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POLICY COMPREHENSION AND PROCEDURES IN HEALTH INSURANCE CLAIM SUBMISSION

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Abstract

This paper explains why many people submit few health insurance claims even when coverage exists. Claim behavior is treated as a staged decision shaped by understanding of benefits, perceived process certainty, and experience with administrative demands during illness. Key causes include limited comprehension of policy terms, inconsistent guidance across service points, and procedures that require time, documents, and repeated verification. Negative expectations about acceptance, prior denial experiences, and unclear reasoning weaken trust and reduce willingness to initiate or continue claims. Non financial burdens matter, including stress, reduced attention while sick, and reluctance to engage in disputes with institutions. Social norms may label claiming as improper for minor costs, while privacy concerns can discourage disclosure through medical paperwork. Structural frictions arise when clinical workflows and claim workflows do not align, forcing patients to coordinate information manually. Limited administrative and digital skills, heavy work schedules, and family responsibilities further reduce follow through. The paper concludes that low claiming reflects combined cognitive, procedural, institutional, and social mechanisms that restrict practical access to contractual rights and shape choices toward direct payment and avoidance of administrative uncertainty.

Keywords: health insurance, claim behavior, administrative burden, trust, procedural fairness, policy understanding, privacy.

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Introduction

Health insurance is designed as a mechanism for transferring the risk of healthcare costs from individuals to the insurer through premium payments and the fulfillment of policy requirements. In a normative order, the existence of an insurance scheme presupposes that when participants experience a covered event, they will use their right to file a claim according to the procedure. The claim is the meeting point between the promise of protection and the realization of benefits, as well as an indicator of whether the legal relationship between the participant and the insurer is running as it should. However, in social experiences that are often discussed, policy ownership or membership is not always in line with the use of claim rights. There are members of the public who pay premiums regularly, but when facing medical expenses, they choose to pay themselves, delay treatment, or use other sources outside of insurance. This kind of choice shows that claiming behavior is determined by how society interprets benefits, risks, and procedures. In the relationship between participants, healthcare facilities, and insurance companies, there is a series of small decisions that determine whether a claim is filed, completed, and maintained until finished (Subagiyo, 2012). This series of decisions is not always guided by the policy text, but by perceptions of ease, certainty, and a sense of security when dealing with health service administration. In the context of more fundamental rights protection, Tampil et al. (2023) emphasize that legal protection guarantees for patients in the fulfillment of health rights at basic facilities such as Community Health Centers are absolutely necessary to realize inclusive service governance.

Filing a health insurance claim requires an understanding of benefit limits, exclusions, waiting periods, referrals, and documents deemed sufficient. Such requirements are reasonable because the insurer needs to ensure that the claim is in accordance with the covered risk and does not cause abuse. However, from the public's point of view, requirements can be perceived as an additional burden when someone is sick or accompanying a sick family member. In such situations, cognitive and emotional energy is often absorbed by medical decisions, service selection, and immediate cost arrangements. In circumstances that demand quick decisions, the claim procedure can be considered a matter that can be postponed, or even ignored (Azizah & Ningsih, 2019). Furthermore, the public often builds an

understanding of insurance from other people's stories, previous experiences, and information circulating in public spaces. If the dominant story emphasizes claim rejection, long processes, or unclear communication, then claims are perceived as carrying a risk of disappointment. This perception can lower the intention to file a claim from the start. Thus, low claims need to be read as a behavioral issue rooted in knowledge, experience, and expectations about services, not just a matter of whether or not formal protection exists. These behavioral expectations are linearly related to the program provider's performance; a study by Issalillah et al. (2021) confirms the significance of the role of insurance institution service quality on the functional satisfaction of participants.

Within the structure of health services, the claim process often intersects with clinical service flows and health facility administration. The public is faced with registration rules, referral requirements, service classes, and provisions for guaranteed drugs and procedures. When service flows are perceived as complex, claims can be considered to extend waiting times and increase uncertainty (Sarwo, 2015). This bureaucratic complexity dynamic is often felt directly at the primary care level, where Darmawan et al. (2022) identified that patient satisfaction analysis at the Surabaya is highly dependent on the responsiveness and quality of actual services received in the field. In certain circumstances, the public may judge that paying directly is faster and simpler, although economically not always more profitable. This kind of judgment illustrates that claim decisions are not always driven by benefit value calculations, but by a preference for process certainty. Furthermore, there is a perceived dimension of power relations. The public can feel their bargaining position is low when dealing with administrative staff, medical terms, and policy provisions. Administrative inferiority can encourage people to avoid situations that require questioning or negotiation. At this point, low claims can reflect the gap between the insurance mechanism design and the user's ability to navigate procedures. This distance is normative because it concerns reasonable access to rights, information comprehensibility, and service governance that respects users.

Low claim rates can also be influenced by how society assesses the morality of using insurance. Some people view claiming as a right that has been paid for through premiums, making its use considered reasonable.

Others may view claiming as an action that could harm the insurer or increase premiums, leading to a sense of reluctance to file a claim except in circumstances considered severe. Such moral views often arise from reasoning about justice, namely who bears the costs and whether someone deserves to receive benefits. In an insurance scheme, the risk-pooling principle does indeed assume solidarity through premiums, but explanations regarding this principle are not always understood by the public. Consequently, some people may choose not to file a claim to maintain a self-image as a person who does not cause trouble, or to avoid the stigma of being a party seeking profit. On the other hand, there are also members of the public who feel hesitant because they fear being considered to be filing an invalid claim, especially when policy provisions are not understood. This concern strengthens the tendency to hold back. Low claims, in this sense, can be shaped by social norms about propriety and by uncertainty about the boundaries of legitimate rights. This description directs the discussion to psychological and social factors that work alongside administrative factors.

Claim behavior is also related to the level of public trust in insurance institutions and healthcare service institutions (Sumarauw, 2013). Trust is built through communication experiences, decision consistency, and the comprehensibility of the reasons why a claim is accepted or rejected. When the public views the insurer's decisions as difficult to predict, they may judge that claiming is a risky activity that consumes time without a guarantee of results. This perception of risk will increase if the appeal or complaint process is perceived to be unclear. Furthermore, information asymmetry between the insurer and the participant can create a sense of imbalance. Participants often feel they do not have sufficient knowledge to argue regarding policy terms or medical justifications. When this imbalance is felt, the most psychologically safe choice is not to file a claim, or to file a claim only for certain cases deemed very strong. Trust is also related to the integrity of personal data and the confidentiality of medical records. Concerns about data usage can make some people reluctant to interact intensively with claim procedures. Thus, low claims cannot be separated from issues of institutional legitimacy, communication transparency, and administrative security. A normative study is needed to map the trust assessment mechanisms that influence claim decisions.

The main problem that needs to be explained is the existence of a gap between the claim rights promised in the health insurance design and the practice of using those rights by the public. Insurance assumes that participants will utilize the claim mechanism when a covered health risk occurs. However, in social practices that are often discussed, membership does not automatically result in claim actions. This gap raises conceptual questions about the causative factors that work before a claim decision is made. These factors can be in the form of unclear benefit information, perceptions of complicated procedures, or uncertainty about claim results. The gap can also be a difference in how costs are interpreted. The public may judge that small costs are not worth claiming because they consider claiming to require a time cost. The public may also judge that claiming has the potential to trigger conflicts with healthcare facilities or insurers (Nurkholidah, 2018). More macroscopically, this inequality of access is rooted in structural arrangements; Hartono et al. (2024) highlight how pharmaceutical companies' regulations and corporate social responsibility in the distribution of generic drugs and patent rights have a direct impact on equity of access in the National Health Insurance System. In a normative framework, this gap touches on the principle of access to rights, namely whether available rights can be used reasonably by those entitled. If the use of rights is highly dependent on administrative capacity, then those rights are at risk of becoming formalities. This problem needs to be described as an issue of the relationship between system design, communication of rights, and user capacity, without proposing solutions at the preliminary stage.

The next problem is the diversity of forms of low claim rates, which are often grouped together as a single symptom. There are situations where the public does not file claims because they do not understand the procedures, situations where the public understands but is reluctant due to bad experiences, and situations where the public assesses that the benefits of claiming are not commensurate with the process. There are also situations where the public decides from the outset not to use insurance at certain facilities due to fear of rejection or fear of receiving different treatment. This diversity shows that low claim rates can arise from a combination of cognitive, emotional, institutional, and social factors. This inequality of psychosocial burdens reflects an uneven structure of environmental and health justice in society; Issalillah and Mardikaningsih

(2022) explain how marginalized communities around landfill sites bear asymmetric health burdens due to weak environmental justice instruments. In a normative framework, grouping these factors is important so that the discussion does not fall into the simple judgment that the public is under-educated or that the insurer is always making things difficult. If factors are not sorted, the description will lose its sharpness and struggle to explain the cause-and-effect mechanism. This problem also demands a distinction between claims that are not filed, claims that are filed but not completed, and claims that are abandoned because the process is considered exhausting. Each form contains different causal factors. Therefore, this study needs to construct a conceptual framework capable of capturing the variation in claiming behavior in an orderly manner, using formal language that can be traced argumentatively.

The urgency of this writing lies in the need to construct a systematic normative explanation regarding the factors causing the low rate of health insurance claims by the public. Such an explanation is necessary because low claim rates do not always mean low healthcare needs, but rather may indicate problems in the understanding of rights, procedural governance, or institutional legitimacy. This is where future-oriented public policy plays a role; Issalillah (2021) emphasizes the importance of advancing the quality of life of the community through the formulation of sustainability policies that prioritize health and equal rights in reality. In the perspective of public policy and service governance, mapping causal factors is important to ensure that the financial protection promised by insurance can be accessed reasonably. In the perspective of contract law, a claim is the execution of a performance related to the promise of protection, so low claim rates can raise questions about the quality of the contractual relationship perceived by participants. In the perspective of behavior, the claim decision is influenced by perceptions of time cost, risk of rejection, and a sense of security when dealing with administration. Therefore, a normative study that unites contractual, institutional, and behavioral dimensions will clarify how to read low claim rates as a complex but map-able problem. This urgency is also related to the protection of financial service consumers, as access to clear information and fair processes are parts of service justice.

The objective of this writing is to develop a conceptual framework that explains the low rate of health insurance claims by the public as a

right-utilization behavior. The description is directed toward identifying categories of causal factors, explaining the assessment mechanisms underlying claim decisions, and organizing the relationships between policy design, service procedures, and institutional trust. This writing aims to clarify the distinctions between various forms of low claiming, including non-filing, delaying, and abandoning the claim process. Theoretically, this writing provides a basis for developing propositions regarding claim behavior within a consumer protection framework. Practically, it offers a conceptual reference for improving the communication of rights and the governance of the claim process.

Method

This study employs a qualitative literature review to construct a conceptual synthesis regarding the low rate of health insurance claims by the public. The materials used include sources on social research methodology, theories of service utilization behavior, and normative legal research methodology, which positions norms and principles as the foundation for argumentation. Dudley (2005) is utilized to organize the systematic search, selection of sources, and the construction of the argumentative flow to ensure each section remains consistent with the problem formulation. Greenfield and Greener (2016) are used to strengthen precision in developing themes, formulating working definitions, and unifying various ideas without rendering the description a mere collection of isolated concepts. The reading is directed toward identifying recurring explanatory patterns in the discourse on claim decisions, such as the understanding of benefits, perceived time costs, and assessments of process certainty. With this approach, the writing remains normative and does not include interviews, field observations, or the presentation of numerical data.

The processing of materials is carried out through systematic reading and thematic coding to group ideas into themes of participant knowledge, information clarity, claim procedure design, service experience, institutional trust, and social norms that shape the perceived appropriateness of filing a claim. Diantha (2016) is used to affirm the workings of normative legal research in justifying legal theory, particularly when linking principles of consumer protection, certainty of rights, and procedural fairness with user behavior. Variations in citation styles are applied proportionally, such as

narrative forms like Greenfield and Greener (2016) and parenthetical forms like (Dudley, 2005), to ensure the narrative flows smoothly. Conceptual validity is maintained through consistency of terminology, the rejection of generalizations that require empirical verification, and the organization of conclusions that follow the problem formulation. The results of the study are presented as an explanatory framework that can be used to interpret low claiming as an issue of access to rights, comprehension of information, and process legitimacy.

Result and Discussion

Regulations regarding health insurance claims in Indonesia are based on a legal framework that distinguishes between mandatory social insurance and voluntary commercial insurance. The main foundation for social health insurance is regulated in Law Number 40 of 2004 concerning the National Social Security System (SJSN) and Law Number 24 of 2011 concerning the Social Security Organizing Agency. Within the Social Security Organizing Agency ecosystem, claim governance is technically regulated through Minister of Health Regulation Number 3 of 2023, which establishes standards for healthcare tariffs and procedures for collective claim submissions by healthcare facilities so that the medical rights of participants are sustainably fulfilled.

For private or commercial health insurance, the main legal umbrella is Law Number 40 of 2014 concerning Insurance, which regulates the obligation of insurance companies to settle claims in a timely and transparent manner (Hutagalung, 2024). This regulation affirms that every insurance policy must contain clear clauses regarding claim procedures, rejection criteria, and dispute resolution timeframes. This aims to protect customers from baseless claim payment delay practices and ensure that insurance companies have sufficient financial resilience to meet their future obligations to policyholders.

The Financial Services Authority (OJK) has a central role in overseeing insurance claim governance through OJK Regulation (POJK) Number 23 of 2015 concerning Insurance Products and Insurance Product Marketing. In this rule, insurance companies are required to have standard operating procedures for handling claims and are prohibited from complicating the submission process with requirements that are irrelevant or not listed in the

policy (Fauzi, 2023). Furthermore, POJK Number 6 of 2022 concerning Consumer Protection in the Financial Services Sector strengthens the customer's right to obtain honest information and access to complaint resolution in the event of a dispute over claim value.

In the health insurance claim submission process, medical documents play a crucial role as authentic evidence of the occurrence of a risk covered by the policy. Regulations regarding this intersect with Minister of Health Regulation Number 24 of 2022 concerning Medical Records, which enables the integration of electronic medical records to accelerate the claim verification process between hospitals and insurance companies (Juniati et al., 2023). Data accuracy in medical records becomes the main determinant of whether a claim will be approved or rejected based on the principle of information non-disclosure, which often becomes a dispute in the insurance industry.

If a claim rejection is considered unilateral or unfair, regulations provide an out-of-court dispute resolution path through the Alternative Dispute Resolution Institution for the Financial Services Sector (LAPS SJK). The existence of this institution is based on POJK Number 61 of 2020, which provides professional and objective mediation and adjudication services for insurance customers (Shidiq et al., 2022). With this mechanism, customers have a more balanced bargaining position to fight for their claim rights without having to go through a court process that takes a long time and costs a lot of money.

The effectiveness of insurance claims is highly dependent on a customer's understanding of policy limitations, such as waiting periods, pre-existing conditions, and annual benefit limits (Wilananda et al., 2023). Literacy regarding these regulations is essential so that the public can choose insurance products that match their medical needs while simultaneously understanding the legal procedures that must be followed if obstacles arise in the disbursement of benefits. Synergy between insurance company compliance and customer diligence is the key to creating a healthy and trusted health protection ecosystem in Indonesia.

The low rate of health insurance claims by the public can be understood as the result of multi-level decisions that occur before, during, and after a person receives healthcare services (Grignon, 2014). At the pre-service stage, an individual assesses whether the health event experienced is

covered by policy benefits, whether the chosen facility is in accordance with the provisions, and whether the required procedures can be met. At the during-service stage, an individual assesses whether using insurance will affect the speed of service, choice of doctor, choice of medication, and comfort of communication with administrative staff. At the post-service stage, an individual assesses whether the requested documents can be collected, whether the claim time limit is still available, and whether the probability of the claim being accepted is large enough to justify the effort expended. Within a normative framework, the claim decision is a form of exercising rights that is highly dependent on information comprehensibility and perceptions of process certainty. If at any stage a participant assesses that the risk of failure or feelings of discomfort are too high, the participant may choose not to file a claim. Such choices often appear rational from the participant's point of view because they minimize potential conflict, reduce administrative burdens, and maintain focus on health recovery. Therefore, low claim rates cannot be understood merely as a lack of need, but as an indicator of the presence of causal factors working within the participant's assessment of procedures, institutions, and benefits.

The factor of knowledge and comprehension of policy benefits is a category of causes that often determines the initial step. Health insurance policies contain technical terms, such as exclusions, benefit limits, ceilings, referrals, and pre-authorization requirements (Ramakrishna, 2023). If participants do not understand these terms, they will find it difficult to distinguish between services that are guaranteed and services that have the potential to be rejected. A lack of understanding creates uncertainty. Uncertainty creates a tendency to avoid claims, as participants do not want to face rejection after spending time managing documents. Within a normative framework, knowledge is not just about reading a policy, but the ability to translate provisions into practical decisions, such as when to request a referral letter and when to request a breakdown of costs. Participants who are not accustomed to healthcare administration may feel hesitant to ask, so information does not increase. This hesitation can be reinforced by previous experiences when questions were not answered clearly. As a result, participants choose the path considered more certain, which is paying for themselves or seeking services that do not require claims. Thus, low claim rates can be explained as a consequence of the

inability to convert policy information into a simple, followable map of actions during situations of illness.

Communication clarity from insurers and healthcare facilities is a causal category that connects knowledge to action. Participants may possess a policy, but information regarding claim procedures is often scattered across various sources, such as brochures, websites, customer service channels, and staff explanations (Fabong et al., 2024). If explanations are inconsistent, participants will be confused about the correct steps. Confusion can lead participants to delay, and delays can end in no claim being filed at all. Within a normative framework, clear communication means explanations that are concise, consistent, and usable for making decisions at the right time. Clear communication also includes explaining the reasons for rejection, because reasons that can be understood enhance the participant's learning for subsequent claims. If the reason for rejection is perceived as vague, participants may judge that the insurer's decision is arbitrary. This assessment lowers trust and reduces the intention to file claims. Furthermore, participants often need situational information, such as how procedures differ between outpatient and inpatient care. If communication does not provide a firm distinction, participants must guess. Guessing is a heavy cognitive burden during times of illness. Thus, communication clarity is an independent causal factor because it shapes the participant's perception of process certainty, rather than just increasing knowledge.

The design of the claim procedure and the number of administrative steps can be a major cause of low claim rates, especially when the procedure is perceived to be time-consuming. Procedures that demand many documents, many signatures, and many verifications can be considered disproportionate to the claim value that will be received (Febrianti & Batubara, 2024). In the participant's assessment, time cost is a real cost. Time costs include waiting in line, photocopying, contacting customer service, and waiting for clarification. If participants judge that these time costs interfere with work or family, participants will hold back. Within a normative framework, long procedures have the potential to turn rights into burdens, because exercising a right requires an investment that not everyone can make. Furthermore, long procedures increase the risk of administrative errors, such as incorrectly filling out forms or missing one

document. The risk of error makes participants worry that the claim will be rejected, so participants choose not to try. Procedures also often require a specific sequence. If the sequence is not understood, participants may skip important steps such as authorization. When steps are missed, participants feel that the claim effort is useless. Thus, procedure design shapes claim behavior through perceptions of time cost and perceptions of the risk of administrative error.

Perception of claim outcome certainty is an intermediate causal factor, as it transforms intention into action or vice versa. Participants assess whether a claim is likely to be accepted (Chen & Urminsky, 2019). This assessment is shaped by personal experience, other people's stories, and the insurer's reputation. If the dominant story is one of rejection, participants judge that claiming is a risky activity. Within a normative framework, outcome certainty is influenced by the transparency of evaluation criteria. If criteria appear complex, participants judge the decision to be difficult to predict. Decisions that are difficult to predict make participants reluctant to incur time costs. Furthermore, outcome certainty is influenced by the consistency between initial information and final decisions. When participants feel they have followed instructions but the claim is still rejected, participants judge that the procedure does not provide protection. This assessment lowers the legitimacy of the process. Process legitimacy is important because claiming is an activity that requires trust in the evaluator. Without legitimacy, participants choose to avoid it. The perception of outcome certainty is also related to the clarity of benefit limits. If benefit limits appear easily changeable through exclusions, participants feel insecure. Thus, low claim rates can be explained as a response to outcome uncertainty shaped by communication experiences, reputation, and the comprehensibility of criteria.

The service experience at healthcare facilities can influence claim decisions through feelings of comfort and being respected (Madathil & Greenstein, 2018). Participants may judge that using insurance will lead to different administrative treatment, such as having to go through specific counters, waiting for verification, or repeating explanations. If participants feel they are being treated as a burden, they will avoid claims on future visits. Within a normative framework, feeling respected is part of procedural justice, which is the experience that the process is orderly and

humane. Procedural justice is important because participants are in a vulnerable condition. When the claim procedure prolongs discomfort, participants judge that claiming is not a psychologically safe option. Furthermore, participants may worry that administrative questions will embarrass them, for example, questions about their ability to pay or their membership status. This concern can be a strong driver for choosing direct payment. Service experience also includes the consistency of information between staff members. If different staff give different information, participants feel they must argue, and many people avoid arguments when they are sick. Thus, service experience becomes a causal factor for low claim rates because it transforms the claim from a mundane administrative activity into a social experience that can cause stress.

Factors of non-financial transaction costs, such as emotional costs and attention costs, are often ignored in discussions about claims, even though they determine behavior (Restocchi et al., 2017). When someone is sick, their capacity for attention decreases. In this state, administrative tasks become heavier than when they are healthy. Claims require focus, accuracy, and diligence in following steps. If this capacity is not available, the participant will delay. Delays can result in documents being lost, deadlines passing, or motivation being lost. Within a normative framework, emotional costs arise when participants feel afraid of being rejected, afraid of being blamed, or afraid of being treated unfairly. Emotional costs also arise when participants must repeatedly explain their medical condition or family condition to different parties. For some people, such repetition causes fatigue. Claims may also require interaction with digital systems that require accounts, passwords, and document uploads. Digital interaction can add burden to people who are not accustomed to it. Thus, low claim rates can be explained as a result of non-financial transaction costs that make claiming feel exhausting. This framework emphasizes that improving claim behavior is not enough by just adding information, because the problem often lies in the limited attention capacity at the time a health event occurs.

Trust in insurance institutions and perceptions of contractual fairness are fundamental categories of causes (Gunay, 2022). Participants bind themselves to an insurance contract because they believe that the promise of protection will be fulfilled according to the provisions. If

participants view the contract as unbalanced, for example, provisions being more easily used to reject than to pay, then participants will judge claiming as a path not worth taking. Within a normative framework, contractual fairness is related to the readability of the policy, the reasonableness of exclusions, and the consistency of the application of provisions. Participants who view the knowledge gap between the insurer and the participant may feel they are always in a losing position. This feeling of losing makes participants avoid interactions that could lead to rejection. Trust is also influenced by access to complaint mechanisms. If complaint mechanisms are perceived as unresponsive, participants feel there is no way forward when a claim dispute occurs. The feeling of having no way forward reinforces the decision not to file. Besides that, participants judge the company's integrity through the way the company answers questions. Standard answers that do not address the problem make participants feel ignored. Thus, low claim rates can be understood as a form of withdrawal from a contractual relationship that is not trusted, even though the contract formally continues through premium payments.

Social norms regarding the appropriateness of filing a claim can suppress the exercise of rights. In some environments, claiming is viewed as an action that should only be taken under specific conditions, such as for severe illnesses or significant costs (Grootegoed et al., 2013). This perspective may arise from values of frugality, a desire not to be a nuisance, or the belief that one should bear costs alone as long as one is able. Within a normative framework, such values are not incorrect as personal ethics, but they can reduce the utilization of rights that are actually provided. When social norms perceive small claims as inappropriate, participants will pay out-of-pocket. This habit can persist even when claims should be easy. Furthermore, social norms may judge frequent claiming as a sign of irresponsible behavior or an indication of profit-seeking. Such stigma makes people reluctant. Social norms can also influence families; for example, families may encourage a sick member not to bother with claim procedures so they can go home sooner. Family pressure can be strong because family members are in a position of caregivers. Thus, low claim rates can stem from community moral judgments that influence the individual. This framework demonstrates that claiming is not merely an economic decision, but a social

one considered through self-image, the judgments of others, and the norms of propriety prevailing in the environment.

Factors of administrative literacy and digital literacy can limit claim access even when benefits are available. Administrative literacy includes the ability to fill out forms, manage documents, and understand terminology (Martin et al., 2023). Digital literacy includes the ability to use applications, upload files, and monitor claim status. When literacy is low, participants will experience friction that makes the process feel burdensome. Within a normative framework, administrative friction turns rights into tasks that require specific expertise. Consequently, rights are no longer equal for all participants. Participants who have family or peer support can be assisted, whereas participants who are alone will be left behind. Furthermore, literacy affects the ability to read messages from the insurer, such as notices about additional documents. If participants do not understand, claims are delayed or closed. Literacy also affects how participants store payment receipts and medical summaries. Without a habit of record-keeping, documents are easily lost. When they are lost, participants choose to stop. This framework confirms that low claim rates can arise from limitations in practical abilities, not from a rejection of insurance. In a normative discussion, literacy factors demand attention because they relate to the principle of reasonable access to benefits, and to the obligation of financial service business actors to provide information that can be understood.

The relationship between participants and healthcare facilities can give rise to a causal factor in the form of dependence on administrative staff as intermediaries (John et al., 2018). Participants often rely on staff to explain documents, convey verification status, and provide guidance. When staff are limited or unresponsive, participants lose their guidance. The loss of guidance makes participants feel the process is unmanageable. Within a normative framework, intermediaries hold an important position because they mediate technical knowledge into practical steps. When mediation fails, participants regard claiming as a task that cannot be completed. Furthermore, participants may feel reluctant to ask for help repeatedly. Reluctance is a social factor that holds back action. Participants may also worry that asking too many questions will disrupt medical services. This concern encourages participants to choose direct payment to avoid additional interaction. Thus, low claim rates can be understood as a

result of dependence on intermediaries who are not always available. This framework is important because it shows that claim access does not depend solely on the contract, but also on the service ecosystem that provides adequate guidance. If guidance is inconsistent, participants will feel that claiming is a territory filled with uncertainty.

Time constraints and claim deadlines can transform a decision from an active intention into total abandonment. Many claim processes contain strict submission deadlines, which are structurally designed to maintain administrative order (Aloun & Manaseer, 2024). However, for a participant, these deadlines can become a significant source of psychological pressure, especially when the individual is still in the process of medical recovery. Within a normative framework, this temporal pressure leads participants to judge that the claiming process adds an unsustainable burden while their health condition remains unstable. Participants may defer the task with the intention of handling it when they are feeling better. This deferral can often result in missing the deadline. Once a deadline is missed, participants learn that the effort of claiming is futile, causing them to abandon any attempt to file in future health events. Furthermore, claims often require specific documents that must be requested at a precise moment, such as an itemized billing statement before leaving the facility. If the participant is unaware of this, acquiring these documents later becomes difficult. This difficulty becomes a negative learning experience, which significantly lowers motivation. Thus, low claim rates can be understood as the result of a fundamental misalignment between the rhythm of health recovery and the rhythm of administrative claim procedures. Health rhythms often cannot be forced, while administrative rhythms are frequently rigid. This lack of synchronization creates a failure point that encourages participants to avoid the process in the future.

Perceptions regarding the quality of protection and the value of premiums can drive a passive attitude toward claim filing. Participants continuously assess whether the premiums paid are commensurate with the benefits they can actually access (Barik et al., 2021). If a participant judges that benefits are limited for example, due to numerous exclusions or strict benefit caps they will deem the claim process as rarely useful. This perception of low utility decreases the attention paid to learning or following procedures. Within a normative framework, attention is a

mental resource allocated to matters deemed valuable. If the perceived value is low, attention is diverted toward other choices, such as personal savings or utilizing cheaper, non-insured services. Value perception is also heavily influenced by the experience of observing the difference between the total service cost and the actual amount reimbursed. If a participant feels the gap is too large, they judge the claim to be unworthy of the effort. This perception can arise even when a claim would cover a portion of the costs, because the participant assesses the administrative effort as not being worth the return. Additionally, participants may judge that filing a claim will increase their future premiums, even if this understanding is not always accurate. This anxiety regarding premium hikes causes participants to hold back. Thus, low claim rates can be explained as the result of a value assessment shaped by an understanding of benefits, past reimbursement experiences, and expectations of future costs.

Factors of preference for certainty and personal control can lead participants to choose direct out-of-pocket payments. In situations of illness, many individuals seek control in order to feel secure. Insurance claims often involve third parties who determine the eligibility and the amount of payment. This involvement of third parties can diminish a participant's sense of control. Within a normative framework, the sense of control influences behavior because people tend to choose pathways they can personally manage. Paying directly is considered a way to conclude the affair immediately without waiting for a third-party decision. Participants may feel that paying directly provides the certainty that the service is finished and there will be no follow-up administrative issues. Filing a claim is perceived as opening a series of follow-up tasks, such as requests for additional documents or verification processes. Furthermore, participants may fear that an administrative error might force them to pay twice. This fear strengthens the preference for direct payment. The preference for control is also evident in the choice of healthcare facilities. Participants may choose facilities that do not cooperate with their insurance because they want the freedom to choose their services. Although this choice may increase their costs, participants value that freedom. Thus, low claim rates can be understood as an expression of a preference for certainty and control, rather than merely as a result of ignorance. This framework helps

explain why providing procedural education alone is often insufficient if the participant's sense of control remains low.

The reputation of the insurer and public narratives regarding claim denials can shape strong negative expectations. These negative expectations lead participants to judge that filing a claim is a field of potential conflict. The imagined conflict may take the form of disputes over documents, medical diagnoses, or referral procedures. Within a normative framework, this imagined conflict triggers avoidance behavior, as individuals naturally steer clear of situations that could induce stress. Negative expectations also create an information selection bias, where participants more easily recall stories of claim rejection than stories of acceptance. This bias increases the perception of risk. Furthermore, public narratives often fail to distinguish between legitimate reasons for rejection and reasons perceived as unfair. When this distinction is absent, all rejections are perceived as injustice. The perception of injustice lowers contractual legitimacy. With low legitimacy, participants are not motivated to utilize formal channels; instead, they choose paths they consider safer. This framework demonstrates that low claim rates can be influenced by the information environment that shapes reputation. Reputation, though social in nature, has real consequences for individual decisions. Thus, the factor of public narrative needs to be placed as a causal category that explains the formation of participant expectations.

Factors of insurance product design, such as benefit structures and exclusions, can influence claims through simplicity or complexity. Complex products with numerous provisions can make it difficult for participants to understand when a claim is appropriate. This difficulty lowers claim frequency because participants choose the safe option of not trying. Within a normative framework, complex products increase cognitive costs. Cognitive cost is the burden of understanding information before acting. When cognitive costs are high, participants delay learning. Delaying learning means claim decisions are made in an unprepared state. Unpreparedness causes claim failure, and failure causes participants to quit. Furthermore, products often differentiate benefits based on service types and classes. This differentiation can cause participants to mistakenly choose non-guaranteed services. Choosing incorrectly triggers a negative experience. Negative experiences strengthen the perception that insurance

is useless. Thus, low claim rates can be explained as a result of product designs that are not friendly to comprehension. This explanation does not state that products must be simple in all respects, but rather asserts that complexity has behavioral consequences. Complexity reduces the exercise of rights. This framework is important for distinguishing between causes that originate from the character of the participant and causes that originate from the character of the product.

The relationship between claims and social stigma related to health conditions can also suppress claim behavior. Some individuals maintain the confidentiality of their health conditions for fear of being judged by their work or social environment. The claim process can be perceived as compromising privacy, for instance, through the medical documents that must be attached and communication with the insurer. Within a normative framework, concerns regarding privacy can be a causal factor for low claim rates, especially for services considered sensitive. Participants may choose to pay out-of-pocket so that there are no administrative traces involving other parties. This concern is reinforced if participants do not trust that their data will be protected. Moreover, social stigma can make participants reluctant to request detailed medical certificates or summaries because they fear staff will ask too many questions. When documents are incomplete, claims are not filed. Thus, low claim rates can stem from considerations of privacy and stigma. This framework expands the understanding that claim decisions are related to social security, not just costs. In normative studies, privacy is a value that must be accounted for when explaining why the public does not utilize their rights. If the claim procedure does not provide a sense of privacy security, then utilization will decline.

The misalignment between clinical workflows and claim workflows can create operational friction. Clinical pathways demand rapid decision-making, whereas claim pathways demand detailed documentation. When a physician selects a specific intervention for patient safety, that intervention may require administrative approvals that are not easily obtained. Participants may feel that procedures interfere with medical decisions. Within a normative framework, this feeling of interference leads participants to judge insurance as an obstacle, prompting them to avoid claims in the future. Furthermore, participants may experience ambiguity regarding when to handle documents whether before or after treatment.

Ambiguity leads to sequencing errors, and sequencing errors can trigger rejections. Rejection becomes an experience that alters behavior. Thus, low claim rates can be understood as a consequence of friction between two systems: the medical service system and the insurance administration system. This framework also explains why some participants choose simpler payment schemes despite higher costs; they value the seamlessness of the clinical flow. In a normative discussion, this friction must be mapped as a structural causal factor because it does not depend solely on the participant's intent. It depends on the coordination design between the facility and the insurer, as well as the participant's understanding of the decision points within that flow.

Factors of rejection experiences or repeated correction experiences can form negative learning. Negative learning occurs when participants conclude that claim efforts are not worthwhile because there are always deficiencies. Deficiencies may relate to documents, submission timing, or service code mismatches. Within a normative framework, negative learning lowers administrative self-efficacy the belief that one is capable of completing a process. When self-efficacy drops, participants will avoid similar processes. Participants will opt for direct payment or choose different services. Negative learning can also lead participants to assume that claiming requires "insider" assistance. This assumption lowers the sense of fairness and decreases motivation. Furthermore, negative learning reinforces pessimistic public narratives. Disappointed participants tend to share their experiences, and those experiences influence others. Thus, negative learning operates at both individual and social levels. Low claim rates can increase due to an accumulation of negative experiences. This framework emphasizes the importance of early experiences. If the initial claim experience is poor, subsequent claim behavior will decline. Conversely, if the initial experience is positive, participants are more confident. However, this study remains normative and does not present frequency measures, but rather explains the learning mechanism as a conceptual cause.

Factors of limited working time and family burdens can make claim filing perceived as an impossible activity. Many individuals have dense work schedules and heavy family responsibilities. Claims often require additional visits, phone communications, or uploading documents activities requiring time that is not always available. Within a normative framework, time

constraints are a structural barrier to the exercise of rights, as rights require active steps. If a person lacks free time, rights become difficult to use. Time constraints also interact with service distance; if a branch office or service point is far away, the time burden increases. This time burden leads participants to ignore claims for costs they deem not significantly large. However, ignoring small costs can become a habit, leading to infrequent claims. This framework shows that low claim rates can be formed by repeated decisions that appear small. Small decisions are shaped by time constraints, which also affect the ability to read policies and store documents. Busy people tend to postpone administration, and postponement leads to lost documents. When documents are lost, claims are not filed. Thus, time constraints and family burdens are causal factors that explain low claim rates without having to blame the participants.

Factors of clarity regarding covered and non-covered costs can influence the desire to file claims. Participants often desire certainty from the outset regarding how much the insurer will pay and how much they must pay themselves. If this certainty is unavailable, participants worry about "surprise costs." The anxiety of surprise costs can drive participants to choose the scheme they can best predict. Within a normative framework, predictability is a primary value in financial decisions during illness. If claiming makes costs difficult to predict, participants avoid it. Furthermore, participants may experience confusion when faced with co-payment or deductible systems. This confusion leads participants to feel that the benefits are not significant. When benefits are perceived as small, claim motivation decreases. Cost clarity is also related to the transparency of billing details. If billing details are not easily understood, participants are not confident that the claim will be paid. Doubt holds back action. Thus, low claim rates can be explained as a result of ambiguous cost-sharing which reduces financial security. This framework asserts that claiming is not merely an administrative process, but one that requires clear cost information to reduce anxiety. If cost information is unclear, participants choose to reduce uncertainty in a way they can control: direct payment.

The quality of customer service relationships and access to assistance can determine whether participants persist in the claim process (Christodoulou & Samuell, 2020). When participants encounter difficulties, they require specific answers. Specific answers help participants

correct documents and move forward, whereas generic answers make participants feel unsupported. Within a normative framework, assistance is a component of procedural fairness, as a fair procedure provides a path for participants to correct errors. If the path for correction is unclear, participants choose to stop. This reciprocal relationship is reinforced by the findings of Khayru and Issalillah (2022), which affirm that service quality interactively and directly determines patient satisfaction within the public healthcare service ecosystem. Access to assistance is also related to response time. If responses are slow, participants judge that the process does not respect the urgency of their health needs. This assessment lowers legitimacy. Furthermore, participants evaluate the attitude of the staff; an unempathetic attitude makes participants feel humiliated. A sense of humiliation drives future avoidance. Thus, low claim rates can stem from the quality of customer service interactions, which shape procedural experiences. Procedural experiences shape trust, and trust determines the courage to file subsequent claims. This framework positions customer service as a significant causal factor, as it is the gateway for participants to transform misunderstanding into correct action. Without this gateway, rights become difficult to use in practice.

Factors regarding the lack of clarity in the relationship between insurance and other financing schemes can confuse participants when choosing a path (Barik et al., 2021). Some participants have more than one funding source, such as family assistance, office facilities, or other programs. When multiple paths are available, participants must decide on the fastest and most certain one. If the rules for coordination of benefits are not understood, participants fear rejection on the grounds of "double claiming." This fear may lead participants to choose only one path and ignore their insurance. This condition is complicated by the sociological facts mapped by Issalillah, Darmawan, and Khayru (2021), where the combination of individual psychological effects, demographic conditions, and the socio-cultural landscape simultaneously influences how society makes decisions related to the utilization or purchase of insurance products. Within a normative framework, coordination of benefits requires clear explanation so that participants do not feel at risk. If such explanation is absent, participants take a conservative decision, which is to avoid claiming. Moreover, participants may consider managing several financing paths a

burden that is not commensurate with the results; they opt for the simplest path. Thus, low claim rates can be understood as a consequence of the complexity of financing choices. This complexity is not a participant's error, but a condition that demands decision-making capacity. When sick, this capacity decreases. This framework explains why participants tend to choose the path that is nearest and easiest to execute, even if that path does not maximize financial benefits. In normative discussion, a complicated map of choices increases the likelihood of avoidance.

The factor of perceived justice namely, whether participants feel they are treated equally also influences claims. When participants perceive that certain individuals more easily obtain approval, they feel the system is unfair (Goecke et al., 2020). A sense of unfairness decreases the motivation to use the system because participants feel their chances are slim. Within a normative framework, procedural justice and equal treatment are the foundations of legitimacy. Legitimacy affects participants' adherence to procedures and their willingness to engage. This aspect of legality demands the strengthening of regulations; a juridical review by Tamaka et al. (2023) underlines that the fulfillment of patient rights within the mandatory health security system must normatively be positioned as a pillar of legal justice that cannot be sidelined. If legitimacy is low, participants will reduce their involvement. Reduced involvement manifests as low claim rates. Furthermore, participants evaluate whether claim decisions are accompanied by verifiable reasons. Verifiable reasons make participants feel treated as subjects, while unverifiable reasons make participants feel treated as objects. Being treated as an object lowers the sense of being valued. A sense of being valued is essential for the courage to ask questions and correct documents. Thus, low claim rates can be understood as a consequence of the perception of low equality. This framework asserts that claiming is a social relationship between the participant and the institution. Social relationships require procedural justice. If procedural justice is not perceived, rights are not exercised.

Factors of financial habits, such as the tendency to pay in cash and avoid administration, can influence claim behavior. Some members of society are accustomed to settling cost matters directly so that the business is finished (Abidi & Khan, 2021). This habit is formed by experiences in various public and private services. Within a normative framework, habits

are behavioral patterns chosen because they are considered efficient. When the habit of direct payment is strong, claiming is perceived as a deviation from the pattern. Deviation requires energy, so people avoid it. This contractual behavioral tendency is rooted in how initial perceptions are built; research by Issalillah and Khayru (2022) proves that the premium nominal and the brand image of insurance corporations crucially shape the public's initial interest or desire to place themselves as insurance customers. Habits are also related to how people store payment receipts. People accustomed to cash often do not keep details. Without details, claiming is difficult. Difficulty makes people assume that claiming is not suitable for them. Thus, low claim rates can be explained as a result of habits that are not aligned with documentation demands. This framework shows that claim behavior does not occur in a vacuum; it rests on habits formed over a long time. Habits can change, but change requires a trigger. Normative study does not determine empirical triggers, but explains that as long as the direct payment habit is considered simpler and more certain, claims will remain low. This reinforces the importance of understanding behavioral factors as causes, not just as supplements.

The factor of perceived fraud risk and concerns about becoming involved in legal problems can suppress claim filing. Some individuals fear that claims may lead to accusations of manipulation or trigger investigations they find intimidating (Abhyankar, 2020). This fear can arise from ignorance regarding the boundaries of legitimate claims. Within a normative framework, such ignorance leads to over-compliance, where individuals avoid legitimate actions for fear of committing an error. Over-compliance reduces claims. To mitigate such administrative fears while simultaneously preventing systemic bias, Bashori et al. (2024) offer a legal analysis on the urgency of utilizing big data and advanced analytics to prevent procedural discrimination while ensuring transparent legal protection for insurance consumers. Furthermore, people may worry that their medical documents will be misinterpreted. They choose not to get involved. Concerns can also arise from news reports about insurance abuse by other parties. Such news may cause people to perceive the system as full of risk, even if they intend to be honest. Thus, low claim rates can be understood as a side effect of an information environment that highlights issues of abuse without providing clear explanations of legitimate actions. This framework emphasizes that a system aiming to increase the

exercise of rights must ensure that participants feel safe when acting correctly. If a sense of security is absent, participants will choose the path that is safe for them: avoiding claims. This explanation is normative as it organizes the relationship between security, knowledge, and the decision to exercise rights.

Low claim rates can also occur when participants view insurance benefits as more suitable for major events, while minor events are easier to pay for out-of-pocket. This view forms a psychological claim threshold. The claim threshold is the subjective limit of when an individual feels that filing a claim is worthwhile. Within a normative framework, the claim threshold is shaped by perceptions of value, time costs, and previous experiences. When the claim threshold is high, claims become infrequent. A high claim threshold may appear rational, yet it can reduce the learning of procedures. Participants who rarely file claims are not accustomed to managing documents. When a major event occurs, participants remain unprepared. This lack of readiness can result in errors and rejections. Rejection reinforces negative learning. Thus, a high claim threshold can create a cycle. This cycle explains why low claim rates can persist even when healthcare needs exist. This framework also demonstrates that claiming is an administrative skill that requires practice. When it is not practiced, ability remains low. Low ability increases the risk of failure, and the risk of failure lowers the intention to file. Thus, low claim rates can be understood as the result of a habit of deferring claims, which appears efficient but produces administrative vulnerability when needed most.

The factor of information integration between the insurer, the healthcare facility, and the participant can determine the smoothness of a claim. When information systems are not aligned, the participant becomes a manual link who must carry documents and re-explain information. This role as a manual link adds a burden. Viewed from a macro-social perspective, this bureaucratic information misalignment intersects with the external dynamics of patients; Warin (2023) explains the existence of a close social relationship between the characteristics of urban living and the social determinants of public health as a whole. Within a normative framework, this burden is not always visible in the policy design, but is felt tangibly in experience. Participants may judge that the system asks them to perform work that should be done by the institutions. This assessment lowers acceptance of the procedure. Furthermore, information

misalignment can lead to errors, such as mismatched identity data or inappropriate service codes. These errors can cause claims to be delayed. Delays trigger frustration, and frustration encourages avoidance. Thus, low claim rates can be explained as a consequence of system misalignment that shifts the burden of coordination onto the participant. This framework shows that causal factors do not always lie with the participant. There are structural factors that make claiming difficult. However, this study remains normative and does not establish levels of difficulty, but rather explains the mechanism of how information misalignment generates friction and how friction reduces the exercise of rights.

Ultimately, the causal factors for low claim rates can be organized as a framework that links knowledge, procedure, trust, and social norms. Knowledge and comprehension determine whether a participant is able to assess the eligibility of a claim. Procedures and administrative burdens determine whether a participant is willing to carry out the steps. Institutional trust determines whether a participant is confident that the process will be fair and the outcome predictable. In the dimension of protecting vulnerable groups, Khayru (2022) reminds us that social support systems have crucial implications for the effectiveness of healthcare service provision, particularly for the fulfillment of the rights of the elderly population who are often constrained by administrative capacity. Social norms and preference for control determine whether a participant feels that claiming is appropriate and safe for their self-image. This framework answers the problem formulation because it shows that low claim rates are not caused by a single factor, but by a combination of causal categories operating at different stages of the decision-making process. Low claim rates can emerge when one of the causal categories is strong enough to hinder action. For example, a participant understands the benefits but does not trust the certainty of the outcome. Or a participant has trust but lacks the time and literacy to prepare the documents. Or a participant is capable but pressured by social norms that judge claiming as inappropriate. Thus, a good normative explanation must map the causal factors and their working mechanisms, rather than simply listing them. This framework can serve as a conceptual foundation for further discussion on rights access and procedural fairness without presenting empirical data.

Conclusion

The conclusion of this writing states that the low rate of health insurance claims by the public can be explained through a combination of conceptual factors operating across knowledge, procedures, service experiences, and social assessments. A lack of understanding regarding policy benefits, unclear communication, and the complexity of claim procedures create a perception that claiming requires significant time costs and carries risks of administrative error. Perceptions of outcome uncertainty, experiences of rejection, and unhelpful customer service decrease trust in the legitimacy of the process. Social factors such as norms of appropriateness, stigma related to health conditions, and preferences for certainty and personal control can drive individuals to choose direct payment despite possessing the right to claim. Structural factors, including the misalignment between clinical and claim workflows, constraints on working time and family burdens, as well as limited administrative and digital literacy, reinforce the tendency to avoid claims. The developed conceptual framework demonstrates that low claiming is the result of a multi-level decision-making process, whereby causal factors can emerge before, during, or after the completion of services.

The implications and suggestions emphasize that interpreting the low rate of claims requires viewing a claim as the exercise of a right that demands comprehension, procedural fairness, and a service experience that respects the participant. Communication regarding benefits and procedures must be understood as part of the access to rights, as unclear information increases uncertainty and encourages avoidance. Claim governance needs to be evaluated based on time burden, risk of error, and the availability of specific assistance, as these factors determine whether a participant persists until the process is complete. Strengthening trust requires understandable decision-making rationales and grievance mechanisms that provide a sense of security, ensuring participants are not afraid to exercise their legitimate rights. Social norms that suppress claims should be interpreted as behavioral factors influencing the claim threshold; thus, public education needs to affirm that claiming is a reasonable action within a contractual relationship. For the advancement of scholarship, further research could develop conceptual indicators

regarding administrative friction, procedural justice, and administrative self-efficacy as explanations for claim decisions.

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