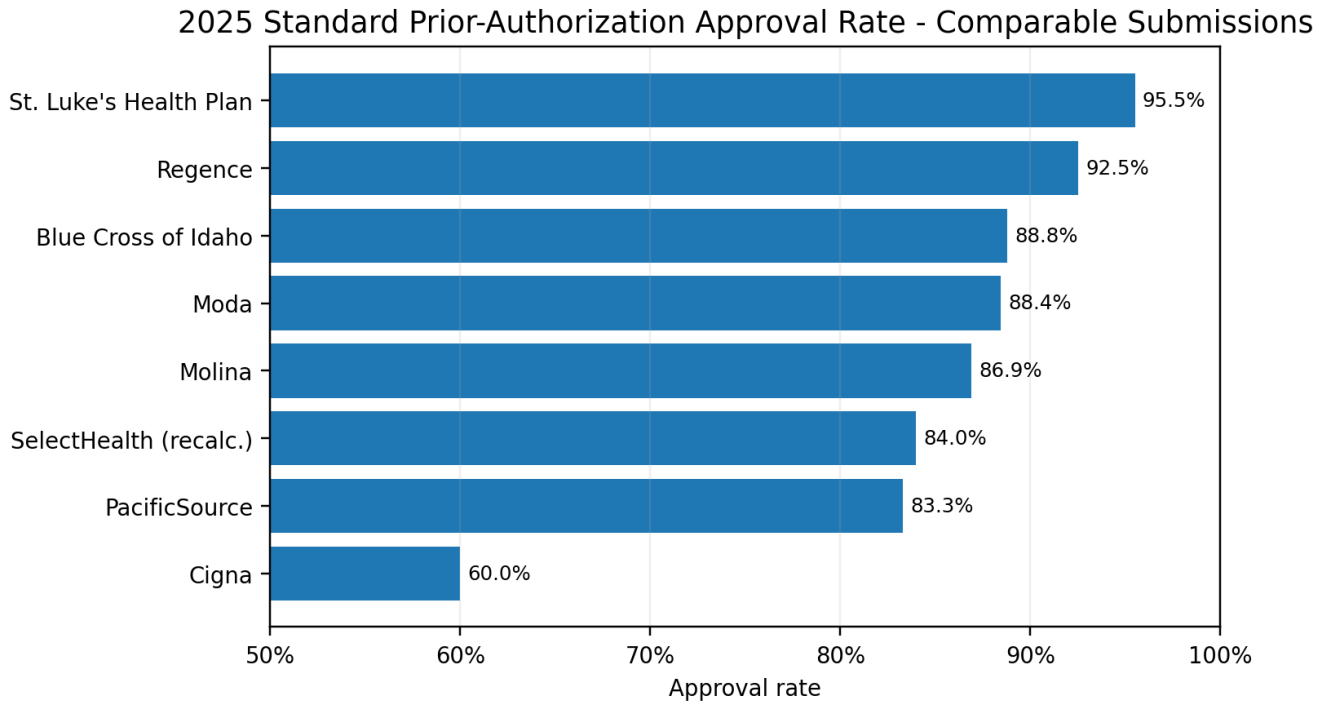


Figure 7. 2025 standard PA approval rates using comparable submissions. SelectHealth is recalculated from the approval and denial counts supplied in its notes. Mountain Health CO-OP and Aetna Life are excluded because their submitted denominators were not comparable; Cigna is retained but reported only 12 total PA requests.

Source/notes: Public Ref. 90 data. Excluding the low-volume Cigna result, the remaining displayed rates range from 83.3% to 95.5% (coefficient of variation about 5%).

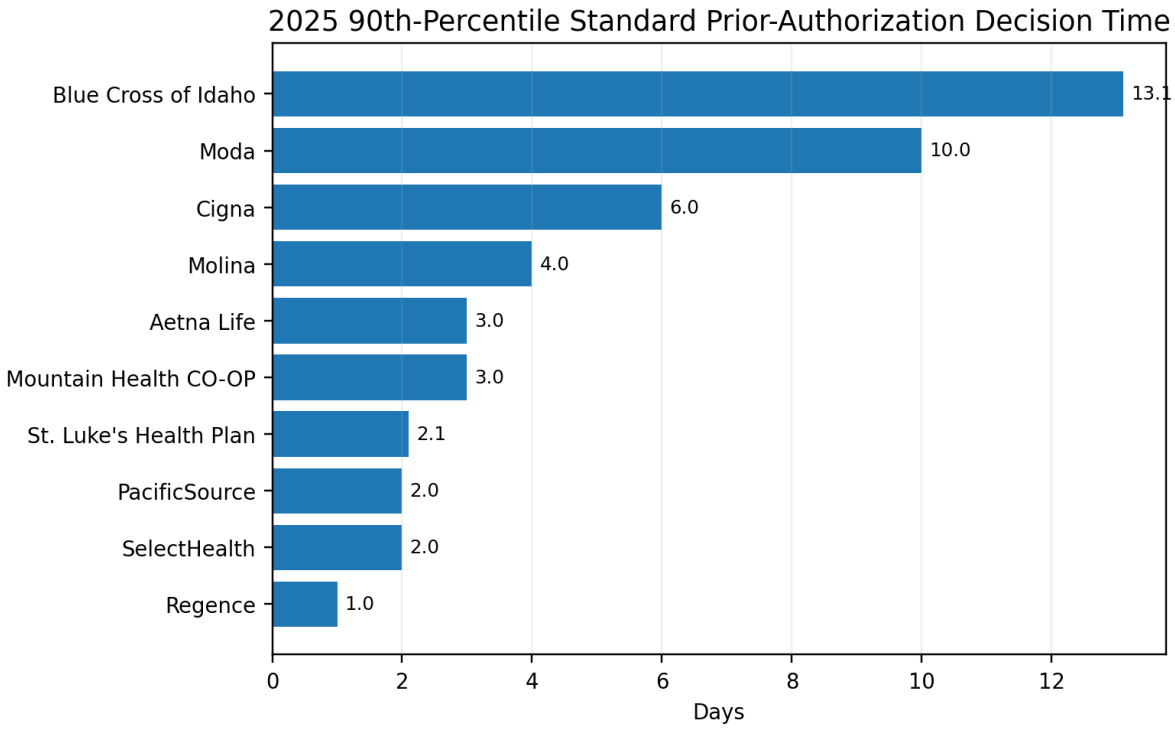


Figure 8. 2025 90th-percentile standard PA decision time. Reported values range from 1.0 to 13.1 days.

Source/notes: Public Ref. 91 data. Moda states its timing is calculated in business days; other submissions may use different timing conventions. This figure therefore indicates operational dispersion, not a fully standardized compliance comparison.

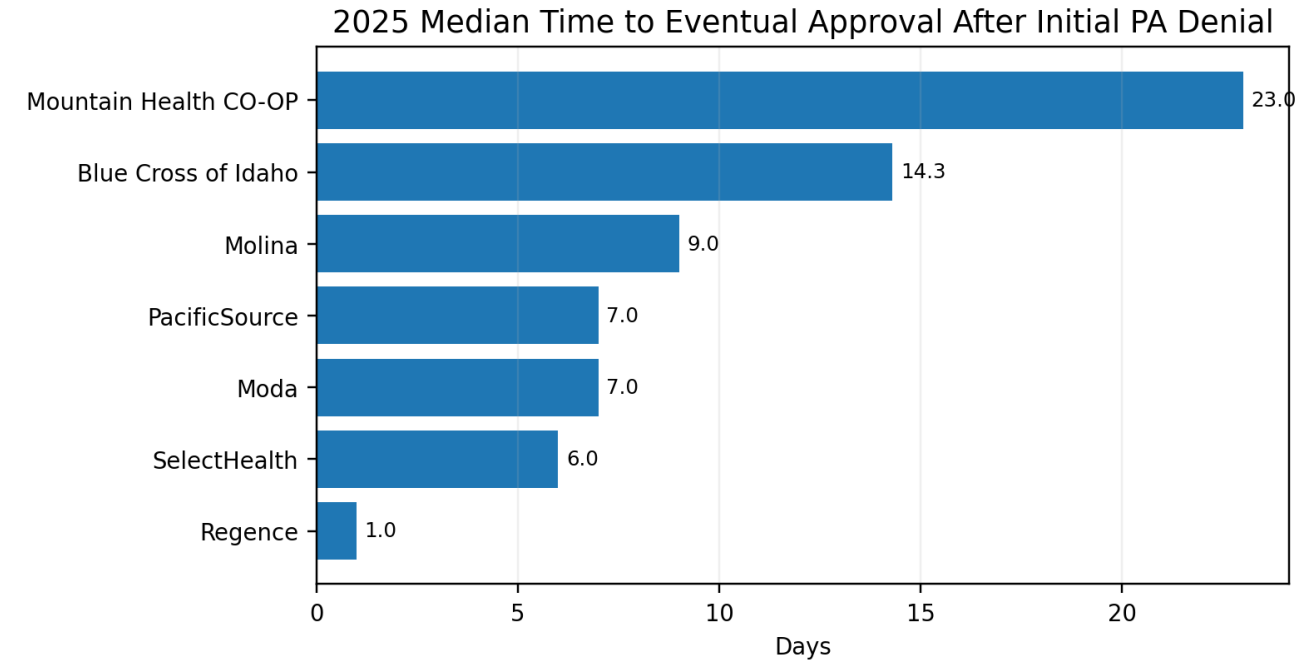


Figure 9. Median time to eventual approval after an initial PA denial, among insurers reporting the metric.

Source/notes: Public Ref. 72 data. Seven insurers reported usable 2025 values; median was 7 days and the range was 1-23 days.

4. STATUTORY INTEREST PAID ON DELAYED PAYMENTS

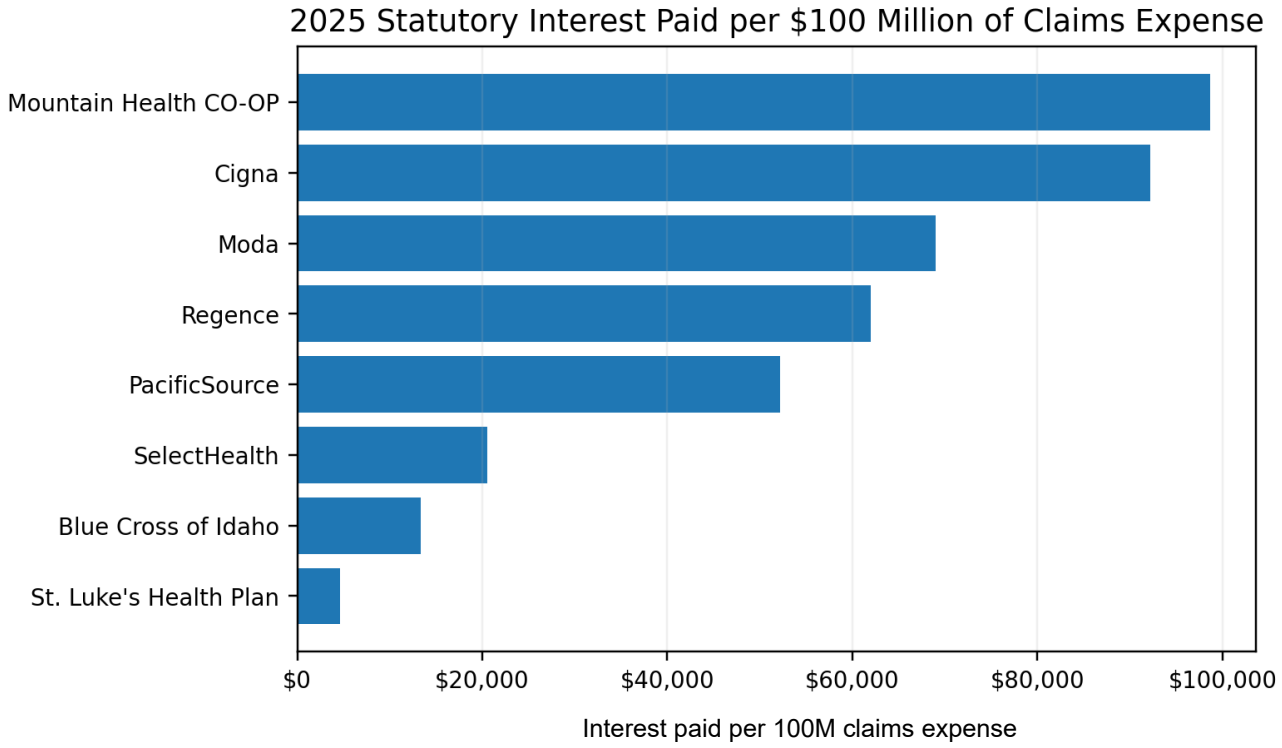


Figure 10. Statutory interest actually paid, normalized by claims expense. One Mountain Health CO-OP value is explicitly identified in the submission as an estimate.

Source/notes: Public Ref. 73 and Ref. 102 data. Aetna did not report state-level interest paid. Normalization reduces - but does not eliminate - scale effects.

Insurers varied widely in interest paid for late payment of clean claims. Electronic claims must be processed within 30 days of receipt and paper claims must be processed within 45 days of receipt (Section 41-5602, Idaho Code). Insurers are charged 12% interest on the unpaid amount of the claim from the date payment was due.

5. WHERE INSURER PERFORMANCE VARIES MOST - AND LEAST

Decision speed and administrative friction vary more across carriers than many final outcome rates. This suggests that Idaho can pursue administrative simplification and timeliness accountability with less risk of sacrificing clinical quality than policies that simply require more approvals or fewer denials.

Metric	2025 range	Relative variation	Insurer	Interpretation
Time to decide 90% of standard PA requests	1.0-13.1 days	Very high (CV 0.86)	Named	Largest reliable gap. Clear target for faster processes.
Median time to eventual PA approval	1-23 days	High (CV 0.74)	Named	May signal delays in care.
Interest paid per claims expense	$4.7K-$98.7K per $100M	High (CV 0.69)	Named	Late-payment costs varied widely; one value was estimated.
Initial claim denial rate	4.9%-23.3%	High (CV 0.58)	Redacted	Wide gap, but definitions and patient mix may differ.
Administrative expense share	12.0%-36.3%	Moderate-high (CV 0.43)	Named	Insurer size and product mix can affect the result.
Claims expense share	77.5%-126.6%	Moderate (CV 0.15)	Named	Shows broad cost pressure, with size and product effects.
Standard PA approval rate*	83.3%-95.5%	Low (CV ~0.05)	Named	Similar results among comparable insurers.
Clean claims paid on time	86.6%-99.9%	Low (CV 0.05)	Redacted	Most results were high, but the lowest result matters.

** Standard PA approval variation excludes submissions with non-comparable denominators and the very small-volume Cigna result for the variation statistic; SelectHealth is recalculated from submitted counts.*

To compare metrics with different units, variation is summarized using the 2025 coefficient of variation (standard deviation divided by the mean) where appropriate. Absolute market-size measures are excluded. The table prioritizes metrics with at least five usable insurer observations and notes material comparability limits.

6. REPORTING OPTIONS

Standardized annual reporting of claims and financial data by insurers and providers would increase accountability and clarify cost drivers.

Purpose	Insurer role	Provider role
1. Track claim denials and payment	Report denials, reasons, appeals, payment time, and interest.	Report clean-claim errors, corrections, and appeals.
2. Track prior authorization	Report approval rates, decision time, reversals, and later approvals.	Report missing records, response time, and past approval results.
3. Measure late payment by insurer size	Report unpaid claims by age, interest owed and paid, and vendor role.	Report accounts receivable by payer and dispute type.
4. Hold insurers responsible for vendors	Report complaints, timing, and fixes by vendor.	Report vendor-specific problems when known.
5. Explain cost growth	Separate prices, use, drugs, administration, reserves, enrollment, and margin.	Report price trends, service mix, site of care, and avoidable use.

APPENDIX A. METHODS AND SOURCES

- Scope. This brief uses data from 11 commercial insurers, the Idaho Department of Insurance, and 2021–2025 Idaho and national Market Conduct Annual Statement reports. The Department of Insurance requested responses from health insurers on behalf of the working group, excluding indemnity, specified disease, short-term limited duration, Medicare Advantage, or Medicare Supplement companies that are not in the individual, small group, or large group markets. Third party administrators managing self-funded plans were also not included. Responses were requested from the following insurers:
    - 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.
    - UnitedHealthcare Insurance Company
    - Molina Healthcare
- Data cleanup. Percentages were put on one scale when the intended format was clear. Times were converted to days only when units were clear. Data with conflicting totals or units were excluded. Select Health’s 2025 standard approval rate was calculated from its reported counts.
- Variation. The coefficient of variation, or CV, is the standard deviation divided by the average. It shows relative spread, not quality. Rates based on few cases can change sharply.
- Trade secrets. If an insurer marked a row as a trade secret, every insurer name is hidden for that comparison. Names appear for public data.
- Limits. The insurer files do not include a full set of measures for quality and access to providers. Policy reviews should consider these outcomes along with cost and administrative results.

APPENDIX B. SOURCE FILES & DATA LIMITATIONS

- 6_Data - Cigna.xlsx
- 7_Data - Moda Health Plan.xlsx
- 9_Data - Mountain Health COOP.xlsx
- 10_Data - SelectHealth.xlsx
- 13_Data - Blue Cross.xlsx
- 14_Data - PacificSource.xlsx
- 15_Data - Regence.xlsx
- 16_Data - St Lukes Health Plan.xlsx
- 17_Data - Molina Healthcare.xlsx
- 18_Data - Aetna-Life-Insurance-Company.xlsx
- 19_Data - Aetna-Health-of-Utah-Response.xlsx
- 3_Data - DOI.pdf
- 3_Data - Idaho Market from DOI.pdf
- 3_Data - National Market from DOI.pdf

- Insurers reported percentages in different formats, sometimes within the same workbook.
- Insurers used different totals to calculate prior authorization rates. Some did not separate urgent and standard requests.
- Insurers measured time in business days, calendar days, or hours.
- Some insurers marked a measure as “not tracked” and also reported a value.
- Insurers grouped denial reasons differently, and some totals did not add up.
- Changes in market participation and enrollment may affect trends over time.

APPENDIX C. REQUESTED METRICS

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	%
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]			

Requested Data from Insurers: 2021-2025					
ID	**Ref**	**Data Element Requested**	**Idaho Code Reference**	**Basis**	**Unit**
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	%
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 / $

Requested Data from Insurers: 2021-2025					
ID	**Ref**	**Data Element Requested**	**Idaho Code Reference**	**Basis**	**Unit**
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
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