The Implementation of Coordination of Benefit (COB) within Indonesian National Health Insurance System (*BPJS Kesehatan*)

Hilda Yunita Sabrie, Zahry Vandawati, Prawitra Thalib
Faculty of Law, Universitas Airlangga, Indonesia

Keywords: Coordination of Benefit, Government, Health, Insurance.

Abstract: The Indonesian national health insurance program is organized by *BPJS Kesehatan* with a compulsory membership covering the entire population of Indonesia; whom its implementation will be carried out by the government gradually. Participants of the health insurance program by *BPJS Kesehatan* are required to pay contributions as a premi in order to obtain health insurance benefits. The benefit in this case is social security to the right of participants and their families. Benefits of health insurance that can be obtained by these participants are individual health services, including promotive, preventive, curative and rehabilitation services, that includes health services and consumed medicine in accordance with the necessary medical needs. Benefits provided by *BPJS Kesehatan* in such a way, by some scholars, are considered to be unable to meet the health needs of the people. Therefore, the government provides this facilities in the form of Coordination of Benefit (COB) or benefit coordination between *BPJS Kesehatan* and Commercial Insurance in order to provide additional benefits of health services that have been obtained by *BPJS Kesehatan* participants' by purchasing additional health insurance products for participants in need of health services improvement. However, the existence of this COB system can indicate the violation of Indemnity principle so that there is a need for a deeper analysis and more careful arrangement in implementing COB system.

1 INTRODUCTION

Coordination of Benefit (COB) or benefit co-ordination is a method whereby two or more insurers underwrite same person for the same health insurance benefit with the limit of total benefit not exceeding the amount of health services that are financed (*Peraturan Badan Penyelenggara Jaminan Sosial Kesehatan Nomor 4 Tahun 2016 tentang Petunjuk Teknis Penyelenggaraan Koordinasi*, 2016). The first party to pay claims is called the primary payer while the party who pays the remainder of the claim is called the secondary payer (Unit Pemasaran BPJS Kantor Cabang Batam, 2015). COB is a system used to determine the liability of payments for health claims when there is more than one guarantor. COB helps ensure that participants who have more than one health insurance will receive an appropriate benefit while also avoiding overpayment by one of the guarantor (Admin AdMedika, 2016).

This COB program is governed by the *Badan Penyelenggaran Jaminan Sosial Kesehatan* Regulation (Hereinafter, BPJS Regulation) No. 4 of 2016 on the Technical Guidelines for the Implementation of Benefit Coordination in the National Health Insurance Program. This COB Program is the implementation of the Law of the Republic of Indonesia Number 40 Year 2004 regarding National Social Security System, Law of the Republic of Indonesia Number 24 Year 2011 on Social Security Administering Body, and Presidential Regulation of the Republic of Indonesia Number 12 Year 2013 regarding Health Insurance as amended several times the latest by Presidential Regulation No. 12 of 2013.

This new COB system will be enforced if *BPJS Kesehatan* participants purchase additional health insurance from the provider of additional health insurance programs that have cooperated with *BPJS Kesehatan*. Presently, there are 33 additional Health Insurance companies listed as the partners of *BPJS Kesehatan* per 2017(Humas *BPJS Kesehatan*, 2017).

COB Principles in *BPJS Kesehatan* is implemented when BPJS Kesehatan participants purchase additional health insurance from the provider of the Additional Health Insurance Program or other Guarantee Agency in collaboration with

Sabrie, H., Vandawati, Z. and Thalib, P.
The Implementation of Coordination of Benefit (COB) within Indonesian National Health Insurance System (BPJS Kesehatan).
DOI: 10.5220/0010051000180023
In *Proceedings of the International Law Conference (iN-LAC 2018) - Law, Technology and the Imperative of Change in the 21st Century*, pages 18-23
ISBN: 978-989-758-482-4

BPJS Kesehatan (Humas BPJS Kesehatan, 2017). *BPJS Kesehatan* will then guarantee the applicable tariff charges under the JKN program, while the remaining tariff will be the responsibility of commercial insurance as long as it complies with the prevailing rules and procedures.

This regulation of coordinated benefits or COB is not a new thing. It has been known since the issuance of the Law of the Republic of Indonesia Number 40 Year 2004 regarding National Social Security System (SJSN), whereas the government has arranged the coordination of benefits as mentioned in Article 23,:

"In case the participant requires hospitalization, then the hospital service class is given based on the standard class". The explanation of Article 23 further states that, "Participants who want a higher grade than their rights (standard class), the difference between the cost guaranteed by the Social Security Administering Body at the cost of improving the treatment class."(Undang-Undang Nomor 40 Tahun 2004 tentang Sistem Jaminan Sosial Nasional, 2004)

The COB system is an implementation of JKN, every citizen will be guaranteed by the JKN program and for those who already have health insurance, the guarantee will be considered as a "top-up payer". Top-up payers are conditions where if the health insurance participant wants a higher class than the participant's rights that is guaranteed by *BPJS Kesehatan,* they can get upgraded by paying the remaining fees to the Additional Health Insurance. In accordance with Presidential Regulation No. 12 of 2013 on Health Insurance, Article 27 paragraph (2) states that *BPJS Kesehatan* and the providers of additional health insurance or insurance programs must be able to coordinate in providing benefits for health insurance participants.

COB system for COB participants conducted by *BPJS Kesehatan* with an Additional Health Insurance Provider by selling indemnity, cash plan and managed care products, providing additional condition as follows: (Berita Negara Republik Indonesia, 2016)

a. *BPJS Kesehatan* as the first guarantor; or
b. Provider of Additional Health Insurance as the first payer.

Regarding indemnity products, hospital cash plan, and managed care, it can be described as follows:

a. Indemnity

Indemnity is a health insurance product where cost reimbursement is based on the limit / benefit owned by health insurance participants referring to the agreement at the time of policy closing. Replacement fees are made based on when each participant is being treated (Humas *BPJS Kesehatan*, 2015).

b. Hospital Cash Plan

Hospital Cash Plan is a health insurance product that provides reimbursement of daily maintenance and compensation expenses if the health insurance participant is hospitalized due to a sickness or accident in accordance with policy guarantees. The amount of reimbursement of the cost is adjusted to the type of premium agreed by the participant of the health insurance (Adira Care, 2016).

c. Managed Care

Managed care is a health insurance product when there is a healthcare financing system compiled based on the number of registered members with controls ranging from service planning and includes contracts with health service provider (Henni Djuhaeni, 2009). This product provides costs reimbursement to health insurance participants in accordance with the costs billed. The cost of bills paid by the insurer is the result of an agreement between the insurer and the hospital (Rachmad Suhanda, 2015). Participants of health insurance are limited to the hospitals that are cooperating with the insurer and on the basis of the agreed agreement at the time of policy closing. Things that can be reimbursed are in accordance with the agreement, such as reimbursement of medicine costs, patient rooms, and so forth.

If a Participant or Business Entity has more than 1 (one) Additional Health Insurance for himself / hers, workers and members of his / her family, then:

a. Coordination of benefits is only made by one of the Additional Health Insurance Providers in collaboration with *BPJS Kesehatan*;
b. Participants or Business Entities may directly register and pay dues to *BPJS Kesehatan* without going through an Additional Health Insurance Provider.

2 THE PURPOSE OF COORDINATION OF BENEFIT (COB)

Related to COB's objectives, there are actually quite a lot of COB's goals, it depends on the viewpoint of what the person is looking at. The government has its own target on health, since improving health services is also included in the criteria of advancing public welfare as stipulated in the preamble of the

1945 Constitution of the Republic of Indonesia. The purpose of COB system is to increase the number of BPJS Kesehatan participants, so then the implementation of the JKN program is being increasingly massive and be more comprehensive (Humas BPJS Kesehatan, 2016). The implementation of COB cooperation will have an impact on the reduction of the contribution fee of the participants with high commercial health insurance, because part of the health insurance cost will be borne by BPJS Kesehatan. It is expected to increase the interest of COB participants because of the relatively cheaper premium; yet, it offers more benefits to be gained.

The next objective is that the COB participants will obtain additional health protection coverage in accordance with the needs required by the participants. This is due to the fact that through COB, participants are not limited to the facility provided by BPJS Kesehatan, but participants can also raise the level of health services and facility in accordance with the standard needed by the participants. With the COB, it is expected that participants will benefit from the presence of coordination between BPJS Kesehatan and Additional Health Insurance (AKT).

Additionally, with the COB system, it is hoped that it will decrease the stigma that there is business competition between BPJS Kesehatan and Commercial Insurance. BPJS Kesehatan is not a private insurance, but the existence of BPJS Kesehatan is intended for raising public awareness about the importance of having health insurance. With COB, participants who are financially capable and want to get a better health care facility can apply for the scheme. Through the coordination between the two, BPJS Kesehatan and Commercial Insurance can complement each other advantages and disadvantages.

3 MECHANISM OF COORDINATION OF BENEFIT (COB)

BPJS Kesehatan in organizing COB program may cooperate with Additional Health Insurance or other guarantor that is in accordance with regulation provisions in the form of: (Peraturan Direksi Badan Penyelenggara Jaminan Sosial Kesehatan Nomor 47 Tahun 2016).

a. Coordination of Benefit

Coordination of benefits is when two or more insurers underwrite same person for the same health insurance benefit with the limit of total benefit not exceeding the amount of health services that are financed. In this case, BPJS Kesehatan with Additional Health Insurance (Commercial Insurance) jointly collaborated to underwrite the same person that applied for COB.

b. Participation Coordination

Coordination of participation includes the registration of business entities that will cooperate with BPJS Kesehatan and Additional Health Insurance, data entry of workers and family members, data change mechanism, including the participant's identity sharing.

c. Coordination of Socialisation

Coordination of socialization between BPJS Kesehatan and additional health insurance or other guarantor body means that they can conduct joint socialization to COB participants for the health facilities, and other related parties programmed. The coordination mechanism of socialization is important because to succeed the COB system program launched by the government it needs to be socialized to the people.

d. Coordination of premium

Coordination of premium can be conducted through the participants premium payment through BPJS Kesehatan or through the Additional Health Insurance.

e. Coordination of Information System

The coordination of the information system of BPJS Kesehatan and additional health insurance or other guarantor bodies taken form into the merging of participants' information.

3.1 Indemnity Principle on the Coordination of Benefit System (COB) within BPJS Kesehatan

BPJS Kesehatan is included in social / compulsory health insurance. Social / compulsory health insurance is conducted to provide social security to a community or group of people. Implementation of social / compulsory insurance is based on mandatory legislation and in it; there are certain objectives of the government to provide protection for the community or some members of the community so that the system is referred to as social insurance. Health insurance is actually one of the development variants of insurance money and loss insurance.

There are several principles underlying an insurance agreement, one of which is the principle of

indemnity. The indemnity principle applies in all insurance agreements, except life insurance. This is because human life is unable to be measured by value.

Indemnity principle is very essential in insurance agreement. Based on Article 253 of Indonesian Commercial Code (*Kitab Undang-Undang Hukum Dagang, KUHD*), Indemnity principle is the amount of compensation should be equal to the amount of losses suffered. Within the indemnity principle, the insurer is only required to compensate proportionally to the loss suffered (Kornelius Simanjuntak, et al, 2011).

In loss insurance, the Insured has the possibility to suffer losses and the insurer is willing to bear it, the event insured in general has been regulated in the policy of events that provide financial losses and the insurer is willing to bear it. An event will not be guaranteed by the policy if the cause includes exceptions in the policy. Thus, this principle guarantees a reasonable and balanced compensation wherein the insured is only allowed to receive reimbursement of fees paid in accordance with the amount of costs that actually being suffered by the insured.

This can be explained in the insurance law through a coverage contract based on the principle of Indemnity that is in essence, is that the Insured receives reimbursement of the cost of recovery (financially) after a loss but the benefit can only be amounted to the situation of the insured before the loss occurs, so then there will be no additional profit of the insured by making a claim.

The Indemnity principle of the COB system is in principle the same as the Indemnity principle applied in the insurance agreement as discussed earlier. Indemnity principle in COB system can be exemplified if we spend money Rp 25.000, - for the cost of purchasing medicine, hence replacement cost obtained by health insurance participant must also match with suffered that is equal to Rp 25.000, - or should not exceed from that amount.

In every insurance agreement there is always the potential for violation of Indemnity principle. Similarly in the COB system, there is potential for violation of Indemnity principle. This is because the concept of coordination of benefits that is applied and become the basic reference in *BPJS Kesehatan*. Coordination of benefits which in essence there is more than one insurer who bear the cost of health insurance from the insured may lead to potential violations of Indemnity principle through the payment of claim that is exceeding the value of the total cost of health services.

Some potential violations of Indemnity principle that is common in COB system in *BPJS Kesehatan* are as follows:

1. Additional Benefit in Additional Health Insurance

When the insured filed a claim to the Additional Health Insurance (Commercial Insurance), there is a potential violation of Indemnity principle. This is because sometimes the existing insurance agreement in health insurance products owned by Commercial Insurance is not only limited to the contracted-on COB system, but sometimes there are additional clauses that are included if the insured willing to pay a premium with a greater value to Additional Health Insurance (Commercial Insurance). Insured not only get the cost of replacing the maximum amount of health services that will be reimbursed by *BPJS Kesehatan* alone, but the insured can also receive reimbursement of the Additional Health Insurance in order to cover the cost difference that has been borne / paid by *BPJS Kesehatan*. Additionally, when the insured applied for a higher premium value as mentioned above, it will then provide higher compensation received causing the violation of indemnity principle. When calculated, the amount received by the insured already exceeds the amount of costs that should be paid by the insured.

2. Product of Hospital Cash Plan

Health insurance products under the Hospital Cash Plan scheme are health insurance products that provide insurance coverage when the insured is hospitalized on the basis of a medical indication and on the recommendation of a doctor caused by illness or accident. In this scheme, the insurer will provide daily benefits of hospitalization in the form of daily cash compensation (Admin, 2015). Such products may potentially lead to violations of Indemnity principle. This is because the product provides the insured of cash when the insured suffers from an illness. This could potentially violate the principle of Indemnity because if the insured has already covered by *BPJS Kesehatan* and Additional Health Insurance, but they still receive cash for their hospitalization. Insured will then receive benefit that is higher than the total value of health care costs suffered by the insured.

3. Submission of Photocopied Invoice of the Claim

Submission of Photocopied Invoice of the Claim may potentially lead to a violation of Indemnity principle. Submission of Photocopied Invoice of the Claim referred here is the condition in which the insured filed a claim for health care costs in the form of a copied. The receipt is filed as a claim on the

cost of health services to Commercial Insurance. This could potentially be a violation of the Indemnity principle because the copy is a copy of the original receipt that has been claimed to *BPJS Kesehatan.* This cannot be denied or avoided since there is no regulation that prohibits a person from insuring an object of insurance on more than one insurer and a person is also allowed to insure an object of insurance on more than one insurer for the same risk (Irene Nindia Laksmi, et al., 2016).

However, if we refers to the provisions of the rules governing the COB system or the regulation of claims filing procedures, there should be no indication of violation of Indemnity principle in COB system in health BPJS. COB scheme in *BPJS Kesehatan* have been created to comply with the indemnity principle through limiting the total benefit in a certain amount that does not exceed the amount of health care that is guaranteed.

In the regulation of health insurance, there are no rules that concretely prohibit a person from insuring an insurance object on more than one insurer for the same risk. This happens because there are rules where if the Insured has filed a claim for the whole loss (claim for the full loss) to one Insurer, then the Insured must not file another claim to the Insurer. This is done to prevent the Insured benefit from the payment of insurance claims (Irene Nindia Laksmi, 2015). In the health insurance mechanism, indemnity principle can be understood that the form of reimbursement given shall meet the cost of treatment.

4 CONCLUSION

This study concludes that there is some indication of indemnity principle violation in the implementation of COB system at BPJS *Kesehatan*. This violation might exist in the form of reimbursement claim that exceeding the cost of health treatment suffered. Providing a clear regulation through the rules governing the COB system or the regulation of claims filing procedures can avoid violation of Indemnity principle in COB system in BPJS *Kesehatan*. COB scheme in BPJS *Kesehatan* have been created to comply with the indemnity principle through limiting the total benefit in a certain amount that does not exceed the amount of health care that is guaranteed.

REFERENCES

Adira Care, “Hospital Cash Plan: Perlindungan Asuransi Kesehatan bagi Pelanggan Individu”. www.asuransiadira.com/news-detail/409-hospital-cash-plan-perlindungan-asuransi-kesehatan-bagi-pelanggan-individu, 22 Desember 2016, h. 1, dikunjungi pada tanggal 18 Desember 2017.

Admin AdMedika, “Tentang Koordinasi Manfaat (Coordination of Benefits)”, www.admedika.co.id/index.php/id/services/admedika-cob, 2016, h. 1, dikunjungi pada tanggal 18 Desember 2017.

Admin, “Asuransi Hospital Cash Plan”, www.equity.co.id/id/produk/asuransi-hospital-cash-plan2015, h. 1, dikunjungi pada tanggal 18 Desember 2017.

Henni Djuhaeni, “Asuransi Kesehatan dan Managed Care”, Thesis, Fakultas Kesehatan Masyarakat Universitas Padjajaran, Bandung, 2009, h. 32.

Humas BPJS Kesehatan, “Asuransi Kesehatan (Indemnity, As Charged, As Charged Combination) Session 2”, www.warnawarniresiko.wordpress.com/2015/03/13/asuransi-kesehatan-indemnity-as-charged-as-charged-combination-session-2, 13 Maret 2015, h. 1, dikunjungi pada tanggal 13 Desember 2017.

Humas BPJS Kesehatan, “BPJS Kesehatan Telah Gandeng Puluhan Asuransi Swasta Lewat Skema Coordination of Benefit (COB)”, www.bpjs-kesehatan.go.id/bpjs/dmdocuments/50ffd304e2c62f7e0e036a79e560ad7a.pdf, 2017, h. 1, dikunjungi pada tanggal 13 Desember 2017.

Irene Nindia Laksmi, Myra Rosana B. Setiawan, “Pembagian Pertanggungan dalam Terjadinya Hospital Benefit antara Asuransi Kesehatan Komersial dan Badan Penyelenggara Jaminan Sosial (BPJS) Kesehatan”, www.digilib.ui.ac.id/naskahringkas/2016-12/S58572-Irene%20Nindialaksmi , 2015, h.7.

Irene Nindia Laksmi, Myra Rosana B. Setiawan, “Pembagian Pertanggungan dalam Terjadinya Hospital Benefit antara Asuransi Kesehatan Komersial dan Badan Penyelenggara Jaminan Sosial (BPJS) Kesehatan”, www.digilib.ui.ac.id/naskahringkas/2016-12/S58572-Irene%20Nindialaksmi , 2015, h.7.

Kornelius Simanjuntak, Brian Amy Prastyo, dan Myra R.B. Setiawan, Hukum Asuransi Cetakan 1, Depok:Djokosoetono Research Center, 2011, h. 49.

Peraturan Badan Penyelenggara Jaminan Sosial Kesehatan Nomor 4 Tahun 2016 tentang Petunjuk Teknis Penyelenggaraan Koordinasi Manfaat dalam Program Jaminan Kesehatan Nasional, (Berita Negara Republik Indonesia Tahun 2016 Nomor 939), Ps. 1 Angka 6.

Peraturan Badan Penyelenggara Jaminan Sosial Kesehatan Nomor 4 Tahun 2016 tentang Petunjuk Teknis Penyelenggaraan Koordinasi Manfaat dalam Program Jaminan Kesehatan Nasional, (Berita Negara Republik Indonesia Tahun 2016 Nomor 939), Ps. 3

Peraturan Direksi Badan Penyelenggara Jaminan Sosial Kesehatan Nomor 47 Tahun 2016 tentang Petunjuk Pelaksanaan Penyelenggaraan Koordinasi Manfaat

dalam Program Jaminan Kesehatan Nasional, Bab I mengenai mekanisme kerjasama.

Rachmad Suhanda, "Jaminan Kesehatan dan Managed Care", Jurnal Kedokteran Syiah Kuala, Vol 15, No 02, , 2015, h. 109.

Undang-Undang Nomor 40 Tahun 2004 tentang Sistem Jaminan Sosial Nasional,

Unit Pemasaran BPJS Kantor Cabang Batam, "Jaminan Pelayanan Kesehatan BPJS Kesehatan Cabang Batam", www.4g92mivec.files.wordpress.com/2015/02/materi-sosialisasi-bpjs-kesehatan.pptx+&cd=1&hl=en&ct=clnk&gl=id&client=safari. 2016, h. 21, dikunjungi pada tanggal 10 Desember 2017.