The Moral Hazard Phenomenon In Health Insurance: A Review Of Driving Factors And Control Strategies

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Abstract

Moral hazard in health insurance is a significant institutional issue that concerns the efficiency, sustainability, and equity of health funding systems. This study intends to comprehensively assess the different types of moral hazard, discern the root causes that contribute to it, and examine the regulatory strategies implemented at both national and international levels. This study employed a methodology characterized by a descriptive literature review, which involved a comprehensive analysis of 25 meticulously chosen peer-reviewed articles. The articles in question were published between the years 2014 and 2025, and they were obtained from reputable databases such as Scopus, PubMed, and Google Scholar. The results indicate that moral hazard presents itself in two main forms. Initially, this phenomenon arises among beneficiaries who may engage in excessive consumption and use of healthcare services lacking adequate medical justification. Secondly, it is apparent that healthcare providers may participate in administrative and clinical manipulation, which includes practices such as upcoding, unnecessary hospitalizations, and fraudulent claims. Several contributing factors to moral hazard can be identified, including deficiencies in the design of the INA-CBGs payment system, a lack of health insurance literacy among participants, and insufficient oversight and auditing mechanisms.The findings presented have considerable implications for policymakers, outlining the necessity to improve the national health insurance system. Structural reforms and the implementation of sustainable, multidisciplinary approaches.

Keywords*: Control strategies; health insurance; moral hazard; payment system and universal health coverage.*

I. INTRODUCTION

Social health insurance acts as a cornerstone for achieving Universal Health Coverage (UHC) in Indonesia[1]. However, severe difficulties such as moral hazard threaten the sustainability of the system, particularly under premium-based funding schemes and case-based reimbursement models[2]. Insurance protection results in either consumptive behavior by beneficiaries or manipulative acts by healthcare providers, moral hazard results and the financial load on the health system is finally increased[3]. In the context of health insurance, moral hazard refers to a shift in the behavior of the insured that increases risk after acquiring coverage. The knowledge disparity between the insurer and the insured causes these phenomena; this condition is sometimes known as information asymmetry. In such instances, beneficiaries may overuse or misuse healthcare services, believing the costs will be paid by insurance[4]. The further emphasizes that moral hazard may appear as individuals with a health insurance policy seeking numerous types of care unnecessarily or through behavioral changes that result in losses for the insurer owing to the nature of the insurance contract itself[5].

The implementation of health insurance programs such as Indonesia's National Health Insurance (Jaminan Kesehatan Nasional or JKN) has considerable obstacles relating to moral hazard[6]. High claim volumes and budget shortfalls within the JKN program are mostly related to moral hazard behaviors, among both members and healthcare professionals. Furthermore, the adoption of INA-CBGs (Indonesia Case-Based Groups) tariffs that do not reflect the true cost of medical services may motivate hospitals to engage in behaviors such as upcoding or claim manipulation both acknowledged forms of provider-side moral hazard[7]. This mismatch of rates puts financial strain on medical facilities, thereby encouraging dishonest claim behavior. From a global viewpoint, similar difficulties are addressed in health insurance systems globally. Measures such as cost-sharing arrangements, the deployment of gatekeeper models, and health service audits have been widely used to reduce overutilization and claim abuse by both beneficiaries and healthcare providers[8].

II. METHODS

This research utilized a descriptive methodology for literature review, including contemporary works relevant to the issue of moral hazard in health insurance programs in Indonesia. The investigation focused on examining the many manifestations of moral hazard, exploring its underlying causes, and evaluating the strategies utilized to minimize it both within Indonesia's National Health Insurance (JKN) framework and in international healthcare settings[9].Articles were selected based on inclusion criteria, which included publications in Indonesian or English from 2020 to 2025 that addressed issues of moral hazard in health insurance. The scope covered patient and provider behaviors, health financing mechanisms, and policy-level interventions. Publications were excluded if they were not available in full text, consisted only of opinion pieces, or were deemed thematically irrelevant[10]. Literature searches were conducted using keywords such as "moral hazard," "health insurance," "utilization behavior," "policy strategy," and "patient behavior," combined with logical operators to refine search results. From this process, 25 peer-reviewed articles were selected and analyzed narratively and thematically to identify patterns of moral hazard behavior and control approaches that have been applied[11].

III. RESULT AND DISCUSSION

In Indonesia, Moral Hazard in health insurance is a complex issue that has significant ramifications for the sustainability of national health insurance programs. A thorough overview of national and international research indicates that moral hazard is presented in two primary forms: activities undertaken by insurance beneficiaries and those performed by healthcare providers. To achieve effective regulation, these two types are influenced by a variety of structural and behavioral factors and require a systematic and sustained approach.

Types of Moral Hazard in Health Insurance

Moral hazard in health insurance can be roughly classified into two types based on a thorough study of literature: those caused by insured individuals and those caused by healthcare providers. Both forms contribute to increased inefficiencies within the system and pose significant risks to the sustainability of national health insurance schemes if left unaddressed. Ex-post moral hazard typically affects the conduct of insurance recipients, who modify their behavior after receiving financial protection. Following the acquisition of insurance, individuals frequently augment their utilization of healthcare services without medically warranted justification[12]. That this conduct manifests as superfluous visits to healthcare institutions and unjustified requests for diagnostic and treatment services devoid of robust clinical justifications. Insured cardiovascular patients utilized specialist services and therapeutic procedures more frequently, often lacking adequate medical rationale.

This conduct not only leads to financial inefficiency but also induces service congestion and diminishes treatment quality for other patients with larger needs[13]. In contrast, healthcare providers' moral hazard is more intricate and systemic. This type generally incorporates structured administrative and technical manipulation in claims submission.Many fraudulent practices within Indonesia's National Health Insurance (JKN) framework, including upcoding, unnecessary hospitalization, and unjustified early readmissions. Upcoding denotes the erroneous amplification of the severity of diagnoses or treatments to secure higher reimbursement rates under the Indonesia Case-Based Groups (INA-CBGs) payment framework[14]. These factors impose direct financial strain on BPJS Kesehatan and jeopardize the integrity of the claim-based health finance system. In a study conducted in utilized social network analysis to reveal the significant partic

ipation of both governmental and commercial healthcare entities in orchestrating fraudulent activities. The investigation uncovered several prevalent fraudulent practices, including the deliberate misclassification of non-covered products and services as eligible for insurance reimbursement, the submission of deceptive reimbursement claims, and the acceptance of patients without appropriate clinical justification[15].The systemic nature of the issue is underscored by the moral hazard that emerges from the actions of both insurance participants and healthcare providers. This hazard encompasses not only individual misconduct but also defective financial incentives and regulatory deficiencies[16]. To effectively confront

these challenges, a comprehensive and coordinated response is necessary. This response should include the integration of advanced, data-driven technologies to enhance claims processing and identify irregularities, fortified auditing mechanisms, improved education for all stakeholders, and legislative reform[17].

Driving Factors of Moral Hazard

Moral hazard in health insurance systems is driven by a mix of structural and behavioral factors. One significant factor is the design of payment mechanisms utilized in the JKN program. The INA-CBGs system attempts to promote efficiency and predictability by allocating fixed prices based on diagnosis and medical procedures. However, this approach creates potential for misreporting diagnoses and procedures to get greater claim values[17]. This negative gaps between actual medical service costs and INA-CBGs tariffs typically lead hospitals to file fraudulent claims to balance operational deficits. This implies that payment systems failing to reflect case complexities can economically incentive providers to participate in moral hazard[18]. Furthermore, a lack of adequate internal auditing and monitoring processes significantly intensifies the issue at hand. The scoping assessment conducted identifies several structural challenges that impede the effective implementation of audits.

These challenges include a lack of awareness regarding the claims system, a deficiency in qualified diagnostic coders, and the presence of suboptimal internal audit systems within healthcare facilities[2],[19]The inadequate provision of structured feedback from BPJS Kesehatan to healthcare facilities regarding audit results or claim inaccuracies substantially aggravates the prevailing operational challenges. Additionally, a critical issue among JKN beneficiaries is the limited level of awareness related to health insurance and healthcare systems[20]. A notable portion of the population continues to demonstrate limited awareness of the operational aspects of healthcare services, especially regarding the structured referral system and the scope of benefits provided by the insurance program. This lack of understanding may result in individuals seeking medical care despite the absence of urgent clinical indications. A common practice among patients is to bypass Primary Healthcare Facilities (FKTP), which are designed to regulate patient flow within the JKN system and seek specialist care directly[21].

This behavior contributes to the growing workload faced by referral hospitals. This situation results in the overutilization of secondary and tertiary services, ultimately leading to a mismatch between claim costs and clinical outcomes. The potential for demand-side moral hazard is heightened due to the information asymmetry that exists between beneficiaries and providers[22]. This situation poses a significant threat to the long-term sustainability of the national health insurance system. In conclusion, moral hazard in health insurance is driven by a mix of payment system design errors, administrative supervision inadequacies, and participant conduct. Addressing the issue effectively involves simultaneous initiatives across these three domains: restructuring the payment system, increasing audit and feedback mechanisms, and improving public health and insurance literacy[23].

Strategies for Controlling Moral Hazard

A multitude of strategies have been formulated and implemented, both nationally and internationally, to mitigate moral hazard in health insurance systems. These encompass financial methods, enhancing referral networks, using technology, and enforcing regulations and administrative sanctions. Initially, cost-sharing mechanisms such as deductibles and co-payments have effectively reduced the unnecessary utilization of medical services. These strategies enhance medical decision-making by distributing a share of the financial responsibility among participants. The higher deductibles markedly decreased non-emergency visits to emergency departments. These strategies must be implemented considering the socioeconomic conditions of participants to avoid obstructing access to essential services, especially for individuals with limited financial resources[24]. Secondly, mitigating participant-driven moral hazard necessitates the reinforcement of the gatekeeping role of primary healthcare facilities. Primary clinics and community health centers, known as Puskesmas in Indonesia, serve as the principal access sites for medical care and referrals within Indonesia's JKN system.

This method aims to ensure that referrals to advanced services are based on clear medical indications. The gatekeeper concept has effectively enhanced primary care efficiency and reduced unnecessary referrals[25]. The National Health Service (NHS) in the United Kingdom exemplifies its

efficacy, having long employed a comparable technique to mitigate cost escalation associated with moral hazard[26].Third, the implementation of information technology specifically artificial intelligence (AI) facilitates the provision of accurate and flexible solutions for digital audits and claim detection. These tools aid in the rapid evaluation of claims to identify fraudulent patterns or irregularities. Developed algorithms that are based on cost analysis and capable of identifying fraud indicators, including the prescription of expensive medications for trivial conditions and discrepancies between procedures and diagnoses[27]. This solution provides cross-facility data integration and longitudinal service tracking, enhancing the accuracy of claim verification[28].

Fourth, the consistent enforcement of regulations and administrative sanctions is crucial for reducing moral hazard, especially among providers. The Ministry of Health Regulation Number 36 of 2015 establishes the regulatory framework for the formation of Fraud Prevention Teams within healthcare facilities. It mandates the design and execution of Standard Operating Procedures (SOPs) and clinical pathways to connect medical actions with patients' clinical requirements[29]. Imposing sanctions, including termination of contracts for facilities found guilty of fraud, sends a strong message that ensuring financial integrity in the health system requires adherence to established norms and procedures. It is essential that the approaches to controlling moral hazards in health insurance are both precise and adaptable. Cost-sharing, gatekeeping optimization, IT integration, and regulatory enforcement play a pivotal role in enhancing the efficiency, equity, and sustainability of national health insurance systems.[30]

Case Study: Moral Hazard in the JKN Program

The implementation of Indonesia's Jaminan Kesehatan Nasional (JKN) by BPJS Kesehatan has significantly altered the landscape of healthcare financing and accessibility. The capitation system in primary care facilities effectively curbs overtreatment; however, moral hazard remains an issue, especially in referral hospitals such as type B and C facilities. Identified problems include service data manipulation, delayed claim payments, and ineffective internal audits[31].Empirical research undertaken across various type C hospitals situated in rural regions of Indonesia has uncovered a noteworthy prevalence of moral hazard. The study's findings revealed that the incidence of upcoding was observed at a rate of 11.9%. Additionally, unnecessary hospitalizations were reported to occur at a rate of 17.8%, while unjustified readmissions were documented at 2.8%. These behaviors highlight the basic incentives that push providers to magnify claims, trying to adhere to INA-CBGs rates, which often do not adequately reflect the actual prices of the services delivered[32].

Moreover, the findings suggest that hospital moral hazard is not merely a chance event; instead, it is influenced by distinct individual and organizational characteristics, such as the age and specialization of physicians, the expertise of coders, and the length of patient admissions[33].The findings presented here underscore the idea that moral hazard within the JKN system is not only structural but also multidimensional. This complexity arises from the intricate interplay of economic incentives, regulatory shortcomings, and individual behaviors in the delivery of healthcare services. Provider characteristics, insufficient training for administrative staff, and ineffective real-time monitoring make hospitals vulnerable to fraud and moral hazard. Comprehensive policy interventions are needed, including audit system updates, human resource capacity building, and stricter adherence to professional ethics standards, to ensure JKN program accountability and sustainability in the future ethics[34].

In comparison to Indonesia, the NHS in the United Kingdom and Medicare in the United States provide more structured models for moral hazard control. The National Health Service (NHS), which is entirely funded through taxation, is underpinned by a nationally integrated health information system and stringent audits, which facilitate the rapid and precise detection and response to fraud. Moral hazard losses amount to £1.27 billion annually. In the interim, Medicare employs historical data-driven algorithms for claim audits and implements cost-sharing mechanisms, including deductibles and co-payments. These systems promote rational service utilization and enhance provider compliance by means of performance monitoring and training[35].

IV. CONCLUSION

This research systematically examines the issue of moral hazard within the national health insurance framework, specifically addressing Indonesia's National Health Insurance program (Jaminan Kesehatan Nasional, or JKN). The two main aspects of moral hazard are the supply side, which includes the clinical and administrative tactics used by healthcare providers to optimize their claims, and the demand side, which deals with the behavior of beneficiaries who might overuse health services because they do not directly incur financial costs. The practices include upcoding, unnecessary hospitalizations, and unwarranted repeat visits. These phenomena are exacerbated by the INA-CBGs payment system, which lacks flexibility in accommodating case variations, the weakness of quality control and claim verification mechanisms, and the limited capacity of oversight functions at the implementation level.Theoretically, this paper enhances the concept of moral hazard not just as an effect of individual rational behavior but as a systemic product of the interaction between policy design, incentive structures, and institutional norms. In this context, a health management strategy anchored in systems governance and institutional theory proves to be more applicable than standard economic theories.

This study emphasizes the necessity of reforming the healthcare payment system by transitioning from diagnosis-based fee-for-service models to value-based payments or capitation schemes that prioritize treatment quality and outcomes. The gatekeeping function at primary healthcare facilities (FKTP) requires enhancement via performance-based incentives, capacity-building for primary care services, and a more stringent referral system. Technology-based interventions, including computerized audits and integrated reporting systems, can effectively reduce fraudulent practices.This study offers a tangible contribution to the formulation of public health policy, namely in strengthening oversight and regulatory frameworks to reduce the possibility of deviations in JKN implementation. Therefore, it is essential to adopt a multi-level, cross-sectoral strategy that engages national and local stakeholders, healthcare institutions, and community members. Strengthening technology-driven policies such as fraud detection systems based on big data and artificial intelligence should be urgently adopted and institutionalized. On the other hand, improving participants' literacy about their rights and responsibilities within the JKN system is also a vital instrument in promoting rational service utilization.

As a literature-based study, this research has limited ability to provide primary data or empirical field findings. The absence of quantitative metrics hinders the precise assessment of both the prevalence and the economic implications of moral hazard. Additional research employing both quantitative and qualitative methodologies, including surveys, case studies, and policy assessments, is essential across various JKN implementation domains. Moreover, adopting a socio-anthropological approach is crucial for analyzing the organizational culture of healthcare institutions as they contend with the pressures of incentive systems.Future research should empirically assess the effectiveness of moral hazard control instruments currently implemented by BPJS Kesehatan and the Ministry of Health, such as e-claims, electronic-based medical audits, and the establishment of anti-fraud teams (TPK).

Comparative studies across countries particularly in nations with well-established social health insurance systems such as South Korea, Germany, and Japan, etc. can offer valuable insights for designing more contextually appropriate JKN reforms. To track how beneficiaries and providers behave in reaction to changes in the financial structure, longitudinal studies are also required. Should it remain unaddressed, its presence may pose a significant threat to the sustainability of the JKN program. If left unattended, its existence could jeopardize the sustainability of the JKN program. Therefore, the primary components of a comprehensive control strategy should be the reinforcement of incentive systems, supervision mechanisms, regulatory frameworks, and participant literacy. This review is expected to provide both theoretical and practical contributions to the development of sustainable, equitable, and efficient health financing policies. The findings and recommendations in this study may serve as key references for policymakers, program planners, and academics in their efforts to strengthen JKN governance and social protection in Indonesia's health sector.

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