Healthcare Insurance Agreement Regarding Financing Of Health Services By Insurance Companies

Dewi Novia Laras[1*], Hanna Yulita[2], Muhamad Ikhsan[3], Erlina Puspitaloka Mahadewi[4]

[1,2,3]Master of Public Health, Faculty of Public Health, Universitas Respati Indonesia
[3]Economic and Business Faculty, Universitas Esa Unggul, Jakarta Indonesia
*Corresponding Author:
Email: larasdewinovia@gmail.com

Abstract.

This study analyzes health insurance as a form of financial protection designed to reduce the burden of medical costs when a participant experiences a health problem. In practice, the relationship between the participant and the insurance provider is based on a legal agreement called an insurance contract. This contract is legally binding on both parties: the insurer (insurance company) and the insured (insurance participant), and includes rights and obligations that must be fulfilled during the coverage period. In Indonesia, public understanding of health insurance contracts remains relatively low. Many participants do not fully understand the content and implications of the agreement they sign, including the terms and conditions, guaranteed benefits, coverage limits, and claims procedures. This approach was chosen to gain a comprehensive understanding of the patterns, causal factors, and impacts of agreement health insurance reported in various cross-country studies and insurance schemes, both public, private, and community-based health insurance contracts, whether administered by social institutions like BPJS Kesehatan (Social Security Agency for Health), or by commercial insurance companies, have different structures and provisions. Problems gap arise when participants lack detailed knowledge of the scope and limitations of their insurance contracts, resulting in underutilization of available benefits. Furthermore, from the service provider's perspective, contract implementation often faces administrative and communication challenges, which can impact participant satisfaction and perceptions of service quality. The result of study is important to examine more deeply the content and implementation of health insurance contracts, as well as the extent to which participants understand their rights and obligations. A better understanding of insurance contracts will improve the effectiveness of health protection and strengthen public trust in the Indonesian health insurance system.

Keywords: *Commercial health insurance; insurance contract; insurance company and insurance claim agreement*

I. INTRODUCTION

The global insurance industry is expected to grow by an estimated 7.5% in 2023, the fastest growth since 2006, the year before the Global Financial Crisis (GFC). Overall, global insurance companies generated EUR6.2 trillion in life insurance (EUR2,620 billion), EUR2,153 billion in general insurance, and EUR1,427 billion in health insurance premiums. Over the past three years, global premium revenues have increased significantly, reaching a staggering EUR1.1 trillion, or 21.5%. (Allianz article, 2024).The Indonesian insurance market experienced solid growth in 2023: premium revenues increased by 3.6% to EUR16.8 billion. However, this overall increase showed very different developments in the life and general insurance segments. For life insurance, premiums declined for the second consecutive year (-7.4% in 2023), while for general insurance, premiums increased by 24.2%, largely due to price increases. Overall, general insurance premium income has nearly doubled over the past three years (Allianz article, 2024)[1]. National development is the primary foundation for achieving social welfare, both economically and socially[2]. In this context, every individual is required to plan their life carefully, including protection against various risks. Insurance exists as a response to this need, becoming a vital part of life planning in modern society. The concept of insurance, derived from the term "insurance" or "asurantie," has been recognized as a crucial instrument for protecting against future uncertainty[3].Throughout life, humans are exposed to various unpredictable risks, such as illness, accidents, or loss of income.

Although humans desire certainty and security, reality shows that risks persist and are difficult to avoid. Therefore, effective mitigation mechanisms are needed. However, risk prevention efforts themselves often require costly sacrifices and carry the potential for additional losses. Therefore, risk management systems such as insurance are an efficient and relevant solution[4].In practice, insurance is based on the principle of transferring risk from the individual to another party, namely the insurance company[5]. The risk previously borne by the individual now becomes the responsibility of the insurance company[6]. Through the

agreed contract, the insurance company is obligated to provide compensation in the event of a loss resulting from an event specified in the policy. Thus, insurance plays a strategic role in providing financial protection and a sense of security for the public[7].Law Number 40 of 2014 concerning Insurance stipulates that insurance is an agreement between an insurance company and a policyholder, under which the company is obligated to provide benefits in the form of compensation for losses, costs, or other risks experienced by the insured, in accordance with the terms and conditions stipulated in the agreement[1], [8]. These benefits can include payments for death, damage, or other forms of loss.

Life insurance and health insurance are two of the most common forms of insurance coverage[9]. In practice, each insured signs a written agreement with the insurance company as a sign of their agreement to the protection provided. These products serve as an important instrument in risk management and represent a form of collective community cooperation in facing life's uncertainties[10]. Insurance contracts have legal standing that binds both parties. The insured is obligated to pay premiums as agreed, while the insurance company is obligated to provide protection as stated in the policy[11]. Insurance companies, essentially, provide a service in the form of a promise to guarantee protection against unpredictable risks, making uncertainty more manageable[12].However, in practice, not all contract implementations run smoothly. Obstacles persist in fulfilling insurance companies' obligations to insureds. One of the most common issues is claim rejections, late benefit payments, and a lack of public understanding of policy terms[13]. Data from the National Consumer Protection Agency (BPKN) shows that between 2017 and April 2021, there were more than 2,000 complaints related to financial services, approximately 70% of which were related to insurance[14], [15]. This issue highlights the importance of adequately understanding the rights and obligations under insurance contracts, both for participants and service providers[16]. Failure to comply with the principles of the agreement, whether due to the fault of the insured or the insurer, has the potential to result in losses for both parties. Therefore, increasing insurance literacy and strengthening regulations are strategic steps to create a fair, transparent, and sustainable protection system[17].

II. METHODS

The study uses a systematic literature review approach to examine the issue of agreement in health insurance and agreement regarding financing of Health Services by Insurance Companies schemes. This approach was chosen to gain a comprehensive understanding of the patterns, causal factors, and impacts of financing contract and agreement, reported in various cross-country studies and insurance schemes, both public, private, and insurance-based[18].The literature search was conducted in May 2025 using scientific databases such as Google Scholar, PubMed, ScienceDirect, and SpringerLink also Indonesian Supreme Court Decisions. The keywords used include: "agreement" AND "health insurance", "financing health insurance" AND "selection bias", "insurance company" AND "agreement health insurance", "health insurance" AND "dropout", and "health insurance enrollment" AND "risk financing behavior". This combination of keywords was designed using Boolean operators to increase the accuracy of the search results.

Inclusion criteria included peer-reviewed articles in English, published between years 2015 to 2025, with an empirical focus (quantitative or qualitative) that discuss adverse selection in health insurance. Editorial articles, opinion articles, and non-peer-reviewed studies were excluded. In addition, studies outside the context of health insurance, such as vehicle or property insurance, were also excluded[18].The article selection process consisted of three stages: (1) title and abstract selection, (2) full-text review to ensure compliance with the inclusion criteria, and (3) data verification, then from the initial search results of >50 articles, 30 final articles that met the criteria were selected. Two researchers conducted the screening process independently to minimize bias. If there were differences in assessment regarding article inclusion, the two researchers discussed to reach a consensus. If the discussion did not result in an agreement, a third researcher was asked to review and decided.Primary data studies were extracted using a standardized format that included title, authors, year of publication, study locus, type of insurance, methods, and main findings related to adverse selection[19]. In addition to data extraction, each study was assessed for quality using the appropriate risk of bias assessment tool:

- For quantitative observational studies, the Newcastle-Ottawa Scale (NOS) was used to assess methodological quality and potential bias.
- For experimental or quasi-experimental studies, the latest version of the Cochrane-Risk of bias tool was used.

Risk of bias assessment was performed independently by two investigators, with the same procedure for resolving discrepancies as in the selection stage. Quality scores were used for sensitivity analyses and to interpret the overall strength of evidence.

III. RESULT AND DISCUSSION

Every individual is inevitably exposed to various forms of risk in their daily lives. These risks, although diverse, have the potential to threaten both life and property. One of the most common types of risk, which can affect anyone, is health risk, namely the possibility of experiencing health problems or illness. From an insurance perspective, risk is defined as uncertainty that can lead to loss, thus becoming a fundamental basis for the insurance mechanism.The right to health is a fundamental human right and a crucial element in achieving prosperity, as stipulated in the Indonesia preamble to the 1945 Constitution and Article 28H paragraphs (1) and (3) of the second amendment to the 1945 Constitution. This article states that every citizen has the right to receive health services and social security to support a decent and dignified life. From birth to old age, humans cannot completely avoid risk. Therefore, as rational beings, humans strive to find ways to manage and anticipate these risks, including the risk of illness. One common protection strategy is health insurance. In this scheme, the insured transfers risk to the insurance company (insurer), which then provides certain benefits or services according to the agreement when the risk occurs.If a participant experiences a health problem, the insurance company is obligated to cover medical or treatment costs in accordance with the policy provisions. Health insurance is part of a social protection system aimed at reducing the economic burden on individuals and assisting the government in achieving overall public welfare.Insurance companies provide protection against uncertainty through a legally binding agreement. Under this agreement, participants are required to pay a premium as a form of risk transfer.

The primary focus of this protection is on unforeseen events that could result in loss, whether physical or asset.Insurance is operated based on key principles such as a contractual relationship, premium payment, compensation for losses, and uncertainty regarding the timing and occurrence of the risk[2]. This legal relationship is regulated by Indonesia Article 1313 of the Civil Code (KUHPer), where the agreement creates rights and obligations between the insured and the insurer. The premium paid represents the transfer of risk, and if the risk occurs, the insurance company is responsible for providing compensation in accordance with the agreed policy. This system allows participants to obtain protection through a premium payment mechanism, in return for benefits provided when a risk occurs, as stipulated in the insurance agreement. An insurance claim is a formal request from a participant to the insurance company for benefits based on the terms agreed upon in the policy. The claims procedure involves an evaluation by the insurance company to determine the validity of the claim. If deemed valid, the company will pay compensation to the participant or their heirs. These claims arise from the legal relationship between the insured and the insurer, where the company is obligated to pay compensation if the insured risk occurs, while the insured is obligated to pay the premium. The premium amount is determined based on the insurance company's risk calculations and statistical data.As the number of insurance participants increases, so does the demand for claims for policy benefits. However, claims are not always processed smoothly. Claims are sometimes rejected or face lengthy processing times.

These issues often lead to disputes, which can even lead to legal action if participants feel their rights have not been met. This research focuses on issues such as these. The author will further examine them through a theoretical approach and relevant legal frameworks. The primary case referenced in this study is Supreme Court Decision Number 20/Pdt.G/2010/PN.Ptk year 2010, involving the health insurance “X” as the defendant. This case began with a regular visit by a marketing agent named “R” to client Ms.“MH”, who ultimately agreed to participate in an insurance program for her child. After fulfilling the requirements and paying a premium of IDR 6,525,000 on September 16, 2009, her child died on September 30, 2009, due to

dengue fever. Ms.“MH” then filed a claim on October 17, 2009. However, the claim was rejected by the insurance company, citing failure to meet the requirements. The plaintiff did not accept the reason for the rejection, as all requirements had been submitted. Even after meeting directly with the insurance company in January 2010, the claim was still rejected. Ultimately, the case went to court, and the Supreme Court ruled that the insurance company had committed a breach of contract and was required to pay compensation of IDR 300,000,000.This ruling demonstrates the importance of the principle of *pacta sunt servanda* in contracts, which states that every agreement is valid as law for the parties to it. This is stipulated in Article 1338 paragraph (1) of the Civil Code. In this case, even though the policy had not yet been issued, all administrative obligations and premium payments had been fulfilled by the insured, so the right to a claim should still be recognized.The principle of utmost good faith is also highly relevant, requiring both parties to act honestly and transparently.

The insured is required to provide accurate information upon registration, while the insurer is required to explain the policy's benefits and exclusions in detail. This principle also aligns with Article 4 of the Consumer Protection Law, which regulates consumers' rights to clear and honest information. Disputes like this reflect a failure to uphold basic insurance principles and demonstrate the importance of trust and a good relationship between insurers and insurance providers. When that trust is violated, legal resolution becomes the last resort for insurers to claim their rights. This was followed by several similar cases in subsequent years.However, the insured had demonstrated good faith by completing premium payments and following insurance registration procedures. The insurer's denial of a claim reflects a breach of contractual obligations, where the insurer is reluctant to fulfill its claim payment obligations without a strong legal basis. This case highlights the importance of the principle of utmost good faith in every insurance contract. This principle mandates openness and honesty between both parties the insured and the insurer in providing information. In this context, insurance companies should provide prospective customers with a thorough explanation of their obligation to disclose detailed medical information. Unfortunately, in this case, there is a disparity between the insured's obligations and the insurer's failure to uphold transparency and its contractual obligations[20]. This ultimately harms the insured, who participated in the insurance contract in good faith. From this case study, we can learn that it is crucial for insurance companies to provide complete and accurate information to prospective policyholders, particularly regarding the obligation to disclose health conditions[21]. Education provided by agents to prospective customers regarding the importance of honesty in completing forms and providing medical history is crucial to avoid future disputes. Detailed information regarding the rights and obligations under the policy must also be explained transparently to avoid any detrimental interpretations by either party when a claim is filed[22].

Health Financing Claims Settlement by Insurance Companies

Health insurance is a fund management system collected from contributions from members or organizations, aimed at funding healthcare services for insured participants. If an incident occurs within the policy's coverage, the insured (insured) has the right to file a claim with the insurance company (insurer) in the hope of receiving compensation according to the provisions[23]. On the other hand, insurers have an interest in protecting themselves from the risk of loss and often exploit formal legal provisions to absolve themselves from responsibility for paying claims[9], [24].In this context, the insurer is obligated to prove a valid legal basis for exemption from liability or cancellation of the policy, in accordance with applicable regulations. Issues like these are not simple because they involve legal interpretation and the application of laws and regulations in the health insurance sector[25]. Therefore, resolving conflicts between disputing parties requires a thorough understanding of insurance law.In practice, insurance dispute resolution can be achieved through various mechanisms, such as direct negotiation, deliberation, and mediation. Mediation involves a neutral third party, the mediator, whose role is to improve communication, create a fair dialogue, provide perspective, and help identify the key issues at the root of the dispute.

One institution that plays a crucial role in this dispute resolution is the Indonesian Insurance Mediation Agency (BMAI). BMAI is an independent institution that provides dispute resolution services through two stages: first, mediation, and if no agreement is reached, adjudication by an adjudication panel[26]. The adjudication decision can be accepted or rejected by the disputing parties, depending on the

outcome of the mediation.Rejection of insurance claims, particularly for life insurance products, can result in losses for customers[27]. This can also undermine public trust in the insurance industry, especially if the rejection is not accompanied by clear and fair reasons. Therefore, in addition to BMAI, disputing parties can also pursue arbitration, either through ad hoc arbitration or through an official institution such as the Indonesian National Arbitration Board (BANI)[28].Insurance policies generally contain a dispute resolution clause that lists the choice of resolution forum, such as court or arbitration. If litigation is pursued, the process begins with a hearing in the District Court, can proceed to an appeal in the High Court, and ultimately ends with a cassation appeal in the Supreme Court. Furthermore, an extraordinary legal remedy is available in the form of a Judicial Review (PK) after a decision has become final and binding[29]. A PK can be filed for specific reasons, such as judicial error, a clear error in the decision, a decision exceeding the claim, or the discovery of new relevant evidence[30].

IV. CONCLUSION

This study highlights the importance of understanding important points to conclude: First, the provisions regarding the validity of an agreement are clearly regulated in Indonesia Article 1320 of the Civil Code (KUHPerdata), which includes the elements of agreement between the parties, legal capacity to enter into an agreement, the existence of a specific object, and legally permissible causes.Second, when forming an insurance agreement, it is crucial to adhere to the basic principles of insurance, particularly the principle of utmost good faith. Honesty in providing information when completing an insurance application form is a vital part of this principle. Any omission or concealment of material facts can be considered a violation of insurance principles.

Third, the insurance company's primary responsibility is to compensate the policyholder if an event occurs as agreed in the contract that causes a loss. However, this obligation can only be fulfilled if the insured event occurs and is in accordance with the terms of the policy. The principle of "no premium, no claim" is a key principle in insurance practice, meaning that claims cannot be processed if premium payments have not been made in accordance with applicable regulations. This aligns with the regulations stipulated in Indonesia Financial Services Authority (OJK) Regulation Number 40 of 2014 concerning Insurance. In the future, conversely, the policyholder also has a fundamental obligation: to pay the premium as agreed in the policy.

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