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Implementation of Risk Management In PT AXA Financial Indonesia Health Insurance Products

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ABSTRACT

The background of importance of risk in the insurance industry is to manage and transfer risk from individuals or groups to insurance companies. In health insurance, the main risk is unexpected medical care costs, which can burden the finances of individuals and insurance companies if not appropriately managed. The purpose of this research is to find out how risk management is implemented in insurance companies, especially AXA Financial Indonesia, what the underwriting process is in accepting and rejecting potential health insurance participants, and how PT AXA Financial Indonesia mitigates (manages) risks. The method used in this research is descriptive qualitative. This study uses several data collection methods, namely: In-Depth Interviews with Underwriters in Insurance Companies, Actuaries who handle risk analysis, and customers as users of insurance services. The interview technique uses open-ended questions to explore deeper insights and other research methods are document and policy analysis in the form of Government Regulations on Health Insurance and Internal Guidelines of Insurance Companies regarding underwriting procedures, claims management, and re-insurance strategies. This research uses the case study method because this method is more suitable if the main research question is how or why, and the focus of the research is on contemporary or current phenomena. This type is a form of research that aims to describe events that occur naturally or are man-made. The results of the research are that PT AXA Financial Indonesia has implemented risk management in its business management.

Keywords: Risk Management; Implementation; Risk Mitigation; Insurance

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INTRODUCTION

An insurance company is a company that controls risk by transferring risk from one party to another party, so that it can be said that its daily activities are managing risks from other parties (the insured). Risk is an uncertainty about the occurrence of an event that

can cause loss. This is what causes the importance of implementing risk management in every insurance company. So that the biggest risk does not lie with the insurance company as the risk bearer. Risk management is a method, method and science that studies various types of risks, how risks occur and how to manage these risks to avoid losses (Syarif, 2003). The feasibility of the risk management process, from the risk identification process to the risk treatment process, will be a big challenge for insurance companies.

Insurance companies as risk transfer institutions implement risk management by formulating existing problems through the underwriting process. Underwriting is the process of resolving and grouping risks that will be borne by the company. An underwriter generally predicts the possibility of the insured suffering a loss. The underwriter's job is a very essential element in insurance company operations, because the goal of underwriting is to increase company profits through receiving risk distribution which is expected to bring profits to the insurance company.

Apart from underwriting, the claims division plays an important role in insurance companies because claims are demands from the insured because of a contractual agreement with the insurance company to guarantee payment of compensation as long as the premium payment has been made by the insured. Simply put, a claim is an official request submitted to the Life Insurance company to make a payment to the recipient. For example, when someone dies and that person has Life Insurance, their heirs can make a claim. If all administrative requirements are met, the insurance company will carry out its obligation to pay the dependents to the heirs according to the agreement stated. Insurance claims do not only apply to life insurance, but also other insurance such as health insurance, education, and so on.

In health insurance, the implementation of risk management is reflected in various risk mitigation strategies that aim to maintain a balance between company profitability and insurance participant protection. Here are some of the main strategies in risk mitigation that are commonly applied, namely: Risk Selection, namely ensuring that insurance participants fall into a manageable risk profile, Claim Management and Fraud Prevention by conducting periodic claim audits, and Reinsurance (Risk Transfer Mechanism) to avoid major losses due to large claims (Izah Normayanti and Ery Agus Priyono, 2024).

Wahyuningsih et.al. (2024) stated that the implementation of risk management in health insurance have a significant impact on industry practices. These findings can help improve the effectiveness of risk mitigation strategies, optimize services for insurance participants, and strengthen the financial sustainability of insurance companies. The implications for stakeholders involved are : 1. For Insurance Companies, they can increase profitability through the implementation of more effective risk mitigation strategies and reduce excessive claim burdens through a data-based approach. 2. For Insurance Participants, they get better health protection with fair and transparent premiums, and can access Health services efficiently and innovatively, for example telemedicine. 3. For regulators (OJK, Ministry of Health and BPJS Kesehatan) to gain

insight into Formulating policies that support a balance between participant protection and industry sustainability, as well as increasing supervision of fraud practices and misuse of claims in health insurance.

Research on the implementation of risk management in health insurance has a high urgency because this sector faces various challenges that can affect the financial stability of insurance companies and the welfare of participants. The phenomena that occur include increasing health costs, high cases of fraud in health insurance, moral hazard and adverse selection risks, the impact of the pandemic and global health crisis and increasingly stringent regulations, indicating an increase in risks that need to be better managed so that health insurance continues to function optimally and sustainably (Maureen et al., 2023).

The urgency of this research is to provide solutions to existing challenges. Among them are: Improving the financial sustainability of insurance companies, maintaining a balance between profitability and participant protection, providing recommendations for stakeholders, and contributing to the development of a more inclusive health insurance model. Based on the description above, the aim of this research is to find out how risk management is implemented in insurance companies, what the underwriting process is in accepting and rejecting prospective health insurance participants, and how PT AXA Financial Indonesia risks are mitigated (managed).

LITERATURE REVIEW

Understanding Risk

Risk is the potential for loss due to certain events occurring. (Darmawi, 2013). Risk is the dispersion of actual results from expected results (Risk is the dispersion of actual from expected results). Risk is associated with the possibility of undesirable or unexpected bad consequences (losses). In other words, "Possibility" already indicates uncertainty. Uncertainty is a condition that causes risk to grow. And if we examine further, the uncertain conditions arise due to various reasons, including: The time interval between planning an activity until the activity ends, the longer the time interval, the greater the uncertainty; Limited availability of required information; Limited knowledge/skills/decision-making techniques.

The Role of Risk Management in The Company

The role of risk management in company management is related to security activities, the aim of which is to protect company property and personnel against losses due to theft, accidents, fires, floods, preventing work strikes, crime and all social or natural disturbances, which may endanger life and development. company. So this activity includes all actions to provide security for company operations and provide the peace of mind and peace of mind needed by all company personnel (including company leaders, owners and employees) (Soeisno Djojosoedarso, 2003).

Risk is an integral part of business and is inherent in company activities (Arifina, 2019). Risk management cannot be avoided and exists in every activity of public and private organizations (Sari et al., 2022). Risk refers to the uncertainty of future events and outcomes. Risk is defined as something that can create obstacles in achieving organizational goals (Pradana & Rikumahu, 2014). Risk management is an approach that adopts a consistent system to manage all risks faced by a company (Prayoga & Almilia, 2013). Risk management is an integral component of good management and decision making at every level in an organization.

Risk management is concerned with making decisions that contribute to the achievement of an organization's goals. The vision, mission and goals of the organization receive more support along with cultivating risk management in the organization (Ratnawati, 2012). The main goal of risk management is to eliminate the possibility of low income achieved by the organization (Supriyadi & Setyorini, 2020). The main target of risk management is to eliminate the possibility of low income achieved by the organization (Raharjo & Wijaya, 2020). Management can control the risks that will be faced in every development of the company and play a role in maintaining company stability (Cahyaningtyas & Sasanti, 2019). It is believed that implementing risk management can reduce the risk of company failure and increase company efficiency and value. Risk management can be defined as a comprehensive risk management system faced by an organization with the aim of improving company performance (Pradana & Rikumahu, 2014).

Health Insurance

Health insurance is a financial product that is quite familiar to the Indonesian people. In 2018 alone, the Central Statistics Agency (BPS) recorded that of the 262 million Indonesian population, 208 million of them or the equivalent of 79.4% were protected by health insurance. This means that for every 1,000 residents, there are 794 people who already have health insurance. This figure shows an increase compared to 2017, where only 716 people were known to have health protection out of 1,000 residents. The presence of BPJS Health starting in 2014 can be said to be the main reason for the increase in health insurance coverage in Indonesia. It cannot be denied that this government facility provides easier access for the public to obtain health protection. However, the presence of private health insurance other than BPJS is also worth considering. The reason is, there are limitations provided by BPJS, for example the coverage of protected diseases or the health services obtained. That way, private health insurance can complement BPJS facilities to protect more optimally. Health insurance is a type of insurance protection that covers medical, surgical, drug and similar costs for the insured or policy holder. This insurance can cover medical expenses due to illness or injury, as well as pay for medical treatment costs directly.

Insurance Company Risk Management

There are four main principles of risk management: Identification, Analysis, Mitigation, and Monitoring. Insurance Company risk management is the assessment and quantification of the likelihood and financial impact of events that may occur in the customer's environment that require resolution by the insurance company, and the ability to spread the risk of these events occurring to other insurance companies in the market.

Insurance exists to provide protection against financial loss. Risk management should be understood before deciding to buy an insurance product. This is so that we are fully aware of what risks can be claimed and which are not the responsibility of insurance.

METHODOLOGY

The method used in this research is a qualitative approach. This qualitative research uses data in the form of written or spoken sentences, events or knowledge or descriptive study projects (Yin, 2008:2). Qualitative research has five methods, namely experiments, surveys, analysis of documentary information, historical and case studies (Yin, 2008:1). This research uses a qualitative descriptive method because this method is more suitable if the main research question is how or why, if the researcher has little opportunity to control the events to be investigated, and the focus of the research is on contemporary or current phenomena. This research uses descriptive research type. This type is a form of research that aims to describe events that occur naturally or are man-made (Sukmadinata, 2008).

This research uses a qualitative descriptive research method, namely by collecting, compiling and describing various documents of actual data and information which is carried out by: Data Collection, collecting data using research instruments such as observation sheets, interview guides, and literature studies; Data Reduction, carrying out data reduction by making a comparative analysis of data that is still saturated; Data Display, presents data with the help of charts, tables; . Conclusion Drawing, conducting discussions and discussions and drawing conclusions.

The subjects of the study were the underwriting, actuarial and customer divisions. The method of determining informants is that informants must have experience or knowledge of Health insurance, can be reached or accessed easily, have credibility and honesty in providing data. This study uses a descriptive method that is more relevant than other qualitative methods in writing this article for the following reasons: it can provide a detailed description, describe phenomena systematically and factually, explain the mechanisms and processes of implementation, assist in policy and practice analysis and not just rely on subjective perceptions.

The underwriting and actuarial divisions were chosen because they can provide technical insight into how risk is calculated and managed in an Insurance Company, they are

professionals who are responsible for calculating risk and premium rates in health insurance. Its relationship to the focus of the study is that the implementation of risk management is highly dependent on actuarial analysis, which includes health risk prediction, appropriate premium calculation, and risk diversification strategies. Underwriting and actuarial decisions will affect the financial stability of the insurance company, so their role is very important in understanding how risk is managed.

While customers were chosen because they provide a perspective on how risk management policies directly impact them. Its relationship to the focus of the study is to help understand whether the implementation of risk management has been running well or there are still weaknesses, such as claim rejections, difficulty in accessing health services, or an imbalance between premiums and benefits received. Customer perception and satisfaction can also be an indicator of the effectiveness of risk management, whether the policies implemented are able to protect the company and continue to provide optimal benefits for customers.

RESULTS

Risk management implemented in insurance companies

Risk management in insurance companies is implemented through a series of strategies and processes to identify, analyze, control, and mitigate risks that can affect the company's financial stability. The following are the main stages in implementing risk management in insurance companies:

- ✓ Risk Identification. Insurance companies must recognize the various types of risks that can affect their operations, such as: Underwriting Risk - The possibility that the premium set is insufficient to cover the claims submitted. Excessive Claims Risk. An unexpected spike in claims due to a disaster, pandemic, or other esxtraordinary event. Investment Risk - Financial market instability can affect the return on investment of collected premiums. Regulatory Risk - Changes in government regulations that can affect insurance policies and business models. Operational Risk - System errors, fraud, or administrative failures that can disrupt the company's operations.

- ✓ Risk Measurement and Analysis. Once the risks are identified, the company conducts an analysis using actuarial and statistical methods to measure the likelihood of the risk occurring and its impact.

- ✓ Risk Mitigation and Control. Insurance companies implement strategies to reduce the impact of risk, such as: Strict Underwriting Policy - Screening potential customers based on their risk profile to ensure that only bearable risks are accepted. Product Diversification - Offering various types of insurance to spread risk and reduce dependence on one type of policy. Reinsurance - Transferring some of the risk to reinsurance companies so that large claims do not burden the

company's finances. Improving Operational Efficiency - Using technologies such as big data and AI to improve the accuracy of risk predictions and speed up the claims process. 4. Risk Monitoring and Evaluation. Risk management is an ongoing process, so companies must routinely evaluate the policies and strategies implemented by: Periodic Audits and Reviews - Evaluating the company's performance against risk management targets, Claim Data Monitoring - Identifying suspicious claim patterns and anticipating new trends in health or other risks and Premium Rate Adjustments - If there is an increase in risk, premiums can be adjusted to maintain financial balance.

The underwriting process in accepting and rejecting potential health insurance participants

Underwriting is the process of evaluating the risk of potential health insurance participants to determine whether they are eligible to be accepted, rejected, or subject to special conditions. This process aims to ensure that the insurance company does not suffer major losses due to claims that are not commensurate with the premiums paid. The underwriter will analyze the risk based on several factors: Age: The older the potential participant, the higher the health risk. Medical History: Chronic diseases such as diabetes, hypertension, or cancer can affect underwriting decisions. Lifestyle: Smoking habits, alcohol consumption, or high-risk jobs (eg miners or extreme athletes) will increase the risk. BMI (Body Mass Index): Obesity can increase the risk of disease, so it can affect underwriting decisions.

Based on the evaluation results, prospective participants will be categorized into one of the following four underwriting decisions: 1. Accepted Without Conditions. If prospective participants are healthy and have a low-risk profile, they will be accepted with a standard premium without any benefit exceptions. 2. Accepted with Conditions or Exceptions. If prospective participants have certain health conditions, the insurance company can: Apply benefit exceptions (for example, not covering pre-existing illnesses before enrollment), Offer higher premiums to adjust for additional risk or Set a waiting period before certain benefits can be claimed. 3. Rejected. If the risk is too high (for example, the prospective participant has a terminal illness such as advanced cancer), then the insurance application can be rejected because of the possibility of a large claim in the near future. 4. Postponed. If prospective participants have a medical condition that is currently undergoing certain examinations or treatments, the company can postpone the decision until there are clearer medical results.

Risk Mitigation and Management by PT AXA

Risk management at PT AXA Financial Indonesia is essential to ensure financial stability and business sustainability. Risks in insurance companies are mitigated and managed through various strategies, including: 1. Portfolio Diversification. Insurance companies spread risk by having a broad policy portfolio, covering various types of products (life insurance, health, vehicles, property, etc.) and avoiding concentration of risk in one

particular region or economic sector. 2. Reinsurance. Insurance companies transfer some of their risk to reinsurance companies to reduce the impact of large claims or disasters. 3. Strict Assessment and Underwriting. Establishing strict underwriting policies to ensure that only manageable risks are accepted. 4. Investment Risk Management. Investments are made with a conservative strategy to ensure sufficient assets to pay claims. Diversify investments in various instruments (bonds, stocks, property) to avoid the risk of market volatility. 5. Technical Reserves and Solvency Capital. Setting aside reserve funds to deal with unexpected spikes in claims, complying with solvency regulations set by financial authorities to ensure the company has sufficient capital. 6. Effective Claim Management. Preventing excessive claims or fraud by implementing a strict verification system and using technology to detect suspicious or fraudulent claims. 7. Compliance with Financial Regulations and Standards. Following regulations from the Financial Services Authority (OJK) or other supervisory bodies to maintain transparency and financial stability. 8. Education and Risk Mitigation for Customers. Providing education to customers about the risks they face and how to reduce the possibility of claims.

Implementation of Risk Management from the Customer's Perspective

Researchers conducted research on 1 underwriting and 1 actuaria from AXA Financial Indonesia, age 45-50 years, gender : female, years of service over 10 years and 2 customers with informant profiles: 36 – 45 years, gender: female, monthly income: 20,000,000 – 35,000,000, type of health insurance product owned: AXA Critical Protector. They have had the product between 3-7 years. From the information obtained, customers understand the concept of risk management and they apply it in their daily lives by taking insurance. There are customers' concerns because genetic factors are closely related to their physical appearance, so they take insurance so they don't have to spend their own money when they are old and sick. So far, customers are satisfied with the protection they have, but still hope that there will be improvements regarding risk management so that the company can be better.

Implementation of Risk Management from an Internal Office Perspective

Next, interviews were conducted with the internal office consisting of BOD, Underwriting Division, Claims Division, length of service: 10-15 years. Underwriting and claims play an important role for insurance companies. Underwriting acts as a filter for SPAJ (Life Insurance Application Letter) which causes large claims. Therefore, usually those who already have a history of critical illness or are very old (over 75 years) cannot have their request accepted.

Underwriting is the process of assessing the risk of potential policyholders. My understanding includes how underwriters evaluate health data, medical history, and other risk factors to determine insurance eligibility and set premiums accordingly. Underwriting also involves determining the limits of risk an insurance company can

accept without threatening profitability. This includes the use of actuaries to manage the overall risk portfolio.

Understanding of how insurance products can be tailored based on individual or group risk profiles, as well as how risks can be mitigated through exclusions or riders in policies. We understand the importance of an effective and fair claims process. This includes verifying claims, assessing validity based on policy terms and conditions, and managing policyholder expectations. An understanding of how to handle large claims that can have a significant impact on the company's reserves, including the establishment of adequate reserves and the use of reinsurance to reduce the financial impact. I also understand the importance of fraud detection in claims to protect companies from unauthorized claims and how technology and analytics can be used to detect suspicious patterns.

Considering that the claims and underwriting departments are the company's front line in determining the company's image in the eyes of customers, it is therefore mandatory to collaborate with all parties regarding these two matters. There are certain parts that must be verified with the main underwriting, such as Health History which must match the initial data. In the context of helping users, we can provide guidance and information involving various aspects of risk management that typically involve cross-departmental collaboration. For example, in implementing insurance risk management, this often involves collaboration between underwriting, claims, finance, legal and information technology departments.

Effective risk management can identify and prevent fraud more quickly and accurately. With advanced fraud detection systems, AXA Financial can reduce false claims, minimize losses, and ensure that legitimate customers receive fast and fair service. Proactive risk management enables AXA Financial to adapt quickly to changing market conditions and new trends. With ongoing risk monitoring and timely strategy updates, AXA can introduce products and services that are more relevant to today's customer needs. With an integrated risk management process in claims handling, AXA Financial can increase efficiency in processing claims, reduce processing time and increase transparency. This contributes to a better customer experience and increases overall satisfaction.

DISCUSSION

Insurance companies need to carry out probability measurements because this is the basis of the insurance business itself. Probability allows insurance companies to manage risk effectively, determine fair premium prices, and maintain financial stability. Insurance aims to protect against certain risks, such as accidents, natural disasters, or death. By measuring the probability of these events, insurance companies can estimate how often an event is likely to occur and how large a loss is likely to be. Probability measurements help insurance companies determine the premiums that policyholders must pay. If the probability of an insured event is high, the premium payable may be higher, and vice versa.

Insurance companies need to ensure that they have sufficient funds to pay claims. By understanding the probability of events that could lead to a claim, companies can manage their cash reserves more effectively. Without accurate probability measurements, insurance companies may insure too large a risk without charging enough premiums, which can lead to financial losses." To continue operating profitably, insurance companies must ensure that income from premiums is greater than claims paid. Probability measurements help companies make smart decisions to achieve this balance. General steps in the probability measurement framework include the first: Risk Identification. The first is to identify and define the risks that policyholders may face, such as the risk of fire, accident, death or disease. Both historical data and statistics regarding similar events are collected to understand the pattern and frequency of such risks.

The second step is Data Analysis. The data collected is analyzed to see past trends and emerging patterns, for example how often accidents occur in a year, measurements of the frequency of occurrence (how many times an incident occurs) and the severity of the impact (how much loss is generated) are carried out.

The third step is to find out the estimated probability, this can be done using a statistical method or model, such as a probability distribution, used to estimate the possibility of a risk occurring based on historical data. Some common models used are the binomial distribution, Poisson distribution, and normal distribution. The second way to find out the estimated probability is by calculating probability. From this model, the probability of each risk occurring is calculated. For example, if the data shows that 1 in 100 houses burn down every year, then the probability of a fire is 1%.

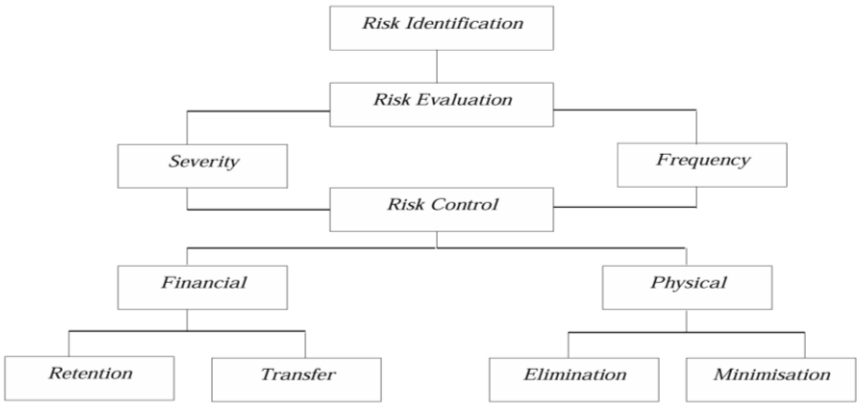

Figure 1. Risk Management Process PT AXA Financial Indonesia

Frequency and severity measurements are two important elements in risk management in insurance companies. These two measurements help companies understand claims patterns and estimate potential losses, allowing for more accurate premium setting and more effective risk management. This frequency measurement refers to how often a claim or loss event occurs in a certain time period. Frequency measurements help insurance companies assess the risks associated with a particular insurance product or

portfolio. If the frequency of claims is high, this indicates greater risk. Information regarding frequency is used to set insurance premiums. Products with a higher frequency of claims may incur higher premiums to offset potential losses. Understanding claim frequency allows companies to develop more efficient claims management strategies, such as preparing resources to handle a high number of claims. By knowing the frequency of incidents, insurance companies can take preventive steps to reduce the occurrence of claims, for example by providing incentives to policyholders to minimize risks.

Severity measurement means measuring the magnitude of losses or costs associated with a claim or loss event. This refers to the financial impact of the claim. Severity helps insurance companies estimate the total liability they must prepare to pay claims. This is important to ensure that the company has sufficient reserves. Severity is used in conjunction with frequency to calculate premiums. Insurance products with high severity (for example, health insurance for critical illnesses) will be subject to higher premiums. Information about severity helps companies decide on the need for reinsurance. For risks with high severity, companies may utilize reinsurance to protect themselves from potential large losses.

By understanding the severity, insurance companies can develop mitigation strategies to reduce the financial impact of claims, such as promoting practices that can reduce the size of losses in certain events. The combination of frequency and severity provides a complete picture of the claim patterns faced by the company. For example, low frequency with high severity indicates the risk of events that occur rarely but have a large impact. By multiplying frequency by severity, insurance companies can calculate the expected losses from a portfolio, which is an important basis for financial planning and premium setting. Information regarding frequency and severity can be used to develop new insurance products that are more appropriate to the risk profile faced by customers.

The focus of the research is to find out how risk management is implemented in insurance companies, how is the underwriting process in accepting and rejecting prospective health insurance participants and how are PT AXA's risks mitigated and managed.

Risk management in insurance companies is carried out by identifying, analyzing, controlling, and monitoring risks periodically. The goal is to protect the company's finances while ensuring that insurance benefits can still be provided to customers on an ongoing basis. Strategies such as tight underwriting, reinsurance, diversification, and utilization of technology are the main keys to effective risk management.

Underwriting in health insurance aims to balance participant protection and the sustainability of the insurance business. Underwriting decisions are based on the risk profile of prospective participants, which includes age, health history, lifestyle, and other factors. Not all participants are accepted. There is a possibility of being accepted

unconditionally, accepted with exceptions, rejected, or postponed. With this approach, insurance companies can maintain their financial stability, increase customer trust, and ensure fair and timely claim payments.

CONCLUSION

The implementation of risk management that applies at PT AXA Financial Indonesia to Health Products is very good. The implementation of risk management is in accordance with the standards set by the Financial Services Authority. PT AXA Financial Indonesia carries out 3 risk management implementation processes, namely risk identification, risk evaluation and risk control. Risk identification is carried out at an early stage when the participant submits a SPAJ (Life Insurance Application Letter) by looking at the personal data of the prospective insurance applicant. The second stage, namely risk evaluation (measurement and monitoring) is carried out by looking at the relationship between frequency and severity (level of loss) of each existing risk using statistical data such as subjective probability theory and relative frequency. Then the third stage is risk control, which includes physical control through elimination and minimization. As well as financial control by means of risk retention of 40%, risk transfer of 60%, and risk sharing.

The underwriting process in accepting and rejecting prospective health insurance participants at PT AXA Financial Indonesia through a strict verification process, including re-examination of medical documentation or interviews with policy holders, can reduce invalid claims. A thorough underwriting process can help identify potential policyholders at high risk. This allows companies to decline or adjust premiums based on the level of risk faced. Risk management also determines the appropriate limits and exclusions in an insurance policy can limit the potential for large, high-risk claims. If coverage is above 3 billion, participants are required to undergo a medical check-up at a designated laboratory in collaboration with PT AXA Financial Indonesia. Educating policyholders about policy terms and conditions, including what is covered and what is not, can prevent invalid claims due to ignorance. A proactive, integrated claims management team can identify and address potentially high-risk claims early, through better communication with hospitals or healthcare providers.

Risk mitigation (management) at PT AXA Financial Indonesia is very good. The insurance business is a service and trust business, so AXA must improve the claim verification and evaluation process to ensure that claims are handled accurately and efficiently. This includes reducing human error and ensuring that submitted evidence is carefully checked. Optimize data integration and access to ensure that all relevant information is available for the claims process. Well-integrated data can speed up claims processing and increase assessment accuracy. Improve the handling of complex claims, such as those involving major damages, serious injuries, or complicated situations. These types of claims require a dedicated approach and a well-coordinated process. Improve customer experience in the claims process by providing fast, transparent and fair service. A claims process that is slow or considered unfair can affect a company's

reputation and customer satisfaction. Ensure that all claims are processed in accordance with applicable regulations and legal requirements.

Implications of the Research

PT AXA Financial Indonesia should develop risk models that utilize historical data and current trends to better estimate possible risks. Work with actuaries to develop better risk assessment models and to predict the financial impact of various risks. Ensure that underwriting policies and procedures are clearly documented and accessible to the entire team. This helps in maintaining consistency and transparency in the risk assessment process. Conduct regular internal audits to assess the effectiveness of the underwriting process and identify areas requiring improvement. Gather feedback from underwriting staff and make adjustments to policies and procedures based on evaluation results and practical experience. Develop a standard workflow for claims handling that covers all steps from claim receipt to settlement. This helps in maintaining consistency and efficiency. Classify claims based on risk level and priority to ensure that claims requiring immediate attention are handled quickly. Develop strategies to mitigate risks related to claims, including steps to reduce legal and financial risks. Create reports and dashboards that provide visibility into claim status, processing time, and other performance metrics. This helps in monitoring performance and identifying problems proactively. Ensure clear and open communication between the claims team, customers and third parties to increase transparency and reduce the potential for disputes. Provide ongoing training to claims staff on the latest techniques in claims management, new technology and applicable regulations. Create professional development programs to increase staff skills and knowledge in claims handling.

Limitation and recommendations

The limitations of this research is only focus on a few health insurance companies, so the results may not necessarily represent the entire industry. The data used may be limited to a certain period, so it does not reflect long-term dynamics. If the research is more of a case study, the results may be difficult to generalize to other companies or other countries with different regulations. Technological developments such as big data and AI in risk management may not have been explored in depth in this study and if this research is conducted in one particular country or region, the results may be less relevant to companies in other countries with different regulations. Future research can expand the scope by analyzing more health insurance companies and using data over a longer period of time. Providing a review of comparative studies between health insurance companies in various countries or with other industries (eg banking or life insurance) can provide greater insight. Further research can explore how digital technologies, such as AI, blockchain, and predictive analytics, can improve the effectiveness of risk management in the health insurance sector. Further research can examine the impact of recent policies and regulations on the risk management strategies of health insurance companies and develop quantitative models to predict risks in the health insurance sector based on historical data and existing trends.

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