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Administrative System and Procedures for Non-Capitation Fund Claims at The Social Security Administration Agency (BPJS) Health Branch Serang

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Abstract: This study aims to identify the procedures or administrative requirements for non-capitation claims at the BPJS Health Branch Serang. The research method used to address the research question is descriptive method. The data sources used are primary data and secondary data. The primary data collected for this final project report is the result of interviews with the employees. The secondary data is obtained by utilizing processed data owned by my internship site, which is the Social Health Insurance Provider Agency (BPJS) Health Main Branch Serang. The research findings show that the administration of non-capitation claims at the BPJS Health Main Branch Serang is well-structured and organized.

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Introduction

The Republic of Indonesia Law Number 24 of 2011 stipulates that PT ASKES transformed into the Social Security Administration Agency (BPJS) for Health as the official health insurance provider starting from January 1, 2014. The BPJS for Health implemented a self-payment system for participants categorized as Workers without Wages (PBPU) where the payment system is billed individually. However, this system has been found to have low compliance rates, especially among independent participants, reaching over 50 percent of the total 19 million participants in 2015 (Razak & Situmorang, 2019). The BPJS for Health has implemented a new system, which is one virtual account, to improve the compliance rate of the community to actively participate as members of the BPJS for Health and emphasizes the mutual aid system among participants of the Social Security Administration Agency (BPJS) for Health (Yanti & Tulis, 2022). In the current system, independent participants are required to collectively pay the premiums that cover all the names in one Family Card (KK) that are registered. This means that every month, independent participants must pay the total bill for all family members cumulatively. It is mandatory for all family members to follow and pay the health insurance premiums so that other family members can be declared as active participants of the Social Security Administration Agency (BPJS) for Health. If a national health insurance participant does not pay the premiums for more than 1 month, then the health insurance card, known as the Healthy Indonesia Card (JKN-KIS), cannot be used for medical treatment, and the card will be considered inactive. Once a participant is enrolled, they cannot withdraw from the system. Furthermore, the premiums that have been paid cannot be refunded, according to Presidential Regulation (PERPRES) No. 19/2016, article 17A.1. If the payment is delayed for more than 1 month from the due date, which is the 10th of each month, the participant's status as a beneficiary of the Social Security Administration Agency (BPJS) will be temporarily suspended. Within 45 days after the status is reactivated, the participant is required to pay a penalty to the Social Security Administration Agency (BPJS) for each inpatient service. The amount of the penalty is 2.5% of the total healthcare service cost for each month of delay. This provision applies if the participant delays payment for up to 12 months, with a maximum penalty of IDR 30,000,000. However, there are still many participants who intentionally do not pay the premiums when they are healthy and only pay when they are sick and require medical treatment. However, the system in BPJS is based on mutual aid, which means that the healthy help the sick, and the sick are assisted by the healthy.

The convenience for participants of the National Health Insurance Program (JKN) currently is that they do not need to record and provide all family member's identification numbers when registering and paying the premiums for BPJS (Romansyah et al., 2017). In addition, participants can save on transaction fees when paying premiums at PPOB outlets that have implemented the BPJS health insurance payment system, as the administration fee is only charged once for the entire family's transactions. However, if there is an outstanding premium in one virtual account, it will affect the membership status of other family members

in BPJS (Maisharoh et al., 2018). So, if one or several family members have outstanding premiums, the other members must pay the entire outstanding amount in order to reactivate the health insurance cards for all members under one family card (Kartu Keluarga/KK).

The Social Security Agency (BPJS) provides an understanding of the National Health Insurance Program (JKN) to all relevant stakeholders to ensure its implementation runs smoothly, effectively, efficiently, transparently, and accountably, and thus it is necessary to establish the Minister of Health Regulation (PERMENKES) on the Guidelines for Implementing the National Health Insurance Program (JKN) (Alamsyah, 2021). This program is part of the national social security system (SJSN). Based on Law No. 40 on the national social security system, social security is mandatory for all citizens. Participants of the National Health Insurance Program (JKN) include the entire population of Indonesia, including foreigners who have worked in Indonesia for at least 6 (six) months and have paid the premiums. There are two types of membership, namely recipients of health insurance assistance (PBI) and non-recipients of health insurance assistance (Non-PBI). The National Health Insurance Program (JKN) is implemented through the Healthy Indonesia Card (Kartu Indonesia Sehat/KIS) with different tariff rates depending on the class chosen by the participants. The National Health Insurance Program (JKN) is administered by the Social Security Agency (BPJS)..

The claim rates in the Social Security Administration (BPJS) include non-capitation rates, which are the payment amount for claims made by BPJS Kesehatan to Primary Health Facilities based on the type and amount of health services provided (Suryani et al., 2016). The types of services that can be claimed as Non-capitation Claims include First-level Inpatient Care (specifically for primary clinics and community health centers with inpatient care), normal childbirth, pre-referral childbirth, emergency basic childbirth procedures, postpartum care (specifically for PONED health centers), Antenatal care (ANC), Perinatal care (PNC), 3-month injectable contraception, IUD, implants, and medical evacuation/ground ambulance (if the facility has its own ambulance). Based on the description in the previous background, the author formulates the problem of how the administrative procedures or requirements for non-capitation claims in BPJS Kesehatan are?

Research Method

This study employs a descriptive method by describing the administration system and procedures of non-capitation claim funds in the Social Security Administration (BPJS) Kesehatan at the main branch office in Serang City. The data sources used are primary data and secondary data. The primary data collected in this final report writing is the result of interviews with employees. The secondary data are data obtained by using processed data owned by my internship place, namely the Social Security Administration (BPJS) Kesehatan at the main branch office in Serang.

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Result and Discussion

BPJS Kesehatan, along with BPJS Ketenagakerjaan (formerly known as Jamsostek), is a government program under the National Health Insurance (JKN) system, which was officially inaugurated on December 31, 2013. BPJS Kesehatan started its operations on January 1, 2014, while BPJS Ketenagakerjaan started its operations on July 1, 2015. BPJS Kesehatan also carries out governing functions in the field of public services, which were previously partially carried out by state-owned enterprises and partially by government institutions. The combination of these business and government functions is reflected in the current status of BPJS Kesehatan as a public legal entity that carries out public services in the field of national social security administration.

BPJS Kesehatan was also established with initial capital funded by the state budget, and subsequently has its own wealth, which includes assets of BPJS Kesehatan and social security funds from sources as determined by law. The authority of BPJS Kesehatan covers the entire territory of the Republic of Indonesia and it can represent Indonesia on behalf of the state in relations with international bodies. This authority is a unique characteristic that distinguishes it from other legal entities or state institutions. Therefore, BPJS Kesehatan is one form of State-Owned Legal Entity (Badan Hukum Milik Negara/BHMN), and its tasks are accountable to the President as the head of state. BPJS Kesehatan was previously known as Askes (Health Insurance), which was managed by PT Askes Indonesia (Persero), but according to Law No. 24 of 2011 on BPJS, PT Askes Indonesia transformed into BPJS Kesehatan on January 1, 2014.

The process of non-capitation claim administration at the Main Branch Office of the Social Security Administering Body (BPJS) for Health in Serang involves a series of activities including gathering, recording, processing, duplicating, sending, and storing information about the amount of claim payment by BPJS for Health to Primary Health Care Facilities (FKTP) based on the type and quantity of health services provided. The purpose of this process is to determine the flow and requirements of a non-capitation claim in order to disburse the payment. The Primary Health Care Facility (FasKes) needs to obtain approval for disbursement, and if the requirements are met, a collective claim assessment will be issued for approval by the Branch Manager and can be disbursed in the finance department.

Furthermore, the procedure for non-capitation claim payment at BPJS for Health involves the payment of non-capitation funds by BPJS for Health to the Health Care Facility based on the type and quantity of health services provided. Prior to this, the Health Care Facility collaborates with the Social Security Administering Body (BPJS) for Health. After the Health Care Facility completes the administration process of submitting a complete and accurate claim, the next step is for BPJS for Health to verify the completeness of the documents (whether accepted or not). If accepted or meets the requirements and terms of BPJS for Health, the Health Care Facility is required to complete the documents/confirmation. Then, the verifier will calculate the non-capitation claim amount. Each claim has a different tariff. After the calculation by the verifier at BPJS for Health and adjustment, the final step is for BPJS for Health (Finance Unit) to disburse the claim funds.

Conclusion

The Non-Capitation Claim Administration System at BPJS for Health demonstrates that the administration of non-capitation claims at the Social Security Administering Body (BPJS) for Health Main Branch Office in Serang is well-structured and organized. The administration of non-capitation claims starts with the Health Care Facility (FasKes) submitting complete and accurate claim documents, which are then received by BPJS for Health for verification by the BPJS for Health verifier regarding the completeness of the claim documents and whether they meet the requirements for disbursement. Subsequently, the non-capitation claim amount is calculated.

References

_____, 2011. Undang-Undang Nomor 24 Tahun 2011 Tentang Badan Penyelenggaran Jaminan Sosial.

_____, 2014. Peraturan Badan Penyelenggara Jaminan Sosial Kesehatan Nomor 1 Tahun 2014 Tentang Penyelenggaraan Jaminan Kesehatan.

Alamsyah, K., Prastiwi, E. N., & Salamah, U. (2021). Implementasi Kebijakan Penyelenggaraan Program Jaminan Kesehatan Daerah Kota Bekasi. *Kebijakan: Jurnal Ilmu Administrasi*, *12*(2), 107-121.

Maysharoh, N. A., & Agustina, I. F. (2018). Efektifitas Pembayaran Iuran BPJS Kesehatan Dengan Sistem 1 Virtual Account (VA) Keluarga. *JKMP (Jurnal Kebijakan dan Manajemen Publik)*, *6*(1), 85-94.

Razak, A., & Situmorang, C. H. (2019). *Sketsa Politik Jaminan Kesehatan Nasional*. Deepublish.

Romansyah, U. A., Labib, A., & Isnawati, M. (2017). Pemenuhan Hak Konstitusional Warga Negara Indonesia: Studi Kasus Jaminan Kesehatan Nasional. *Justitia Jurnal Hukum*, *1*(1).

Suryani, A. I., & Suharyanto, A. (2016). Implementasi Program Badan Penyelenggara Jaminan Kesehatan (BPJS) Dalam Meningkatkan Pelayanan Administrasi Kesehatan di Rumah Sakit Umum Sibuhuan. *Publikauma: Jurnal Administrasi Publik Universitas Medan Area*, *4*(1), 86-99.

Yanti, H., & Tulis, R. S. (2022). Strategi Badan Penyelenggara Jaminan Sosial (BPJS) Kesehatan Cabang Kota Palangkaraya Dalam Menangani Peserta Yang Menunggak Premi Atau Iuran (Studi Pada Kantor BPJS Kesehatan Kota Palangka Raya). *Jurnal Administrasi Publik (JAP)*, *8*(1), 38-44.