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Analysis Of The Causes Of Delay In Private Insurance Claims Payment And Its Impact On Jih Hospital's Cash Flow

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Abstract

Delayed insurance claim payments represent a common financial challenge faced by private hospitals. This study aims to identify the factors causing delays in private insurance claim payments at JIH Hospital and analyze their impact on the hospital's cash flow. Using a qualitative approach involving interviews and observations over four months, data were collected from the hospital's Billing Unit Head and Financial Manager. The findings revealed that delayed claim payments stem from internal factors, such as incomplete supporting documents, manual administrative processes, and slow document sign-offs by physicians, as well as external factors, including insurers' demands for additional documentation and unstable financial conditions of insurance companies. Despite insurance receivables contributing 47-48% of total revenue, JIH Hospital successfully mitigated the cash flow impact of delayed claims through comprehensive financial management strategies. These included adjusting the schedule of non-routine liability payments to align with claim receipt patterns and maintaining a minimum cash reserve equivalent to one month's revenue. This study recommends strengthening legal aspects in insurance partnership agreements, accelerating digital transformation for billing workflows, and developing comprehensive training programs for relevant staff.

Keywords: Hospital, insurance, delayed claim payments, cash flow, insurance claims.

INTRODUCTION

JIH Hospital, formerly known as Jogja International Hospital, was established by the Islamic University of Indonesia Waqf Foundation (YBW UII) and is managed by PT

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Medika Farma (PT UMF). The hospital began its operations on February 5, 2007, and obtained ISO 9001:2008 Certification on May 20, 2010. The name change from Jogja International Hospital to Rumah Sakit JIH was a response to national regulations, in accordance with the Regulation of the Minister of Health of the Republic of Indonesia No. 659/Menkes/Per/VIII/2009 on World-Class Indonesian Hospitals (Article 15), and reinforced by a letter from the Director General of Medical Services No. YM.02.10/III/2743/10. Officially effective as of August 1, 2010, the institution adopted the new name as part of its alignment with international healthcare service standards.

The hospital's ISO certification achievement reflects the realization of its vision and mission. Its vision is to become the leading premium private hospital in Yogyakarta by promoting sustainable healthcare services grounded in Islamic principles. In line with its 2025 targets, JIH Hospital is committed to achieving international service standards with a core focus on patient safety and customer satisfaction. To support this vision, the hospital has developed a mission that includes: (1) building a premium private hospital by providing excellent service; (2) developing clinical and hospital services that meet international standards with an emphasis on patient safety and customer satisfaction; (3) nurturing trustworthy, skilled, professional, and competent human capital based on Islamic values; and (4) enhancing hospital performance through effective control and supervision systems. These values are reinforced by the hospital's organizational culture known as AMPUH—an acronym for Amanah (Trustworthy), Melayani dengan Sepenuh Hati (Wholehearted Service), Profesional (Professional), Unggul (Excellent), and Harmonis (Harmonious). JIH Hospital also upholds a quality policy to ensure beneficial, Sharia-based, and internationally standardized premium healthcare services for the community.

JIH Hospital's organizational structure supports its operations through four main divisions. The Medical and Nursing division is responsible for managing medical and nursing aspects, setting clinical policies, supervising medical practices, and ensuring high standards of patient care. The Marketing and Sales division is tasked with developing strategies to enhance the hospital's image and visibility, as well as managing healthcare service sales. The Operations division oversees the hospital's daily activities and physical infrastructure, ensuring smooth support for patient care and clinical functions. Meanwhile, the Finance division manages financial aspects, including patient billing and accounts receivable, to maintain healthy financial operations.

Hospitals play a vital role in public health service delivery, and insurance is an inseparable component of their function. Insurance has become an integral part of modern healthcare systems, protecting patients from catastrophic health expenditure while

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ensuring access to medical services (WHO, 2010). It also serves as a strategic revenue source for hospitals through partnerships with insurance companies (Finkler, 2020). However, such collaborations often come with challenges. During observations at JIH Hospital, the researcher found that delayed payments of private insurance claims posed a potential threat to cash flow. This aligns with prior findings from government insurance cases (BPJS Kesehatan), where Suhadi (2022) noted that delays can hinder hospital cash cycles, particularly for medication procurement and staff payments. Yuliyanti & Thabrany (2018) emphasized the negative impact on operational liquidity and service stability, while Haryono & Budiarsih (2024) observed that delayed claims force inefficient fund allocations, reducing service quality. Based on initial observations, this study aims to identify the causes of private insurance claim delays at JIH Hospital and assess their impact on cash flow. Given the lack of studies focused on private insurance in Indonesia—most literature centers on BPJS—this research seeks to fill that gap. With private insurance contributing 47–48% of JIH Hospital's total revenue, understanding and improving claim management is crucial for ensuring financial sustainability without compromising service quality.

LITERATURE REVIEW

Health Insurance

According to the Law of the Republic of Indonesia Number 40 concerning Insurance, insurance is defined as an agreement between two parties—namely the insurance company and the policyholder—where the insurer receives premiums in exchange for providing compensation due to uncertain events or making payments based on the insured's death or survival. Article 246 of the Indonesian Commercial Code (KUHD) supports this definition, viewing insurance as a contract for compensation in exchange for premiums. Conceptually, insurance is a social mechanism that reduces risk by transferring it from individuals to insurers (George E. Rejda, 2020), and economically, it serves as a cost redistribution system through risk pooling (John Smith, 2021). In healthcare, insurance not only protects patients from catastrophic medical expenses but also supports hospitals through insurer partnerships, balancing patient protection with institutional sustainability (Wardhana, 2023).

Health insurance allows individuals to receive reimbursement or coverage for medical costs under a formal contract (Centers for Medicare & Medicaid Services, 2023). It serves as a financial safety net during illness or accidents (Wardhana, 2023) and aligns with risk management principles (George E. Rejda, 2020). Beyond its commercial role, health insurance is also a policy tool to promote social equity (OECD, 2022), exemplified

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by BPJS Kesehatan in Indonesia and Medicare in the U.S. The World Health Organization (2023) highlights its role in achieving universal health coverage by pooling funds from various sources. Wardhana (2023) outlines various health insurance types in Indonesia—such as individual, family, critical illness, and global health insurance—and emphasizes implementation principles like mutual assistance, fairness, responsibility, and sustainability, which ensure effective and equitable service delivery.

Cashflows

Based on PSAK No. 2, the cash flow statement is a key component of financial reporting that shows cash inflows and outflows from operating, investing, and financing activities over a specific period (Ikatan Akuntan Indonesia, 2009). Trianjani Nia (2020) defines cash flow as information about cash inflows and outflows and cash equivalents of an entity during a particular period. Through the cash flow statement, users aim to understand how the entity generates and utilizes its cash and equivalents. According to Investopedia (2024), cash flow refers to the movement of money in and out of a business over a period of time. When inflows exceed outflows, the net cash flow is positive; otherwise, it is negative. Cash flow reflects not only liquidity but also serves as a vital indicator of a company's ability to sustain operations and long-term growth. The Financial Accounting Standards Board (FASB) ASC 230 mandates that cash flow reports must transparently disclose cash sources and uses through consistent classifications: operating, investing, and financing activities (FASB, 2024).

Donald E. Kieso (2022), in *Intermediate Accounting*, defines cash flow as "the inflow and outflow of cash related to a company's primary activities, as well as investing and financing that affect liquidity position." A strong operating cash flow shows the company's ability to generate cash from core business activities, which is essential for business continuity. Gary A. Porter (2023) in *Financial Accounting: The Impact on Decision Makers* adds that negative investing cash flow is not always unfavorable, as it may reflect spending on productive assets that support long-term growth. The cash flow statement serves several strategic purposes in financial reporting, including evaluating financial structure, assessing cash generation efficiency, supporting cross-company performance comparisons, and improving decision-making (Ikatan Akuntan Indonesia, 2009; IFRS Foundation, 2024; Donald E. Kieso, 2022; Stephen H. Penman, 2023; American Institute of CPAs, 2024; Eugene F. Brigham, 2024).

Research on delayed insurance claim payments in hospitals has largely focused on the National Health Insurance (JKN) and government health insurance schemes, with

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limited attention given to private insurance claims in private hospitals. To ensure the originality of this study and to position it within existing literature, it is necessary to review relevant previous studies, even if they are in different contexts. This helps avoid overlapping discussions and offers a specific contribution to private insurance claim management and its impact on the financial condition of private hospitals.

Suhadi (2022) found that delays in BPJS payments were due to incomplete claim documents and budget deficits, affecting hospital operations such as drug procurement and staff salaries. Yuliyanti & Thabrany (2018) revealed that only 60% of claims were paid within a month, with delays caused by poor medical coding, record-keeping, and BPJS's unstable finances, disrupting drug availability and equipment maintenance. Haryono & Budiarsih (2024) highlighted delays of 7–45 days due to administrative inefficiencies, which impacted cash flow and healthcare quality. These studies suggest the need for improved claim processes, better communication, and financial safeguards to maintain hospital service quality.

RESEARCH FRAMEWORK

Based on the description and explanation of theoretical investigations and hypotheses, a research model can be created which is used in this research. This research model is shown in the following figure:

RESEARCH METHODS

This study employs a qualitative approach to explore the phenomenon of delayed insurance claim payments and their impact on the cash flow of JIH Hospital. According to Hadisaputra (2021) in his book *qualitative research* is a scientific approach aimed at exploring and understanding human behavior and social phenomena in their natural context, producing descriptive data that are analyzed in depth and comprehensively through verbal or written expressions. In this context, the qualitative approach enables the researcher to gain an in-depth understanding of the delay in claim payments from the perspective of the head of the billing unit, including its underlying factors and the interactions between stakeholders such as the finance department and insurance parties. The unit of analysis in this study is the finance department of JIH Hospital (Maharani & Mahalika, 2022). Data are collected from primary sources through interviews and observation. The interviews, as defined by Hadisaputra (2021), involve direct dialogue with informants and are conducted with the finance manager and the head of the billing unit to assess the impact of cash flow on operations and identify causes of claim delays,

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respectively. Observations were carried out during a four-month internship at JIH Hospital, from February 5 to June 5, allowing the researcher to describe the research setting and participants' behavior (Hadisaputra, 2021). Data were then analyzed using qualitative descriptive analysis, which, according to Moleong (2017) and Hadisaputra (2021), is designed to present a complete picture of the social phenomenon by interpreting data deeply without testing hypotheses.

RESULTS

The main respondents in this study were Mrs. Nur Azizah, the Head of the Billing Unit, and Mr. Danan, the Finance Manager at JIH Hospital. The interview with Mrs. Nur Azizah was conducted in-depth at her home for a duration of 60 minutes, while Mr. Danan's interview took place at JIH Hospital for 30 minutes. The data collection process was designed to create a calm and conducive environment for in-depth discussions, allowing both respondents to provide detailed information regarding internal control and financial management aspects. Additionally, the author conducted a 4-month internship at JIH Hospital, where direct observations were made of operational processes, including identifying delays in claim payments. The data analysis involved a detailed explanation of the main themes identified by the author, systematically analyzed through the collected interview and observation data, resulting in comprehensive information regarding the context and dynamics of the delayed insurance claim payments at JIH Hospital. The collected interview data covered the billing or claims process at JIH Hospital, factors causing delays in claim payments (both internal and external), legal and contractual aspects affecting claim payment delays, the impact of these delays on hospital cash flow and operations, and finally, the risk mitigation strategies employed by the hospital to address delayed claim payments.

DISCUSSION

In this section, the author discusses the research questions previously identified. These questions are addressed based on observations and interviews conducted at JIH Hospital. The billing process at JIH Hospital follows a systematic series of steps before claims are paid by the insurance company. According to the author's findings from interviews and observations, the process starts when the bill is issued by the cashier's billing unit. In line with the hospital's Key Performance Indicator (KPI), the bill should be issued within one day after the patient receives the service. The billing unit then checks the completeness of supporting documents, such as radiology results, laboratory tests,

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ultrasound reports, and medical resumes. If any documents are incomplete, the billing unit confirms with the relevant department to complete the paperwork. Once the documents are verified, the bills are categorized based on the type of insurance and whether the patient is in inpatient or outpatient care. For inpatient cases, documents must be cleared before the patient is discharged, while outpatient patients often carry their documents, requiring a checklist to be recreated based on data from the system dashboard. The next step is the determination of the sending date, after which the hospital sends the claim to the corresponding insurance company. If payment is not received within the set timeframe, reconciliation is initiated. The hospital ideally expects the entire claims process, from sending the bill to receiving payment, to be completed within 14 to 30 days, though in practice, this often takes 30 to 60 days.

The delay in claim payments is attributed to both internal and external factors. Internally, delays are caused by incomplete supporting documents, such as missing ultrasound results or delayed radiology readings, despite the hospital's KPI of completing them within one day. Manual administrative processes, slow document sign-offs by doctors, and discrepancies between inpatient and outpatient procedures also contribute to delays. Externally, delays are influenced by the insurance companies' demands for additional documents, financial difficulties within the insurance companies, and inconsistencies in their verification and payment schedules. These findings align with previous research by Yuliyanti & Thabrany (2018), which highlighted similar internal and external factors, such as incomplete documentation and financial issues within insurance companies, as causes for delayed claim payments. Suhadi (2022) also observed that delays in claims were linked to incomplete documents and difficulties faced by the JKN insurance system. At JIH Hospital, internal factors include incomplete documentation, manual verification processes, and inconsistencies between inpatient and outpatient procedures, while external factors include additional documentation requests by insurers, unstable insurance company finances, and inconsistent payment mechanisms.

The legal and contractual aspects of the claims payment process also act as barriers to smooth billing at JIH Hospital. As indicated in the interviews, the hospital's contracts are often not followed as agreed upon. For instance, claims are supposed to be paid within 30 days after review, but the actual review process by insurance can take up to two months due to third-party verifiers (e.g., Admedika). Additionally, there are ambiguous contract clauses, such as one stating that guarantees will be void if they do not match the tariff book, which is typically reviewed after the claim has been submitted. JIH Hospital's legal team faces difficulties in understanding complex contract language,

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especially when insurance companies alter terms unilaterally or use medical terminology not easily understood by non-clinical staff. Furthermore, delays in claims payments are expected to impact the hospital's cash flow and operational stability. However, at JIH Hospital, delays in claims do not significantly disrupt cash flow. According to interviews, "The impact has been minimal because we carefully calculate cash inflows and outflows." The hospital has adjusted its financial obligations to align with the timing of insurance claims, ensuring the hospital can maintain liquidity despite delays. Additionally, JIH Hospital's operational budget is carefully allocated, prioritizing employee salaries and routine expenses, while non-routine payments are managed through a 60-day payment schedule, thus ensuring smooth operational continuity despite unpredictable claims payout timelines.

CONCLUSION

Based on the research findings, the delay in insurance claim payments at JIH Hospital is caused by both internal factors, such as incomplete supporting documents, manual administrative processes, and slow document signing by doctors, and external factors, including the demand for additional documents from insurance companies, unstable financial conditions of insurance firms, and the involvement of third-party verifiers which extend the claims process. Unlike previous studies, the delay in claims at JIH Hospital does not significantly affect cash flow or hospital operations, thanks to prudent financial management strategies, such as aligning payment schedules with claim receipt patterns to maintain liquidity and solvency. JIH Hospital has mitigated the risks of claim delays through a comprehensive approach, including maintaining a minimum cash reserve, implementing a stop-release policy for overdue insurances, restricting bank loan usage, and adopting digital transformation through e-signatures and real-time claim monitoring systems. Furthermore, proactive communication with insurance companies has been crucial in preventing conflicts and ensuring operational continuity without compromising healthcare service quality.

RECOMMENDATION

Based on the findings of this research, the following recommendations may be considered by JIH Hospital to minimize delays in insurance claim payments: 1) Strengthen the legal aspects of insurance agreements by clarifying contract clauses related to claim payment deadlines and the consequences of delays. It is essential to specify a clear and definitive claim verification period, avoiding ambiguous terms like "after review is

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complete," to reduce opportunities for insurance companies to delay payments and provide legal certainty for the hospital in the billing process. 2) Expedite the digital transformation of the claims billing process, prioritizing the development of an integrated system that can track claim status in real-time. This system should include automatic notifications for incomplete documents and payment reminders to insurance companies, reducing reliance on manual processes and minimizing human error, especially in sorting documents and determining submission dates, which currently take about 1-1.5 hours per process. 3) Develop a comprehensive training program for billing staff and related units (such as nurses and medical staff) to enhance their understanding of the documentation requirements and specific claims criteria from each insurance company. The program should cover legal language in insurance contracts, the use of document scanning technology (to address issues with difficult-to-duplicate ultrasound/radiology results), and the standardization of internal verification processes before invoices are sent to insurance companies.

MANAGERIAL IMPLICATIONS

The findings of this study provide valuable insights for hospital management in mitigating the risks of delayed insurance claim payments. By strengthening the legal framework of insurance agreements, hospitals can ensure clearer expectations and reduce the possibility of delays due to ambiguous terms. The adoption of digital transformation, including integrated systems for real-time claim tracking and automated notifications, will streamline the billing process and minimize administrative errors, enhancing operational efficiency. Furthermore, investing in comprehensive staff training on documentation requirements and contract specifics can ensure that all parties involved in the claims process are well-prepared, ultimately reducing delays and improving cash flow management. These managerial strategies can help hospitals like JIH sustain operational continuity and financial stability despite external challenges.

RESEARCH LIMITATIONS

This research is limited by its focus on a single case study at JIH Hospital, which may not fully represent the diverse practices and challenges encountered by other healthcare institutions. Additionally, the study primarily examines internal and external factors impacting claim delays without considering other potential variables, such as patient volume or the diversity of insurance providers, which could influence the claims process. Future research could explore broader samples across multiple hospitals to

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validate the findings and examine other dimensions of insurance claims, including customer satisfaction and long-term financial impacts.

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