

# Health Regulations e-Alert

## Key updates on Indonesia's health insurance reform

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### Introduction

In May 2025, the Financial Services Authority (OJK) issued Circular Letter (SEOJK) No. 7/SEOJK.05/2025 on health insurance products, which was originally scheduled to take effect on 1 January 2026. However, on 30 June 2025, Commission XI of the Indonesian House of Representatives (DPR) and the OJK announced their agreement to postpone its implementation until further notice.

Following this development, on 22 December 2025, the OJK issued OJK Regulation (POJK) No. 36/2025 regulating the strengthening of the health insurance ecosystem, which is set to take effect three months from the issue date. In this POJK, some of the provisions of the previous SEOJK have been revised. Notably, insurers must sell health insurance products without co-payment features (while limits are applicable to products with co-payment features), and the waiting period for critical and chronic illness benefits has been shortened.

New provisions have also been introduced, including new restrictions imposed on repricing exercises and requirements to conduct public awareness programs on healthy lifestyles. Meanwhile, certain requirements, such as those for coordination of benefits (COB), digital integration, a Medical Advisory Board (DPM) and fraud detection systems, have remained the same.

The OJK has set an implementation period of one year from the POJK issue date. During this transition period, companies are expected to adjust their operational governance and products to comply with the new POJK.

The POJK covers health insurance products, which are defined as "insurance products providing cover for one or more types of risk related to the insured's health or a decline in the insured's health conditions." As the POJK is intended to ease the utilisation of healthcare facilities and services, products with cash benefits (e.g., hospital cash plans) are not within the scope of the POJK. Critical Illness (CI) products would be under the scope of the POJK if they provide inpatient/outpatient benefits, but not if they only provide lump-sum benefits.

Below is a summary of the POJK, with comparisons with the previous SEOJK where relevant:

### Co-payment

The previous SEOJK mandated that all health insurance products *must* implement a co-payment scheme; however, the new POJK stipulates that companies *may* implement co-

payment schemes but *must* provide health insurance product variants *without* co-payments.

If insurers *do* decide to implement co-payment schemes, the policyholder must bear 5% of each claim, which is lower than the 10% mandated in the previous SEOJK. Maximum limits for the policyholder's portion are still at the same level, which are IDR 300,000 for outpatient claims and IDR 3 million for inpatient claims. Additionally, companies are permitted to apply an annual deductible if mutually agreed with the policyholder and clearly stated in the policy. In the event of accidents, CIs as defined in the policy, or force majeure, the co-payment scheme is waived. The POJK does not provide any definition of a CI.

The new POJK also requires insurers to present a comparison of premiums for policies with and without co-payment schemes during policy sale and renewal.

### Coordination of benefits

Companies are required to prioritise the implementation of COB, which organises and shares liability for benefits with other insurance providers and benefit administrators, including the government's Social Security Administrator for Health (BPJS Kesehatan). The POJK mandates that all health insurance product features must enable COB implementation.

Additionally, the insurer must develop internal policies and procedures for the implementation of COB and ensure compliance. The OJK also requires other parties to support COB. For instance, healthcare providers are expected to provide the infrastructure for allocating claim billing between the insurer and BPJS Kesehatan (or other benefit administrators) when COB is effective.

### Product design

#### Underwriting

Insurers are advised to consider conducting a medical check-up (MCU) for individual health policies, in line with their underwriting policies. For group health insurance, instead of an MCU, insurers must obtain a claim performance report from the policyholder when issuing the policy. The report includes information regarding the number of participants, amount of premiums/contributions, amount of claims paid and loss ratio data. However, the requirement in the previous SEOJK mandating a quarterly claim performance report for each group health policyholder has been removed in the new POJK.

## Repricing

The new POJK mandates that repricing due to claim experience, increased risks, or medical inflation can only be done at most once a year. When repricing, the company must provide written notice within a maximum of 30 calendar days before the repricing date, with information that includes:

- a. clear argument as to why the repricing was done
- b. detailed comparison of pre- and post-repricing premium/contribution amount
- c. alternatives available to policyholders

Companies are obliged to set internal policies and procedures for their repricing processes and ensure every repricing cycle is aligned with said internal procedures. Additionally, companies are prohibited from setting repricing premiums/contributions that lead to higher profit margins compared to what were initially submitted to OJK when launching the product.

## Waiting period

Companies are required to set a maximum waiting period of six months for individual health insurance products that provide benefits for critical illness, chronic illness and/or specific illnesses explicitly stated in the insurance policy, which is shorter than the one-year waiting period mandated in the previous SEOJK. The waiting period can be waived in cases of emergencies caused by accidents and/or force majeure events.

## Insurer operational requirements

### Digital integration with healthcare providers

Insurers must have adequate digital capabilities to enable electronic data exchange with healthcare providers and allow access to verify policy membership. The systems should capture essential information such as claims paid, medical services provided and discharge summaries.

In addition, the systems should include databases with disease classification standards, supporting the assessment of the appropriateness of medical services and medications provided and facilitating utilisation reviews. A utilisation review is defined as a process to assess whether the healthcare services provided to a policyholder are appropriate to ensure cost and quality control.

Furthermore, the information systems must support electronic processing, storage and protection of data.

### Medical advisory function

Insurers are required to establish a DPM comprising specialised medical professionals. The DPM is responsible for advising the company on the implementation of utilisation reviews and providing recommendations related to healthcare services and developments in medical practice that may be relevant to the company.

The DPM can be formed in-house or through collaboration with third-party administrators (TPAs), other companies or external providers of DPM services.

## Data governance

Strong emphasis is also placed on data governance and confidentiality. Insurance companies must ensure that all personal and medical data collected from policyholders and providers is securely stored, used solely for permitted purposes and managed in accordance with applicable privacy regulations. This obligation extends to all related parties, such as the DPM, TPA, digital service providers and healthcare providers, who are also expected to protect the privacy of all personal and medical data.

In addition, insurers are required to retain health insurance claims records and related documents for a minimum of ten years, thereby ensuring auditability and regulatory traceability.

## Public programs and awareness

As a new requirement in the POJK, insurance companies must implement programs that actively encourage policyholders to adopt and maintain a healthy lifestyle. In addition, companies are required to regularly provide educational health information to the public to increase awareness and promote healthier living habits.

## Partnership with third-party administrators

Insurers must ensure that their contracts with healthcare providers and TPAs adhere to OJK's prescribed standards. These agreements should clearly define service scopes, claims processing timelines, escalation mechanisms and performance obligations to safeguard policyholder interests and maintain service quality.

## Milliman insights

The new POJK aims at resolving issues within the healthcare sector in Indonesia that have been building up over recent years. Over this time, health insurance has slowly become less affordable, driven by poorly controlled medical claims pushing up loss ratios and eroding insurer profitability, resulting in frequent premium increases.

The likely impact of the new POJK on the industry can be assessed from various angles, as outlined below:

1. Many of the mandated provisions, such as annual repricing practices and shorter waiting periods, are already broadly aligned with current market practice. As such, the new POJK serves to formalise good practices, instead of introducing large-scale changes to existing product design and management, which is likely to limit the immediate impact on an industry level. However, at an individual company level, those that are not yet implementing these practices are likely to incur the highest operational costs in transitioning into compliance with the new POJK (including system enhancements and product adjustments).
2. Given the optional nature of the provisions aimed at improving claims experience through reducing moral hazard, such as co-payment features, the long-term

claim experience improvements and the premium savings for policyholders from these practices will depend on the extent of adoption of these optional provisions within each company. It remains to be seen if this option will increase in prevalence across the industry in the next few years.

3. Nevertheless, policyholders are still likely to observe improvements in their healthcare experience, given several provisions aimed at streamlining the healthcare process, such as COB implementation and data sharing. The data governance requirements would also enhance policyholder confidence in the management of their data.

Overall, the new POJK aims to be more flexible than the previous SEOJK for both policyholders and insurers alike, although this flexibility might result in the retention of existing practices and minimal changes at an industry level. Although the OJK is showing its commitment to building a more transparent and sustainable health insurance market whilst championing policyholder protection, the effectiveness of the measures outlined in the POJK is contingent upon the extent to which industry adoption differs from existing practices.

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