SSJ
Social Sciences Journal
Volume 3 Issue 2, 2026 (341-350)
ISSN (*online*) : 3047-7646
Homepage : https://jurnalunived.com/index.php/SOSJ
Doi : https://doi.org/10.37676/sosj

Legal Review Of Health Insurance Claim Denial

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Received [15-07-2026] Revised [20-08-2026] Accepted [25-082026)

Abstract. Health insurance provides financial protection against health risks, yet disputes over claim denial remain frequent in Indonesia. This study analyzes the legal basis of health insurance claim rejection, identifies the principal causes of disputes, and examines legal protection available to policyholders. A normative juridical method was applied through statutory and conceptual approaches using legislation, legal doctrine, scientific literature, and relevant regulatory materials. The analysis shows that claim denials commonly arise from incomplete medical documentation, pre-existing-condition clauses, waiting periods, policy exclusions, and differences in the interpretation of medical necessity between hospitals and insurers. The contractual imbalance between insurers and policyholders, combined with limited transparency of policy terms, can intensify disputes. Existing protection is grounded in contract law, consumer protection law, insurance regulation, and Financial Services Authority rules, but implementation requires greater consistency. Stronger disclosure standards, standardized medical-necessity criteria, digitalized claim verification, and effective complaint and dispute-resolution mechanisms are required to improve fairness, transparency, and legal certainty in Indonesian health insurance services.

Keywords: Claim Denial; Health Insurance; Legal Protection; Policyholder; Insurance Dispute.

INTRODUCTION

Health insurance is an important instrument in the modern health care financing system because it provides financial protection against the risk of illness and medical service needs. The existence of health insurance is expected to be able to increase public access to quality health services without causing a high cost burden. The legal relationship in health insurance involves the insurance company as the insurer, the participant as the insured, and the hospital as the health service provider.

However, the implementation of health insurance in Indonesia still faces various problems, one of which is the rejection of health insurance claims. Claim disputes often occur due to differences in interpretation between insurance companies, hospitals, and participants on the content of policies and coverage provisions. Denial of claims not only has an impact on insurance participants, but also affects hospital operations due to late payment of health services.

According to Gunawan (2020), the rejection of health insurance claims is generally caused by the application of policy exclusion clauses, incompleteness of medical documents, pre-existing conditions, and assessment of medical necessity for certain medical procedures. In addition, Dewi (2020) stated that the lack of transparency of policy information and the imbalance in the bargaining position between insurance companies and participants also increase the risk of claims disputes.

Legally, the relationship between the insurance company and the participant is based on an agreement as stipulated in Article 1338 of the Civil Code which states that any legally made

agreement shall be valid as a law for the parties. In the context of consumer protection, Law Number 8 of 1999 concerning Consumer Protection also gives insurance participants the right to obtain clear, true, and non-misleading information regarding the insurance products used.

The problem of refusal of health insurance claims is important to be studied because it concerns aspects of legal protection, legal certainty, and fairness in contractual relationships. In addition, claim disputes also have an impact on the quality of health services and the cooperative relationship between hospitals and insurance companies. Therefore, a comprehensive legal study is needed regarding the practice of rejecting health insurance claims in Indonesia. This study aims to analyze the legal aspects of health insurance claim rejection in Indonesia, identify the factors that cause claim disputes, and analyze the form of legal protection for health insurance participants.

Previous research on health insurance claim disputes has generally focused on consumer protection, insurance company defaults, and the implementation of the principle of good faith in insurance law. Dewi's research (2020) focuses on the legal protection of insurance participants in health claim disputes. Meanwhile, Gunawan's research (2020) focuses more on the administrative aspects and legal basis of claim rejection by insurance companies.

Another study conducted by Mulyadi (2020) discusses the mechanism for resolving health insurance disputes through mediation and litigation, but previous studies are still limited to normative analysis of consumer protection and have not comprehensively examined the legal relationship between insurance companies, hospitals, and participants in modern health service practices. In addition, studies on differences in medical necessity interpretations, cost containment policies, and the impact of claim rejection on hospital operations are still relatively limited. This study seeks to provide a more comprehensive analysis of health insurance claim denial by integrating the perspectives of treaty law, consumer protection, health law, and claims administration practices in hospitals. This study also analyzes the relationship between regulatory aspects and claims implementation practices.

The novelty in this study lies in the multidimensional analysis of the rejection of health insurance claims which is not only studied from the perspective of consumer protection and agreement law, but also associated with the administrative practice of hospital claims, the concept of medical necessity, the cost containment policy of insurance companies, and its implications for health services. This research also offers an integrative approach between insurance regulations, health law, and medical service practices in analyzing health insurance claim disputes in Indonesia. In addition, this study highlights the importance of standardizing the interpretation of medical necessity between hospitals and insurance companies as an effort to minimize claim disputes and increase legal certainty for health insurance participants in Indonesia.

LITERATURE REVIEW

Health Insurance Agreements and Good Faith

Health insurance creates a contractual relationship in which the insurer undertakes to provide coverage according to the policy, while the insured is required to disclose material information and comply with agreed terms. The principle of pacta sunt servanda gives binding force to a valid agreement, while the principle of good faith requires both parties to act honestly and transparently. In health insurance, this obligation is especially important because risk assessment depends on medical information that may be technically complex and difficult for policyholders to interpret.

Consumer Protection and Information Transparency

Insurance participants are also consumers of financial services. Consumer protection requires clear, accurate, and non-misleading information concerning benefits, exclusions, waiting periods, claim procedures, and the consequences of inaccurate disclosure. Because insurance policies are generally standardized contracts prepared by insurers, the bargaining position of the parties is not fully equal. Transparency therefore becomes a central element of legal protection and a practical means of reducing disputes.

Medical Necessity and Claim Administration

A distinctive issue in health insurance is the assessment of medical necessity. Treating physicians determine clinical needs based on the patient's condition, whereas insurers may apply internal utilization-review and cost-containment standards. Differences in these perspectives can generate disputes over hospitalization, diagnostic procedures, implants, medicines, and other interventions. Effective claim governance therefore requires standards that respect clinical judgment while allowing insurers to perform legitimate risk and cost control.

METHODS

The research method used in this study is a normative juridical method with a statutory approach and a conceptual approach. The normative juridical approach is used to examine legal norms, principles, and principles related to the rejection of health insurance claims as well as legal protection for health insurance participants in Indonesia (Soekanto & Mamudji, 2019). The legislative approach is carried out through a review of various relevant regulations, including the Civil Code, Law Number 8 of 1999 concerning Consumer Protection, Law Number 40 of 2014 concerning Insurance, and Financial Services Authority Regulation Number 69/POJK.05/2016 concerning the Business Implementation of Insurance Companies. Meanwhile, a conceptual approach is used to analyze legal concepts regarding insurance agreements, the principle of good faith, medical necessity, consumer protection, and legal relationships between insurance companies, hospitals, and insurance participants (Khairandy, 2019).

This research is descriptive analytical, which systematically describes the practice of rejecting health insurance claims and analyzes its legal implications for the protection of the rights of insurance participants. Analytical descriptive research aims to provide a comprehensive understanding of the application of regulations and claims dispute resolution practices in health services (Marzuki, 2021). The focus of the research is directed at the factors that cause the rejection of claims, forms of legal protection for participants, and dispute resolution mechanisms that can be taken in the event of a dispute between hospitals, participants, and insurance companies.

The data sources in this study consist of primary legal materials, secondary legal materials, and tertiary legal materials. Primary legal materials are in the form of laws and regulations related to health insurance and consumer protection. Secondary legal materials are obtained through books, scientific journals, legal articles, and previous research relevant to the research topic (Rahardjo, 2016). The tertiary legal materials are obtained from legal dictionaries, encyclopedias, and other reference sources that support the research analysis.

The data collection technique is carried out through library research, which is by studying and inventorying various legal materials and literature related to the research object. The data that has been obtained is then analyzed in a qualitative descriptive manner through the process of identification, classification, interpretation, and conclusion drawing systematically to obtain a complete picture of legal protection against the rejection of health insurance claims in Indonesia.

RESULTS

Factors Causing Health Insurance Claim Denial

The rejection of health insurance claims is still one of the most frequent problems that causes disputes between insurance companies, participants, and health care facilities. The rejection of claims is not only related to administrative issues, but also related to the legal interpretation of the content of the policy, consumer protection principles, and medical assessment of the health services provided to patients. This condition shows that health insurance claim disputes have multidisciplinary dimensions involving legal, administrative, and medical service aspects (Dewi, 2020).

Based on the results of the study, the most common factor that causes the rejection of claims is the incompleteness of medical documents. Insurance companies generally require various supporting documents such as medical resumes, supporting examination results, hospitalization indications, details of medical procedures, and chronology of the patient's illness as the basis for verifying claims. Discrepancies between medical documents and insurance company administrative provisions often lead to delayed or denied claims. In some cases, insurance companies ask for additional documents that are not explicitly included in the policy, thus prolonging the claim verification process (Mulyadi, 2020).

In addition to incompleteness of documents, the application of pre-existing condition clauses is also the dominant cause of claim rejection. The clause basically aims to prevent adverse selection in the health insurance system. The application of pre-existing condition clauses often gives rise to differences in interpretation between participants and insurance companies.

Based on the analysis, many participants felt that they had never had a history of the disease before, but the insurance company assessed that the condition existed before the policy was active based on the results of the medical examination while the patient was undergoing treatment (Khairandy, 2019).These problems show that information transparency in insurance policies is still a weakness in insurance practices in Indonesia. Many participants do not understand in detail the scope of coverage, policy exceptions, or provisions regarding pre-existing conditions. As a result, participants only know that there are coverage restrictions when the claim process is carried out. This condition reflects an imbalance in the bargaining position between insurance companies as policymakers and participants as users of insurance services (Agustina, 2019).Another factor that also often causes claim disputes is the application of a waiting period or waiting period.

The waiting period is a specific period after an active policy where some illness cannot be covered by the insurance company. This provision is actually a risk control mechanism that is commonly used in the insurance industry. However, many participants did not understand the details of the waiting period so they felt disadvantaged when the claim was rejected on the grounds that the disease was still in the waiting period (Gunawan, 2020).In addition to administrative aspects and policy provisions, differences in interpretation regarding medical necessity are also one of the main causes of health insurance claim disputes. In the medical world, doctors have the professional authority to determine medical actions based on the patient's clinical condition. Insurance companies often have their own internal standards in determining whether or not a medical procedure is considered worthy of coverage. These differences in interpretation often cause conflicts, especially in diagnostic measures, observational hospitalizations, the use of certain implants, and minimally invasive measures (Dewi, 2020).

The findings of the study show that doctors assess that patients need hospitalization because there is a risk of worsening clinical conditions, while insurance companies assess that the condition can still be treated outpatiently. These differences in viewpoints show that there is a conflict between clinical considerations and insurance companies' cost containment policies. As a result, participants are often at a disadvantage because they have to bear the cost of health services independently (Mulyadi, 2020).

Table 1. Principal Factors in Health Insurance Claim Denial

Factor	Legal/Administrative Issue	Potential Impact
Incomplete medical documents	Supporting records do not satisfy verification requirements	Delay or rejection of claim
Pre-existing conditions	Different interpretation of prior disease or disclosure	Coverage dispute
Waiting period	Claim occurs within an excluded initial period	Participant bears treatment cost
Policy exclusions	Benefits are outside contractual coverage	Disagreement over scope of policy
Medical necessity	Clinical judgment differs from insurer criteria	Dispute over hospitalization/procedure

Source: Synthesized from the article analysis and cited literature.

Legal Protection and the Claims Relationship

Legally, the relationship between the insurance company and the participant is based on the legal principle of the agreement as stipulated in the Civil Code. Article 1338 of the Civil Code emphasizes that every legally made agreement is valid as a law for the parties. In the context of health insurance, a policy is the basis of a contractual relationship that regulates the rights and obligations between insurance companies and participants (Harahap, 2017).

As an agreement, an insurance policy should be implemented based on the principle of good faith. This principle requires all parties to provide information honestly and not to hide material facts that may affect the implementation of the agreement. Participants are obliged to explain their health condition correctly at the time of policy application, while insurance companies are required to provide clear information about coverage benefits, policy exclusions, and claim procedures (Miru, 2018).

The position of insurance companies tends to be more dominant than participants because policies are generally arranged in the form of standard agreements. Participants do not have the opportunity to negotiate the content of the policy clause and are only given the option of accepting or rejecting the policy. This condition has the potential to cause an imbalance in the legal relationship between insurance companies and participants (Rahardjo, 2016).

Law Number 8 of 1999 concerning Consumer Protection provides legal protection to insurance participants as consumers of financial services. Article 4 of the Consumer Protection Law states that consumers have the right to obtain true, clear, and honest information about the condition of the goods and/or services used. Therefore, insurance companies are obliged to convey all policy provisions in a transparent and non-misleading manner (Agustina, 2019).

The lack of transparency of policy information is one of the main causes of health insurance claim disputes. Many participants assume that all health care costs will be covered by insurance companies, even though there are various restrictions and exclusions set out in the policy. When the claim is rejected, the participant feels that the insurance company is not performing its obligations properly. This condition shows that the insurance literacy of the Indonesian people is still relatively low (Gunawan, 2020).

In addition to consumer protection, the legal aspect of claim rejection is also related to the principle of fairness in treaty law. A denial of a claim made without a clear reason or without a strong legal basis can be categorized as a form of default. So that insurance companies must have an objective and accountable basis in every decision to reject claims (Harahap, 2017).

The regulation shows that the legal relationship in health insurance claims is based on the principles of consumer protection, legal certainty, and good faith of the parties

In the modern health care system, hospitals and insurance companies have a close cooperative relationship through cashless and managed care systems. The collaboration aims to make it easier for participants to obtain health services without having to make direct payments to the hospital, but the system also poses various administrative and financial challenges for hospitals (Mulyadi, 2020).

Insurance companies generally have different claims verification standards. These differences include indicators of medical necessity, indications of hospitalization, use of medical devices, and classification of medical measures. The disparity in administrative standards between insurance companies causes hospitals to adjust the claims administration system to the policies of each insurance company (Dewi, 2020).

This condition often leads to delays in claim payments and increasing hospital receivables. In high-cost health services such as surgery, implant use, and intensive care, late payment of claims can significantly affect hospital cash flow. Even so, hospitals still have the obligation to provide medical services to patients regardless of the patient's financing status (Agustina, 2019).

In addition to financial issues, hospitals are also often the party that has to explain the decision to reject claims to patients even though the decision is under the authority of the insurance company. It is not uncommon for patients to blame hospitals for thinking that information about coverage benefits is not explained in the first place. These conditions can affect the relationship between patients and health service facilities (Gunawan, 2020).

On the other hand, insurance companies also face challenges in controlling the ever-increasing cost of health services. The development of medical technology and the increasing number of chronic diseases have caused the value of health insurance claims to be higher. Therefore, insurance companies implement various cost containment policies such as medical audits, drug formularies, benefit restrictions, and medical necessity evaluations to maintain financing efficiency (Dewi, 2020).

Cost containment policies are often seen as an obstacle by hospitals and insurance participants. This research shows that insurance companies refuse certain medical procedures on the grounds that they do not meet medical indications based on the company's internal standards. This condition shows a disharmony between the doctor's clinical considerations and the insurance company's financing policy (Mulyadi, 2020).

Table 2. Legal Framework for Health Insurance Claim Protection

Legal Instrument	Core Relevance
Civil Code, Article 1338	Binding force of valid insurance agreements and contractual obligations
Law No. 8 of 1999 on Consumer Protection	Rights to accurate information, fairness, and consumer remedies
Law No. 40 of 2014 on Insurance	Regulation of insurance business and policyholder protection
POJK No. 69/POJK.05/2016	Operational requirements for insurance companies and claim administration

Source: Civil Code, Insurance Law, Consumer Protection Law, and related OJK regulation.

Claim Dispute Resolution

Health insurance claim dispute resolution can be done through various legal mechanisms, both through non-litigation and litigation channels. The initial stage of dispute resolution is usually carried out through an internal complaint mechanism to the insurance company. If a settlement is not reached, participants can file a complaint with the Financial Services Authority (OJK) as a regulator of the financial services sector (Marzuki, 2021).

In addition to through the OJK, claim disputes can also be resolved through mediation, arbitration, the Consumer Dispute Resolution Agency (BPSK), and civil lawsuits in court. Mediation is often chosen because it is considered faster and less expensive than the litigation process, but the effectiveness of dispute resolution is highly dependent on the good faith of the parties to the dispute (Soekanto & Mamudji, 2019).

In the context of consumer protection, insurance participants have the right to obtain legal certainty on the coverage benefits promised in the policy so that insurance companies must implement the principles of transparency and accountability in the claims process. Rejection of claims made without a clear legal basis has the potential to give rise to civil lawsuits and consumer complaints (Rahardjo, 2016).

Digitization of the claims system can be one of the solutions to increase the efficiency and transparency of the claims verification process. With digital systems, the exchange of medical and administrative data can be done faster, reducing the risk of delays and administrative errors. In addition, digitalization also helps improve coordination between hospitals and insurance companies (Dewi, 2020).

In addition to digitalization, standardization of medical necessity is also needed to reduce differences in interpretation between doctors and insurance companies. The preparation of joint guidelines regarding hospitalization indications, surgical procedures, the use of medical devices, and supporting examinations can help minimize claim disputes and increase legal certainty for health insurance participants (Mulyadi, 2020).

Thus, the denial of health insurance claims cannot be seen solely as an administrative issue, but also as a legal and consumer protection issue. Regulatory harmonization, policy transparency, and better coordination between insurance companies, hospitals, and regulators are needed so that the health insurance system can run fairly and provide legal certainty for all parties (Soekanto & Mamudji, 2019).

Table 3. Health Insurance Claim Dispute Resolution Mechanisms

Mechanism	Function
Internal complaint	Initial review and reconsideration by the insurer
OJK complaint	Regulatory facilitation and consumer-protection channel
Mediation/Arbitration	Non-litigation settlement through negotiated or adjudicative process
BPSK	Consumer dispute settlement where legally applicable
Civil litigation	Court-based enforcement of contractual or consumer rights

Source: Synthesized from the article analysis and cited literature.

DISCUSSION

The study shows that claim denial is a multidimensional problem rather than a purely administrative event. Incomplete documentation can be corrected through better hospital claim management, but disputes over pre-existing conditions, exclusions, and medical necessity require interpretation of contractual rights and legal principles. Consequently, the quality of claim administration is inseparable from the quality of legal protection offered to policyholders.

The strongest recurring issue is information asymmetry. Insurers possess specialized knowledge of policy language and claim rules, while participants may understand insurance mainly as a promise that treatment costs will be covered. When exclusions and waiting periods are not communicated in plain and accessible language, the standardized nature of the policy can produce an unequal contractual relationship. Consumer-protection norms therefore have a corrective role by requiring transparency, fairness, and accountable reasons for claim decisions.

Medical necessity creates a second layer of complexity because clinical and financing perspectives do not always coincide. Doctors may consider hospitalization or a procedure necessary to prevent deterioration, while the insurer may classify the same intervention as outside its utilization criteria. A sustainable solution should not eliminate cost control, but should establish shared evidence-based criteria and a clear review process involving appropriate medical expertise. Such a framework would reduce arbitrary interpretation and make claim decisions easier to justify.

The relationship between hospitals and insurers also has operational consequences. Delayed or rejected claims can increase hospital receivables and disrupt cash flow, while patients may mistakenly attribute an insurer's rejection to the hospital. Digital claim systems, standardized documentation, and transparent communication can reduce these frictions. At the dispute stage, a graduated mechanism beginning with internal review and regulatory complaint, followed where necessary by mediation, arbitration, consumer dispute settlement, or litigation, provides a more proportionate pathway than immediate court action.

CONCLUSION

The rejection of health insurance claims in health service practices in Indonesia is generally influenced by incompleteness of medical documents, differences in interpretation of medical necessity, provisions of pre-existing conditions, policy waiting periods, and exclusion

clauses in insurance policies. This condition shows that claim disputes are not only related to administrative aspects, but also related to differences in understanding of legal provisions and the implementation of claim verification between insurance companies, hospitals, and insurance participants. Normatively, legal protection for health insurance participants has been regulated in the Civil Code, Law Number 8 of 1999 concerning Consumer Protection, Law Number 40 of 2014 concerning Insurance, and regulations of the Financial Services Authority. However, the implementation of legal protection in practice still does not fully provide legal certainty and optimal protection for health insurance participants.

This study found that the transparency of policy information, the completeness of medical documentation, and the standardization of medical necessity assessments are important factors in minimizing the occurrence of health insurance claim disputes. Therefore, it is necessary to strengthen coordination between insurance companies, hospitals, and regulators in developing a more transparent, objective, and accountable claim verification mechanism. In addition, the Financial Services Authority and the government need to develop national guidelines on medical necessity and dispute resolution in order to create legal certainty and balanced protection for all parties in the health service system in Indonesia.

LIMITATION

This study is based on normative legal analysis and secondary materials and therefore does not measure the frequency of specific denial reasons in individual insurance companies or hospitals. Future research may combine legal analysis with claim-file audits, interviews with insurers and hospital claim units, and policyholder surveys to assess how disclosure practices and medical-necessity standards operate in practice.

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