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DELAYS IN HEALTH INSURANCE CLAIMS AT A THIRD-PARTY ADMINISTRATOR (TPA) PT. XYZ IN 2024

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Abstract

Third-Party Administrators (TPA) play a crucial role in managing health insurance claims. However, delays in claim processing remain a major issue that negatively affects customer satisfaction. This study aims to describe the occurrence of delayed health insurance claims at one TPA in Indonesia in 2024. A descriptive quantitative approach was used, analyzing 442,279 secondary claim records to determine the frequency, type, and underlying causes of delayed claims. The findings revealed that 34% of all claims were classified as pending. Most pending claims involved outpatient and cashless services. The leading cause of the delay was incomplete documentation (55%), followed by invoice revisions and further claim investigations. These delays were largely attributed to unresolved administrative issues. Improving claim service quality in TPA requires the implementation of digital processing systems, enhanced staff competencies, and real-time document monitoring mechanisms.

Keywords: Pending Claims, Health Insurance, Third-Party Administrator, Claim Documents, Health Service

Introduction

Third-Party Administrators (TPA) serve a critical role in the health insurance system, particularly in bridging the administrative process between policyholders, healthcare providers, and insurance companies. Their presence allows for the delegation of complex claim processing tasks, enabling insurance companies to focus on risk management while ensuring that policyholders receive timely service. Efficient claim management is therefore a key determinant of both customer satisfaction and the perceived credibility of the service provider. In a competitive health insurance market, the ability to process claims swiftly and accurately not only affects consumer loyalty but also strengthens the operational reliability of the health insurance ecosystem.

In Indonesia, where health insurance penetration continues to increase alongside the population's growing awareness of healthcare financing, the speed and accuracy of claim processing have become some of the most critical benchmarks in evaluating insurance service quality (Hasan, 2021). As health insurance services expand in both coverage and complexity, so does the expectation for transparent, accountable, and responsive administrative processes, particularly in claim settlements.

Health insurance claims are generally divided into two payment schemes: reimbursement and cashless. In the reimbursement scheme, policyholders must initially bear the costs of healthcare services and later submit supporting documents to apply for reimbursement through the TPA. This process requires a high level of accuracy and completeness in documentation from the policyholder. In contrast, the cashless scheme enables policyholders to receive treatment by simply presenting their insurance membership card at a partnered healthcare facility. The healthcare provider then bills the insurance

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company directly through the TPA. This method is more seamless from the patient's perspective but requires rigorous backend verification to ensure compliance with insurance terms and service-level agreements (PAMJAKI, 2014). Additionally, claims are categorized by type of service: inpatient and outpatient. Inpatient services refer to medical care requiring admission and overnight stays, while outpatient services are limited to day-care treatments, consultations, or minor procedures without hospitalization.

According to the 2024 second-semester customer satisfaction survey conducted by a private national TPA, the company's Net Promoter Score (NPS) dropped significantly by 13.4 points, from 86.7 to 73.3 (internal source, PT. XYZ, 2024). This decline is a cause for concern, especially because one of the most frequently cited complaints from customers was the delay in health insurance claim payments. Such delays highlight persistent challenges in the TPA's internal workflows and signal that the claim management process still contains gaps that have yet to be systematically resolved.

One major contributor to claim processing delays is the high volume of claims marked as "pending." These are claims that must be returned either to the healthcare provider (in the case of cashless claims) or to the policyholder (for reimbursement claims) for additional documents, clarification, or correction. This back-and-forth process significantly extends the administrative cycle and may create a bottleneck in service delivery (Kultsum, 2022).

In practice, pending claims also result in duplicated administrative work. Claim staff are required to re-verify and re-process the same claim multiple times, which undermines operational efficiency and increases the likelihood of human error. A study by Kultsum (2022) identified that the most common causes of claim delays included incomplete supporting documents, delays in the submission of medical resumes, and inconsistencies between submitted data and the conditions outlined in the policy. These findings are echoed by Hasan (2021), who stressed the importance of administrative skills and continuous training for claim staff, especially in areas related to verification, documentation, and communication with external stakeholders.

The impact of delayed claims is not limited to policyholders. Healthcare facilities that depend on timely reimbursement to sustain operations also experience financial strain due to payment delays. Cash flow disruptions can potentially reduce their ability to provide quality care and maintain operational efficiency. Given the systemic nature of these issues, it is essential to explore them in greater detail. This study, therefore, aims to describe the factors contributing to delayed health insurance claims at PT. XYZ, a Third-Party Administrator (TPA) in Indonesia, throughout 2024. The study adopts a descriptive quantitative approach using secondary data drawn from the company's internal claim management system.

Method

This study employed a descriptive quantitative approach aimed at portraying the condition of delayed health insurance claims at a Third-Party Administrator (TPA) company in Indonesia, hereinafter referred to as PT. XYZ. The study utilized a retrospective method to analyze claim data that had been recorded in the company's administrative system over the course of one calendar year.

The research was conducted within the operational environment of PT. XYZ, which provides health insurance claim administration services to members from various companies and institutions on a national scale. Data collection and processing were carried out from January to December 2024.

The population in this study consisted of all claim records documented at PT. XYZ throughout 2024, totaling 442,279 claim entries. From this population, purposive sampling was applied to select claims that met the criteria for delayed or pending status and were relevant to the research variables. The total sample analyzed consisted of 148,423 claims, comprising both cashless claims submitted by

healthcare providers and reimbursement claims submitted by policyholders, all of which had experienced a pending status at some point during the claim process.

Data were collected through documentation methods utilizing the internal claim information system at PT. XYZ, which records submission dates, validation dates, claim statuses (pending or not pending), as well as the types and sources of claims. The data were analyzed descriptively using Microsoft Excel software to present the frequency, distribution, and percentage of pending claims along with their contributing factors.

This study refers to a similar research model developed by Kultsum (2022), who investigated the causes of pending claims in another TPA in Indonesia. Kultsum's study identified incomplete documentation, delays in medical resume submission, and data entry errors as dominant causes of claim delays. By comparing results across different settings, this research aims to strengthen the understanding of systemic issues in claim processing within TPAs.

The study utilized anonymized secondary data and did not involve any personally identifiable information, thereby eliminating the need for formal ethical clearance. Nevertheless, all data handling procedures were conducted in accordance with principles of confidentiality and organizational data integrity.

Results

This study aimed to describe the condition of delayed health insurance claims at the Third-Party Administrator (TPA) PT. XYZ during the period from January to December 2024. The analysis was conducted using secondary data comprising a total of 442,279 claims recorded in the company's claim management system. Among these, 148,423 claims or approximately 34% were identified as having a pending status.

The term "pending" refers to claims that cannot be immediately processed for payment due to administrative issues. These issues may include incomplete documentation, data discrepancies, invoice revisions, or the need for further clarification through claim investigations. Claims with pending status are returned either to the healthcare provider (for cashless claims) or to the policyholder (for reimbursement claims) for completion or correction, thereby prolonging the claim processing time and potentially delaying payments to insured members and partner healthcare facilities.

Table 1 Pending Claims Based on Payment Scheme

Payment Scheme	Percentage
Cashless	66%
Reimbursemet	34%

Pending claims can be categorized based on the payment scheme: reimbursement or cashless. The data show that out of the total pending claims in 2024, 97,523 claims (66%) were cashless, while 50,900 claims (34%) were reimbursement claims. The higher proportion of cashless claims being delayed indicates that the high volume of daily transactions and administrative requirements increases the risk of documentation errors or deficiencies.

Table 2 Pending Claims by Type of Service

Type of Service	Number of Claims	Claim value
Inpatient	29%	92%
Outpatient	71%	8%

When categorized by service type, outpatient claims accounted for the largest share of pending claims, totaling 105,342 claims (71%), whereas inpatient claims comprised 43,081 (29%). However, when viewed from the value of the submitted claims, inpatient services represented the vast majority, amounting to IDR 1,166,974,924,425 (92%) compared to only IDR 102,583,069,342 (8%) for outpatient services. This indicates that while outpatient claims are more frequently delayed, delays in inpatient claims have a more significant financial impact on healthcare providers' cash flow and financial sustainability.

Table 3 Causes of Pending Claims

Payment Scheme	Percentage
Incomplete documentation	55%
Invoice revision	26%
Investigation/review	9%

Analysis of the causes of claim delays revealed that incomplete documentation was the most prevalent issue, affecting 81,154 claims or 55% of total pending claims. Additionally, 38,270 claims (26%) were delayed due to invoice revision requirements, typically caused by inconsistencies in billing amounts, cost breakdowns, or invoice formats that did not comply with administrative standards. Another 13,308 claims (9%) were subject to further investigation or review, often related to benefit validation, suspected duplication, or special conditions requiring additional clarification. These findings emphasize the importance of improving claim documentation and verification processes at both the healthcare provider and member levels.

Table 4 Turnaround Time for Pending Claims

Resolution Time	Percentage of Claim	Percentage of Claim Value
1 – 14 days	61%	65%
15 – 30 days	38%	34%
31 – 60 days	1%	1%

The turnaround time (TAT) analysis showed that the majority of pending claims were resolved within 1–14 working days. However, a notable portion of claims required more than 14 days for resolution. Although fewer in number, these longer delays can have systemic consequences on member satisfaction and hospital cash flow. Extended TAT is often associated with more complex cases, delayed documentation from providers, or the need for further clarifications during claim review.

Discussion

The findings of this study indicate that out of a total of 442,279 claims processed by PT. XYZ throughout 2024, as many as 148,423 claims or 34% were categorized as pending. This figure reflects that one-third of all submitted claims could not be processed immediately, highlighting a significant administrative challenge within the TPA's claim management system.

In terms of payment schemes, cashless claims accounted for a higher percentage of delays compared to reimbursement claims 66% versus 34%, respectively. This pattern aligns with the operational characteristics of cashless claims, which are submitted directly by healthcare providers. Consequently, the claim process heavily relies on the administrative accuracy and compliance of external parties. Any non-compliance with the applicable procedures or partnership agreements (PKS)

may increase the likelihood of pending claims. According to the *Standard Operating Procedure: Provider Claim Process* (PT. XYZ, 2023), claims that fail to meet submission standards are subject to revision requests, which subsequently delay processing.

From the perspective of service type, outpatient claims were more frequently delayed, accounting for 71% of pending cases. This is likely due to the higher frequency of outpatient visits and the diverse range of medical services involved, which may increase the risk of documentation gaps or errors. Nevertheless, despite being fewer in number, inpatient claims had a significantly greater financial impact, representing 92% of the total value of pending claims. This finding underscores that delays in inpatient claim processing are more critical in terms of financial consequences for healthcare providers compared to outpatient delays. This is consistent with the study by Kultsum (2022), which noted that while outpatient claims are more frequent, inpatient claims tend to exert greater pressure on the financial stability of healthcare partners.

The primary reasons for pending claims were incomplete documentation (55%), invoice revisions (26%), and the need for further investigation or review (9%). The dominance of incomplete documentation indicates a persistent gap in compliance with established claim submission protocols by both members and providers. This also suggests the need for greater consistency in document preparation and submission in accordance with the *Standard Operating Procedure: Reimbursement Process* (PT. XYZ, 2021). These findings are supported by Hasan (2021), who emphasized the role of administrative factors—particularly those related to documentation quality and form completion as major contributors to claim delays. The requirement for invoice revisions highlights the lack of accurate cost verification prior to submission, while additional investigation indicates the presence of potentially problematic cases involving suspected fraud, claim duplication, or unusual conditions that require further clarification.

Collectively, these findings suggest that the core challenges in claim processing are not merely related to payment schemes or service types, but more fundamentally to administrative compliance, document quality, and the capacity of systems and human resources to manage complex claim workflows. As such, strategic efforts are needed to address these issues comprehensively. These may include enhancing digital claim systems, automating verification processes, conducting regular training for healthcare providers and members, and strengthening internal audit and quality control functions to reduce the proportion of pending claims and ensure timely service delivery.

Conclusion

This study reveals that delays in health insurance claims remain a significant operational challenge for Third-Party Administrator (TPA) PT. XYZ. Of the 442,279 claims processed throughout 2024, a total of 148,423 claims or approximately 34% were categorized as pending. Cashless claims accounted for the majority of these delays (66%), compared to reimbursement claims (34%). Furthermore, although outpatient claims were more frequently delayed, inpatient claims contributed the most in terms of the total monetary value of delayed claims. This finding highlights the greater financial risk posed by delays in inpatient services, which could disrupt the cash flow and financial planning of partner healthcare providers.

The primary causes of pending claims were incomplete documentation, invoice revisions, and the need for further investigation or review. These three factors reflect an ongoing issue of low compliance with established claim submission procedures, both on the part of insured members and healthcare facilities. Therefore, solving the problem of delayed claims cannot rely solely on internal verification systems, but instead requires a collaborative approach involving providers. This includes implementing regular training and outreach, document digitalization, and early warning systems to ensure more complete and timely submissions.

Overall, these findings reinforce the urgency of improving administrative management in the claim process as a strategic measure to reduce the rate of delayed claims. Doing so will not only enhance the efficiency of the TPA's operational workflow but also improve customer satisfaction and the financial stability of healthcare provider partners within the insurance ecosystem.

References

[1] Hasan WW. Faktor-faktor yang berhubungan dengan keputusan klaim asuransi kesehatan kumpulan PT. SGMW Motor Indonesia pada pialang asuransi PT. Cipta Integra Duta tahun 2020. Jakarta: Sekolah Tinggi Ilmu Kesehatan Indonesia Maju; 2021.

[2] PAMJAKI. Dasar-dasar asuransi kesehatan. Jakarta: Perhimpunan Ahli Manajemen Jaminan dan Asuransi Kesehatan Indonesia (PAMJAKI); 2014.

[3] Enciety Business Consult. Laporan survei customer experience semester II tahun 2024. Jakarta: PT. XYZ; 2024.

[4] PT. XYZ. Standard Operating Procedure: Provider Claim Process. SOP No: SOP/HCLJK/001/I-02, Revisi 08. Jakarta: PT. XYZ; 6 September 2023.

[5] Kultsum R. Faktor-faktor yang berhubungan dengan terjadinya klaim pending asuransi kesehatan di Third-Party Administrator (TPA) PT X tahun 2021. Semarang: Universitas Diponegoro; 2022.

[6] PT. XYZ. Standard Operating Procedure: Reimbursement Process. SOP No: ADM/SOP/COM/008/I-02, Revisi 07. Jakarta: PT. XYZ; 6 Desember 2021.

[7] Dewi A. Analisis prosedur pengajuan dan pembayaran klaim pada perusahaan asuransi (suatu studi pada Asuransi Jiwa Bersama Bumiputera 1912 Ngawi). Media Wisata. 2008;3(2).

[8] Tajudian A. Analisis pengetahuan SDM, penggunaan sistem informasi dan kelengkapan klaim terhadap penolakan klaim reimbursement di PT Gesa Assistance tahun 2016. J Ilmiah Kesehatan. 2017;16(3).

[9] Swa.co.id. Alih daya pengelolaan administrasi klaim asuransi [Internet]. 2006 [diakses 2025 Jun 4]. Tersedia dari: https://swa.co.id/read/16562/alih-daya-pengelolaan-administrasi-klaim-asuransi

[10] PT. XYZ. Lampiran Perjanjian Kerja Sama (PKS) dengan Provider. Jakarta: PT. XYZ; 2024.