Coordination Of Benefit (COB) Program Development Analysis: A Case Study Of Healthcare Insurance In Indonesia

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Abstract.

The present study reports the first comprehensive study on the coordination of benefits program in healthcare insurance in Indonesia. Every individual Indonesian citizen who works is required to have health insurance as a fulfillment of the obligation to be physically and comprehensively healthy. Ownership of health insurance can be through government programs which are mandatory government policies for every employee or health insurance managed by the services of a commercial insurance company. So that every Indonesian employee or citizen generally has 2 health insurance memberships, one is commercial insurance and the other is mandatory insurance from the government, BPJS health insurance. The use of health insurance from commercial insurance is the first choice, while BPJS health insurance is used as a backup if the coverage limit on commercial insurance has expired. With limited coverage limits provided by private insurance based on premium payments for each class registered by the company, the government facilitates a program to use the benefits of the two health insurances simultaneously, known as the Coordination of Benefits between BPJS Health and commercial insurance. This study uses a qualitative method to analyze how far this program has progressed, as well as the development of an additional health insurance benefit program in Indonesia. The end goal of this research it can be concluded that highlighting the benefits of this program that can be maximized by health insurance participants, what obstacles are faced by participants, as well as health services when using the coordination of benefits program and its development in the future.

Keywords: *Commercial insurance company, coordination of benefits, health insurance and health benefit.*

I. INTRODUCTION

The development of health insurance in Indonesia before 2014 was dominated by commercial health insurance managed by private insurance companies. Health insurance is only owned specifically for individuals who work both in government agencies and individuals who work in private companies. The National Health Insurance Program (JKN) was born based on Law Number 40 of 2004 concerning the National Social Security System, which mandates that the health insurance program is mandatory for all Indonesian citizens.The JKN program in Indonesia is managed by BPJS by applying the principles of social insurance and the principle of equity, and aims to ensure that participants receive health care benefits and protection in meeting their basic health needs. In the framework of implementing social security for all Indonesian people in the health sector, at the beginning of 2014 the Indonesian government has transformed PT. Askes (Persero) to become BPJS. BPJS is tasked with providing health insurance for more than 121 million Indonesians. The presence of BPJS Health has a positive impact on the insurance industry in the country. This is because the health insurance program implemented by BPJS Health can help introduce the importance of insurance to the public. Since the Enactment of Law in Indonesia No. 24 of 2011 concerning the Social Security Administration Agency (BPJS), Indonesia is undergoing reforms in health financing, although this policy still provides an opportunity for Commercial Insurance to work together to implement JKN as a partner by implementing the Coordination of Benefit (COB) program and scheme.

On June 21, 2016 the Government through Health Social Security Administration Agency Regulation Number 4 of 2016 concerning Technical Guidelines for Coordinating Benefits in the National Health Insurance Program issued regulations related to Coordination of Benefits (COB). In this Regulation of the Health Social Security Administering Body what is meant by Health Insurance is a guarantee in the form of health protection so that participants receive health care benefits and protection in meeting basic health needs provided to everyone who has paid contributions or whose contributions have been paid by the government. While Participants are everyone, including foreigners who work for a minimum of 6 (six) months in Indonesia, who have paid contributions. This regulation defines benefit coordination as a method in which two or more insurers bear the same person for the same health insurance benefits, limiting the total

benefits to a certain amount which does not exceed the amount of health services paid for. Meanwhile, what is meant by benefit coordination participants are participants who include themselves and are registered as BPJS Health Participants and Additional Health Insurance Participants. On November 17, 2020 the Indonesia Government issued Regulation of the Health Social Security Administration Number 4, year of 2020 concerning technical guidelines for guaranteeing health services with additional health insurance in the health insurance program as a substitute for the previous technical instructions because they were deemed to be not in accordance with the developments and needs of the community.Coordination of benefits (COB) allows plans that provide health and/or prescription coverage for a person with Medicare to determine their respective payment responsibilities (i.e., determine which insurance plan has the primary payment responsibility and the extent to which the other plans will contribute when an individual is covered by more than one plan).

In this agency regulation what is meant by Supplemental Health Insurance is commercial health insurance that is voluntarily purchased outside of mandatory social health insurance. Health Insurance Additional Health Insurance Participants, here in after referred to as Health Insurance Additional Health Insurance Participants, are participants who enroll themselves and are registered as Health Insurance Participants and Additional Health Insurance Participants.The number of participants in the National Health Insurance (JKN) program organized by BPJS reached 222.5 million people as of December 31, 2020. This figure is equivalent to 81.3% of the population in Indonesia. The highest percentage was found in BPJS Health Contribution Assistance Recipients (PBI) and companies or offices with 36.62% and 33.87% respectively. The next health insurance is 24.12% non-PBI BPJS, 9.56% regional health insurance (Jamkesda), and 0.85% private insurance. Currently, out of a total of 26.78 million private wage earners, only 482,000 participants use the COB mechanism. BPJS Health as the first guarantor has provided quite comprehensive benefits so that the burden of commercial health insurance claims can be reduced. This opportunity is not wasted by commercial health insurance companies in Indonesia. BPJS Health noted that 52 additional health insurance companies had signed a collaboration with the COB scheme (BPJS Health, 2016). In 2015, a list of 49 private insurance companies that cooperate with BPJS Health through the Coordination of Benefits (COB) scheme.

II. METHODS

This research is qualitative research with an analytic descriptive approach. Based on the purpose of this study is to describe the latest developments of the health insurance Coordination of Benefits (COB) program in Indonesia. The data collection technique used by researchers in collecting data and information is to present secondary data where the information comes from the official website of BPJS Indonesia, government regulations, the internet, official government websites and literature review of the latest scientific journals related to the development of Coordination of Benefits.Benefits, besides that the data were obtained through in-depth interviews with program implementers in the field to confirm the completeness of the relevant policies or data involved in this study. Data collection through interviews and observations was carried out from March to May 2023. The technique for determining informants in this study used purposive sampling. The informants consisted of BPJS health claim officers and Directors of X Group Hospital.

III. RESULT AND DISCUSSION

Coordination of Benefits (COB)

Coordination of benefits (COB) allows plans that provide health and/or prescription coverage for a person with Medicare to determine their respective payment esponsibilities i.e.: determine which insurance plan has the primary payment responsibility and the extent to which the other plans will contribute when an individual is covered by more than one plan. COB relies on many databases maintained by multiple stakeholders including federal and state programs, plans that offer health insurance and/or prescription coverage, pharmacy networks, and a variety of assistance programs available for special situations or conditions.

The COB Process:

- Ensures claims are paid correctly by identifying the health benefits available to a medicare beneficiary, coordinating the payment process, and ensuring that the primary payer, whether medicare or other insurance, pays first.
- Shares medicare eligibility data with other payers and transmits medicare-paid claims to supplemental insurers for secondary payment. Note: An agreement must be in place between the Benefits Coordination & Recovery Center (BCRC) and private insurance companies for the BCRC to automatically cross over claims. In the absence of an agreement, the person with Medicare is required to coordinate secondary or supplemental payment of benefits with any other insurers he or she may have in addition to Medicare.
- Ensures that the amount paid by plans in dual coverage situations does not exceed 100% of the total claim, to avoid duplicate payments.
- Accommodates all the coordination needs of the benefit. The COB process provides the True Out of Pocket (TrOOP) Facilitation Contractor and Part of Plans with the secondary, non-Medicare prescription drug coverage that it must have to facilitate payer determinations and the accurate calculation of the TrOOP expenses of beneficiaries; and allowing employers to easily participate in the Retire Drug Subsidy (RDS) program.

The Purpose Of Coordination of Benefits (COB)

The goal of the COB system is to increase the number of BPJS participants, so that the implementation of the JKN program in Indonesia becomes more massive and comprehensive (Humas BPJS Health, 2016). The coordination of benefits transaction is the transmission from any entity to a health plan for the purpose of determining the relative payment responsibilities of a health plan for health care claims or payment information. The implementation of the COB collaboration will have an impact on reducing the contributions of participants with high commercial health insurance, because part of the health insurance costs will be borne by BPJS.It is hoped that this will increase the interest of COB participants because premiums are relatively cheaper; however, it offers more benefits to be had.

The next goal is that COB participants will get additional health protection insurance according to the needs needed by the participants. This is because through COB participants are not limited to the facilities provided by BPJS Health, but participants can also improve the degree of health services and facilities according to the standards needed by participants. With COB, it is hoped that participants will benefit from coordination between BPJS Health and Additional Health Insurance (AHI).In addition, the existence of the COB system is expected to reduce the stigma of business competition between BPJS Health and Commercial Insurance. BPJS Health is not a private insurance, but the existence of BPJS Health is intended to increase public awareness of the importance of having health insurance. With COB, participants who are financially able and want to get better health facilities can apply for the scheme. Through the coordination of the two, BPJS Health and Commercial Insurance can complement each other's advantages and disadvantages

Benefit Coordination Mechanism

In the world of insurance, Coordination of Benefit (COB) applies when there is cooperation between two insurance companies to cover the same customer so that the customer gets the maximum benefit from the insurance program he chooses. Currently, the Coordination of Benefits in Indonesia through BPJS Health can be the main claim payer, while commercial insurance acts as a secondary or supporter. In practice, if there are claims from participants, BPJS will pay claims up to the amount covered by BPJS and private insurance will cover the rest according to the amount covered. In accordance with Health Social Security Administration Agency Regulation No. 4 of 2020 Health Insurance Participants can increase the care that is higher than their rights by participating in the Additional Health Insurance program.An increase in treatment that is higher than their rights is carried out, with the provisions of BPJS Health as the guarantor and first payer; and Supplemental Health Insurance as guarantor and second payer. BPJS Health as the guarantor and first payer first provides guarantees to AHI health insurance coverage participants and makes payments for health service fee bills to health facilities.

Additional Health Insurance as guarantor and second payer guarantees and pays bills for the difference in health service fees for class increases for executive inpatient and outpatient rights to health facilities. Additional Health Insurance program to coverage participants who want to improve their treatment which is higher than their rights must inform the health facility at the beginning of the guarantee.Health facilities are required to inform Additional Health Insurance program to coverage participants or their families about the provisions regarding the Difference in Costs before receiving health services. Providing information is carried out directly at the time of registration and/or indirectly through information media owned by health facilities. This information contains at least an explanation of the service fees borne by BPJS Health and the amount of the difference in costs that must be borne by AHI participants or Additional Health Insurance. If Additional Health Insurance (AHI) the participant and or family who has received information is willing to pay the difference in costs, the Additional Health Insurance participant or family will gives written approval.

Situation	Who's primary	Who's secondary
You're married and both you and your spouse have separate health plans	Your employer	Your spouse's employer
A child has dual coverage by married parents	Whichever parent has the first birthday in calendar year	Parent with later birthday
A child has divorced parents	Whoever has custody	N/A
A child has own policy (from school or work) and still on parent's policy until 26	Child's plan	Parent's plan
A child is married and on spouse's policy and continues on parent's policy until 26	Child or child's spouse's plan	Parent's plan
A child under 26 is pregnant and on a parent's plan	Child's plan	N/A
Workers' compensation and health insurance plan	Workers' compensation	Health plan

Fig 1. Situation and simulation of COB in Health Insurance, 2023

What are the different types of coordination of benefits? Coordination of benefits is not one size fits all, there are a few different types of COB coverages:

1. Carve out: The amount your primary plan paid is deducted from how much your primary plan can pay.
2. Non-duplication: If the primary health insurance plan paid an amount that is equal to or more than what the secondary plan would pay, then the secondary plan does not pay out at all.
3. Traditional: Your health insurance plans combined can cover up to 100% of your medical expenses.

There are various situations when two health insurers need to coordinate on medical claims. You and your spouse may be eligible for two different policies from your jobs. Your spouse might be on Medicare and you have your own health plan. You might be under 26 and have your employer's and parent's insurance coverage.

IV. CONCLUSION

Based on the results and review of the literature related to the implementation of the Coodination of Benefit (COB) program, this study can conclude that the current developments are as follows:

The implementation of benefit coordination cooperation with private insurance in the national health insurance program (JKN) has not run optimally. BPJS for health implements a tiered referral system when referring patients to advanced health facilities, this causes participants to not be able to freely choose the desired health facility but must follow the rules imposed by BPJS for health. This causes participants with additional health insurance to be reluctant to choose BPJS for health as the main health insurance they use, they tend to use the additional health facilities they have to be more flexible in choosing the desired advanced level of health facilities.In addition, not all hospitals carry out service procedures with coordination of benefits. Some hospitals no longer carry out benefit coordination programs, they provide options for participants or patients to choose one of the health insurance they have, whether social health insurance, in this case BPJS health or other additional health insurance, they have. So that when participants choose to use BPJS health facilities, all costs of care or medication will be borne by BPJS health in accordance with BPJS health regulations. On the other hand, if participants choose commercial health insurance, then all costs of treatment will be borne by commercial insurance according to the amount of premium they have.The Coordination of Benefit (COB) Program is a cooperation program offered by BPJS Health to BPJS Health

participants who also have additional health insurance. With this program, apart from being able to provide benefits to the people who are COB participants, it is also hoped that BPJS Health participants will use insurance facilitated by this government, to be able to use it as the main health insurance for both individuals and families of BPJS Health participants.

- First, the author indicates that there are several obstacles encountered related to the not yet properly implemented program for health insurance in Indonesia. This is including the tiered referral system that applies to BPJS Health when the first health facility refers patients to advanced level health facilities, so that participants are considered inflexible.
- Second, the health insurance participants were not aware of the Coordination of Benefits program. The four limitations of hospitals that cooperate with BPJS, especially implementing the Coordination of Benefit program.
- Third, not all hospitals accept the Coordination of Benefit (COB) guarantee program.

The benefit coordination programs for health insurance participants with private insurance will no longer be claimed through BPJS since the MOU between BPJS and private health insurance ended in January 2021. However, the fixed benefit coordination program can be used by health insurance participants with additional health insurance, the claim process is carried out by the hospital directly to the additional health insurance if there is a difference in treatment costs. The health insurance program with additional health insurance is implemented according to rules and policies between hospitals and commercial insurance. The greatest challenge for insurers in the future, which highlights the need for effective COB solutions, is that they are usually reliant on their customers to inform them when COB might apply. The complexity of insurance means that many consumers, even with the best of intentions, fail to provide their insurers with timely and correct information. This results in higher payouts, as well as increased administrative costs when overlapping coverage is discovered after a claim has already been processed and paid. Inefficient COB processes can also decrease consumer satisfaction, especially if they are not settled quickly and efficiently or require significant involvement from consumers who may be going through traumatic health experiences. Today, modern big data solutions can be the best solution and transforming the calculation of COB. Data mining and scoring algorithms can identify consumers in the future, who either have or are likely to have additional insurance coverage, allowing insurers to prioritize those cases and determine whether COB is appropriate before a claim is processed.

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