Idaho Legislature

FINAL RECOMMENDATIONS: HEALTH INSURERS WORKING GROUP

OCTOBER 27, 2026

WORKING GROUP SUMMARY

MEMBERS:
Senator Mark Harris (Cochair)
Senator Kevin Cook
Senator Carl Bjerke
Senator Josh Keyser

Representative Dustin Manwaring (Cochair)
Representative Josh Wheeler
Representative Cornel Rasor
Representative Soñia Galaviz

STAFF:

Jennifer Kish (Secretary)
Frances Lippitt (Budget)
Alex Penny (Impact)
Kyle Slominski (Research and Legislation)

MEETING DATES:

AUGUST 11, 2026
SEPTEMBER 15, 2026
OCTOBER 14, 2026

CHARGE

The working group was organized by legislative leadership to 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 insures 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.

SUMMARY OF WORKING GROUP

The working group convened on August 11, September 15, and October 14, 2026, in room WW55 of the Idaho Statehouse. The committee proceedings were broadcast on Idaho Public Television. The official minutes of the committee are available as an item of public record.

The Administrator of the Insurance Division within the Department of Administration presented on the State of Idaho's health plan during the initial August 11, 2026 meeting. The group's discussion concerned the State of Idaho's health plan, an ongoing contract dispute between Regence and Portneuf Hospital affecting approximately 3,000 state employees[1], and developing an initial list of questions to gather information from insurers, providers, the Department of Insurance, and the Office of Group Insurance.

On August 18, 2026, 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. All data requests were for the period 2021 through 2025. 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.

On September 15, 2026, the state administrator of Montana's self-funded health plan presented on the

[1] On August 17, 2026, Regence and Portneuf reached an agreement restoring in-network coverage retroactive to June 15, 2026.

Montana plan's performance over the last few years as a comparison point to Idaho's hybrid funding model. The Director of the Idaho Department of Insurance presented on how health insurers are regulated. Staff presented a review of the information received from insurers and providers and recent health insurance policy trends nationally. In-person testimony included comments from the CEO of Portneuf Medical Center on the Department of Insurance's assistance in resolving the contract impasse with Regence and comments from a provider of a small private practice regarding challenges with administrative and preauthorization requirements.

On October 14, 2026, the President/CEO of the Idaho National Hospital Association presented to the working group on community hospital data and other states' policy reforms. In-person testimony included a provider's frustration with the opacity of reimbursement rate negotiations with certain insurers and a state employee's difficulties ensuring continued coverage of a necessary medication for her husband.

ANALYZING INSURER PERFORMANCE

The working group reviewed national trends in health insurance policy[2] and requested specific data elements from insurers, providers, the Department of Insurance, and the Office of Group Insurance, which are listed at the end of the same report. The group evaluated complete questionnaires and data workbooks received from 11 insurers and five providers. Although this was a small sample of data, the largest carriers in the state participated, providing a snapshot of over 45% of Idaho's total accident and health insurance market for 2021 through 2025. The working group reviewed two data briefs summarizing the trends and themes identified in the data, the highlights of which are outlined below[3].

FROM INSURERS

- **Claim denials increased.** The weighted denial rate among responding insurers rose from 9.1% in 2021 to 13.5% in 2025. Idaho's state 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%.
- **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 would benefit from one reporting standard.

[2] Health Insurance Policy Briefing. 2026. Slominski, Kyle & Penny, Alex. Idaho Legislative Services Office.
[3] Health Insurer and Provider Data Briefs. 2026. Lippitt, Frances. Idaho Legislative Services Office.

FROM PROVIDERS

- **Rural hospitals face greater payment friction.** Initially denied billed dollars were 29.0% rural versus 20.9% urban. Of initially fully denied dollars, 47.6% remained fully denied in rural hospitals versus 38.6% urban.
- **Prior authorization workload increased** across all three providers with complete data.
- **Denial trends are mixed.** From 2024 to 2025, initial denials fell at Portneuf and Madisonhealth but rose at St. Luke's.
- **Financial pressure differs across providers.** In 2025, reported operating margins were -4.37% at Steele Memorial, -2.19% at Madisonhealth, and +1.47% at St. Luke's.

The working group additionally reviewed completed questionnaires or written testimony without data from one insurer, six providers, and three individuals. Insurers and providers generally agreed on the following points:

- 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.

Overall, responses from insurers and providers identified wide variation in administrative friction and approval timelines by carrier, with some carriers demonstrating shorter timelines to prior authorization approvals since 2021, and others trending toward lengthier prior authorization approvals. Where national averages were available, Idaho's market generally performed better, with a lower initial denial rate and shorter timeline for prompt payment.

STATE OF IDAHO HEALTH PLAN DATA

Working group members have also requested de-identified claims-level data from the Office of Group Insurance and Regence for the State of Idaho's health plan. Although that data has not yet been received, the working group encourages the prompt resolution of this request to allow the Office of Group Insurance and the Legislature to fully analyze plan utilization and claims trends. A standard process for regular transmission of claims-level data as requested would allow improved oversight of the plan.

RECOMMENDATIONS

Hearing from insurers, providers, and the public allowed the working group to identify common friction points in claims processing among commercial carriers, providers, and the insured. In response, the group put forward the following six unanimous policy recommendations, three of which include proposed legislation for the Legislature to consider during the 2027 legislative session:

- **Uniform provider credentialing.** Recommending legislation authorizing the Department of Insurance to establish the uniform credentialing process, while leaving each plan's network participation decision with that plan.

- **Prior authorization reform.** Recommending legislation that would reform the prior

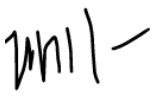
authorization process by establishing transparency requirements, decision timelines, and notice and appeals standards.

- **Prompt payment and claims processing standards**. Recommending legislation that amends the prompt payment statute to establish clear, reciprocal timelines for claims processing, and provides the Department of Insurance rulemaking authority to establish standardized requirements for the submission, processing, and payment of health insurance claims under its authority.

- **Annual data collection and report**. Recommending a resolution asking the Department of Insurance to collect key metrics from applicable insurers and providers and providing the authority to collect claims data from providers.

- **Plan for insurance for School Benefits Trust.** Recommending the Legislature direct the Department of Insurance to submit a plan for the School Benefits Trust for medical insurance, which may include an RFP.

Respectfully,





Mark Harris
Idaho State Senator
Legislative District 35
Working Group Co-Chair

Dustin Manwaring
Idaho State Representative
Legislative District 29
Working Group Co-Chair

cc:
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Toni Lawson, Chief Advocacy Officer, Idaho Hospital Association
Nicole Mikesell, Revenue Cycle Manager, Premier Eye Care of Eastern Idaho
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ATTACHMENT. RECOMMENDATIONS & UNANIMOUS MOTIONS

1. UNIFORM PROVIDER CREDENTIALING.

PROPOSAL: Legislation could be drafted to require the Department of Insurance to implement a uniform credentialing process, which would provide a standardized application for providers to submit to insurers. This would reduce administrative paperwork and processing wait times. The department would need the authority and potentially rule making. The department recommends a delayed January 1st effective date.

MOTION 1: Uniform provider credentialing. I move that the cochairs work with members, staff, and outside entities to scope a bill authorizing the Department of Insurance to establish the uniform credentialing process, while leaving each plan's network participation decision with that plan.

2. PRIOR AUTHORIZATION REFORM.

PROPOSAL: Legislation similar to House Bills 841 and 611 of the 2026 legislative session would establish statewide rules for how health insurers handle pre-approvals to reduce delays in care. Below is a summary of HB 841:

Insurers must publicly post all services that require prior authorization along with the clinical criteria used to review requests. The bill requires insurers to follow standardized electronic prior authorization processes, provide clear documentation requirements, and give advance notice before changing authorization rules.

The legislation also sets timelines for decisions. Insurers must issue a determination within seven days for standard requests and within 72 hours for expedited requests when a delay could seriously harm the patient. If a request is denied, insurers must provide the clinical reasons for the denial and explain the appeal process. Appeals must be reviewed by a licensed health care professional with appropriate expertise who was not involved in the original decision.

The bill also establishes minimum validity periods for approved authorizations, protections against improper revocation of approvals, and continuity of care protections when patients change insurance plans. It gives the Idaho Department of Insurance enforcement authority, requires annual reporting of prior authorization data, and allows penalties for noncompliance.

MOTION 2: Prior authorization reform. I move to recommend the cochairs work with members, staff and outside entities to develop legislation that would reform the prior authorization process by establishing transparency requirements, decision timelines, and notice and appeals standards.

3. PROMPT PAYMENT AND RECIPROCAL CLAIMS PROCESSING STANDARDS.

PROPOSAL: Amendment of the prompt payment statute to establish reciprocal timelines for both insurers and providers and clear claims processing standards set by the Department of Insurance could reduce delayed payment and administrative rework.

Reciprocal Timelines for Prompt Payment

Establish clear, reciprocal timelines and standardized requirements for the submission, processing, and payment of health insurance claims.

The committee has heard concerns from both providers and payers about delays and administrative burdens in the claims process. Providers report delays in payment, repeated requests for information, unnecessary complexity, and denials. Payers report that providers sometimes delay submitting documentation, fail to respond to requests for information, or submit claims without the documentation necessary to determine payment.

Rather than addressing only one side of the process, Idaho should establish reciprocal accountability.

A policy could establish a "shot clock" for both parties:

- **Providers** would have a defined period to submit the documentation and information reasonably necessary to process a claim after the service is provided or after the insurer requests additional information.

- **Insurers** would have a defined period to process and pay a clean claim once all required information has been received.

- If an insurer determines that a claim is not clean, it would be required to identify the specific missing information or documentation needed, rather than making repeated or unclear requests.

- Once the provider supplies the requested information, the payment clock would restart or continue according to a clearly defined statutory timeline.

- Standards should also establish what constitutes a complete or "clean claim" so that providers and payers have a common understanding of when the payment clock begins.

Standardized "Clean Claim" and Procedure Requirements

Idaho should also explore establishing standardized requirements for commonly performed procedures. A significant percentage of routine health care services have predictable documentation, coding, and medical-necessity requirements. For these services, insurers could establish standardized requirements for:

1. Whether prior authorization is required;

2. What clinical documentation is required;

3. What information must accompany the claim;

4. What constitutes a clean claim; and

5. The timeframe in which the claim must be adjudicated and paid.

The objective would be to move routine services through a predictable process rather than requiring providers and insurers to repeatedly resolve the same administrative questions. This approach could reduce unnecessary administrative costs, shorten the time between service and payment, reduce avoidable denials and appeals, and provide greater predictability for both providers and payers. Most importantly, it would create a process in which providers are responsible for timely submission of complete information and insurers are responsible for timely payment once that information is received.

The policy should be developed with appropriate exceptions for complex claims, coordination of benefits, fraud investigations, medical-record requests, and circumstances outside the control of either party.

MOTION 3: Prompt payment and claims processing standards. I move that the cochairs work with members, staff and outside entities to develop legislation that amends the prompt payment statute to establish clear, reciprocal timelines for claims processing, and provides the Department of Insurance rulemaking authority to establish standardized requirements for the submission, processing, and payment of health insurance claims under its authority.

4. Annual paired data collection and report.

PROPOSAL: Legislation or resolution could be drafted to ask the Department of Insurance to collect and annually present to the germane committees on criteria from regulated insurers such as denial rates and prompt claims payment information, as well as the related data from providers. This data should include standardized metrics on the use and cost associated with independent dispute resolution. The Department (DOI) can collect the data, anonymize it and share it.

MOTION 4: Annual data collection and report. I move to recommend staff draft a resolution asking the Department of Insurance to collect key metrics from applicable insurers and providers and providing the authority to collect claims data from providers.

5. Develop a Plan for Insurance for School Benefits Trust.

PROPOSAL: A resolution could be drafted to direct the Department of Insurance to issue a new Request for Proposal for medical insurance on behalf of the School Benefits Trust.

The Trust serves over 100 LEAs (districts and charters). There are approximately 13,000 members that don't know what comes next for them. They are currently under contract with Blue Cross of Idaho, but the agreement was put forward with significant haste. It would go a long way with our schools to know what the options are and how to plan for health insurance going forward. This may help renew a conversation about schools joining the State insurance plan, if it is at all possible.

MOTION 5: Plan for Insurance for School Benefits Trust. I move to direct the Department of Insurance to submit a plan for the School Benefits Trust for medical insurance, which may include an RFP.

6. DIRECT BRIEFS OF INSURER AND PROVIDER DATA.

PROPOSAL: Direct staff to complete data briefs analyzing the claims and financial data the working group received from insurers and providers.

MOTION 6: Direct data briefs. I move to direct staff to complete briefs on the data the working group has collected from insurers and providers.