

HEALTHCARE FINANCING AND REIMBURSEMENT: A GLOBAL REVIEW OF MAJOR TOPICS AND TRENDS

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LAWS AND REGULATIONS ON HEALTHCARE FINANCING AND REIMBURSEMENT

1. Please provide a bird's-eye view on the healthcare economy, indicating, in general terms, the role of the government (public healthcare) and private actors (private healthcare).

Indonesia's healthcare economy is characterised by a dynamic interaction between the public and private sectors, with the government – specifically the Ministry of Health (MOH) – playing a central role in regulating healthcare services and standards nationwide. This includes overseeing the funding and management of healthcare infrastructure. While the private sector plays a significant role by operating private hospitals, clinics and laboratories, these operations are closely regulated by the MOH to ensure compliance with national healthcare standards and policies.

The National Health Insurance (*Jaminan Kesehatan Nasional* – JKN) programme, administered by the Social Security Administrator for Health (*Badan Penyelenggara Jaminan Sosial* – BPJS), dominates the healthcare insurance landscape. By law, participation in the JKN programme is mandatory for all Indonesian citizens and certain foreign workers employed in Indonesia. Contributions to the programme are paid either by the individual, their employer and/or the government, as applicable. Additionally, provincial and municipal boards are established to support the implementation of the JKN programme to address regional needs.

Private insurance is also widely utilised, particularly among private corporations. While healthcare services are generally subject to MOH regulations, the business activities of private insurance companies are regulated and supervised by the Financial Services Authority (*Otoritas Jasa Keuangan* – OJK). It is not uncommon for employers to enrol their employees to private insurance companies, in addition to the JKN programme.

Additional payors in the healthcare system include foundations and non-governmental organisations (NGOs), which usually fund and provide services for specific healthcare programmes, often targeting remote areas or specific diseases.

Despite the existence of the JKN programme and private insurance, out-of-pocket payments remain a source of healthcare funding, particularly for services provided by private facilities or for treatments and medications not covered by the JKN programme or private insurance. Patients may also prefer out-of-pocket payments, as insurance programmes – whether through JKN or private insurance – can sometimes result in prolonged administrative processes at healthcare facilities.

2. Please provide a high-level overview of the legal framework regarding healthcare financing and reimbursement.

The primary legal framework governing healthcare financing and reimbursement in Indonesia is Law No. 17 of 2023, as amended ('Health Law') and Law No. 40 of 2004, as amended ('National Health Insurance Law'). These laws lay the foundation for the overall healthcare system, including funding and contribution mechanisms. A central element of this framework is, as referred to in Q1, the JKN programme. Additionally, implementation is further guided by government regulations, BPJS regulations and region-specific regulations.

Various industry codes and standards also guide the healthcare sector, such as ethical codes and professional standards developed by associations like the Indonesian Medical Association (*Ikatan Dokter Indonesia – IDI*) and the Indonesian Hospital Association (*Asosiasi Rumah Sakit Swasta Indonesia – ARSSI*). These codes regulate the behaviour of healthcare providers, ensuring quality care and ethical practices in the delivery of services, regardless of whether medical insurance is involved.

The OJK, as the supervisory agency for private insurance companies, has also issued several regulations and guidelines to ensure the financial health, fairness and transparency of their operations. Additionally, private insurance companies follow codes of conduct and ethical guidelines issued by the relevant association, such as the Indonesian Health Insurance Association (*Asosiasi Asuransi Jiwa Indonesia – AAJI*). These guidelines often align with broader industry standards to promote responsible business practices, safeguard customer protection, and ensure compliance with healthcare-related regulations. They include codes applicable not only to insurance companies but also to insurance agents, reinforcing ethical and professional standards across the industry.

Negotiations between healthcare providers and payors (such as BPJS and private insurance companies) typically focus on service rates, the inclusion of treatments or medications in reimbursement schemes and administrative claim procedures. Given their administrative nature, these negotiations are often conducted directly between providers and payors, without mediation or facilitation by professional associations. On the other hand, professional associations are generally involved in higher-level discussions, such as with the government, to advocate for or influence the formulation of new regulations and policies.

3. What are the key regulators and supervisory bodies regarding healthcare financing and reimbursement?

The MOH is the primary government agency responsible for regulating the healthcare sector in Indonesia, including the development and implementation of policies related to healthcare financing and reimbursement. While the MOH plays a central role in overseeing national healthcare standards, the JKN programme is specifically administered by the BPJS, which plays a pivotal role in managing contributions and reimbursements under the JKN programme and reports directly to the President of the Republic of Indonesia.

In addition, other specialised bodies and industry organisations play significant roles in shaping healthcare financing and reimbursement in Indonesia. The OJK, for example, supervises private healthcare insurance companies to ensure their compliance with financial regulations, while industry organisations such as the IDI, ARSSI and AAJI contribute to policy development and govern industry ethical codes. Furthermore, the Business Competition Commission (*Komisi Pengawas Persaingan Usaha – KPPU*) may intervene in cases where anti-competitive practices threaten the fairness of the healthcare financing market.

The courts, alongside alternative dispute resolution forums, play an instrumental role in the interpretation and enforcement of healthcare financing and reimbursement laws. Alternative dispute resolution forums such as the Financial Services Sector (*Lembaga Alternatif Penyelesaian Sengketa Sektor Jasa Keuangan* – LAPS SJK) and the Indonesian National Arbitration Board (*Badan Arbitrase Nasional Indonesia* – BANI) help resolve conflicts between healthcare providers, payors and patients. These disputes often involve issues such as reimbursement rates, insurance claims, or the application of specific legal provisions under the JKN or private insurance schemes. The courts and alternative dispute resolution forums generally ensure that healthcare financing mechanisms comply with statutory requirements and uphold the principles of fairness and equity. They also have the authority to impose penalties or fines on parties found responsible for causing losses in these disputes.

4. Has there been a change with healthcare financing and reimbursement as a consequence of the Covid-19 pandemic?

No. In response to the Covid-19 pandemic, several regulations were indeed introduced in Indonesia to address aspects of healthcare services and reimbursement, but primarily aimed at managing the pandemic. These regulations generally focus on pandemic mitigation efforts, such as requiring local governments to: (1) support the provision of medicines and medical supplies, and (2) distribute medicines, vaccines, immunisation support tools and medical supplies to community health centres (*puskesmas*) and/or other healthcare facilities. That said, there have been no explicit regulatory changes specifically targeting healthcare financing and reimbursement mechanisms as a direct consequence of the pandemic.

However, the Indonesian government, through one of MOH's publications, has underscored its commitment to improving the healthcare system based on evaluations of the pandemic's impact. Key measures taken include enacting the Health Law, which serves as an omnibus law for the healthcare sector, as well as government and other agency/local regulations to implement the Health Law. While these measures aim to strengthen the overall healthcare system, they remain general in nature and do not provide specific provisions for financing and reimbursement systems as a response to the pandemic.

5. Who has access to the healthcare system as a patient on the one side and as a medical service provider/supplier of medical goods on the other side? What are the conditions of admission?

Indonesian citizens are automatically eligible for participation in the JKN programme. Foreign workers employed in Indonesia for a minimum of six months are also entitled to participate in the JKN programme. However, non-participants – such as Indonesian citizens not yet enrolled in the programme and foreign workers who have not met the six-month employment requirement – are still entitled to access healthcare facilities through personal payments. Additionally, the law designates specific groups as Recipients of Health Insurance Contribution Assistance (*Penerima Bantuan Iuran Jaminan Kesehatan*), meaning individuals who receive subsidies for health insurance premiums under the JKN programme. These groups typically include low-income individuals and those unable to afford the contributions.

While the JKN programme covers a wide range of healthcare services, treatments provided outside of Indonesia are not covered.

In cases of emergency, JKN participants are entitled to receive urgent medical services at any healthcare facility, regardless of whether it has a partnership with BPJS or not. If the healthcare facility is not affiliated with BPJS, the participant must be transferred to a participating facility once the emergency is addressed, and the patient is stable for transfer. Notably, healthcare providers – whether or not affiliated with BPJS – are prohibited from charging emergency service fees to JKN programme participants and are required to reimburse the amount to BPJS.

Healthcare providers that intend to participate in the JKN programme must meet specific standards set by BPJS. These standards vary depending on the type of healthcare provider, such as whether they are hospitals, clinics, health centres (*puskesmas*), etc. However, general requirements include holding valid operational permits, obtaining accreditation certifications, and forming cooperative agreements with other entities within the healthcare network, such as pharmacies and laboratories.

BPJS will further conduct a selection and credentialing process to assess the technical criteria of healthcare facilities, including human resources, facility completeness, scope of services and service commitment. These criteria will determine the terms of the agreement between BPJS and the healthcare provider, the types of services offered, the capitation rate and the number of JKN participants the facility is expected to accommodate. Finally, healthcare providers must undergo a re-credentialing process before the expiration of their agreements to maintain their eligibility for continued collaboration with BPJS.

Furthermore, the law stipulates that government-owned healthcare facilities that meet these requirements must collaborate with BPJS, while participation for private healthcare facilities remains optional.

HEALTH INSURANCE FINANCING AND COVERAGE

6. How are health insurance carriers financed? How are premiums determined?

Health insurance carriers in Indonesia, particularly under the JKN programme, are financed through a combination of capitation payments, case-based group payments, reimbursements, and contributions from individuals, employers and the government, based on the rates pre-determined and regulated by the MOH and BPJS.

As a reference, capitation refers to a fixed per capita monthly payment made in advance by BPJS to healthcare facilities in the first level. The amount ranges determined by the number of participants (patients) per month, as set under MOH Regulation No 3 of 2023, based on the type of healthcare facility. BPJS further establishes the capitation rates through agreements with healthcare facility associations. Special capitation rates also apply to facilities in remote areas, determined without considering the risk profile of registered participants or the facility's performance. BPJS is obligated to make capitation payments each month.

For healthcare facilities providing specialised or sub-specialised individual medical services, including advanced or specific treatments, BPJS reimburses these referral healthcare facilities at the advanced level through case-based group claim payments. These payments are based on service packages categorised by disease diagnosis and procedures, covering all hospital resources used in the treatment, both medical and non-medical. The government determines the applicable categories and tariffs for these services.

The regulation also recognises non-capitation payments (ie, reimbursements), which apply to services based on the type and number of healthcare services provided. Non-capitation services

include ambulance services (subject to regional government-set tariffs), specific health screenings, certain inpatient services and dental prosthetics. These reimbursement rates, outlined in MOH Regulation No 3 of 2023, are periodically submitted to BPJS for claims processing. For non-BPJS partner healthcare facilities, reimbursements are also applicable in specific cases such as emergency medical actions.

Furthermore, the financing of the JKN programme is also derived from contributions (*iuran*) paid by:

1. *Individual participants*: Employees and self-employed individuals pay premiums, which are determined based on their income levels, but limited to a certain threshold.
2. *Employers*: Employers contribute a portion of the contributions for their employees.
3. *Government subsidies*: The government subsidises contributions for recipients of Health Insurance Contribution Assistance.

The premium amount for recipients of Health Insurance Contribution Assistance is determined under Presidential Regulation No 82 of 2018, while contributions for other participants are calculated as a percentage of income, with the government setting an upper limit for the income base.

Lastly, premiums for private health insurance are determined by the individual insurance carriers but are subject to oversight and regulation by the OJK.

Premiums for the JKN programme are generally reviewed by the MOH and BPJS, but like any other governmental policies, decisions or determinations, they can be subject to oversight and potential judicial review. In cases where there are disputes regarding contribution amounts, the courts may be called upon to interpret the relevant laws and regulations, particularly if there is concern about fairness or legality. However, the judicial review process for JKN contributions is typically more limited, since the programme is heavily regulated by the government and designed to align with national health policy goals.

7. How is coverage of medical services by health insurance carriers regulated? Are there differences in coverage for in-person medical appointments and telemedicine appointments?

Generally, private health insurance companies have flexibility in defining the scope of coverage as well as premium amounts under their plans and products, although their determinations must comply with OJK regulations and guidelines. This allows them to offer varied benefits and coverage options tailored to different consumer needs. Providers may include a wide range of medical services, such as elective surgeries, specialised treatments and services not covered under the JKN programme. Therefore, they typically design tiered coverage plans based on premium levels, enabling customers to select from basic packages to more comprehensive options depending on their preferences and financial capacity.

In contrast, the mandatory JKN programme has its coverage for healthcare services strictly defined by regulations. These regulations specify the services and treatments covered by the JKN programme, as well as those excluded from coverage. Notably, the government retains flexibility to adjust coverage under the JKN programme, as the MOH may authorise additional healthcare services to be included in the programme based on health technology assessments, provided they consider the adequacy of contributions and consult with the Ministry of Finance.

Lastly, with the increasing use and recognition of telemedicine/teleconsultancy platforms, particularly during the Covid-19 pandemic period, telemedicine/teleconsultancy is included in the coverage of the JKN programme. Nonetheless, detailed regulations regarding insurance coverage for telemedicine/teleconsultancy have yet to be established, as current regulations only specify that they are subject to capitation payments, meaning they are compensated by BPJS. Private insurance companies also recognise the growing importance of telemedicine, and therefore often including it as part of their plan or product offerings.

HOSPITAL SECTOR

8. How are services provided by hospitals in the stationary (inpatient) and ambulatory (outpatient) settings financed and reimbursed?

Both stationary (inpatient) and ambulatory (outpatient) services are primarily covered under the JKN programme as benefits available to JKN programme participants, and as such, their financing and reimbursement remain consistent with our response in Q6. The financing and reimbursement for these services depend on whether they fall under capitation payments, the case-based group system or non-capitation payments. For healthcare services not covered under the JKN programme, these can either fall under the benefits provided by private insurances or be paid directly through out-of-pocket payments.

9. How are the prices of such services determined? How is economic efficiency controlled?

The pricing or tariff determination we are aware of primarily focuses on the payments or reimbursements of healthcare services under the JKN programme. However, according to the Health Law, hospitals must set their tariffs in accordance with the national tariff structure and the maximum tariff cap established for their region. The MOH determines the national tariff structure based on unit cost components while considering regional conditions. Subsequently, the governor of each province sets the maximum tariff cap for hospitals within their jurisdiction, aligning it with the national tariff structure.

Therefore, hospital tariffs primarily refer to regional regulations, as these are closely tied to factors such as the availability of facilities and healthcare workers in the area, the minimum wage of employees in the region, and other considerations unique to each province.

While we are unaware of specific tariffs for other healthcare services (such as for clinics, healthcare centres and private practices), it is likely that their implementations follow the same principle as outlined above: ie, ultimately determined by the local government while adhering to MOH guidelines.

Regarding pricing matters, please also note that these are subject to supervision by the KPPU as briefly explained in Q3.

HEALTHCARE PROVIDERS IN PRIVATE PRACTICE

10. How are services provided by physicians, therapists, laboratories and other service providers financed and reimbursed?

A healthcare facility is defined by the Health Law as a healthcare service facility used to provide individual healthcare services, including promotive, preventive, curative and rehabilitative efforts. This means that, arguably, private therapists and physicians are also included –

particularly deemed as rehabilitative efforts – and they are eligible to cooperate with BPJS in the JKN programme. Regulations also recognise independent medical practices, such as medical or dental practices, as well as other healthcare professionals, which refers to certain types of higher education for health efforts. This would, by extension, include physicians and therapists. Their financing and reimbursement under the JKN programme remain consistent with the scheme as outlined in Q6.

For diagnostic support services, these generally refer to assistance in identifying or confirming a patient's medical condition, and therefore may include laboratory tests, radiology services, etc. Diagnostic support services are also covered under the JKN programme coverage, whereby for primary level diagnostic services, such as basic laboratory tests and routine screening, they are typically reimbursed under the capitation payment system. Advanced diagnostic services, such as specialised tests, high-end screening procedures or complex laboratory evaluations, are reimbursed through the case-base group payment.

11. How are the prices of such services determined? How is economic efficiency controlled?

Please refer to our responses in Q9 above.

PHARMACEUTICALS AND MEDICAL DEVICES

12. How are pharmaceuticals and medical devices financed and reimbursed?

Essentially, JKN programme participants are entitled to health insurance benefits, which include both medical and non-medical benefits. Medical benefits refer to individual healthcare services, including medications, medical devices and disposable medical supplies, as required based on medical needs. Therefore, pharmaceuticals and medical devices are also included in the coverage of the JKN programme, with their financing and reimbursement remaining consistent as outlined in Q6 above. However, the MOH and BPJS further regulate which drugs and use of medical devices are covered under the JKN programme, including limitations on maximum prescriptions.

In exceptional cases, it is unlikely that early access or off-label use would be covered by BPJS, as healthcare providers and BPJS generally adhere strictly to the written regulations. For such matters, escalation to a higher level of authority would be necessary. That said, the likelihood of resolution is not only low but also potentially prolonged due to bureaucratic processes.

13. How are the prices of pharmaceuticals and medical devices determined? How is economic efficiency controlled?

Pharmaceutical companies essentially determine the Highest Retail Drug Price (*Harga Eceran Tertinggi Obat* – HET), which is the maximum selling price for drugs at pharmacies, drug stores and hospital/clinic pharmacies, based on guidelines issued by the MOH. However, the distribution of medicines is also regulated by the National Agency of Drug and Food Control (*Badan Pengawas Obat dan Makanan* – BPOM), making BPOM regulations and guidelines also applicable. While for the use of medical devices, our interpretation generally indicates that these fall under the hospital tariff as referred to in Q9.

Additionally, the government has established an e-catalogue system, ie, an electronic information system containing the list, types, technical specifications and prices of specific

goods provided by various suppliers for government procurement, including drugs and medical devices. This system ensures transparency and consistency in drugs and medical devices pricing, particularly for public sector procurement.

LITIGATION INVOLVING HEALTHCARE FINANCING AND REIMBURSEMENT

14. Please provide a high-level overview of major litigation topics and landmark cases regarding healthcare financing and reimbursement.

There have not been any significant litigation cases specifically concerning the JKN programme. However, there are occasional instances where individuals file lawsuits regarding treatments or medications that are not covered under the JKN programme but are considered essential by the patient. These cases are typically highly specific to individual circumstances and are challenging to trace online.

On the other hand, major cases related to the JKN programme often revolve around fraud allegations involving healthcare providers. Common schemes include submitting false or fraudulent claims, where healthcare providers manipulate patient records to inflate costs. For instance, a hospital might exaggerate the severity of a diagnosis or unnecessarily prolong a patient's treatment to secure higher reimbursements. In some cases, hospitals have also been accused of manipulating medical records or performing phantom billing.

These fraudulent practices are typically investigated through a coordinated effort by the MOH, BPJS and Corruption Eradication Commission (*Komisi Pemberantasan Korupsi – KPK*). If the allegations are proven, the parties involved (such as the healthcare institution, personnels, employees, etc) may face administrative sanctions and even criminal charges.

RECENT DEVELOPMENTS AND TRENDS

15. What are the recent developments and trends for the next few years? Please outline any unresolved issues, proposed changes, or trends for healthcare financing and reimbursement and briefly indicate how these may foreseeably affect the medical sector in the near future.

One notable development is the projected increase in the contributions for the JKN programme. This addresses the forecasted deficit of IDR20tn in 2024, likely largely attributed to a rise in healthcare utilisation following the Covid-19 pandemic. Nonetheless, from our observation, the government is also exploring several stabilisation strategies, including the implementation of a Coordination of Benefits (COB) scheme. Under this framework, BPJS would coordinate with private insurance companies to share the costs of healthcare services. This collaborative approach seeks to distribute financial responsibility more effectively between public and private payors.

Lastly, the existing class-based structure of the JKN programme will also be replaced with a standardised inpatient care system, ensuring a more equitable distribution of healthcare services across all socioeconomic groups, while improving financial predictability.