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Analysis of Health Insurance Claim Decisions in Indonesia

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Abstract. This research explains the process of filing a claim, as well as one Indonesian health insurance company's decision-making process regarding medical claims. The research is descriptive and qualitative, and the data was collected using observations, interviews, and relevant company documents. In the claim submission process, a claim form must be filled out and accompanied by all the required documents. Claims are approved, rejected, or postponed (a pending claim). The decision process for claims includes completing the necessary documents and verifying that the data submitted is accurate. Incomplete documents can cause claim settlements to be postponed. If the customer does not complete the requested documents within 30 days, the claim will be rejected. If submitted information is not valid, if fraud or abuse is indicated, or if a claim includes a policy exclusion, its submission will require further investigation, and a decision about the claim will be postponed. Investigations can be done by contacting the customer, a claim forum, the hospital, or other related parties.

Keywords: *filing claims, claims decision, health insurance*

1 Introduction

The role of insurers has become increasingly significant when dealing with complex and uncertain living conditions (Sendra, 2009). The main role of insurance is to provide protection to individuals and organizations against possible financial losses. Accordingly, the insurer promises to reimburse the insured, according to an agreement signed by both parties, in exchange for the payment of premiums. In conducting business, insurers take on several functional roles, such as underwriting, actuarial work, reinsurance, customer service, marketing, legal work, accounting, human resources, information systems, and claims administration (Brown et al., 2002).

The claims department is responsible for checking, evaluating, and determining claim payments. When participation reflects production, then insurance claims give meaning to the success of production (Ramli et al., 1999). This department determines whether claims are approved, rejected, or suspended. Paying claims promptly improves participants' satisfaction and establishes a company image that can affect its cash flow and long-term success (Ilyas, 2003). Therefore, the claim department is a vital functional part of an insurance company. By looking at the decision-making process of an Indonesian insurance company, this paper focuses on how insurance companies build their image through claim procedures.

2 Literature Review

2.1 Health Insurance

Health insurance transfers the risk of financial loss due to an illness, accident, or disability from individuals to insurers (Iskandar et al., 2011). Health insurance can cover a wide range of expenses, including medicine, hospital care, surgery, and protection against loss of income if the insured becomes disabled (Thabrany et al., 2005).

2.2 Claim Administration

Health Insurance–Utilization Review, Claim Management and Fraud, translated by Yaslis Ilyas, focuses on claims administration by HIAA (Health Insurance Association of America). Health insurance fraud is detected by gathering evidence or facts relating to sickness and injury, benchmarking them to the terms of a policy, and then determining the benefit that can be paid to an insured or a claims collector. The claim itself represents a contractual bond between two parties (Ramli et al., 1999).

2.3 Claim Verification

Claim verification, the second step in the claim procedure, takes place after receipt of a claim but prior to making a decision about it. It is accomplished by a claims administrator and a claims analyst. In verifying a claim, a claims analyst analyzes and correlates information in filing documents with policy provisions. The verification steps include the following:

1. Policy Status Verification
   A claims analyst first verifies the premium payment made by the customer, which affects the status of the customer's policy. Policies are divided into three categories: in-force, lapsed, or terminated.
2. Verification of the Insured
   A claims analyst verifies that the policy owner is in fact insured and examines if he or she has more than one policy. If so, the second policy is checked to see if it can be processed. This avoids double claims.
3. Verification of Requirements for a Complete and Valid Claim Submission
   To reimburse a filed claim, a claims analyst checks the completeness of claim documents to determine their validity. For health insurance, the validity of a hospital stamp and/or a doctor's signature can provide sufficient evidence. The required documents must also be submitted before the policy's expiry date.
4. Benefit Verification
   A claims analyst must verify that a policy covers the losses specified in a claim's filing, such as hospital treatments. Insurance companies only reimburse up to a policy's limits. Charges above these limits are borne by the customer.
5. Policy Exclusions
   A claims analyst checks product specifications and conditions and losses not covered by the policy, such as waiting periods and preexisting conditions. If a claim passes these tests, it is submitted in accordance with the applicable provisions.
6. Determine the Contestable Period
   If the policy's contestable period has not ended, a claims analyst generally investigates if the claim contains any misrepresentations. If so, he then determines whether or not the policy should be cancelled.
7. Technical Analysis
   Technical analysis considers proposed claims, types of claims, diagnosis and condition of the insured, correlations between treatment and diagnosis, length of hospital admission and diagnoses, and frequency of hospitalization. Good technical analysis, usually performed by a claims analyst, requires experience

2.4 Decisions About Claims

Ramli et al. (1999), in their book *Management Claims*, segregate claims in the following manner:

1. Claims Are Rejected Completely
   Claim rejection occurs if the health services received are not covered by the insurance plan or if a claim contains inconsistencies. Most claim denials occur because the health care received is not covered by the policy.
2. Claims Are Partially Accepted
   Exclusions, coordination of benefits, limitations, or other conditions can limit claim payments.
3. Claims Pending Settlement
   Pending settlements are usually for claims with incomplete requirements.
4. Fully Accepted Claims
   Claims are paid out in full if all procedural requirements have been met.

3. Methodology

3.1 Type of Research

This descriptive research applies a qualitative approach. Qualitative research, by contrast, attempts to understand social or human problems (Moleong, 2007).

3.2 Data Types and Sources

This study used both primary and secondary data. Primary data was obtained by direct observation and secondary data from documents.

3.3 Data Collection Methods

Direct interviews and observations were conducted by claim handlers. Documents analyzed dealt with the acceptance, delay, or rejection of claims.

4. Results and Discussion

While a claims analyst makes a decision about a claim based on verification, ultimately, his or her participation ends after he or she reports to a claims manager, who makes the final decision about a claim, often in consultation with the insurer's chief operating officer or board of directors.

1. Claim Approval
   If claim documents and all related information are complete and valid, and if a claim cannot be turned down because of a waiting period, special disease, or preexisting condition, the insurance company will process the claim. The claims department will then generally approve the claim within 14 working days of receipt. However, approval does not always lead to full, 100% reimbursement, because all submitted costs may not be covered by the policy.
2. Rejected
   Rejection of a claim usually begins with a pending claim that requires further investigation. A claim denial must be supported by convincing evidence. Before rejecting a claim, a claims analyst must first investigate existing information to substantiate the rejection. Investigations can be done by:
   a. Direct Contact with Customers
   Insurance agents and claims adjusters can contact customers directly. They are also allowed to visit customers' residences, as well as those of related parties.
   b. Confirmed to the claim forum
   This confirmation is done *via* email. It aims to know ownership as well as history of customer claims in other insurance companies.
   c. Hospital Confirmations
   To know if a proposed treatment is correct, a claims analyst must confirm this with the relevant hospital by phone or email. A claims analyst may send an advanced attending physician's statement to the hospital where the customer was treated. Information has been done or not the treatment is in can by phone directly to the Hospital or from the claim forum. It aims to obtain more valid and complete customer medical data, which will illustrate whether or not the customer has misrepresented information or committed fraud.
   d. Confirmation with a Related Party
   In addition to customers and hospitals, insurers also interact with other parties in the filing of claims, such as institutes of education, Company, and Authorities. These interactions can find policy exclusions (waiting periods, special diseases, and PEC), as well as fraud.
3. Pending Claims
   Claims can be postponed if the required documents are incomplete, if information in the submitted documents is invalid, or if documents include exceptions, fraud, or abuse.

5. Conclusion

Claim procedures include claim receipt, verification, decision-making, and settlement. Claim verification, which greatly influences the overall claims process, is done by completing health claim and analysis worksheets. If a claim's required documents are in order, and if a claim has no exclusions, it will generally be approved. However, if the required documents are not in order, due to invalid information, fraud, abuse, or policy exclusions, the claim will be investigated further, and a decision will be postponed.

Facts can be confirmed with the customer, the claim forum, the hospital, or other related parties. If an investigation concludes that the claim contains policy exclusions or fraud, it is rejected.

References

Brown, J. L. & Kristen L. F. (2002). *Insurance Administration*. Atlanta, Georgia: LOMA (Life Office Management Association).

Ilyas, Y. (2003). *Asuransi Kesehatan–Review Utilisasi, Manajemen Klaim dan Fraud (Kecurangan Asuransi Kesehatan)*. Depok: Fakultas Kesehatan Masyarakat Universitas Indonesia.

Iskandar, D. (2011). *Dasar-Dasar Asuransi: Jiwa, Kesehatan dan Anuitas*. Jakarta: Asosiasi Ahli Manajemen Asuransi Indonesia (AAMAI).

Moleong, L. J. Metodologi Penelitian Kualitatif, Bandung: PT. Remaja Rosdakarya, 2007

Ramli, R., & Badrun, S. (1999). *Manajemen Klaim*. Depok: Program Diploma III AKK Fakultas Kesehatan Masyarakat Universitas Indonesia

Sendra, K. (2009). *Klaim Asuransi: Gampang!*. Jakarta: BMAI (Badan Mediasi Asuransi Indonesia) bersama PPM.

Thabrany, D. (2005). *Dasar-Dasar Asuransi Kesehatan*. Jakarta: PAMJAKI (Perhimpunan Ahli Manajemen Jaminan dan Ahli Asuransi Kesehatan Indonesia).