

**Research article**

# The Public Policy Dynamics of Increasing Health Insurance Rates in a Developing Country

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**Abstract.**

Health insurance plays an important role in the COVID-19 pandemic. As a part of public policy, examining increasing health insurance contributions in developing countries is important to understand the dynamics, formulation processes, pros and cons, and implications for public participation. This study considered the increasing contributions of Indonesia Health Insurance (BPJS) and the findings indicated that the government faces a dilemma. On one side, the income of citizens is relatively diminished due to the restrictions on mobility as a result of the pandemic. On the other side, during the pandemic, health services need to perform well. Considering that health insurance is part of a national social security system, which is a common feature in developing countries, public health costs should be the responsibility of the State. Therefore, the increase in the BPJS Kesehatan rate needs to consider the ability of the citizen, and also ensure a positive impact on improving health services for the citizen.

**Keywords:** public policy dynamics, public participation, positive impact

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## 1. Introduction

Almost all countries face the dynamic of public policy, because it involves bargaining to formulate, implement, and evaluate public policy. This is also a cycle and process of rolling out a public policy that includes the dynamics of formulation, implementation, and evaluation to policy advocacy. The public policy cycle follows several stages, starting from agenda setting, followed by policy formulation, policy adoption stage, policy implementation, and ends with policy evaluation (Wijaya, Hayat, & Sujarwanto, 2020; Kumorotomo, 2019).

The dynamics of public policy also as reference the ruling political elites often, which could significantly positive and negative. This means that the role of the elite in public policy can have a positive meaning, if the public policies produced by this elite group, while in power can win new ideas or ideas that will bring improvements in the conditions of society and the state. But on other hand, it will have a negative meaning when in a political system, if the public policy that is decided is a reflection of the tastes and desires of the ruling elite only (Fauzi AN, Rostyaningsih D, 2018). In their explanation,


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Fauzi and Dewi argue that this is closely related to the elite's desire and need to maintain the status quo, thus choosing a conservative policy.

The Indonesian government has repeatedly increased BPJS Kesehatan contribution rates. The peak was when BPJS Kesehatan contribution increased in the midst of the Covid-19 pandemic, while at that time many people whose incomes were drastically reduced and/or they got fired impact of the Covid-19 pandemic. The decrease in people activity in the crowd has made many companies got a decrease in revenue to the point that they are no longer able to operate. Then, is the increase in BPJS Kesehatan contribution in the midst of the Covid-19 pandemic was the right policy?

As a public policy, the increase in contribution on Health Insurance are things that need to be studied dynamics in depth, particularly in the midst of the Covid-19 pandemic which has not given a signal that it will end. The policy of increasing contributions, which also occurs in developing countries such as Malaysia, Thailand, etc., deserves to be elaborated on its dynamics because it is directly related to the expectations and needs of the citizen. The hope of the citizen is, of course, that the higher contributions paid will have an impact on better health services with all their carrying capacity.

The purpose of this study is to discuss the dynamics of increasing BPJS Kesehatan rates, especially in the midst of the Covid-19 pandemic. Result of this research wants to contribute for the government's evaluation of the policy of increasing BPJS Kesehatan rates in the midst of the Covid-19 pandemic which still unfinished happen.

## 2. Literature Review

### 2.1. The Dynamic of Public Policy

According to Anggara (2014), understanding the dynamics of public policy means that we have to recognize what the change. Focus of this is on policy formulation and policy implementation process. The dynamic of public policy has open and close system. Close system is a responsive system about the change that start from inside of that system. Open system is a system that not responsive only from inside, but from their environment too. Implementation of the system creates feedback that changes the structure of the system.

## 2.2. BPJS Kesehatan

Originally, the health insurance in Indonesia during 1968-2005 is just only for Veteran, State Civil Administration (PNS), Retired State Civil Administration, Public Company Employee, and their family. The organizer to manage the health insurance was change time by time. At first, when 1968, Badan Penyelenggara Dana Pemeliharaan Kesehatan (BPDPK) manage the health insurance for Veteran, State Civil Administration (PNS), Retired State Civil Administration. Changed to Perum Husada Bakti (PHB) that handle the health insurance for State Company Employee too. In 1992, changed to PT Askes that usually called Askeskin to handle the health insurance to running the health insurance program for the poor. BPJS Kesehatan start running since 2014 to handle all citizen in Indonesia (BPJS Kesehatan, 2020). Since January 2014, the National Health Insurance (JKN) has been held with the aim of guaranteeing citizens to receive health care benefits and protection in meeting their basic health needs. The implementation of JKN is one part of the national social security system mandated by Law (UU) Number 40 of 2004 concerning the National Social Security System. JKN is organized by the Health Social Security Administrative (BPJS), which is a transformation of PT Askes (Persero). All citizens including foreigners who have worked for at least six months in Indonesia are required to participate in this health insurance Program (Bappenas, 2014).

The main stakeholder of JKN is BPJS Kesehatan, which has the task of (1) accepting registrations for JKN participants; (2) collect JKN contribution rates from Participants, Employers, and the Government; (3) managing JKN funds; (4) finance health services and pay for JKN benefits; (5) collect and manage JKN Participant funds; and (6) provide information regarding the implementation of JKN. This is based on Law (UU) No. 24 of 2011 Article 11. Therefore, BPJS has the authority to (1) collect payment of contribution rates; (2) placing social security funds for short-term and long-term investments by considering aspects of liquidity, solvency, prudence, security of funds, and adequate returns (JKN, 2021); (3) supervise and check the compliance of Participants and Employers in fulfilling obligations; (4) make an agreement with health facilities regarding the amount of payment for health facilities that refers to the standard contribution set by the Government (JKN, 2021).

## 3. Research Methods

This paper is the result of research using an empirical approach. Empirical research is research aiming to provide an explanation of a series of phenomena which occur on the

basis of observations. In this case, the researcher makes indirect observations using secondary data from both previous studies and official state public policy documents.

The collected and verified data is analyzed through a qualitative approach. With a qualitative approach, an in-depth understanding of the phenomena of concern will be obtained, through the interpretation of the data collected. Furthermore, the author uses a data triangulation mechanism to measure the validity of the information collected through the literature study.

The systematic discussion begins with a brief explanation of BPJS Kesehatan as a health insurance in developing country. This research focused on the reason background of the increase contribution rate policy including the pros and cons of the policy are. In addition, it will also describe the objectives to be achieved with the increase in contributions. Then, this paper describes in detail the process of evaluating the increase in contributions for public health services. At the end of the article, describes the lessons that can be learned by developing countries from the experience of increasing BPJS Kesehatan contributions.

## 4. CONCEPT AND DISCUSSION

### 4.1. Social Security, Health Insurance and Contribution Increase Concepts and Policies

According to the World Bank, there are three important policy of the core in social protection, namely: (i) Social Security (old age pension, disability, unemployment, labor, health, and informal savings accumulation, and others); (ii) Social Assistance (Direct Cash Assistance, in-kind assistance, cost relief and tax incentives, as well as subsidies); and (iii) Workers (active labor market Programs and regulations). Thus, social security is a form of social protection to ensure that all people can meet their basic needs for a decent life (Bakarudin FN, Wibawa F, Nggao F, et. al, 2020).

More technically, the World Health Organization states that many families have difficulty getting health services because they do not have enough health funds. Especially when one of their families experiences a catastrophic illness where this will drain their family finances a lot (WHO, 2017). Universal Health Coverage created by WHO aims to make everyone get access to the health services they need wherever they are without financial difficulties (WHO, n.d.).

In the context of developing countries face challenges in building strong and reliable health systems. The challenges faced include inadequate financing of health services, lack of coordination between institutions, and a lack of health workers (Putri RN, 2019).

Other developing countries had a different experience. In Thailand, for example, the government opens vacancies for health workers to serve in rural areas. In addition, the government also provides local residents with the opportunity to become doctors where after completing their education, they will be placed in their hometown as medical personnel and will be given adequate allowances and incentives. Therefore, people in rural areas have medical personnel who come from their own regions. In the context of Indonesia, if there is no continuous improvement in access to health services, the principle of *gotong-royong* that is expected to be eroded and jeopardizes the sustainability of JKN. Furthermore, rural communities who have difficulty accessing health services will prefer to stop paying contribution rates because it is difficult to get benefits from the contribution rates they pay every month.

The policy of increasing contributions was also carried out by the Malaysian Government. The reasons for this are raising costs, issues of long-term sustainability, increased tax rate, efficiency, and people's expectations that service quality can be improved. Therefore, Malaysia has changed its health system from health services that were previously dominated by the government, to now involve the private sector more (Chongsuivatwong V, Phua KH, Yap MT, et. al, 2011). The health financing system in Malaysia consists of public health and private health. Sources of funds for public health come from public taxes to the federal government, state revenue budgets, as well as SESCO and EPF agencies, where the existing funds are channeled for preventive and promote health programs. The Malaysian government stipulates Universal Coverage for curative and rehabilitative health programs, in which all people are guaranteed health services by paying a rate of 1 RM to get health services from general practitioners, while for services from specialist doctors it is 5 RM. However, this health financing system is not included in the category of serious diseases that require high medical costs. The Malaysian government exempts taxes on medical devices and medicines. This has an impact on lower operating costs. Doctors also have to choose a place of practice whether to practice in private or government-owned health services. The existence of high income from doctors will affect the quality of service. To claim health financing, government hospitals see the amount of expenditure that occurred in the previous year and then the hospital is only able to submit a budget to the Ministry of Health/Ministry of Health (Putri RN, 2019).

## 4.2. Lessons from Indonesia

Social Security in the health sector for the citizen in Indonesia is realized through the National Health Insurance (JKN). The fundamental of JKN is *gotong royong*, where healthy people help sick people by regularly paying monthly contribution rates.

All citizens in Indonesia are protected by the JKN program through Universal Health Coverage (UHC). There are four character by Universal Health Coverage (UHC), namely Universal, Supply Side, Demand Side that Affordable and Sustainable. Universal where everyone is protected; Supply Side where health facilities must be adequate with the best, quality, and timely services; Demand Side or people ratel the Program which runs quite affordable, UHC does not mean that everyone was covered and free, but everyone gives participates according to his ability, so do not let the rate of monthly contribution rate above the ability of the citizen; and the last is sustainable, namely the program that is implemented must be sustainable (BPJS Kesehatan, n.d.).

The case in many developing countries, Indonesia is also facing the problem of the BPJS budget deficit, namely the cost of claims is much higher than the contribution rates earned. Research conducted by INITIATIVE (Aida CN, Chrisnahutama A, 2020) in 2019 stated that the problems that resulted in the JKN deficit include: (1) the burden of a bloated health services, exceeding the revenue sources; (2) the contribution rate is still low, far below the claim against the guarantee provided. In 2018, the average participant contribution rate was IDR 394,009 per year, while health insurance claims were IDR 453,232 per year or a gap of IDR 59,223 per participant per year; (3) lack of transparency on the financial management of BPJS Kesehatan; (4) the coverage of participation is not yet maximal, both from the PBI category, Non-Wage Recipient Participants (PBPU), and Wage Recipient Participants (PPU), as well as the lack of participant compliance in paying contribution rates, especially in the PBPU category; (5) the burden of health funding for catastrophic diseases continues to increase; (6) FKTP as a firstliner has not functioned optimally, which is still focused on curative services, not promotive and preventive services; and (7) inefficiency of tiered referrals in Advanced Class Referral Health Facilities (FKRTL), where generally type B hospitals will accept patients who cannot be treated by the type of hospital below with a fairly serious condition, meaning that the costs incurred by the hospital become inefficient. Results of research conducted by Firdaus and Wondabio (2019) also states that the deficit JKN because revenue is always lower when compared with claims expenses in each year.

### 4.3. Policy Formulation Process

The National Health Insurance (JKN) is a guarantee in the form of health protection so that participants receive health care benefits & protection in meeting basic health needs that are given to everyone who has paid dues/contribution rates paid by the government. From a historical perspective, the presence of JKN is the embodiment of the Declaration of Human Rights (HAM) or Universal Independent of Human Rights by the United Nations (UN) which was rolled out on December 10, 1948. In particular, Article 25 paragraph 1 of the declaration states that, "Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including the right to food, clothing, housing and medical care and necessary social services, and is entitled to security for when unemployed, sick, disabled, widowed, reaching old age or other circumstances that result in a lack of livelihood, which is beyond his control". Then in 2005 in Geneva the WHA Resolution was initiated by the World Health Organization (WHO) in which every country needs to develop United Health Coverage (UHC) through a social health insurance mechanism to ensure sustainable health financing (Kementerian Kesehatan, 2013).

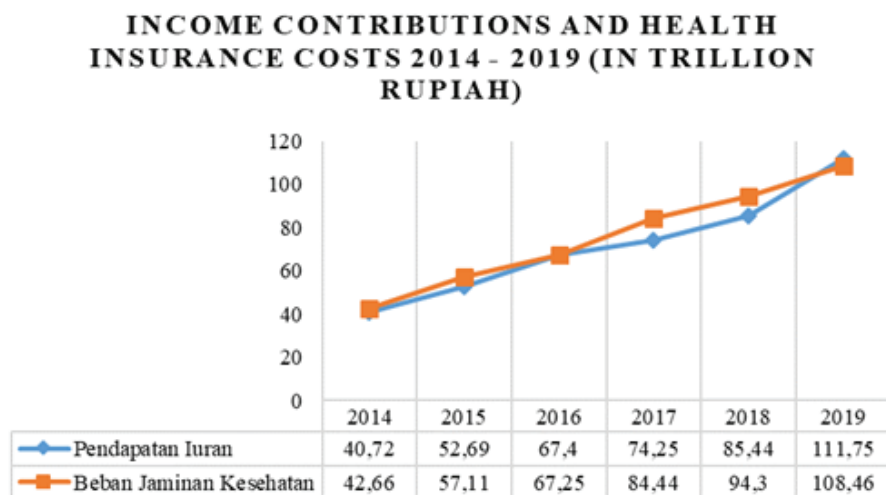
From a constitutional perspective, as stated in the 1945 UUD Article 28 H paragraphs (1), (2), and (3) states, (1) Everyone has the right to live in physical and spiritual prosperity, to have a place to live, and to have a good and healthy environment. and have the right to obtain health services; (2) Everyone is entitled to special facilities and treatment to obtain the same opportunities and benefits in order to achieve equality and justice; (3) Everyone has the right to social security that allows his/her full development as a useful human being. Furthermore, in paragraph 34 paragraphs (1), (2), and (3) of the UUD 1945 it is stated that, (1) the poor and neglected children are cared for by the state; (2) The state develops a social security system for all the people and empowers the weak and underprivileged in accordance with human dignity; (3) The state is responsible for the provision of proper health care facilities and public service facilities (Kementerian Kesehatan, 2013).

The principles that are firmly held and applied in the JKN-BPJS Program are (1) the principle of *gotong royong*, where the mechanism of mutual cooperation is applied from capable participants to underprivileged participants in the form of compulsory participation for all people. In simple terms, healthy participants help sick participants, thereby fostering the value of social justice for all Indonesian people; (2) the Non-Profit Principle, where the funds collected are not intended to seek profit for the organization, but to fulfill the participants need as much as possible; (3) Principles of Transparency,

Prudence, Accountability, Efficiency, and Effectiveness, which are applied and underlie all fund management activities originating from participant contribution rates and the results of their development; (4) The principle of portability, which is intended to provide sustainable guarantees even if the participant changes jobs or resides within the territory of the Negara Kesatuan Republik Indonesia; (5) Principle of Mandatory Membership, which meant that all the people involved, so that everyone can be protected; (6) The principle of the Trust Fund, where the funds collected from participant contribution rates are entrusted to the organization to be managed as well as possible in order to optimize the funds for the welfare of the participants; and (7) Principle of Social Security Fund Management Results, which are used entirely for program development and for the greatest benefit of participants (Kementerian Kesehatan, 2013).

#### 4.4. Increasing of Contribution Rate in Midst of Covid-19 Pandemic

Since its launch, the BPJS Kesehatan Program got a deficit in the first two years. In 2016, for the first time BPJS was not a deficit. This happened again in 2019. So that in its journey since 2014-2019, only two times BPJS did not a deficit.



**Figure 1:** Income Contribution rate and Health Insurance Cost 2014 - 2019. (Source: (BPJS, 2020), processed)

This has an impact on the amount of contribution rates gradually increasing (See, Graph 3.5.1). A result of the BPJS cash showing a deficit, where the cost of claiming health services is higher than the contribution rates paid by participants. Other indications are the contribution rate of JKN contribution rates below the actuarial calculation value, the low discipline of participants to pay contribution rates, the high burden of



chronic medical expenses, the not yet optimal function of First Class Health Facilities (FTKP) in promote and preventive efforts (Aida CN, Chrisnahutama A, 2020).

Following is the change in the BPJS Kesehatan contribution rate for PBPU from time to time.

TABLE 1: Changes in Rate for JKN PBPU Participants from Periode to Periode

Regulation		Classes (in Rupiah)		
		Class 1	Class 2	Class 3
2014	Presidential Regulation No. 111/2013 Article 16F	59,500	42,400	25,500
2016	Presidential Regulation No. 28/2016 Article 16F	80,000	51,000	25,500
2020	Presidential Regulation No. 75/2019	160,000	110,000	42,000

Source: Presidential Regulation 111/2013, Presidential Regulation 28/2016, and Presidential Regulation 75/2019.

The government has raised BPJS contribution rates three times (See, Table 3.4.1). The first time through Presidential Regulation No. 111/2013 issued on 27 December 2013. The PBI rate is set at Rp 19,225. The contribution rate of the State Civil Administration participants is set at 5 percent of the basic salary and family allowances with the distribution of 3 percent being borne by the government and 2 percent borne by the workers. For State Civil Administration who are not civil servants, the contribution rate is calculated from fixed income. Meanwhile, non-State Civil Administration participants' contribution rates are divided into two periods. The payout from January 1, 2014 until June 30, 2015 is 4.5 percent of salary or wages per month provided that 4 percent is borne by the employer and 0.5 percent is paid by the participant. Furthermore, since 1 July 2015 the contribution rate is paid to 5 percent of salary or wages per month provided that 4 percent is borne by the government and 1 percent is paid by the participants. Presidential Regulation No. 111/2013 does not stipulate the lower limit, but the upper limit, which is twice the non-taxable income (PTKP) with married status with 1 child, which is used to determine the division of care classes for Non-State Civil Administration and State Civil Administration participants who are not civil servants. Class I includes participants with a salary up to 1.5-2 times the taxable income and class II for participants with a salary or wages below 1.5 PTKP (Bakarudin FN, Wibawa F, Nggao F, et. al, 2020).

The PBPU and BP rate are set for class I of Rp 59,500 and class 2 of Rp 42,500. Meanwhile, the contribution rate for pension recipients is set at 5 percent of the amount

of the basic pension and family allowances received per month with a distribution of 3 percent borne by the government and 2 percent by pension recipients. Contribution rates for veterans, independence pioneers, and widows, widowers, or orphans of veterans or independence pioneers, are set at 5 percent of 45 percent of the basic salary of civil servants class III/a with a working period of 14 years per month, paid by the government.

The government then changed the provisions regarding JKN-KIS contribution rates in Presidential Regulation Number 19 of 2016 concerning the Second Amendment to Presidential Regulation No. 12/2013 concerning Health Insurance which was stipulated on February 29, 2016 and came into force on April 1, 2016. PPU and the amount of dues for PBI, PBPU, and BP. In the Presidential Regulation, it was discussed that the PTKP no longer used, but a nominal value of Rp. 8 million. The adjustment to the upper limit will also affect the treatment class for PPU and State Civil Administration for non-PNS. The treatment class limit is set at IDR 4 million. Participants with a monthly salary or wages of up to Rp 4 million enter class II and participants whose salary or wages exceed Rp 4 million enter class I. PBPU and BP contribution rates, apart from pension recipients and participants of veterans and independence pioneers, have increased in all classes. Class I participants increased to Rp 80,000, class II to Rp 51,000 and class III to Rp 30,000. while the PBI participant rate borne by the government are either from Rp 19,225 to Rp 23,000. In contrast to other participant segments, which took effect on April 1, 2016, the increase in PBI participant rate was actually implemented earlier, namely on January 1, 2016 (Bakarudin FN, Wibawa F, Nggao F, et. al, 2020).

The contribution increase policy turned out to be a challenge (contra) by other stakeholders, are the citizen and the DPR. In several working meetings with the Ministry of Health, DJSN, Ministry of Finance, and BPJS Kesehatan in early 2016, Commission IX of the DPR requested that the increase in PBPU and BP contribution rates be postponed. In particular, the legislators asked that the PBPU and BP class III rate not be increased. The government then canceled the increase in rate by issuing Presidential Regulation Number 28 of 2018 concerning the Third Amendment to Presidential Regulation No. 12/2013 Regarding Health Insurance on March 31, 2016. In the new Presidential Regulation, the government revised the increase in class III PBPU and BP contribution rates from Rp 30,000 to 25,500. Thus, the amount of PBPU and BP contribution rates is the same as before, while its validity still refers to the previous Presidential Regulation, April 1, 2016.

A year later, the government adjusted the rate through Presidential Regulation No. 75 of 2019 concerning Amendments to Presidential Regulation No. 82/2018 concerning

Health Insurance. there are some changes in the Presidential Regulation. First, the participants' contribution rates, PBI category rose from Rp 23,000 per person per month to Rp 42,000, up 82.61 percent. Second, class I PBPU and BP participants' rate increased 100 percent from Rp 80,000 to Rp 160,000, class II increased 115.69 percent from Rp 51,000 to Rp 110,000, class III was good 64.71 percent from Rp 25,500 to Rp 42,000. Third, for Non-Governmental PPU, there is only a change in the upper limit for calculating the PPU participant's contribution rate from Rp 8 million to Rp 12 million. Thus, the increase in contribution rates only applies to workers who receive a salary or wage per month above Rp 12 million. Contribution rates for workers who receive a monthly salary or wages of up to Rp 12 million have not changed.

Fourth, participants in the State Civil Administration category run into three changes: the scope of salary/wages, the salary/wages upper limit, and the composition of dependents used for the calculation of contribution rates. The amount of salary/wages changes from basic salary and position allowances or general allowances, professional allowances, performance allowances or additional income for regional civil servants. Except for village heads, village officials, and government employees who are not civil servants which are calculated based on fixed income. Meanwhile, the upper limit of salary/wages increased from IDR 8 million to IDR 12 million. The composition of the percentage of dependents paid by the government increase from 3 percent to 4 percent. The percentage of contribution rates borne by workers decreased from 3 percent to 4 percent. The percentage of contribution rates borne by workers decreased from 2 percent to 1 percent. Thus, the burden of paying government contribution rates increases.

In addition, there are differences in the application of new contribution rates based on the group of participants. The increase in dues for the PBI segment took effect on August 1, 2019, while for the State Civil Administration borne by the central government it took effect on October 1, 2019. The increase in rate borne by the central government took effect earlier compared to others, although Presidential Regulation No. 75/2019 was only set on October 24, 2019.

Since the first time the contribution rate was increased in 2016, for the first time BPJS claims have not exceeded the contribution rate income. However, this did not last long. In the following year, from 2017-2019, BPJS again experienced a budget deficit. This can be an illustration that the increase in BPJS contribution rates does not in fact last long to make BPJS cash not in deficit.

Rejection or contra from the citizen side regarding the increase in contribution rates, especially in the PBPU and BP segments. Komunitas Pasien Cuci Darah Indonesia

(KPCDI), for example, filed a petition for judicial review against Article 34 Paragraph (1) and Paragraph (2) of Presidential Regulation No. 75/2019 to the Supreme Court (MA). The lawsuit was represented by Tony Richard Samosir as Chairman of the Supreme Court of the Republic of Indonesia No. 7 P/HUM/2020 which was decided in a deliberation meeting of the Supreme Court on February 27, 2020. In that decision, the Supreme Court annulled Article 34 Paragraph (1) and Paragraph (2) of Presidential Regulation No. 75/2019.

The government accepted the Supreme Court (Mahkamah Agung) decision and then translating new provisions through Presidential Regulation No. 64 Year 2020 on the second amendment to the Presidential Regulation No. 82 Year 2018 About Health Insurance that is set on 5 May 2020. It also refers to the Covid-19 pandemic againsts across countries in the world. Changes in rate are enforced in three times. The first phase for the January-March 2020 period, whose contribution rates still refer to Presidential Regulation No. 75/2019. This is because the Mahkamah Agung (Supreme Court) decision was made on 27 February 2020 and received by the Government at the end of March 2020 (Bakarudin, et al., 2020). The second phase starts from April to June 2020. The amount of the contribution rate is reduced and equated with what is stipulated in Presidential Regulation no. 82/2018. The third stage, the period after July 1, 2020, with class I participant rate being IDR 150,000 and class II being IDR 100,000. Meanwhile, class III participants are divided into two periods: July-December 2020 the fixed rate is IDR 25,500 and since January 2021 the rate has increased to IDR 35,000.

There are several new things regulated in Perpres No. 64/2020. First, the government subsidizes class III participant rate to ease the burden on people affected by the Covid-19 pandemic. In addition, subsidies are given in order to maintain the financial sustainability of BPJS Kesehatan. Contribution rates from class III participants received by BPJS Kesehatan are still calculated at Rp. 42,000, the difference is the responsibility of the government which is directly deposited to BPJS Kesehatan. In the July-December 2020 period, class III participants pay Rp. 25,500 per person per month, while the remaining Rp. 16,500 is paid by the central government. Since January 2021, with the increase in the premium for class 3 participants to IDR 35,000, the remaining IDR 7,000 is subsidized by the government: IDR 4,200 for the central government and IDR 2,800 for the local government. The subsidy is only given to participants who pay the dues. On the other hand, participants will not be subsidized if they do not pay the dues that are their share. This is one way to encourage class III participants to pay dues obediently.

Second, in 2020, BPJS Kesehatan provides relief in the payment of monthly dues in arrears when participants reactivate their membership. In accordance with the provisions, participants who are in arrears must pay the monthly dues in arrears for a maximum period of 24 months. Especially for 2020, participants only pay 6 months of dues in arrears to activate their membership. The remaining balance can be paid off no later than 2021. Another relief, participants who have just reactivated their membership can take advantage of health services within 45 days after being activated. In its provisions, such participants are required to pay a fine of 5 percent of the estimated cost of the Indonesia Case Based Groups (INA-CBGs) package based on the diagnosis. Specifically for 2020, the fine is only 2,5 percent (Bakarudin FN, Wibawa F, Nggao F, et. al, 2020).

#### **4.5. The Concept and Mechanism of Contribution Rates in JKN and Role of BPJS Kesehatan in Amidst Pandemic Covid-19**

Contribution rates rate are very important in a health insurance system. The amount of contribution rates must be sufficient to finance health services properly and must be sufficient to fund quality BPJS Kesehatan operational activities at a reasonable economic price. The calculation of JKN contribution rates is different from premiums for commercial insurance companies. In the world of insurance, the contribution rate amount is determined by the amount of benefits and the participant's disease risk class according to actuarial calculations. The greater the benefits received and the higher the participant's disease risk, the higher the contribution rate. Different things apply to JKN, namely the amount of JKN contribution rates is not linked to the benefits and risks of participant disease. The amount of the contribution rate is determined based on the ability of the participant. Therefore, workers' contribution rates are calculated based on a percentage of wages with the application of lower and upper limits. Meanwhile, PBPU and BP participants were given choices according to their abilities. In terms of the benefits of medical services, all participants are treated equally, not differentiated. Class differences are only for non-medical services, such as medical treatment room facilities (Bakarudin FN, Wibawa F, Nggao F, et. al, 2020).

The amount of payment from BPJS Kesehatan to health facilities is determined using the Ministry of Health Regulation Number 27 concerning Technical Guidelines for the Indonesian Case Base Groups System (INA-CBGs). BPJS Kesehatan develops a system of health services, quality control of services, and payments for health services to increase the efficiency and effectiveness of BPJS Kesehatan. The list and the highest

prices for medicines and medical consumables guaranteed by BPJS Kesehatan are also determined in accordance with the laws and regulations (Bappenas, 2014).

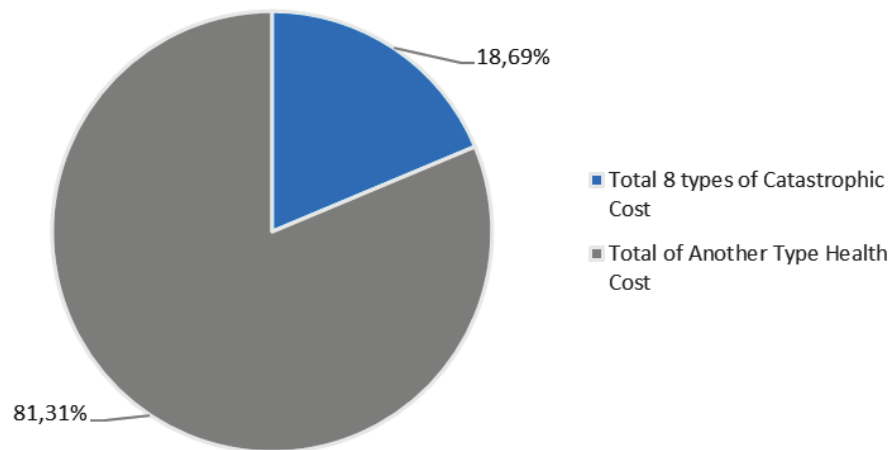
Since Covid-19 pandemic against Indonesia, BPJS Kesehatan has a role to verify who infected to Covid-19. For financing of patients being treated with certain emerging infectious diseases including Covid-19 infection can be claimed to the Ministry of Health (Kemenkes) through the Director General of Health Services. It means that BPJS Kesehatan doesn't cover the claim of Covid-19 patients. The claim of emerging infection of Covid-19 covered by Government based on the Minister of Health Regulations 59/2016. BPJS Kesehatan is considered accustomed to verify the Hospital, that's why the Minister of Finance appoints BPJS to verify Covid-19 patients. BPJS Kesehatan already gave the detail information to all hospital about how to claim to Health of Ministry and maintain the coordination Health Ministry to make sure the claim of Covid-19 patients will better day by day (BPJS Kesehatan).

#### 4.6. Pros and Cons of Increase in Contribution Rate

Minister of Finance Sri Mulyani explained that there were four factors causing the BPJS deficit, namely low contribution rates, participants who were not disciplined in paying contribution rates, low classes of activity in paying contribution rates, and financing for catastrophic diseases (cancer, heart, and kidney failure) very large. According to the Ministry of Finance, the Bureau of Communications and Information Services stated that to cover the BPJS budget deficit, the government increased the dues for each class where classes 1 and 2 rose 100 percent while for class 3 it rose 65 percent (Wijayanti L, Nur Z, Laraswati D, Pimada LM, 2020). Meanwhile, another factor that causes the BPJS budget deficit is due to the classification of the standard class of Contribution rate Assistance Recipients (PBI) with the Non-PBI standard class (Gloria, 2020).

There are several factors that cause BPJS to experience a deficit. First, the amount of JKN contribution rates is below the actuarial calculation. In the world of insurance, premiums are calculated on an actuarial basis by considering a number of risks that will occur. According to a study by the Indonesian Actuary Association (PAI), class I PBPU and BP rate should be IDR 274,204 per person per month, class II IDR 190,639, and class III IDR 131,195. The results of the calculation of the amount of the PBPU segment's contribution rate are very high, so it is estimated that the purchasing power of the people will not be able to afford it. The government set it lower, because it considers the ability of the citizen. Through Presidential Regulation No. 75/2019, the government sets PBPU and BP class I contribution rates at IDR 160,000 or only 58 percent of the

dues that should be, class II at IDR 110,000 or 58 percent of the dues that should be, and class III at IDR 42,000 or only 32 percent of the rate. dues that should be. Thus, from the outset DJSK was predicted to always be in deficit.



**Figure 2:** Percentage of Catastrophic Disease Cost 2019. (Source: (BPJS, 2020))

Second, high utilization rate. On the other hand, the high class of utilization shows that the JKN Program is very beneficial for the citizens. On the other hand, the utilization actually creates a high guarantee burden. The high utilization is also supported by the range of utilization values that can be said to be unlimited. As shown in Figure ??6.1, the share of the insurance burden for the eight types of catastrophic diseases has reached 18.69 percent. Catastrophic disease is a type of high-cost disease. The high utilization of catastrophic diseases also illustrate that the citizen has not implemented a healthy lifestyle. High utilization and indefinitely make up the gap between tuition and the cost per participant will be widened. Third, the class of collectability of the contribution rates of PBPU and PB participants is not yet maximized. JKN-KIS participants in the PBPU and BP categories are the segment with the highest claim ratio, but the lowest contribution rate collectability. In addition to paying dues compliance, compliance with being a JKN participant is also still a problem (Bakarudin FN, Wibawa F, Nggao F, et. al, 2020). In addition, BPJS Kesehatan claims have not been evenly distributed. BPJS claims are mostly used by urban people who have easier access to health services. This makes contribution rates from rural communities who have difficulty accessing health services used for urban communities (Gloria, 2020).

In the context of the BPJS budget deficit, the government has taken several steps to overcome it. *First*, the relief fund that the reached from several sources. The largest



amount of aid funds for DJSK came from the central government with a total of IDR 13.85 trillion, followed by funds from BPJS Kesehatan assets consisting of grants of IDR 9.57 trillion and contribution rates of IDR 1.07 trillion. In 2018, there are funds sourced from cigarette taxes amounting to Rp682,38 billion (BPJS Kesehatan, 2019). To support the provision of these aid funds, the government made regulatory adjustments related to health social security assets. In 2018, the government issued new provisions on the implementation of JKN through Presidential Regulation No. 82/ 2018 about Health Insurance. The Presidential Regulation replaces the previous Presidential Regulation which has been amended several times. One of the new things stipulated in the Presidential Regulation is the contribution rate of the cigarette tax which is part of the rights of the regions (provinces/districts/cities) to support the financial sustainability of the JKN Program. Article 99 paragraph 6 of Presidential Regulation No.82/2018 states that there is a form of government support for regions through contribution rates from the cigarette tax share of the rights of each province/district/city. Furthermore, in Article 100 it is stated that the amount of contribution rate from the cigarette tax is set at 75 percent of the 50 percent realization of cigarette tax revenue from the share of rights for each province/district/ city. The contribution rate is immediately deducted to be transferred to the BPJS Kesehatan account. This is an effort to increase the role of local governments in supporting the JKN-KIS Program.

*Second*, controlling costs, both through government policies and internal efforts by BPJS Kesehatan. The government issued a policy on cost sharing and cost differentials, as well as coordination of benefits through Presidential Regulation no. 82/2018. Cost-massage is an additional rate paid by JKN participants when receiving health service benefits that can lead to misuse of services, while the difference in costs is an additional rate paid by JKN participants when obtaining health care benefits that are higher than their entitlement (upgrading treatment). Benefit coordination is cooperation in the payment of health service benefits between providers of health service Programs in accordance with their respective authorities. The organizers in this case are BPJS Employment for the Work Accident Insurance (JKK) Program, PT Jasa Raharja for traffic accidents, PT Taspen (Persero) for the JKK Program for ASN, PT Asabri (Persero) for the JKK Program for members of the TNI/ Police, ASN within the Ministry of Defense and Police, as well as health insurance companies.

*Third*, optimizing the collection of dues. BPJS Kesehatan strengthens the synergy with the Deputy Jaksa Agung Bidang Perdata dan Tata Usaha Negara pada Kejaksaan Agung Republik Indonesia through the signing of a Memorandum of Understanding on Handling Legal Issues in the Civil and State Administrative Sector. This is done



as an effort to strengthen compliance enforcement, both payment of contribution rates and participation. In each region, BPJS Kesehatan provides a Special Power of Attorney (Surat Kuasa Khusus) to State Prosecutors throughout Indonesia. In addition, BPJS Kesehatan also made a breakthrough by developing various service channels to facilitate payment of contribution rates and forming JKN cadres. One of the functions of JKN cadres scattered in various regions in Indonesia is to "collect" the contribution rates of JKN-KIS participants.

*Fourth*, BPJS Kesehatan applies a Supply Chain Financing (SCF) scheme, which is a bill financing Program for BPJS Kesehatan partners in collaboration with financial institutions to assist in accelerating the receipt of payment for health care claims through invoice collection before payment is due. This scheme is also used for payments that are past due. Until the end of February 2020, the utilization of SCF reached Rp 19.5 trillion and as of the end of March 2020 there were 38 banks and financial institutions that had provided benefits for financing health care bills through SCF to health facilities.

The parties that contra to increasing contribution were the public. The majority of people reject the increase in BPJS Kesehatan contribution rates. Research conducted by Hasibuan et al (Hasibuan R, Purnama TB, Susanti N, 2020) stated that out of 97.3 percent of respondents, 78.1 percent of respondents reject the increase of BPJS contribution. This affects the decline in the utilization of Puskesmas by the citizens. In addition, family income that does not increase also makes people prefer to go down from class. According to the researchers, the increase in rate is considered less targeted. The government needs to identify participants who have greater ATP, as is the case with the tuition system at universities, family income can be a determinant of student payment class.

#### **4.7. Direct Impact of Increase in Contribution**

Undeniably, the increase in JKN contribution certainly has positive and negative impacts (Wijayanti L, Nur Z, Laraswati D, Pimada LM, 2020). The positive impact in improved services, overcoming the deficit, growth of the pharmaceutical sectors, improved infrastructure, improved socialization BPJS Program, and reaching wider borne diseases, and increasing the reach of the hospital. However, the negative impact is also not small. The most noticeable impact is that participants prefer to drop out of class. According to the findings of the Research Center of the Indonesian House of Representatives Expertise Board stated that as many as 800,000 participants chose to drop out of class and it is still possible to increase, stop paying contribution rates and switch to private insurance,

inflation due to increasing money supply, and increasing poverty due to rising costs of BPJS will reduce consumption other goods so that the data of the poor will increase (Retnaningsih H, 2020).

Therefore, the increasing contribution rate in the midst of Covid-19 pandemic should have consequences for better service to citizens particularly in the hospitals of BPJS Kesehatan partner. It is because people are aware that the policy to increase the contribution in the midst of a pandemic is not a good deal to citizens. To compensate for the awareness, the BPJS Kesehatan through hospital and medical service partners should ensure that they will give their best service to citizens.

## 5. Conclusion

The dynamics of public policy is basically a policy cycle that follows several stages, starting from the preparation of the agenda, followed by policy formulation, then the policy adoption stage, then policy implementation, and ends with policy evaluation. Meanwhile, public policy tools/instruments include laws and regulations, public services, aspects of public financing and taxes, and the last instrument is an appeal. Meanwhile stages of policy development and public implementation include the preparation of the agenda, policy formulation, adoption stage of policies and policy implementation, and evaluation of policies.

The dynamics policy of increasing health insurance rate in developing country also undergo and complex stages. Based on the concept of health insurance as part of universal social security, the formulation and adoption of a contribution increase policy aims to protect and improve public health services. Learning from the policy rate increase National Health Insurance-BPJS, show that the policy has the complexity of the formulation and actors are many and varied, and the direct impact to the high society, create a policy that is very important and strategic to be kept under review in order to more effectively provide benefits to the citizen.

In addition to its very dynamic formulation process, involving bureaucratic and political elite stakeholders, the policy has also generated various pro and con responses. However, from administrator side, ensure that BPJS contribution not harm society because it should be increased quality and after service of health services, such as the consumer care in every hospital service facilities in order to receive complaints directly BPJS participants. In addition, the administrative process is also shortened and simplified. In addition to internal improvements, the BPJS management also increases the awareness of the population to participate in paying contribution rates, by ensuring

that the facilities and benefits obtained will be better. The policy to increase the contribution rate in midst pandemic is not a good deal for almost citizen. So many citizen has a decrease income and/or they got fired from their job when pandemic.

The role of BPJS Kesehatan in the midst of pandemic is as a verifactor to the hospital and government. However, citizen put their hope that BPJS Kesehatan and hospital will give their better service to them, impact of the increase of contribution rate. The key to contribution dues positive impact on the citizen is how in governance manages the BPJS funds. Managing the BPJS should apply the principles of transparency, accountability and participation in the contribution increase policy in order to get a positive response from the public.

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