Comparison of Commercial Health Insurance and Health Social Security in Indonesia

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Abstract

The health financing system in Indonesia is organized through two main schemes, namely health social security and commercial health insurance. Health social security, which is realized through the Health Social Security Administration Agency (BPJS), is mandatory and based on the principles of mutual cooperation, non-profit, and social justice with the aim of ensuring access to health services for the entire population without discrimination. In contrast, commercial health insurance is voluntary and is organized under a civil agreement between the insurer and the participant, with the main principle of risk transfer and the calculation of individual risk-based premiums. The difference in the characteristics of the two systems causes differences in financing mechanisms, service standards, legal relations between the parties, and the claim dispute resolution process. This article aims to analyze and compare commercial health insurance and health social security in Indonesia comprehensively from a health law perspective. This study uses a normative juridical method with a legislative and conceptual approach, supported by secondary data in the form of scientific literature, previous research results, and legal provisions related to the social security and insurance system. The analysis focused on differences in legal principles, health service guarantee mechanisms, patterns of legal relations between participants, organizers, and hospitals, and their implications for patient legal protection and financing certainty for hospitals. The results of the study show that health social security emphasizes the state's function in fulfilling the right to health and social protection, while commercial insurance emphasizes freedom of contract and business risk management. These differences have a direct impact on health service practices, especially related to financing, claims, and potential disputes. Therefore, a complete understanding of the differences between commercial insurance and health social security is important as a basis for policy formulation, increasing legal protection for patients, and strengthening legal certainty and sustainability of health service financing in Indonesia.

Keywords: *Health insurance, social security, BPJS Kesehatan, commercial insurance, health law*

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Introduction

Health financing is one of the most crucial aspects in the implementation of a country's health system. Without a financing system that is fair, sustainable, and accessible to all people, quality health services are difficult to realize. In Indonesia, health service financing is organized through two main mechanisms, namely health social security and commercial health insurance. These two mechanisms have different philosophical foundations, objectives, and legal characteristics, but both play an important role in ensuring the financing of health services for the community. Health social security in Indonesia is administered by the state through the Health Social Security Administration Agency (BPJS) as a constitutional mandate and a manifestation of the state's responsibility in fulfilling the right to health. This system is mandatory and based on the principles of mutual cooperation, non-profit, and social justice, where economically able participants also bear the burden of less fortunate participants (Thabrany, 2014; Rosa, 2019). Through this system, the state seeks to ensure that every citizen has access to decent health services without being hampered by financial means.

On the other hand, commercial health insurance is administered by private insurance companies based on a civil agreement between the insurer and the insured. Commercial insurance is voluntary and based on the principle of risk transfer, where participants pay premiums in exchange for guaranteed health service financing in accordance with the terms of the policy. Legal relations in commercial insurance are greatly influenced by the principle of freedom of contract, so that the rights and obligations of the parties are determined in detail in insurance agreements (Sastrawidjaja, 2018; Simanjuntak, 2020) The existence of the two health financing systems in practice often causes differences in treatment in health services, both in terms of guaranteed benefits, claim mechanisms, and financing standards applied in hospitals. Hospitals as health service providers are in a strategic and complex position, because they must adjust services and administration to the provisions of health social security and commercial insurance at the same time. The difference in payment and claim mechanisms between the two systems often raises operational problems and potential disputes, especially related to pending or rejected claims (Utami, 2021; Hadjon, 2015)

For patients or participants, the difference between social security and commercial insurance is often not fully understood. Many participants thought that both systems provide the same protection, even though they have different limitations and consequences in law and practice. This misunderstanding has the potential to cause losses for patients, either in the form of claim rejection, additional fees, or limited access to certain health services. Therefore, a more comprehensive understanding of the fundamental differences between commercial health insurance and health social security is needed. From a health law perspective, the comparison between commercial insurance and health social security is important because it concerns the protection of patients' rights, legal certainty for hospitals, and the responsibility of the state and business actors in the insurance sector. Health social security is closer to state administrative law, while commercial insurance is in the realm of civil law and consumer protection law. These legal differences have direct implications for the mechanism of supervision, dispute resolution, and the form of legal accountability if there are problems in health services or financing.

Based on this background, this study considers it necessary to conduct an in-depth comparative study of commercial health insurance and health social security in Indonesia. This study not only compares the concepts and mechanisms of the two systems, but also analyzes their implications for patients and hospitals in healthcare practice. With the health law approach, it is hoped that this research can provide a more understandable understanding and become the basis for recommendations to strengthen legal protection and increase the effectiveness of the health financing system in Indonesia.

Problem Formulation

The existence of two health financing systems in Indonesia, namely commercial health insurance and health social security, creates fundamental differences in terms of goals,

principles, and legal basis. These differences in health service practices often have an impact on financing mechanisms, service guarantees, and legal protection for patients and hospitals (Thabrany, 2014; Utami, 2021). In addition, the legal difference between health social insurance which is in the realm of public law and commercial health insurance which is in the realm of civil law and consumer protection gives rise to different legal implications in the settlement of claims disputes (Sastrawidjaja, 2018). Based on this description, the formulation of the problem in this study is how are the concepts, principles, and legal foundations between commercial health insurance and health social security in Indonesia, as well as their implications for the legal protection of patients and hospitals? And how do the financing mechanisms and dispute resolution of claims in commercial health insurance and health social security differ from the perspective of health law and consumer protection?

Research Methods

This study uses a normative juridical research method that focuses on the analysis of the differences between commercial health insurance and health social security from the perspective of health law and consumer protection. The normative juridical method was chosen because this study focuses on the study of legal norms, principles, principles, and doctrines that govern the health financing system, not on empirical field data collection. This approach is used in legal research to analyze laws and regulations and legal concepts that are relevant to the issue being studied (Soekanto & Mamudji, 2019).The approaches used in this study include a statutory approach and a conceptual approach. The legislative approach is carried out by examining various legal regulations that regulate health social security and commercial health insurance, including Law Number 40 of 2004 concerning the National Social Security System, Law Number 24 of 2011 concerning the Social Security Organizing Agency, Law Number 40 of 2014 concerning Insurance, and Law Number 8 of 1999 concerning Consumer Protection. Through this approach, the differences in regulatory objectives, scope of responsibility, and guarantee and dispute resolution mechanisms in each health financing system are analyzed. A conceptual approach is used to examine health law theory, insurance law theory, and consumer protection theory as the main analytical framework. Health law theory is used to understand health financing as part of the fulfillment of the right to health and the state's obligation to ensure access to health services. Insurance law theory is used to explain the contractual legal relationship between the insurance company and the participant, including the principle of risk transfer and the principle of good faith. Meanwhile, consumer protection theory is used to assess the position of patients as potentially weak parties in legal relations with insurance companies (Thabrany, 2014; Stuart, 2018; Utami, 2021). The type of data used in this study is secondary data, which consists of primary legal material, secondary legal material, and tertiary legal material. Primary legal materials include laws and regulations and official policies related to the health social security system and health insurance. Secondary legal materials are textbooks, scientific journals, and the results of previous research relevant to health law, insurance law, and consumer protection. Tertiary legal materials are used as a support to clarify the legal terms and concepts used in this study.

The data collection technique is carried out through library research by searching, inventorying, and examining various relevant legal and literature sources. The data that has been collected is then analyzed qualitatively by descriptive-analytical method, namely describing and comparing the legal provisions and concepts that govern commercial health insurance and health social security, then drawing conclusions systematically in accordance with the formulation of the research problem. With this method, the research is expected to be able to provide a clear and easy-to-understand understanding of the legal implications of the differences between the two health financing systems.

Literature Review

The theoretical foundation in this study is prepared to provide a strong conceptual and normative basis in answering the formulation of the research problem, namely regarding the difference between commercial health insurance and health social security in Indonesia from the perspective of health law and consumer protection. The foundation of this theory serves as an analytical foothold so that the discussion is not only descriptive, but is able to systematically explain the legal position of the parties, the purpose of the regulation, and the normative implications of each health financing system.

Based On The Theory Of Health Law

Health law theory departs from the view that health is a human right as well as a constitutional right of citizens. The right to health is not only defined as the right to obtain medical services when a person is sick, but also includes the right to a fair, affordable, and sustainable health system. In this perspective, the state has an obligation to respect, protect, and fulfill the right to health through public policies, regulations, and the implementation of a health financing system that favors the interests of the community (Thabrany, 2014). Health financing is a key element in fulfilling the right to health. Without a fair and sustainable financing system, access to quality health services will be difficult to realize, especially for economically disadvantaged groups. Therefore, health law theory places health financing as part of the state's responsibility in realizing social justice and general welfare (Rosa, 2019).

Health social security is a concrete manifestation of health legal theory. This system is designed as a social protection instrument to ensure that all citizens can access health services according to their medical needs without discrimination in economic ability. The principle of mutual cooperation allows for cross-subsidization between healthy and sick participants, as well as between able and incapable participants. The non-profit principle emphasizes that health social security is not profit-oriented, but rather on the fulfillment of the right to health as a public interest.

In the legal context, health social security is in the realm of public law and state administration. The legal relationship between participants and social security providers is not a private contractual one, but a public legal relationship regulated by laws and regulations. The state is responsible for ensuring the continuity of the system, setting service standards, and supervising its implementation. If there is a problem in service or financing, the resolution mechanism is more administrative. In contrast, commercial health insurance is not born from the state's obligation to fulfill the right to health, but rather from the public's need for additional financial protection against health risks. In health law theory, commercial insurance is seen as complementary or supplementary to the health social security system. This means that commercial insurance can expand service options or increase convenience, but it cannot replace the role of the state in guaranteeing universal access to health (Thabrany, 2014). Thus, health law theory provides a normative basis that the health financing system must be directed to protect patients' rights and ensure equitable access to health services. The distinction between health social insurance and commercial health insurance should be placed within the framework of a national health policy oriented towards human rights and social justice.

Based On Insurance Legal Theory

Insurance legal theory views insurance as a risk transfer agreement between the insurer and the insured. In this relationship, the insurer promises to provide reimbursement for losses or expenses incurred as a result of an uncertain event, while the insured is obliged to pay premiums in return for such coverage. This legal relationship is civil in nature and is based on the principle of freedom of contract (Sastrawidjaja, 2018). Commercial health insurance is a direct application of insurance legal theory in the health sector. The insurance company has the right to determine the type of risk insured, benefit limits, cost ceilings, and certain exclusions as long as they are clearly stated in the policy. This principle aims to maintain a balance of risk and sustainability of the insurance business. However, in practice, the policy provisions are

often not fully understood by the participants, thus triggering disputes when claims are rejected (Simanjuntak, 2020).

In addition to the principle of freedom of contract, insurance legal theory also recognizes fundamental principles such as the principle of utmost good faith, the principle of indemnity, insurable interest, and the principle of subrogation. The principle of good faith requires openness and honesty from both parties, both at the stage of closing the agreement and in the implementation of the insurance agreement. In the context of health insurance, this principle requires participants to disclose their health conditions honestly, while requiring insurance companies to explain the benefits and exclusions of policies in a transparent manner. The principle of indemnity emphasizes that the purpose of insurance is to compensate for losses or costs arising from risk, not to provide benefits to the insured. In health insurance, this principle is realized through reimbursement of health service costs according to the provisions of the policy. However, the application of this principle is often limited by exclusion clauses and benefit ceilings, which in practice can create conflicts between health protection goals and insurance business interests (Sastrawidjaja, 2018).

When compared to health social security, the application of insurance legal theory is limited. Although social security participants pay contributions, the legal relationship formed is not entirely private contractual. The state through BPJS Kesehatan acts as a social security provider, not as a commercial insurer. Therefore, the principles of risk selection and profit orientation are not strictly applied as in commercial insurance. This difference shows that health social security has a different legal character and cannot be equated with commercial insurance.

Based On Consumer Protection Theory

Consumer protection theory departs from the assumption that consumers are in a weaker position than business actors, especially in terms of information and bargaining positions. In the context of commercial health insurance, insurance participants are positioned as consumers of financial services who are entitled to obtain legal protection for the products and services they receive. This protection includes the right to true, clear, and honest information, as well as the right to fair treatment (Utami, 2021). In commercial health insurance practice, consumer protection theory is particularly relevant to assessing the fairness of policy clauses. Insurance policies are generally drafted unilaterally by insurance companies with technical language that is difficult to understand. Vague exclusion clauses, multi-interpreted benefit restrictions, and complicated claims procedures have the potential to harm participants. Therefore, consumer protection theory requires that insurance companies draft policies transparently and not abuse their dominant position (Hadjon, 2015).

In contrast, in health social security, the concept of consumer protection is not applied directly because the legal relationship formed is public. However, the principle of protection for participants remains relevant in the form of administrative protection and state accountability. Health social security participants have the right to receive services according to the provisions and have the right to file a complaint if they suffer losses due to inappropriate services or financing. Consumer protection theory also emphasizes the importance of an accessible and fair dispute resolution mechanism. In commercial insurance, claims disputes are generally resolved through civil mechanisms or alternative dispute resolution institutions. In health social security, dispute resolution is more administrative. Both mechanisms have their own advantages and limitations, but the principles of justice and protection of participants must remain the main foundation (Utami, 2021).

Overall, the integration of health law theory, insurance law theory, and consumer protection theory provides a comprehensive analytical framework for understanding the difference between commercial health insurance and health social security. This theoretical approach is an important basis for assessing the legal implications for patient protection, certainty of financing for hospitals, and the formulation of policy recommendations in the field of health financing.

Research Methodology

The research method used in the research entitled *Analysis of Legal Certainty of Informed Consent in Emergency Medical Actions Based on Law Number 17 of 2023* is normative legal research using a descriptive analysis method. This research was conducted by examining and examining various legal provisions contained in laws and regulations related to the approval of medical measures (*informed consent*) and the implementation of medical measures in emergency situations. This approach focuses on the analysis of legal norms regulated in Law Number 17 of 2023 concerning Health as the main legal basis in the implementation of health services in Indonesia.

Results

This discussion was made to explain the difference between commercial health insurance and health social security in Indonesia, as well as their impact on patient legal protection and the certainty of financing health services for hospitals. The difference between these two systems is not only related to the method of payment or claim process, but also to the legal basis and purpose of its implementation. Health social security is organized as a form of state responsibility in guaranteeing the right to health for all citizens, while commercial health insurance runs based on agreements between insurance companies and participants with the aim of financial risk transfer. In health service practice, the two systems often intersect and cause various problems. Patients can experience difficulties when medically needed services are not fully covered by the financing system, either due to limitations in social security rules or due to the provisions of commercial insurance policies. On the other hand, hospitals are in a difficult position because they have to continue to provide services according to medical standards and professional ethics, but at the same time face the uncertainty of payment from the guarantor. This condition shows that the issue of health financing is not only an administrative problem, but also a legal issue that has a direct impact on patients and health service providers.

Therefore, this discussion uses an approach that combines three points of view, namely health law, insurance law, and consumer protection. This approach is used to understand more fully how the differences in health financing systems affect the legal position of patients and hospitals in health service practices. With this approach, this discussion is expected to provide a clear picture of the legal implications of the difference between commercial health insurance and health social security, as well as the basis for formulating recommendations that are fairer and in favor of the interests of patients and the sustainability of health services.

Implications Of The Difference Between Commercial Health Insurance And Health Social Security On Patient Legal Protection And Certainty Of Health Service Financing

This discussion focuses on the differences between commercial health insurance and health social security in Indonesia, reviewed from the perspective of health law and consumer protection, as well as its implications for patient legal protection and certainty of health service financing for hospitals. This discussion uses three conceptual frameworks, namely health law theory (which places health as a right), insurance legal theory (which emphasizes contractual relations and risk transfer), and consumer protection theory (which highlights the inequality of position and information between business actors and consumers). This integration is important because in practice, the issue of financing health services almost always involves a combination of the three, namely there is a dimension of citizens' rights, there is a dimension of contracts and policies, and there is a dimension of protection of weaker parties.

First, when viewed from the perspective of health law, health social security is a state instrument to realize the right to health. Within the framework of Universal Health Coverage (UHC), health financing should ideally provide financial protection so that people do not fall into poverty due to health costs, while ensuring equitable access to quality services (World Health Organization, 2010; World Health Organization, 2014). In Indonesia, this logic is

realized through mandatory health social security and the principle of mutual cooperation. The principle of mutual cooperation means that health risks are shared together, so that healthy and able participants can support sick and underprivileged participants. The non-profit principle emphasizes that the administration of social security is not profit-oriented, but rather on social protection and the sustainability of the system. In this perspective, patients (participants) are not solely buying products, but citizens who have the right to access services according to their medical needs (Thabrany, 2014; Rosa, 2019).

However, health legal theory also reminds that the fulfillment of the right to health does not mean "all services without limits", because the financing system always has limited resources. Consequently, health social security requires cost control instruments and benefit standards, for example through benefit packages, tariff setting, and service protocols. At this point, the classic dilemma arises, namely how to ensure cost control does not reduce access to medically needed services. In practice, problems often arise when an action is considered clinically necessary by doctors/hospitals (medical necessity), but is considered not in accordance with the benefit package, does not meet administrative criteria, or does not meet the requirements for claim verification. It is this tension between "medical necessity" and "administrative compliance" that often gives rise to pending or partially paid claims, which ultimately impact patients and hospitals (Thabrany, 2014; Rosa, 2019).

Second, in contrast to social security, commercial health insurance is born from private laws and market mechanisms. Insurance legal theory views insurance as a risk transfer agreement between the insured (participant) and the insurer (insurance company), with premiums in exchange for the insurer's promise to pay certain costs or losses if a risk occurs. Because the relationship is contractual, the protection limit is determined by the policy, namely benefits, ceilings, deductibles, co-payments, exclusions, waiting periods, and claim procedures. Here, the principle of freedom of contract provides space for insurers to formulate policy conditions, but it is balanced by principles such as the principle of utmost good faith and the need for the formulation of clear clauses so as not to harm weaker parties (Sastrawidjaja, 2018; Simanjuntak, 2020).

On a practical level, the main difference that is immediately felt is the way the two systems view "risk" and "liability bearing". In social security, risk is shared collectively and aims to protect the population. Risk selection is not the main door because the system is mandatory and based on solidarity. In commercial insurance, risk tends to be managed selectively, namely premiums are adjusted to the risk profile, there is underwriting, and there are certain exceptions to maintain business sustainability. As a result, commercial insurance often uses pre-existing condition clauses, certain limits, or exclusions of certain diagnoses/actions. In theory, this is legal if it is clearly regulated in the policy, but in practice it often triggers disputes because the interpretation of the clause can differ between participants, hospitals, and insurers (Sastrawidjaja, 2018; Utami, 2021).

Third, when commercial insurance is placed in the context of consumer protection, the position of the patient/participant becomes increasingly important. The theory of consumer protection departs from the fact that consumers are often in a weaker position than business actors, mainly due to information inequality. Insurance policies are technical, long, and often "legal" and "medical" documents, so they are not easy to understand. Many participants only understand the limits of protection when a claim occurs—that is, at the most financially and psychologically vulnerable moments. This is where the risk of practices that are detrimental to consumers arises, such as multi-interpreted exclusions, overly promotional explanation of benefits, or complex and multi-layered claims processes. From a consumer protection perspective, insurers should provide true, clear, and honest information from the beginning, as well as implement fair and transparent claims handling (Utami, 2021; Hadjon, 2015).

These legal differences (public on social security vs. private on commercial insurance) also have implications for the "dispute resolution pathway" and "the way of judging right and wrong". In social security, disputes are more often in the form of administrative disputes,

namely whether the referrals are appropriate, whether the claim procedures are appropriate, whether the diagnosis and actions are in accordance with the provisions, whether the INA-CBGs code is appropriate, and so on. The correction mechanism tends to be administrative and layered. While in commercial insurance, disputes often shift to contractual disputes over whether the policy's benefits cover the action, whether the exclusion applies, whether the waiting period has passed, whether there is any misrepresentation, and so on. These contractual disputes are often influenced by the interpretation of policy clauses, so that the principle of good faith and clarity of clauses are very decisive (Sastrawidjaja, 2018; Utami, 2021).

The most obvious implication of these differences appears to be the legal protection of patients. In social security, patients have a normatively stronger basis of protection because they are supported by the idea of the right to health and state obligations. However, normatively strong protections are not necessarily always strong in practice if administrative mechanisms create barriers to access or if restrictions on benefits impose a significant cost burden. This means that legal protection of patients in social security is a "public right", but it still requires governance and supervision so that it does not turn into an administrative obstacle (Thabrany, 2014; Rosa, 2019). In commercial insurance, patient protection is a "contractual right" and a "right as a consumer". If the contract is clear and the claims practice is honest, the protection can be very good. However, if the clause is vague or the claim practice is not transparent, the patient becomes very vulnerable because it depends on the insurer's interpretation and the patient's ability to object (Utami, 2021; Hadjon, 2015).

In the context of hospitals, the differences between the two systems have consequences that are not simple. Hospitals have a professional and ethical obligation to provide services according to professional standards, minimum service standards, and patient safety principles. In emergency conditions, hospitals cannot postpone services due to warranty issues. However, once the service is provided, the hospital must face the reality of financing, whether the cost is fully covered, partially covered, or rejected. On social security, hospitals face the risk of delayed claims, code corrections, or reduced payments due to verification. In commercial insurance, hospitals face the risk of claim denial due to policies, differences in interpretation of medical necessity, or changing administrative requirements. This situation puts hospitals in a position "between service obligations and financial risks" (Utami, 2021; Hadjon, 2015).

If drawn deeper, these differences also raise legal issues regarding the standard for assessing "medical necessity". In clinical services, medical necessity is determined by the doctor's consideration based on the patient's condition, evidence-based medicine, and professional standards. However, in financing, medical necessity is often "translated" into administrative criteria and benefit packages. When discrepancies occur, the patient and the hospital may incur losses the patient bears additional costs or delayed actions, the hospital bears the claims receivable. Therefore, a clear intersection is needed between clinical standards and financing standards, so that cost control does not conflict with patient safety and the right to health (World Health Organization, 2014; Thabrany, 2014).

In the case of Patient A who has BPJS and commercial insurance) shows the complexity of benefit coordination. In ideal situations, commercial insurance can serve as a complement to cover the difference or additional services that are not covered by social security. However, in a dispute situation, the two guarantors can "throw each other". Social security states part outside the package/administrative, commercial insurance states a pre-existing condition or not according to the policy. If there are no strict coordination rules, the patient can be the main victim. Patients have paid dues and premiums, but still bear the burden of large costs. From a consumer protection perspective, this is dangerous because it has the potential to create an "illusion of protection". Consumers feel safe because they have two guarantors, but when risks occur, the protection is ineffective (Utami, 2021; Hadjon, 2015).

On the other hand, commercial insurance companies do have legal arguments based on the policy. However, insurance legal theory demands caution in the application of exclusion

clauses, especially pre-existing conditions. If pre-existing is applied too broadly, for example all degenerative diseases are considered pre-existing before coverage without proof of prior diagnosis, then insurance coverage becomes meaningless. In theory, exceptions can, but should be clear, proportionate, and enforced in good faith. Good faith here not only demands the honesty of the participants, but also demands that the insurer not overinterpret the clause to reject the claim (Sastrawidjaja, 2018; Simanjuntak, 2020).

Another problem that also often occurs is information communication at the time of policy closure. Consumer protection theory emphasizes that benefit and exclusion information should be provided in a clear, simple, and non-misleading manner. If the information is only conveyed in the form of a long policy without adequate explanation, the participant can be said to have no reasonable opportunity to understand. In the context of disputes, this can strengthen the argument that information inequality occurs and that business practices need to be monitored so as not to harm consumers (Utami, 2021; Hadjon, 2015). At the policy level, this demands transparency standards for health insurance products and honest claims handling standards.

Furthermore, legal differences also affect the claim dispute resolution strategy. For social security, administrative channels and complaint mechanisms need to be made more responsive, so that claim disputes do not drag on and do not interfere with hospital cashflow. Late payment of claims is not only a financial problem, but can also reduce the quality of services as hospitals face operational limitations. Within the framework of the right to health, systemic barriers like this can ultimately impact patients at large (Thabrany, 2014; Rosa, 2019). For commercial insurance, the dispute resolution mechanism should prioritize a quick and fair settlement, for example through mediation or alternative institutions, with assessment standards that take into account medical facts and the principle of good faith, not just the policy text alone (Sastrawidjaja, 2018; Utami, 2021).

In terms of hospital governance, the difference between the two financing systems requires hospitals to build strong and risk-based claims management. This includes complete medical documentation, recording of clear medical indications, and effective communication with the guarantor. However, it is important to emphasize that strengthening administration must not lead to "administrative medicine" that shifts the focus of services from patient needs to claims needs. In the theory of health law, the top priority remains the safety and medical needs of the patient. Therefore, the ideal is the harmonization of the claim system that follows the logic of the service (evidence-based), not because the service is forced to follow the logic of the claim alone.

Considering all these descriptions, it can be emphasized that the difference between commercial health insurance and health social security is not just a technical difference in financing, but a structural difference that affects the legal protection of patients and the certainty of financing for hospitals. Social security is strong in public rights but is vulnerable to administrative barriers and financing limitations, while commercial insurance is flexible and can complement, but vulnerable to inequities in information and policy interpretation. Therefore, a comprehensive legal approach is needed. Health law ensures the right to health and fair access, insurance law ensures contract certainty and good faith, consumer protection ensures fairness and transparency for participants. Policy harmonization and strengthening the benefit coordination mechanism are key so that patients do not become disadvantaged parties, as well as for hospitals to obtain adequate financing certainty to maintain service quality.

Case Examples

Health Care Financing Disputes between Commercial Insurance, Social Security, and Hospitals A 52-year-old female patient, hereinafter referred to as Patient A, came to the referral private hospital with complaints of severe chest pain that radiated to her left arm, accompanied by shortness of breath and cold sweats. Based on the initial examination at the Emergency Facility, the doctor determined the diagnosis of Acute Coronary Syndrome (ACS) which

required immediate medical action in the form of intensive care and follow-up supporting examinations. Patient A is registered as a class II health social security participant (BPJS Kesehatan), and has commercial health insurance as additional insurance (top-up).

Because the patient's condition is an emergency, the hospital provides medical services according to professional standards and minimum service standards without waiting for the certainty of cost guarantee. The patient undergoes intensive care in the cardiac care room, serial laboratory examinations, ECGs, as well as cardiac catheterization procedures on clear medical indications. All of these actions are carried out based on considerations of patient safety and urgent medical needs.

After the patient is declared stable and discharged, the hospital submits a claim for health service financing to BPJS Kesehatan in accordance with applicable regulations. However, in the claim verification process, BPJS Kesehatan approved the payment of only part of the treatment fee, on the grounds that some actions and use of certain tools were considered to exceed the benefit package guaranteed in the INA-CBGs system. As a result, there is a difference in the cost of health services that are not paid to hospitals.

To cover the difference in costs, the hospital then filed a claim with the commercial health insurance company owned by Patient A. However, the commercial insurance company rejected the claim on the grounds that the heart condition experienced by Patient A fell under the category of pre-existing condition, as stated in the policy exclusion clause. Insurance companies argue that coronary heart disease is a degenerative disease that existed before the insurance coverage period, even though the patient has never received a diagnosis or treatment beforehand.

The rejection of the claim by the commercial insurance company caused a dispute over the financing of health services. Patient A is disadvantaged because it has to bear a considerable difference in treatment costs, while the hospital faces the risk of financial loss due to unpaid claims. On the other hand, insurance companies adhere to the terms of the policy as the legal basis for the rejection of claims. From the perspective of health law theory, this case shows the tension between the state's obligation to guarantee the right to health through social security and the limitations of the financing system implemented. Health social security does aim to ensure access to health services, but in practice there are still restrictions on benefits that can have an impact on hospital and patient financing (Thabrany, 2014). In an emergency, hospitals cannot postpone services for administrative reasons or financing certainty, so financial risks are a consequence that must be faced.

From the perspective of insurance law theory, the denial of claims by commercial insurance companies is based on the principle of freedom of contract and exclusion clauses in policies. However, the application of the pre-existing condition clause broadly and without adequate explanation to participants has the potential to be contrary to the principle of good faith. In many cases, participants do not clearly understand the limitations of the protection provided by commercial health insurance policies (Sastrawidjaja, 2018).

Meanwhile, from the perspective of consumer protection theory, Patient A is in a weak position in the legal relationship with the insurance company. The vagueness of policy clauses and denial of claims based on the insurer's unilateral interpretation can be categorized as practices that are detrimental to consumers. Patients as consumers of insurance services have the right to receive clear, honest, and non-misleading information about the benefits and exclusions of the policy from the beginning of the agreement (Utami, 2021).

This case concretely illustrates how the legal difference between health social insurance and commercial health insurance can cause problems in health service practice. Patients have the potential to be the most disadvantaged, while hospitals are in the difficult position between the obligation to provide medical services and the risk of unsecured financing. Therefore, it is necessary to harmonize policies, transparency of insurance policies, and strengthen legal protection mechanisms for patients and hospitals so that the goals of the health financing system can be achieved fairly and sustainably.

Elegal Analysis

a. Analysis Based on Health Law Theory

In the perspective of health law theory, Patient A's case should be placed within the framework of the right to health as a human right and a constitutional right of citizens. The state has an obligation to ensure that every citizen has access to safe, quality, and non-discriminatory health services. This obligation is not only normative, but also operational through the implementation of the health social security system. In this case, the hospital's action to provide medical services quickly and comprehensively to Patient A in an emergency condition is in line with the principles of health law and medical ethics. In emergency situations, patient safety and medical needs must be a top priority, so that administrative considerations and certainty of cost guarantees cannot be used as an excuse to delay or limit services. This is in accordance with the principle of medical necessity in health law, where medical measures are considered valid and mandatory if clinically necessary to prevent disability or death of patients. However, problems arise when the health social security system does not cover all the costs of the services that have been provided. The rejection or payment of part of the claim by BPJS Kesehatan on the grounds that the INA-CBGs benefit package shows that there is a tension between the principle of the right to health and the principle of cost control. From the point of view of health law theory, the limitation of benefits that leads to the imposition of costs on patients has the potential to undermine the purpose of social security as an instrument of social protection.

Health legal theory emphasizes that financing restrictions should not eliminate the essence of the right to health, especially in cases of emergency. Therefore, if the restriction of the financing system causes patients to bear the burden of large costs or the hospital suffers significant losses, then normatively it can be questioned whether the system is in line with the principles of social justice and the fulfillment of the right to health as referred to in the theory of health law (Thabrany, 2014).

b.Analysis Based on Insurance Legal Theory

From the perspective of insurance law theory, the legal relationship between Patient A and the commercial health insurance company is a private contractual relationship that is subject to the principles of freedom of contract and the principle of good faith. The insurance company bases the denial of claim on the pre-existing condition clause listed in the insurance policy. Theoretically, insurance legal theory does give insurers the authority to limit the guaranteed risks, as long as the restrictions are clearly outlined in the insurance agreement. Exclusion clauses, including pre-existing conditions, are essentially allowed to maintain a balance of risk and sustainability of the insurance business. However, insurance legal theory also emphasizes that exclusion clauses must be formulated clearly, specifically, and not multi-interpreted (Sastrawidjaja, 2018). In this case, the insurance company states that the heart disease experienced by Patient A is a degenerative disease that existed before the coverage period, even though the patient has not been diagnosed or undergone treatment before. The broad application of pre-existing condition clauses like this has the potential to violate the principle of good faith, especially good faith on the part of the insurer. Insurance participants cannot reasonably be considered to be hiding a health condition that has never been medically known.

According to insurance law theory, the denial of claims based on a unilateral interpretation of a policy clause can be categorized as a deviation from the principle of contractual balance. Insurance should not be carried out in such a way that almost all health risks can be excluded, as this is contrary to the purpose of insurance as an instrument of risk transfer. In this context, the denial of claims by commercial insurance companies deserves legal criticism because it has the potential to empty the meaning of insurance protection itself.

c. Analysis Based on Consumer Protection Theory

Within the framework of consumer protection theory, Patient A must be positioned as a consumer of insurance services who is in a weaker position than the insurance company. Information asymmetry is the main problem in this legal relationship. Insurance policies are prepared unilaterally by insurance companies with technical and complex language, making them difficult to comprehensively understand by participants. The denial of the claim on the grounds of pre-existing condition in this case indicates that the participant may not have obtained sufficiently clear information regarding the policy's coverage limitations. From the perspective of consumer protection theory, this condition has the potential to violate consumers' rights to true, clear, and honest information. Exclusion clauses that are multi-interpreted or disproportionately applied can be categorized as clauses that are detrimental to consumers.

Consumer protection theory also emphasizes that consumers should not be burdened with risks that are not reasonably predictable or controllable. Acute heart disease that is only diagnosed for the first time and requires emergency action is difficult to categorize as a risk that has been consciously approved to be excluded by consumers. Therefore, the denial of claims by commercial insurance companies in this case can be seen as an unfair practice and contrary to the principles of consumer protection (Utami, 2021).

Meanwhile, in health social security, even though the legal relationship is public, the principle of participant protection remains relevant. Health social security participants have the right to receive services according to medical needs and have the right to a complaint mechanism if they feel disadvantaged. However, when the financing system is unable to cover all service costs, participants remain in a vulnerable position, so that the goal of social protection becomes less optimal.

Based on these three theories, it can be concluded that Patient A's case reflects a structural conflict between health law, insurance law, and consumer protection. Health law theory demands the equitable fulfillment of the right to health, insurance law theory emphasizes compliance with contracts and risk management, while consumer protection theory demands fairness and transparency in the relationship between participants and insurance service providers. In these conditions, patients have the potential to be the most disadvantaged, while hospitals are in a dilemma between the obligation to provide medical services and the risk of unsecured financing. Therefore, this theory-based legal analysis emphasizes the need for policy harmonization, strengthening supervision of commercial health insurance practices, and improving the health social security system to be in line with the principles of patient rights protection and social justice.

Case-Based Legal Recommendations

The rejection of health insurance claims not only impacts participants as policyholders, but also has serious consequences for hospitals and healthcare workers as service providers. In the modern healthcare system, hospitals rely heavily on claim payments as the main source of operational financing. When claims are denied, delayed, or only partially paid, hospitals are in a position of financially, operationally, and ethically vulnerable (Rosa, 2019; Simanjuntak, 2020).

a. Recommendations for Patients (Social Security and Commercial Insurance Participants)

First, patients need to be strengthened as legal subjects who have the right to information, the right to proper health services, and the right to an objection mechanism. In the case of an emergency, the patient should not bear the financing risk due to differences in administrative interpretation or policy clauses. Therefore, it is necessary to affirm the principle of medical necessity prevails, namely that urgent medical needs must be the main basis for financing guarantees, both by social security and commercial insurance. Second, patients are advised to get legal education and insurance literacy from the beginning of membership. This education includes an understanding of benefits, policy exclusions, waiting periods, and claims and

objection procedures. In the context of consumer protection, insurance companies are obliged to convey such information in a clear, simple, and non-misleading manner, so that patients can make conscious and rational decisions.

Third, in the event of a rejection of an adverse claim, patients need to be given effective access to a fast and low-cost dispute resolution mechanism, either through internal complaints, mediation, or alternative dispute resolution institutions. A non-litigation approach needs to be prioritized so that patients are not further harmed by lengthy and complex legal processes.

b.Recommendations for Hospitals

Hospitals need to strengthen legal governance and claims administration as part of risk management. In case of an emergency, the hospital has acted in accordance with health laws by prioritizing the safety of the patient. However, to minimize the risk of unpaid claims, hospitals need to ensure that medical documentation and claims administration are compiled in a complete, accurate, and consistent manner with established standards. Furthermore, hospitals are advised to develop internal SOPs for handling claims disputes, including an escalation mechanism for objections to social security providers or commercial insurance companies. This SOP is important so that hospitals are not always in a defensive position when a claim is rejected, and have a strong legal basis in conducting negotiations or mediation.

In addition, hospitals need to play an active role as patient advocates in the context of health service financing. This role does not mean taking over the patient's responsibility, but ensuring that the patient's right to services and cost guarantees is fought for proportionately. A collaborative approach between hospitals, patients, and insurers is expected to reduce conflicts and increase trust between parties.

c.Recommendations for Health Insurance

Commercial health insurance companies need to review policy exclusion clauses, especially related to pre-existing conditions. The clause must be formulated in a specific, transparent, and not multi-interpreted manner, and not applied broadly so as to eliminate the essence of insurance protection. The application of an overly loose exclusion clause has the potential to be contrary to the principle of goodwill and the principle of consumer protection.

In addition, insurers are advised to adopt a fair claim handling approach, which is a claim assessment that considers the patient's medical context and factual condition, rather than mere textual interpretation of the policy. In the case of a newly diagnosed and emergency illness, the denial of the claim should be the last step after an objective and transparent medical assessment has been made. Insurance companies also need to strengthen an independent and accountable internal dispute resolution mechanism, so that participants are not directly directed to the litigation route. This approach is in line with consumer protection principles and can increase public trust in the health insurance industry.

d.Recommendations for Countries

The state has a strategic role in harmonizing health social security laws and commercial health insurance. Based on this case, a policy is needed that affirms that emergency services and essential medical needs should not be limited by uncompromising financing mechanisms. Regulations need to ensure that benefit restrictions do not unfairly shift the burden of financing to patients or hospitals. In addition, the state needs to strengthen the supervisory function of commercial health insurance companies, especially related to policy transparency and claims handling practices. This oversight is important to prevent disproportionate claims denial practices and protect the interests of insurance service consumers.

Finally, states are advised to develop clearer coordination mechanisms between health social security and commercial insurance, for example through the coordination of benefits. This mechanism is expected to prevent overlap or gaps in guarantees, so that fair and sustainable health protection goals can be achieved.

Conclusion

Based on the results of the theoretical discussion and case analysis that has been described, it can be concluded that the health financing system in Indonesia consisting of health social insurance and commercial health insurance has fundamental differences, both in terms of objectives, principles, and legal foundations. Health social security is organized as a state instrument to fulfill the right to health as a human right and constitutional right of citizens, by emphasizing the principles of mutual cooperation, non-profit, and social justice. In contrast, commercial health insurance operates in civil and business law, with an orientation on risk transfer, the principle of freedom of contract, and premium-based risk management (Thabrany, 2014; Sastrawidjaja, 2018). These differences in characteristics have direct implications for the level of legal protection of patients and the certainty of financing for health services. In health social security, patients are positioned as citizens who have the right to health services, so the state is obliged to ensure access to services according to medical needs. However, in practice, the limitations of financing systems and cost controls often lead to limitations on benefits that can have an impact on patients and hospitals. Meanwhile, in commercial health insurance, the legal protection of patients is highly dependent on the content of the policy, so the interpretation of exclusion clauses and pre-existing conditions is often a source of claim disputes (Utami, 2021; Hadjon, 2015).Analysis based on health law theory shows that health financing cannot be seen solely as an administrative or contractual issue, but as part of the fulfillment of the right to health that must uphold the principles of justice and humanity. In the context of a medical emergency, medical necessity should be the main consideration in guaranteeing financing for health services. Financing restrictions that disproportionately shift the burden to patients have the potential to conflict with the purpose of health social security as a social protection instrument (Thabrany, 2014; Rosa, 2019). From the perspective of insurance law theory, the denial of claims by commercial health insurance companies is indeed justified as long as it is based on the provisions of a valid policy. However, the broad and non-transparent application of the exclusion clause has the potential to violate the principle of good faith and distort the meaning of insurance protection itself. Therefore, insurance legal theory requires a balance between the interests of the insurer and the protection of the insured so that the goal of risk transfer can be achieved fairly (Sastrawidjaja, 2018; Simanjuntak, 2020). Furthermore, from the perspective of consumer protection theory, patients as insurance participants are in a relatively weak position due to information inequality and bargaining positions. Vague policy clauses and disproportionate claims denial practices have the potential to harm insurance service consumers and are contrary to the principles of fairness and transparency. Therefore, consumer protection in the field of health insurance is an important aspect to ensure legal certainty and public trust in the health financing system (Utami, 2021; Hadjon, 2015).

Thus, this study confirms that the differences between commercial health insurance and health social security are not only technical, but also structural and normative. Legal protection of patients and the sustainability of health services can only be realized if there is policy harmonization, a complete understanding of the role of each system, and the strengthening of the principles of health law, insurance law, and consumer protection in a balanced manner.

Suggestions

Based on these conclusions, some suggestions that can be submitted are as follows. First, for patients or health insurance participants, it is necessary to increase legal literacy and insurance literacy on an ongoing basis so that patients understand their rights and obligations in the social security system and commercial health insurance. A good understanding of benefits, policy exclusions, and the mechanism of claims and objections is expected to reduce the potential for patient losses due to claims rejection that are not understood from the beginning. Second, for hospitals as health service providers, it is recommended to strengthen claims governance and legal risk management through the preparation of clear standard operating procedures, complete medical documentation, and an effective coordination system

with social security providers and insurance companies. Hospitals also need to develop their role as companions or advocates for patients in the financing process, so that patients' rights to services and cost guarantees can be fought proportionately. Third, for commercial health insurance companies, it is recommended to evaluate and improve policy clauses, especially exclusion clauses and pre-existing conditions, so that they are formulated clearly, specifically, and not multi-interpreted. Insurance companies also need to apply the principle of good faith consistently in handling claims, taking into account factual medical conditions and the urgency of service, so that insurance coverage does not lose its substantial meaning. Fourth, for the state and policymakers, it is recommended to harmonize regulations between the health social security system and commercial health insurance, as well as strengthen the supervisory function of health insurance implementation practices. Clearer arrangements regarding the coordination of benefits between social security and commercial insurance need to be developed so that there are no gaps or overlaps in guarantees. In addition, the state needs to ensure that cost control policies do not sacrifice the essence of fulfilling the right to health and social justice for the community.

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