Economy Risk Classification And Legal Principles In Insurance Coverage For Modern Insurance Practice In Indonesia

Ariska Agustina[1*], Prima Paramita Putri[2], Evi Kusumastuti Setianingrum[3], Erlina Puspitaloka Mahadewi[4]

[1,2,3]Master of Public Health, Faculty of Public Health, Universitas Respati Indonesia, Indonesia
[4]Universitas Esa Unggul, Jakarta, Indonesia
*Corresponding Author:
Email: drg.ariska@gmail.com

Abstract.

This study analyzes the legal principles underlying insurance coverage and economy risk classification in modern insurance practices. The principles of insurance law: utmost good faith, insurable interest, indemnity, subrogation, proximate cause, are important foundations in regulating the relationship between the insurer and the insured. On the other hand, risk classification plays a crucial role in the assessment, premium determination, risk selection, and risk management by insurance companies. The method used is a literature study with a normative approach, examining regulations, legal doctrines, scientific literature, and practices in the insurance industry. The results of the study indicate that a deep understanding of the principles of insurance law and risk classification can improve transparency, contractual fairness, moral hazard risk mitigation, operational efficiency in the insurance industry. Risks in insurance are classified into two main categories, namely pure risk which is related to the possibility of loss alone and speculative risk which involves the possibility of profit or loss. The six basic principles of insurance law, insurable interest, utmost good faith, proximate cause, indemnity, subrogation, contribution are the foundation for the formation and implementation of a valid insurance contract. The development of digital technology, the use of big data, artificial intelligence, machine learning in the insurance sector, has brought significant changes to risk classification methods, underwriting, and claims assessment processes. In conclusion, a comprehensive understanding of legal principles and risk classification is essential to ensure legal protection, increase public trust, and support the sustainability of health and general insurance practices in the modern era for Indonesia.

Keywords: *Insurance coverage; modern insurance; principles of insurance law; risk classification and risk management.*

I. INTRODUCTION

Insurance is an instrument of protection against uncertain risks. In Indonesia, insurance practices are regulated through the Commercial Law Code (KUHD) and reinforced by financial industry regulations. In a legal context, an insurance agreement is a reciprocal contract between the insurer and the insured that must meet legal principles and principles. In practice, the relationship between the insurer (insurance company) and the insured (policyholder) is regulated by several legal principles that aim to ensure justice, certainty, and balance of rights and obligations of both parties[1]. Basic principles such as utmost good faith, insurable interest, indemnity, subrogation, and proximate cause are the legal foundations that determine the validity and effectiveness of an insurance contract. These principles are designed to ensure fairness, transparency, and legal protection for both parties. In modern insurance practices, especially health insurance, it is important to understand how these legal principles are applied, as well as how risks are classified to determine eligibility for coverage[2]. In the modern insurance era, technological developments such as big data, artificial intelligence (AI), and machine learning have changed the traditional paradigm in identifying and classifying risks. However, this transformation also raises new challenges, including data privacy issues, algorithmic bias, and regulatory gaps. This article presents an in-depth review of legal principles in insurance coverage and risk classification based on national legal sources and international practices[3].

II. METHODS

This study is a qualitative study with a descriptive approach that aims to describe the factors that influence the development of insurance in Indonesia based on legal principles, insurance coverage, and risk classification in modern insurance practices in Indonesia[4]. The method used is a literature review, with secondary data collection sourced from government regulations, the official website of the Indonesian Ministry of Health, scientific journals, books, and online publications through open access platforms such as

Google Scholar, PubMed, and Science Direct. Additional data was obtained through in-depth interviews with experts to confirm the completeness of policies and related data[5].This study uses a normative approach in legal and economic insurance aspects, through a review of laws and regulations, academic literature, and documents from international insurance organizations such as the International Association of Insurance Supervisors (IAIS). Primary data sources include the Indonesian Commercial Law (KUHD), Law No. 40 of 2014 concerning Insurance in Indonesia, and various Regulations of the Indonesian Financial Services Authority, including POJK No. 23/POJK.05/2015, POJK No. 71/POJK.05/2016, POJK No. 14/POJK.05/2018, POJK No. 14/POJK.05/2020, POJK No. 14/POJK.05/2021, and POJK No. 13/POJK.05/2022. Other supporting sources are Indonesian Law No. 8 of 1999 concerning Consumer Protection, Law No. 24 of 2007 concerning Disaster Management, and Bank Indonesia Regulation concerning reinsurance in Indonesia[6].

III. RESULT AND DISCUSSION

The results of this study indicate that the legal principles in insurance coverage agreements play an important role in ensuring fairness, transparency, and protection of the rights and obligations of each party in the insurance contract. The six main principles, namely Insurable Interest, Utmost Good Faith, Proximate Cause, Indemnity, Subrogation, and Contribution, are the basis for the legality and validity of each insurance agreement[7].

1. Insurable Interest Principle

The insurable interest principle emphasizes that the insured party must have a legal or economic interest in the insured object. The legal basis for the Insurable Interest Principle includes: Article 250 of the Commercial Law Code (KUHD): "If a person who has made an insurance for himself or if a person for whom an insurance has been made, at the time the insurance is made does not have an interest in the insured goods, then the Insurer is not required to provide compensation." According to Article 250 of the Commercial Code, every insurance agreement requires an interest (Insurable Interest). Article 268 of the Commercial Code (KUHD): "A coverage may concern any interest that can be valued in money, can be threatened by a danger and is not excluded by law." Therefore, the Insurance Company can only cover/close the insurance of property from a person/legal entity that has an interest in the property at the time of closing. The four main things in insurable interest include: there must be an object, right, soul that can be insured/insured; the object, right & soul must be the object of the insurance; the insured will receive benefits if the principal of the insurance is not damaged, and conversely will suffer losses if the principal of the insurance is damaged; there must be a legal relationship between the Insured and the Principal of the Insurance[8].

2. Utmost Good Faith Principle

The principle of utmost good faith requires both parties to the contract to disclose all material facts. This study found that negligence in disclosing information by the insured, whether intentionally or not, can cancel the insurance contract in accordance with Article 251 of the Commercial Code[9]. In modern practice, this principle has been further developed in the form of transparency clauses and disclosure obligations in international policies[10]This insurance principle also explains the risks that are guaranteed or excluded, including all terms and conditions of insurance clearly and thoroughly.Good Faith according to Article 251 of the Commercial Code is All false or untrue news or all concealment of circumstances known to the insured, no matter how honest it is on his part, which is such that the agreement will not be made or will not be made based on the same conditions, if the insurer knows the true condition of the object, causing the insurance to be void[10].

3. Proximate Cause Principle

Proximate Cause is basically insurance that replaces losses that are not replaced in other types of insurance. Proximate cause is simply the earliest main cause. This principle is very necessary because in insurance there is difficulty in determining the main cause. For example, in one incident there are consecutive events that cause losses. Losses arising from a series of events must be analyzed based on the

dominant or main cause. For example, a fire caused by lightning that is exacerbated by a hurricane will be analyzed to determine whether the risk is part of the policy coverage[11].

4. Indemnity Principle

The indemnity principle ensures that the insured is compensated according to the actual loss without gaining any profit. According to Articles 252, 253, and 278 of the Commercial Code, the insurer must return the insured to the financial position before the loss occurred. Indemnity or compensation is defined as compensating someone for the loss suffered. A mechanism that requires the insurer to provide financial compensation (compensation) in an effort to place the insured in the financial position he had immediately before the loss occurred (KUHD articles 252, 253 and reinforced in article 278). This study also confirms that the principle of indemnity guarantees the insured to be returned to his original financial position before the loss occurred. Based on Articles 252, 253, and 278 of the KUHD, the insurer is obliged to provide compensation equivalent to the actual loss value, not to provide benefits. The practice of indemnity is seen in health and property insurance products that use the payment method[12].

Contract Elements in Insurance

According to Vaughan & Vaughan, there are five elements that must be present in an insurance contract, namely Offering and acceptance, Considerations, Legal objects, Competent parties; and Legal statement (legal form).

1. Offering and Acceptance

An insurance contract must contain a statement that there is a party offering and a party accepting the offer. In health insurance, the insured party (potential health customer) "offers" to the insurance company to cover the risks arising from health/illness, and the insurer party (insurance company) "accepts" the offer submitted by the insured. If the insurer agrees to the insured's offer, it should be stated in the health insurance contract[13]. In this offer and acceptance process, there are two types of contracts that can be made by both parties, namely a written contract and an oral contract. Generally, health insurance contracts are made in writing, especially to prevent fraud, especially by the insured. Some conditions require an oral contract, especially contracts for property and debt insurance, but it is difficult to prove statements in an oral contract that have been violated by one of the parties. In the process of offering and accepting to bear the risk which is then stated in the contract, there is a significant role for insurance agents[14]. The role and authority of insurance agents in approving contracts are divided into three, namely:

a. Express authority
   called stipulated authority, which is the authority specifically given to insurance agents/marketers by insurance agents/insurance companies to expedite the signing of the contract. The contract is stated in an agency contract with the authority, among others, to act as an insurer's representative in approving certain insurance clauses. General authority as an agent receive sales commission, have a contract to cancel the contract.
b. Implied authority
   called incidental authority, is an additional authority of an insurance agent that is incidental or needed to carry out authority outside of express authority. For example, the authority to promote insurance and receive premium payments from the insured.
c. Apparent authority
   called ostensible authority, is the additional authority of the insurance agent to convince the insured that the contract signed by the insurance agent can bind the insurance company (insurer). However, this type of authority is generally only in property and debt insurance[15].

2. Consideration

Consideration (or considerations) is the power that binds both parties in a health insurance contract because it contains the substance of values that must be carried out by each other. Consideration concerns the agreements that must be made to carry out the contract, for example: Agreement to pay losses by the insurer; Agreement to pay premiums by the insured. In health insurance, the contract is valid if the initial premium has been paid[16].

3. Legal Object

To achieve its goals, an insurance contract must have legal force. This means that all statements or considerations in the insurance contract can be legally accounted for in court if one party violates the agreement.

4. Competent parties

The definition of competent parties is parties who have the legal capacity to be included in the contract from a legal perspective. Generally, this legal capacity does not apply when it comes to two things, namely parties who cannot be subject to adult law, also called minors; and parties who are mentally incompetent. Some courts of law set different age limits, some set them under 21 years of age, or under 18 years of age[17].

5. Legal Form

Insurance contracts must meet the formal legal standards applicable in the country where the contract is executed. Insurance policies generally follow the standards applicable in all countries, but this is not the case for health insurance policies. However, in health insurance policies there are 12 statements/provisions that must be specifically included and translated into contracts based on applicable law[8].

Risk Classification in Insurance Practice

The results of the study also show that in modern insurance practice, risks are classified into several categories. Only pure risks can be insured because these risks do not involve an element of profit and are unintentional. Examples of pure risks include fire, disease, or accidents. On the other hand, speculative risks such as investment or gambling are not insured because they conflict with the principle of insurable interest[18].Although coverage may exceed the actual price or interest, it is only within certain limits (double insurance). In the context of regulation, POJK No. 14/POJK.05/2021 requires insurance companies to implement comprehensive risk management for the entire insurance portfolio, including the use of digital technology in risk assessment (risk profiling). This is in line with the direction of IAIS in 2021, which emphasizes the importance of implementing digital technology in an inclusive and responsible manner in the insurance industry. In addition, with the emergence of digital financial innovation (fintech), POJK No. 13/POJK.05/2022 emphasizes that new risk classification and mitigation must be strengthened, especially those related to data security, transparency of underwriting algorithms, and consumer protection[19]. Principle-based supervision and regulation as explained by Baldwin and Cave (2022), are becoming increasingly relevant to be applied in this context.

Thus, legal principles in insurance and risk classification cannot be separated from regulatory and technological developments. Adaptation to these dynamics is an absolute requirement for the insurance system to remain relevant, fair, and accountable in serving the needs of modern society[12]. POJK No. 14/POJK.05/2021 requires the implementation of comprehensive technology-based risk management[20].Digital advances such as big data and AI strengthen underwriting methods, but also pose new risks such as algorithmic bias. IAIS (International Association of Insurance Supervisors) in 2021, emphasizes the importance of implementing principles-based regulations in facing these challenges. Thus, a strong understanding of legal principles and risk classification is the basis for facing the dynamics of modern insurance. The results of this study indicate that the legal principles in insurance coverage agreements play an important role in ensuring fairness, transparency, and protection of the rights and obligations of each party in the insurance contract. The six main principles, namely Insurable Interest, Utmost Good Faith, Proximate Cause, Indemnity, Subrogation, and Contribution, are the basis for the legality and validity of each insurance agreement[21].

IV. CONCLUSION

Legal principles in insurance coverage play a central role in establishing a fair and balanced contractual relationship between the insurer and the insured. Principles such as insurable interest, utmost good faith, indemnity, proximate cause, subrogation, and contribution are not only legal norms, but also protection instruments to prevent arbitrariness in insurance practices[21].In the era of increasingly digitalized modern insurance, these principles must remain as a reference even when faced with new challenges such as

algorithmic bias, data privacy, and the development of big data and artificial intelligence technology[22]. In addition, risk classification is key to effective risk management. A deep understanding of the differences between pure and speculative risks, as well as their grouping into special risks and fundamental risks, helps insurance companies in selecting risks, setting premiums, and developing accurate protection strategies[14]. Therefore, harmonization between understanding legal principles and risk classification approaches is essential in order to realize a fair, efficient, and sustainable insurance system for all parties involved.

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