Business and Management Quarterly Review, 10(1/2), 11-22, 2018
ISSN 2180-2777

THE INFLUENCE OF APPLICATION OF FULLY INSURED PLANS FINANCING MECHANISMS ON EMPLOYEE HEALTH SERVICES

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ABSTRACT

This research aim determines whether there is an influence of the application of financing mechanisms Fully Insured Plans, which is one way of financing the group health insurance, againts the employees health care. Moreover, the aim of this research is to determine how much the application influence these mechanisms toward employee health care. The population used was an employee of PT Cakrawala Andalas Televisi that has Ekamedicare Syariah card which is a place where transactions are carried out the research. Probability Sampling is used as a sampling method in this research. The research sample is using respondensi result of employees that chosen at random. The results showed that there is an influence of the application of financing mechanisms Fully Insured Plans to employee health care at PT Cakrawala Andalas Televisi. Besides, it also known that there is the direction of the relationship between health benefits and administrative procedures with health care that claims the greater health benefits and claims administration procedures is, the faster it is getting a good health care .
Keywords : group health insurance, fully insured plans , employee health services, health benefits

INTRODUCTION

Health is human property which is very valuable and needs to be maintained so that health care is one of the basic needs of human life. For the workforce, health care will increase work productivity and can provide great benefits for the employees themselves, the company and national development in general. The implementation of a health care system is inseparable from the cost factor, because a system with good service certainly requires a lot of money. Now the problem depends on each company, how to implement a health care system for an efficient workforce and how much is budgeted for it. For a company, the maintenance of health workforce can be held alone (Self Insured Plans) or it can also be delegated to other parties, namely insurance companies that provide Fully Insured Plans health insurance products. In Indonesia, companies generally face obstacles in organizing an employee health service system due to the high medical costs that increase every year. These problems encourage companies to look for alternatives to overcome these problems. One alternative is to transfer risk so that the company can still provide health insurance for its employees, for example by buying a collection of health insurance products for its employees.

The benefits obtained from this collection of health insurance products are reimbursement of benefits if the insured during the insurance period experiences an event which results in being hospitalized. Benefits provided are in accordance with the agreed benefit table between the company as the policy holder and the insurance company. This benefit table can contain inpatient benefits, or inpatient benefits along with other additional benefits that have been agreed by both parties PT Cakrawala Andalas Televisi is a private company engaged in the media industry and has implemented health services for its workforce. From its inception in 1993 to early 2013, PT Cakrawala Andalas Televisi held its own health services for all its employees (Self Insured Plans). But then since May 1, 2013 the company bestowed most of its work on insurance companies, namely PT Asuransi Jiwa Sinarmas MSIG Life through Ekamedicare

Syariah products, because of the background of several things:

1) Health scheme that is not competitive because it has not been reviewed until 2013. The reimbursement system applied in all medical treatments and other health services causes employees to have to pay in advance to pay for medical expenses, even though not all employees have enough money to pay fees great treatme
2) Increase in medical costs that cannot be avoided. Many economic factors influence the increase in medical costs, such as high-tech medical examinations or increasingly healthier devices and motives to seek benefits from providers of health facilities.
3) Many employee candidates when offering compare health benefits with other companies.
4) Administrative procedures when registering patients that require time because there must be a guarantee letter from HRD first even though the patient must immediately get help.

Based on this thought it is necessary to conduct research on the Effect of the Application of Fully Insured Plans Financing Mechanisms on Employee Health Services. Thus, this current study is attempts to;

1. To find out whether there is an effect of the implementation of the Fully Insured Plans financing mechanism on employee health services?
2. To find out how much influence the implementation of the Fully Insured Plans financing mechanism on employee health services?

REVIEW OF LITERATURE

The employee health service system is part of risk management carried out by a company. Risk management includes identifying and assessing the financial risks that we face. To eliminate or reduce our exposure to certain financial risks, we can choose at least four options, namely:

a. Avoiding Risk
b. Controlling Risk
c. Receive Risk
d. Transferring Risk

In the health care system, the option is generally to accept risks and transfer risks. Risk management method by accepting the risk, in which a company bears full responsibility for all payments of fees and costs associated with it or can be referred to as Self-Insurance Plan. Another option is to divert risk and if the company transfers risk to another party, it means that the company transfers financial responsibility for the risk to another party, which is generally based on the provision of compensation. Generally companies do this by buying insurance coverage

Risk Transfer Theory

The employee health care system is closely related to the welfare of the workforce. If labor welfare increases, work productivity also increases. Therefore the company needs a good employee health service system that can meet the needs of its employees. As mentioned earlier, there are companies that carry out their own health services for their employees, but there are also companies that hand over their insurance to the insurance company. One thing to note, that the loss must be a loss due to an accident (accidental losses), which means that the arrival must be from the outside, unpredictable and unintentional. So in this case if the company delegates health services to its insurance workers, namely through health insurance products, it means that the company reduces and diverts part of the risk of high health care costs to parties.

Health Insurance

Health insurance is an insurance that provides protection from the risk of financial loss caused by illness, injury due to an accident or disability / incapacity suffered by the insured. The two main insurance coverage are as follows.

a. Medical Expense Coverage provides benefits for the payment of treatment for pain and injury suffered by the insured.
b. Disabillity Income Coverage provides the benefit of reimbursing the insured who cannot work due to illness or injury.

Health costs are basically divided into:
a. Health Care Costs, which are the costs that a person must incur so that his health is maintained. For example: for health check-ups, buying vitamins, and others.
b. Outpatient Fees, which are costs that must be paid to pay for a doctor's consultation, if someone is sick.
c. Inpatient Fees, which are the costs that must be incurred to pay the costs associated with hospitalization, if someone is sick and must be hospitalized.
d. Drug costs, which are the costs that must be spent to buy drugs.
e. Operating Costs, which are costs that must be incurred if someone must be operated on in a hospital.

Social Health Insurance
According to Article 1, Law of the Republic of Indonesia No. 40 of 2004 concerning the National Social Security System states that social insurance is a compulsory collection mechanism that comes from contributions to provide protection for the socioeconomic risks that befall the participants and / or their family members. Social insurance aims to ensure the access of all people who need health services regardless of their economic status or age, social insurance has the function of redistribution of rights and obligations between various groups of people: rich, poor, healthy, sick, young, low risk, high as a manifestation of the nature of human civilization.

According to Sulastomo (1997), there are several principles of social health insurance applied in Indonesia, namely:
a. Participation is mandatory
b. Fee / Premium based on percentage of income / salary
c. Fees / premiums are shared by the workplace / company and labor (50% -50%)
d. Workers / participants and their families obtain comprehensive health insurance
e. Workers / participants receive compensation during illness
f. The role of the big government

Commercial Health Insurance
Commercial health insurance is a type of health insurance whose participation is voluntary. The main goal of organizing commercial health insurance is the fulfillment of diverse individual desires for health insurance needs. The premium for insurance is adjusted to the amount of guarantee or benefit borne. Based on the type of membership, commercial insurance is divided into 2 (two) types, namely:
a. Individual Health Insurance
b. Collection Health Insurance
Still according to Sulastomo (1997), the principles of commercial health insurance are:
a. Participation is voluntary
b. Fees / premiums are based on absolute numbers, in accordance with contractual agreements
c. Workers / family members receive health care benefits according to the contract
d. The role of the government is relatively small.

Collective Health Insurance Financing Mechanism
The method used in paying claim fees for group insurance programs and administrative fees is known as the Funding Mechanism (financing mechanism) program. Several financing mechanisms are available for group insurance programs. Some group insurance programs are Fully Insured Plans - the group insurance policyholders make monthly premium payments to insurance companies, and insurance companies assume responsibility for all claim payments. On the other hand, there is a program called Self Insured Plans, which is a program in which a company bears full responsibility for all claim payments and costs associated with it.

a. Self Insured Plans Financing Mechanism

In a general Fully Insured Plans, the insurance company must determine an adequate premium rate to (1) pay the claim issued; (2) cover insurance company costs, which include agent commissions, overhead costs (such as building salaries and rent), and state premium taxes; and (3) providing benefits to insurance companies. By insuring yourself health insurance coverage for its employees, a company can avoid some of these costs that are taken into account in determining insurance premium rates.[3] From the data obtained, in 2008 in the United States, 89% of workers who worked in companies with a total of 5,000 workers or more used the Self Insured Plans financing mechanism. It can be said that this financing mechanism is more suitable for companies that have large numbers of workers. In the Self Insured Plans financing mechanism there are two main costs that must be considered: fixed costs and variable costs. Fixed costs include administration fees, stop-loss premiums and other fees charged per employee. The fee is billed monthly by the operator and is charged a fee based on the registration plan. Meanwhile, variable costs include payment of claims for health services. These costs vary from month to month based on health care used by employees and dependent. Another advantage of the Self Insured Plans financing mechanism is customization. In addition, the company also saves money over time with the assumption that the total claims paid are lower than the exact premium. The lack of this mechanism is that employees who are vulnerable participants experience an increase in health costs that cannot be expected. If the claim costs exceed normal expectations, the employee must pay the whole or part of the excess costs incurred.

b. Fully Insured Plans Financing Mechanism.

Fully Insured Plans is a traditional financing method for group health insurance programs. The insurance company issues a group health insurance policy based on an advanced period of one year, and every annual premium paid is for that year's coverage only. The new premium rates will be charged annually based on the sex and age achieved by the insured group members. This group health insurance premium rate is usually guaranteed for 12 months. At the end of the policy year, insurance companies can make new premium rates for the group. According to Karen Bender there is a lack of this mechanism in terms of finance and administration. From the financial side, the amount of premium can be greater than the claim that occurred due to the existence of premium taxes, assessments, insurance commissions. Whereas from the administrative side, the company must follow the administration procedure of the insurance company, where inconsistencies can occur in internal procedures. Besides that, there were complaints from employees about the network of hospital providers or clinics and the benefits received.

RESEARCH METHODS

In this study, the author uses a type of quantitative research. Quantitative research requires researchers to make observations that can be quantified (changed in the form of numbers) and then analyze the numbers. After the theory is revealed to be research indicators or often called research instruments, then researchers can measure the social phenomena observed. Because in quantitative research social phenomena or social reality are converted into numbers, then from the beginning researchers need to understand the measurement scale of social phenomena or the object under study.

Data collection

The population is general and encompasses a variety of circumstances, so that the population in this study were all employees of PT Cakrawala Andalas Televisi registered as participants in the Sharia Ekamedicare Health insurance group totaling 1091 people, consisting of 799 male employees and 292 female employees. The total number of participants including with his wife and children from employees of PT Cakrawala Andalas Televisi is 3097 people. However, due to limited access to time and place to conduct research on the entire population, in this study the researcher took the same population. Based on this formula obtained the number of samples to be used in the study were 91.60369 respondents rounded up to 92 respondents. The origin of the division of employees who became respondents did not affect the characteristics of the sample so the researchers did not determine the number of samples for each division. The randomly selected employees will be asked to fill out the questionnaire that the researcher has provided. In this study the author distributed questionnaires about 130 sheets and returned as many as 102 sheets. Following the number of respondents according to the existing formula, the number of samples

used was 92 respondents. The contents of the questionnaire will then be processed so that the results of the study can be known.

Health Insurance Benefits Variables
Testing the validity and reliability of the variable health insurance benefits is carried out on the 12 (twelve) indicators used. Based on the results of the validity test, the twelve indicators have a value above the correlation limit of 0.25. Therefore it can be concluded that all indicators of the variable are valid. Furthermore, from all indicators that pass the validity test in this variable, Cronbach's alpha value is 0.901 (table attached). The Cronbach's alpha value is above the number 0.5 which means that the overall indicator in the variable is reliable.

Variable Claim Administration Procedure
Furthermore, from all indicators that pass the validity test in this variable, Cronbach's alpha value is 0.753 (table attached). The Cronbach's alpha value is above the number 0.5 which means that the overall indicator in the variable is reliable.

Employee Health Service System Variables
Furthermore, from all indicators that pass the validity test in this variable, Cronbach's alpha value is 0.773 (table attached). The Cronbach's alpha value is above the number 0.5 which means that the overall indicator in the variable is reliable.

Correlation and Regression Analysis
In addition to calculating the Pearson correlation value is also tested the significance of the correlation coefficient (r) to determine whether the relationship between variables is significant or not. To find out the relationship, hypothesis is proposed.[10]
Ho: the correlation of the two variables is zero
Ha: the correlation of the two variables is not equal to zero

Regression Analysis
In this study, employee health service system variables are independent variables, while health insurance benefit variables and claims administration procedure variables are dependent variables. Because there is 1 (one) dependent variable (Y) and 2 (two) independent variables (X1, X2), multiple regression analysis will be used with the equation written as follows:

$$Y = a + b_1 X_1 + b_2 X_2$$

Hypothesis Statistics Test
Hypothesis testing is a procedure that will produce a decision that is the decision to accept or reject the hypothesis that has been formulated. Associated with the previous research hypothesis, which reads:

Ho: Fully Insured Plans financing mechanism does not affect the employee health service system
Ha: The Fully Insured Plans financing mechanism affects the employee health service system

CASE STUDY

Fully Insured Plans Financing Mechanism

As stated in the introductory chapter, the mechanism of Fully Insured Plans financing is a method of financing employee health services used by PT Cakrawala Andalas Televisi This financing mechanism uses the services of an insurance company in handling the risk of reimbursing health costs for sick employees and their family members. In this case Pt Cakrawala Andalas Televisi uses the Ekamedicare Syariah product which is a group health insurance product of PT Sinarmas MSIG Life. PT Cakrawala Andalas Televisi began using Ekamedicare products since May 1, 2013 which is also an active policy date with a coverage period of 1 (one) year. For a year-long coverage PT Cakrawala Andalas Televisi must pay a premium of Rp. 4.5 billion of which the payment is made quarterly so that every 3 (three) months PT

Cakrawala Andalas Televisi must pay Rp. 1,125 billion to Sinarmas. Funds for premium payments are taken from company funds that are allocated specifically for the implementation of employee health services.

Health Benefits

Even though it is called the Fully Insured Plans financing mechanism or if it is translated into coverage that is fully borne by the insurance, but in practice not all health insurance coverage is transferred to the insurance, due to the nature of the insurance object that has a high cost risk, frequent frequency and probability of the possibility of occurring tall one. Health benefits of reimbursement of labor costs, reimbursement of optical costs and dental treatment are health benefits provided by the company to its employees but not covered by insurance or in other words borne by the company.

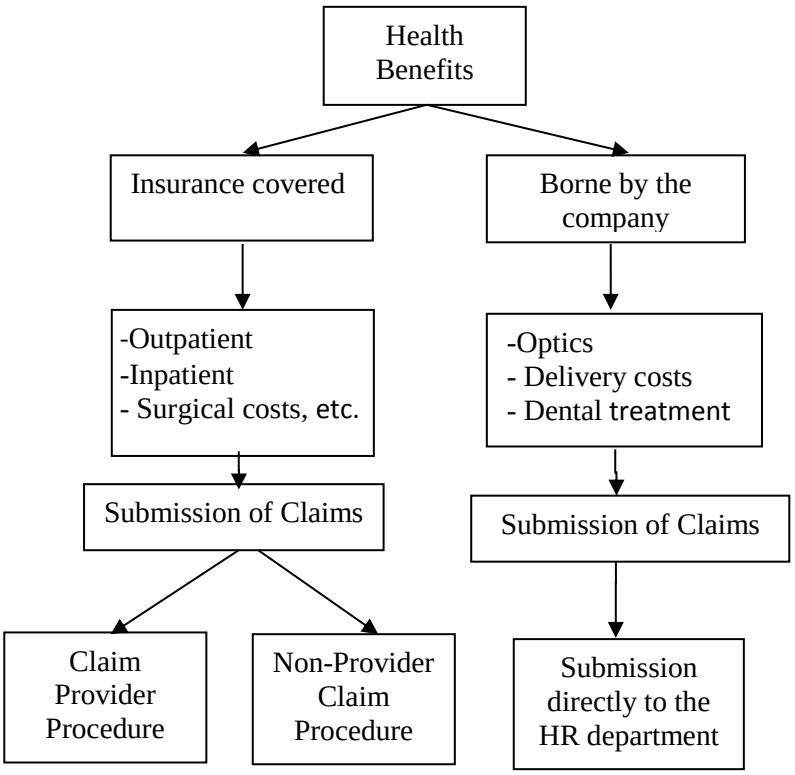

Figure 1: Health Benefits Coverage Chart

From the results of observations conducted by researchers, most employees complained about the cost of specialist doctors amounting to Rp. 85,000 for one visit is considered inadequate. That is because the cost of specialist doctors in both Provider and non-Provider Hospitals is mostly above Rp. 100,000 for one visit (Data on the amount of health benefits of PT Cakrawala Andalas Television attached). In addition there is also a complaint that specialist fees are only valid for 1 (one) visit a day, whereas in practice many patients are required to check with several specialists on the same day, so employees must bear the excess costs of medical specialist.

Claim Administration Procedure

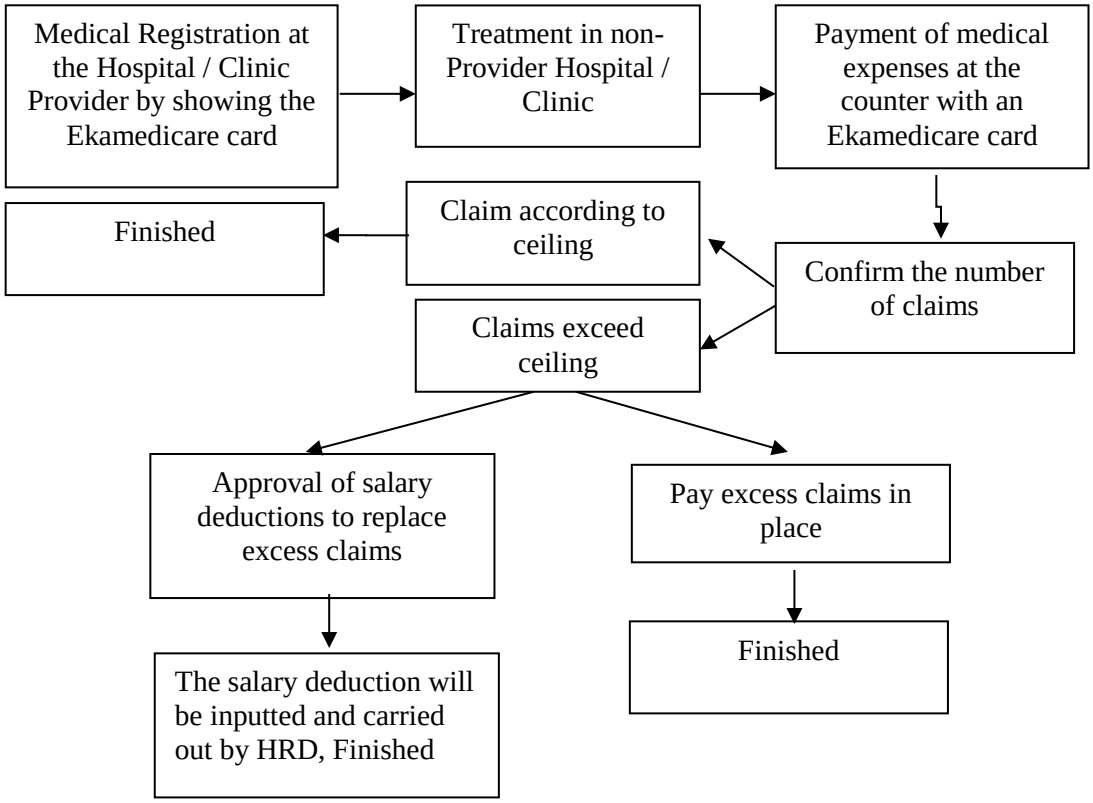

Figure 2: Claim Process Flow in Hospital / Clinic Provider

Excess of Implementing Employee Health Services with Fully Insured Plans Financing Mechanisms. From the results of observations in the field in organizing employee health services with a financing mechanism Fully Insured Plans have several advantages including:

a. Employees Do Not Need to Issue First Money for Medication
With the new system, if employees seek treatment at a Provider Hospital or Clinic employees do not need to spend money first, unless there is an excess claim. That can still be overcome by choosing to make salary deductions to pay for the excess of the claim. However, all of these advantages do not apply if the employee chooses to seek treatment at a hospital or clinic which is not a Sharia Ekamedicare product provider.

b. Administration Becomes More Practical and There are More Facilities
The administration process at HRD PT Cakrawala Andalas Televisi also became lighter. With this new system the HRD does not need to take care of the entire claim process. The HRD only needs to take care of reimbursement claims from the results of the treatment of employees at the Hospital or Clinic Provider. In addition there are several facilities obtained from Sinarmas including medical history applications that can be accessed by employees to monitor their medical history and also discounts at several merchants if they show a Sharia Ekamedicare card.

Clinic Non-Provider

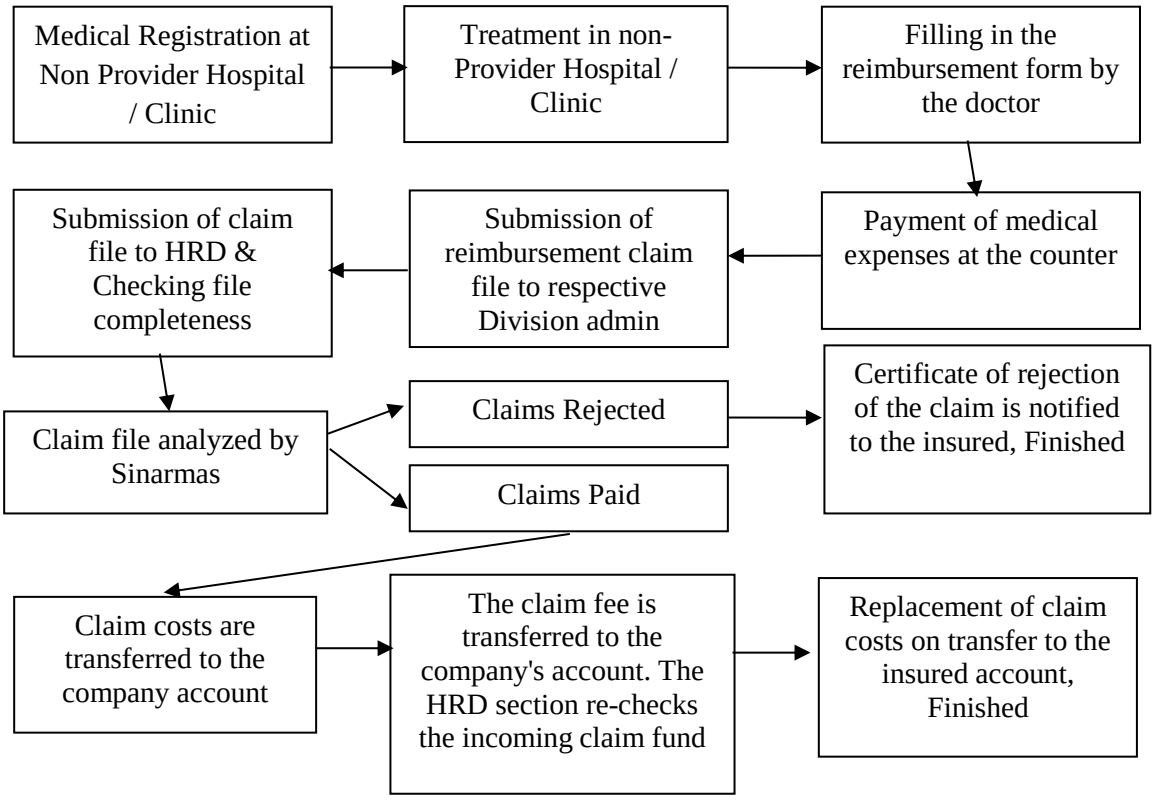

Figure 5: Claim Process Flow in Non-Provider Hospitals / Clinics

c. Handling for Critical Patients Faster

With this new system, critical patients who need emergency treatment can be immediately served without the need to wait for a guarantee letter from HRD PT Cakrawala Andalas Televisi. Patients or their families only need to show the Sharia Ekamedicare card to the administration so that they can be handled immediately. With the existence of the card, all costs for the patient's needs will be guaranteed by Sinarmas. Even though in practice there is coverage that is not covered by Sinarmas, the cost will be borne in advance by the new Sinarmas then it will be coordinated with the HRD of PT Cakrawala Andalas Televisi so that the patient can still walk.

d. Treatment for Permanent Employees Covered Even though the Limit Is Out

When the payment limit for an employee for both outpatient benefits and hospitalization benefits has expired, employees who seek treatment can still be borne in advance the cost of treatment by Asuransi Sinarmas with the note that salary deductions will be made to the employees concerned. Asurasnsi will later coordinate with the HRD section of PT Cakrawala Andalas Televisi how much is the cost of the employee's responsibility. In the previous system using the Self Insured Plans financing mechanism, employees whose health benefits had been exhausted had to pay for their own medical expenses. It can be said that with a new system employees whose health benefits have been exhausted can be helped by payments using the salary deduction system.

Lack of Implementation of Employee Health Services with Fully Insured Plans Financing Mechanisms

a. Reimbursement Claims Payment Takes Long Time

Based on observations in many areas, many respondents believed that the duration of payment of claims for reimbursement borne by Sinarmas took a long time. After being confirmed with the HR department, this was due to the HRD having to re-check the claim money that entered the peer account from Sinarmas with the existing claim data to then be sent back to the account of the employee who submitted the related claim. The process takes 1 (one) to 2 (two) weeks because the quantity of financial work is also quite a lot. The Insurance Party promises that the claim replacement money will be paid within 14 (fourteen) working days, but due to the procedure, the employee's replacement claim will be received in less than a month. To overcome these shortcomings, the HRD immediately implemented a new procedure to speed up the claim payment process by asking Sinarmas to transfer directly to the account of the employee who submitted the claim.

b. Benefits for the Cost of General Practitioners and Less Competitive Specialists

With the recent increase in health costs, many employees argue that the benefits for outpatient care in particular the costs of general practitioners and specialists are less competitive, so there are many claims overload. The benefit of general practitioners is Rp. 60,000 and specialist doctors amounting to Rp. 85,000 are considered less competitive because most Sharia Ekamedicare providers are large or well-known hospitals and clinics so that doctor fees can reach 30% more expensive than the benefits provided. Many employees compare the previous financing mechanism where the overall costs of general practitioners and specialists will be covered as long as the limit is still there. The employees really hope that the benefits can be raised, but of course this is not an easy thing for HRD to fulfill. This is because the overall health benefits covered by insurance include the benefits of the doctor's fees depending on the premium paid by the company where the premium has been adjusted to the company's financial ability.

c. Specialist Doctor Fee Only Takes One Time Examination per Day

In medical practice, often a patient whose disease has not been diagnosed is required to conduct a laboratory examination and then the results are re-examined to several different specialist doctors and carried out within 1 (one) day. For example, in the case of an employee seeking treatment from a general practitioner because he experienced complications from blurred vision, the general practitioner indicated that there was a sugar supply but could not confirm it before further investigation. Then the doctor refers the patient to check the ophthalmologist and internal medicine specialist for further analysis. For this reference, the patient also conducts further examination in one day.

d. Payroll Administration Becomes More Complex

In the event of excess claims or overlimit claims, employees will be subject to salary deductions. From the results of interviews with the HRD section of PT Cakrawala Andalas Televisi, they experienced difficulties in processing payroll because they had to calculate salary deductions for employees who had an obligation to pay excess claims. The salary deduction cannot be done directly because the HRD section of PT Cakrawala Andalas Televisi must look at the ability of employees because there are employees who have many obligations such as housing, vehicle and others. Employee salary deductions are usually made at 10% up to 20% or a maximum of 40% of medical expenses which are their responsibility to be adjusted to the ability of employees.

RESEARCH RESULTS AND INTERPRETATION

Characteristics of Respondents

Most respondents were female respondents as many as 49 respondents while men were 43 respondents. Furthermore, the age range of respondents was at the age of 20 years to 55 years with the youngest age of 21 years and the oldest age of 54 years. With the majority of respondents as many as 36 people in the age range 21 to 25 year. From these data, the most respondents came from the Sport division as many as 21 people and the second was from the production division. Furthermore, the least number of respondents came from the audit & compliance section where there were only 2 respondents in it. Please note that the

number of respondents in each division does not affect the calculation process because the questionnaire has been distributed randomly. Respondent data also showed that there were 47 unmarried respondents and 45 unmarried respondents. Whereas of the 45 respondents who were married, around 37.8% of respondents did not have children, then 24.4% of respondents had 1 child, then 26.7% of respondents had 2 children, 8.95% of respondents had 3 children and only 2.2% of respondents had 4 children.

Description of Research Variables

a. Health Benefits Variables

From the results of data processing research that has been carried out is known that the health benefits variable consists of 12 (twelve) indicators used to show that the extent of respondents' expectations are met with the health benefits provided in the Fully Insured Plans financing mechanism. Most respondents answered "disagree" for indicators 1, 2, 3, 4, 10, 11 and 12. While for indicators 5, 6, 7, 8 and 9 respondents answered quite agree. If we look at the overall indicators contained in the health benefit variable, then the mean value of all items is 2.63. This means that respondents do not agree to the amount of health benefits provided in the Fully Insured Plans financing mechanism.

b. Variable Claim Administration Procedure

From the results of data processing research that has been done is known that the claim administration procedure variable consists of 6 indicators that are used to show that the extent to which respondents agree to administrative procedures applied in the Fully Insured Plans financing mechanism. Most respondents answered "quite agree" for indicators 1, 2, 4, and 6. While for indicator 3 respondents answered "agree" and for indicator 5 respondents answered "disagree." If we look at the overall indicators contained in the claim administration procedure variable, then the mean value of the entire item is 2.96. This means that respondents agree enough on the speed of claim administration procedures applied in the Fully Insured Plans financing mechanism.

c. Employee Health Service Variables

From the results of data processing the research that has been carried out is known that the employee health service variable consists of 6 (six) indicators that are used to show that the extent to which the respondents agree that the existing employee health services are going well. All respondents answered "quite agree" for all indicators. If we look at the overall indicators contained in the employee health service variables, then the mean value of all items is 2.92. This means that respondents agree that the existing employee health services are going well.

Interpretation

Based on the correlation test results, there is a weak relationship between health benefits and employee health services indicated by the correlation number 0.386 and the moderate relationship between administrative procedures and employee health services is indicated by the 0.445 correlation number. Then it can be seen from the positive correlation coefficient number there is a unidirectional relationship between health benefits and administrative procedures for claims with health services. Where if the health benefits are getting bigger and claim administration procedures are getting faster then health services are getting better. Based on the results of calculations using SPSS 16.0 it was found that there was an influence between health benefits and administrative procedures for claims on employee health services. This is indicated by the significance value F 0,000 smaller than the level of significant $\alpha = 0.05$, so there is a significant effect of health benefits (X1) and claim administration procedures (X2) simultaneously on employee health services. Based on the Determination Coefficient shown in the figure R square is equal to 0.269 indicating that 26.9% variation in employee health service variables can be explained by health benefit variables (X1) and claims administrative procedure variables (X2) and the remaining 0.731 or 73.1% explained by other variables. So, the magnitude of the influence of the implementation of the Fully Insured Plans financing mechanism, represented by health benefits and administrative claims procedures, was answered at 26.9%.

CONCLUSION OF RESEARCH RESULTS

1. There is an influence of the implementation of the Fully Insured Plans financing mechanism on employee health services at PT. Andalas Television Horizon.
2. The effect of the implementation of the Fully Insured Plans financing mechanism represented by health benefits and administrative procedures for employee health services is known to be 26.9%
3. There is a unidirectional relationship between health benefits and administrative procedures for claims and health services seen from a positive correlation coefficient. Where if the health benefits are getting bigger and claim administration procedures are getting faster then health services are getting better

RECOMENDATIONS

Academic

For other researchers who want to research about employee health services, researchers recommend using cost data as a complement to the data so that it can be seen whether the costs of organizing employee health services are directly or inversely proportional to the results of existing health services. Researchers suggest examining other variables in their effects on employee health services such as other insurance ownership variables by examining whether respondents who have similar insurance with greater benefits tend to regard existing employee health services as poor.

Practical

The first to HRD managerial PT Cakrawala Andalas Televisi to maintain the existing health service system and try to increase the benefits of employee health so that the need for health services is increasingly fulfilled. In addition, it is expected to cooperate with the Sinarmas by providing access for employees to find out the amount of residual ceiling, claim history and others. Then the second to PT Asuransi Sinarmas MSIG Life as a provider of Sharia Ekamedicare products to be able to expand the network of hospitals and clinics so as to make it easier for employees of PT Cakrawala Andalas Televisi and their families to seek treatment. and also always prioritizes speed in the process of handling reimbursement claims. Furthermore, for the employees of PT Cakrawala Andalas Televisi to prioritize treatment at the network of hospitals or clinics which are Sinarmas providers and also use the e-sehat.co.id website to obtain health history data and information about health. Then employees are expected to be more orderly in terms of administrative procedures for reimbursement claims to avoid being denied claims due to submissions that exceed the deadline. And the last is for the administrative staff in each division to prioritize the administrative process of reimbursement claims to be submitted to the HR department.

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