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Legal provisions and responsibilities for fraud in Indonesia's national health insurance services

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Abstract. Since the enactment of Act Number 40 of 2004 concerning the National Social Security System (JKN) and Act Number 24 of 2011 concerning the Health BPJS, BPJS membership has increased sharply. However, fraud-related issues are also escalating, undermining efforts to realize citizens' constitutional right to health. This paper attempts to analyze the laws governing legal accountability and liability concerning fraud in health services and its implementation. This study uses an empirical legal research method to explore how fraud occurs when implementing national health insurance. Empirical data is obtained by conducting focus group discussions and interviews with some stakeholders implementing the National Health Insurance (JKN) system. Legal responsibility for fraud in health services is regulated both generally and specifically. The sanctions and legal responsibilities for fraud can be in the form of administrative sanctions as regulated in Article 6 Paragraph (1) of the Minister of Health's Regulation Number 16 of 2019, civil sanctions in the form of compensation based on the provisions of Article 1367 of the Civil Code or criminal sanctions based on the provisions of Article 378 of the Criminal Code. The paper concludes by recommending regulatory improvements and stronger institutional oversight to ensure accountability and minimize fraud in the JKN system.

1. Background

Health is every citizen's right as affirmed by Article 28 H of Paragraph (1) of the Republic of Indonesia's Constitution (UUD NRI 1945) stating that every citizen has rights to get physical and spiritual prosperity, to have a home, and to enjoy a good and healthy environment, and to receive health services. The State must be responsible to fulfill the rights as affirmed by Article 34 of Paragraph (3) of the Constitution which states, "The state is responsible for the provision of adequate health services and public service facilities." To implement this goal of health insurance, the government has enacted Law Number 24 of 2011 concerning the Social Security Administering Body (BPJS) which came into effect on January 1, 2014.

In 2022 43.06% of the population had accessed health services through outpatient facilities. This figure has increased compared to the previous year, namely from 40.4%. This percentage is expected to increase continuously as the morbidity rate increases to 13.36% in 2022 from 13.04% in 2021. Of this number, 43.32% of outpatients choose Community Health Centers (*Puskesmas)* for treatment, a significant increase compared to 17.87% in 2021.

JKN membership and access to health services are benchmarks for quantitative success. However, complex issues also arise, including actions that damage or diminish the public trust in health care facilities, such as widespread reports on fraud within the health care system. These actions can be categorized as errors (*dolus*) or negligence (*culpa*) which can be categorized as fraud in health care affairs.

Fraud in health care is defined as a form of deliberate efforts to create or obtain benefits that should not be enjoyed by individuals or institutions and can harm other parties. Meanwhile, according to the Regulation of the Minister of Health of the Republic of Indonesia (*Permenkes*) Number 16 of 2019 on The Prevention and Handling of Fraud and the Imposition of Administrative Sanctions for Fraud in the Implementation of the Health Insurance Program, fraud is defined as "an act committed intentionally to obtain financial gain from the health insurance program in the

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National Social Security System (SJSN) through fraudulent acts that are not in accordance with statutory provisions."

Alexander Marwata, Deputy Chairman of the Corruption Eradication Commission (KPK), said in the 2024 National Meeting on Health Facilities for BPJS of Health (September 19, 2024) that the health care system in 2024 had approximately IDR 150 trillion in funds for supporting health care services for 98% of the registered Indonesians. It was found that losses caused by fraud were about 10% of the public health expenditures or approximately IDR 15 trillion. The cases that have never been reported are about manipulations/phantom billings carried out by health facilities (*faskes*), both central and regional, which collaborate with Health BPJS.[2]

One of the most vulnerable areas of fraud in SJSN's program often occurs at the health facility (*faskes*) level. It can occur at both primary and secondary health facilities. Although the greater possibility occurs at the primary health facilities, greater financial losses happen at the referral health facilities. The primary health facilities are more susceptible to making unnecessary referrals to avoid incurring higher capitation fees paid by Health BPJS. Meanwhile, advanced referral health facilities are more susceptible to adding excessive diagnosis codes (upcoding) to inflate billing costs.

Based on the above background, the researchers are interested in conducting a study entitled: "Implementation of Legal Responsibility for Fraud in National Health Insurance Health Services". The research questions are as follows:

1. How is legal responsibility for fraud in health services regulated under the National Health Insurance?

2. How is legal responsibility for fraud in health services implemented under the National Health Insurance?

2. Discussion

2.1 Legal Responsibility

2.1.1 Definition of Legal Responsibility

Here are some terms for the theory of legal responsibility in several languages; *Teori Pertanggungjawaban Hukum* (Indonesia), The theory of legal liability (English); *De theorie van wtteelijke aansprakelijkheid* (Dutch); *Die theorie der hafting* (German). It is defined as a theory that analyzes the responsibility of legal subjects or perpetrators who commit unlawful acts or criminal acts that cause harm, disability, or death to another person. The word responsibility (*verantwoordelijkheid*) itself is defined as an obligation to bear responsibility and losses (if sued), in the fields of Criminal, Civil, and Administrative Law. According to The Indonesian Big Dictionary (KBBI) the word responsibility means the state of being obliged to bear everything (if something happens, you can be sued, blamed, prosecuted, and so on).

Therefore, the party who must be sued or accept responsibility for an unlawful act is the party who committed the act. However, under certain conditions, another party may be held responsible for another person's action, known as vicarious responsibility theory.[3]

Legal responsibility can be defined as follows:

a. Black's Law Dictionary:

Legal Responsibility:

1) Responsibility which court recognize and enforce as between parties litigant.

2) Responsibility recognized and enforced by the court between parties in a dispute.

[2] https://nasional.kompas.com/read/2024/09/19/23045561/kpk-sebut-kerugian-akibat-fraud-di-bidang-kesehatan-capai-rp-20-t?page=all&utm_source=Google&utm_medium=Newstand&utm_campaign=partner

[3] Mardani, 2024, Teori Hukum – Dari Teori Hukum Klasik Hingga Teori Hukum Kontemporer, Jakarta: Kencana, hlm. 233

b. Responsibility imposed on a legal subject for committing an unlawful act.

c. Subject to compensation and/or criminal responsibility.

Two terms for legal responsibility:

1) Responsibility refers to civil legal responsibility, namely responsibility for wrongdoing by a legal subject related to the existence of an element of loss.

2) Responsibility refers to broader meaning beyond civil responsibility.

According to J.H. Niewenhuis, as quoted by Mardani, responsibility is the obligation to bear compensation for violations of norms. These violations of norms can occur due to: a) unlawful acts; b) breach of contract. The responsibility rests on two pillars, namely violation of law and fault.[4]

Theories of legal responsibility based on fault:

1) General principles in criminal and civil laws.

2) Responsibility is imposed on the perpetrator of a criminal offense due to fault or negligence

3) Articles 1365 and 1366 of the Civil Code (BW) define fault as the determining factor in responsibility.

4) The concept of fault: intent and negligence.

5) Receiving compensation if proven guilty.[5]

Essentially, responsibility based on presumption is responsibility based on fault but with the burden of proof shifted to the defendant. This theory is used to analyze the responsibility of legal actors (subjects) who commit unlawful acts. This is meant as an act that incurs losses or costs or opposes/resists a criminal offense for the wrongdoing of their actions.[6] In Indonesian, responsibility is defined as the obligation to bear (be responsible) for something (if something happens or if there is a discrepancy that can be sued, questioned, and prosecuted).

The meaning of self-responsibility means an effort to be willing to bear the costs (maintain, manage), to guarantee and there is a statement about one's full willingness to carry out obligations for what is charged. Hans Kelsen's means legal responsibility by referring a person who is legally responsible in bearing his responsibility for a certain action. In other words, the person is willing to accept sanctions that are prosecuted through legal channels for his actions that are not in accordance with the law itself (contradictory). Kelsen also stated that "failure to exercise the care required by law is called negligence; and negligence is usually seen as ‘fraud of another type’ of *culpa* although less severe than a mistake, committed because of anticipating and intending, with or without malice, harmful consequences."[7]

2.1.2 Fraud Regulation in Healthcare Facilities and Referral Systems

In the National Health Insurance implementation, fraud in the referral system is regulated in Minister of Health Regulation Nr. 16 of 2019 concerning the Prevention and Handling of Fraud and the Handling of Administrative Sanctions for Fraud in the Implementation of the Health Insurance Program.

[4] Ibid., hlm. 234
[5] Muh. Nizar, dkk, “Ajaran Kausalitas Dalam Penegakan Hukum Pidana”, 2019, *Jurnal Education and development*, Vol. 7 (1), Edisi Januari 2019, hlm.49
[6] Peter Mahmud Marzuki, *Pengantar Ilmu Hukum, Cet. Ke-Dua,* Kencana Pernada Media Groub, Jakarta, 2009, h. 158.
[7] Salim HS dan Erlies Septiana, *Penerapan Teori Hukum dan Penelitian Disertasi dan Tesis*, Rajawali Pres, Jakarta, 2013, hlm. 7

Fraud is defined as an act of deception in both public and private spheres using improper, fraudulent, and manipulative methods that harm many people, including individuals and entities.[8] There are two factors that cause fraud, namely motivation and opportunity. Several motivational factors that encourage a party involved to commit fraud include lack of incentives and economic pressure, greed, internal pressure, and work environment that condones fraud.[9] This is related to the opportunity factors, namely an environment with inadequate control and supervision and circumstances that allow for collusive behavior among fraud perpetrators. The impacts of fraudulent acts are massively destructive.[10]

Fraud in health insurance programs is essentially an act of deception, trickery, or fraudulent conduct against health care programs by defrauding patients of the services provided to them for unlawful gain, involving individuals, healthcare entities, and even the participants themselves.[11] Any act (including negligence) of concealing facts about health care services with the aim of deceiving others or other parties can be categorized as health care fraud, including false claims, complex schemes, strategies to conceal something, value misrepresentation, service misrepresentation, inflated claims, and abuse of the health insurance system.[12]

4 Regarding fraud in health care programs implementation, Article 2 of Minister of Health Regulation Number 16 of 2019 stipulates: "Fraud in health care program implementation is possibly committed by health care participants, Health BPJS, healthcare facilities, drug and medical device providers, and even all parties who commit and/or contribute to the fraud."

Types of fraud committed by participants as regulated in Chapter II of the Attachment to Ministerial Regulation Number 16 of 2019 include: 1) falsifying participant data and/or identity to obtain health services; 2) lending, renting, or selling participant ID belonging to another participant or to oneself; 3) exploiting one's rights for unnecessary services, including requesting referrals to FKRTL for non-medical reasons, collaborating with health facilities to obtain health services not in accordance with medical indications, forcing additional diagnostic tests, medications not medically indicated, providing false information in establishing a diagnosis; and others.

Types of fraud committed by health facilities or health service providers, which can be committed by doctors, specialists, or other health workers as regulated in Chapter II of the Attachment to Ministerial Regulation Number 16 of 2019 include:

a) Fraud by FKTP service providers, include 1) to misuse of capitalization and/or non-capitalization funds of FKTP owned by the Central and Regional Governments; 2) to collect fees from participants that do not comply with statutory provisions; 3) to manipulate non-capitalized claims, such as false/fictitious claims (phantom billing), extended length of stay, cloning claims from other patients, and repeat billing for previously billed cases; 4) to refer patients that do not comply with statutory provisions;

b) Fraud by FKTL providers include 1) to manipulate diagnoses; 2) to plagiarize claims from cloned patients, created by copying claims from existing patients; 3) to make false/fictitious claims; and 4) to inflate drug and/or medical device bills; and others.

Meanwhile, the types of fraud committed by drug and medical device providers include: 1) the drug providers registered in the electronic catalog reject drug orders without a clear reason; 2) the drug providers delay drug delivery without a clear reason; 3) to providing and/or receive bribes and/or rewards related to health insurance programs; 4) the medical device providers registered in the electronic catalog refuse ordering medication without a clear reason;

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[8] Sarah Andiri et al, "Pengaruh Kompetensi, Independensi, dan Tekanan Waktu Auditor Investigatif Terhadap Pengungkapan Fraud", 2021,Jurnal Akrual Vol. 14 No. 2, hlm.151

[9] Andi Yaumil Bay Thaifur, "Studi Kualitatif Fraud Pelayanan Kesehatan: Literature Review", 2023, MPPKI Vol.6 No.6, hlm. 1069

[10] Natalis Christian dan Joelyn Veronica, "Dampak Kecurangan Pada Bidang Keuangan dan Non-Keuangan Terhadap Jenis Fraud di Indonesia", 2022, JRAMB Vol. 8 No.1, hlm 95

[11] Yustin Nur Faizah et al, *"Fraud Detection in Healthcare Organitation: a Bibliomatric Analytics Approach"*, 2021, International Colloqulum on Forensics Accounting and Governance, Vol.1 No.1, hlm. 96

[12] Andi Yaumil Bay Thaifur, Op.Cit, hlm. 1066

Based on the description above it is clear that any referral by medical personnel of primary health care facilities (FKTP) does not comply with the provisions of laws and regulations, as stated in Appendix I, Chapter II on the List of Clinical Practice Guidelines Based on Problems and Diseases as regulated in Ministerial Decree Nr. Hk.01.07/Menkes/1186/2022 on Clinical Practice Guidelines for Doctors at Primary Health Care Facilities, and based on Articles 4, 5, and 7 of Ministerial Regulation Nr. 1 of 2012, showing fraud committed by FKTP. This aligns with the provisions of the fourth, sixth, and seventh dictums of Minister of Health's Decree Nr. Hk.01.07/Menkes/1186/2022, which stipulate that the clinical practice guidelines must be used as a reference in developing standard operating procedures (SOP) at each primary health care facility (FKTP). Modifications to the clinical practice guidelines may only be made under certain circumstances and must be documented in the medical record, specifically in the context of special patient circumstances, emergencies, resource limitations, and in the development of evidence-based medicine and technology. Therefore, any referral by medical personnel at a FKTP that does not meet the aforementioned criteria constitutes fraud.

Regarding the fraud committed by the FKTP mentioned above, its resolution process, as stipulated in Chapter IV on Fraud Handling in the Appendix to Minister of Health's Regulation Nr. 16 of 2019, is as follows:

a) Resolution by health facilities/Health BPJS/other stakeholders: a. The fraud prevention team at the health care facilities, together with management, resolve fraud cases discovered through early detection. b. The outcome of the resolution may include internal improvements and/or the imposition of internal sanctions to the perpetrator. c. If the fraud case cannot be resolved internally the fraud prevention team of the health care facilities report the case to the fraud prevention team of district level or city health office.

b) Resolution by the fraud prevention team at the district level/city health office: a. The team at the district level/city health office resolve fraud cases discovered through detection or as reported by the health care facilities. The resolution mechanism may involve verification and confirmation with the relevant parties. The resolution process may be assisted by experts. b. The outcome of the resolution may include recommendations for improvements and/or the imposition of administrative sanctions.

c) Settlement by the fraud prevention and handling team at the provincial level: a. The fraud prevention and handling team at the provincial level resolve fraud cases discovered through detection or being reported by the district/city fraud prevention team. The settlement mechanism can be carried out through investigative examinations of the relevant parties. The settlement process can be assisted by experts. b. The results of the case resolution can be in the form of recommendations for improvement and/or the imposition of administrative sanctions. c. In the event that the fraud case cannot be resolved by the fraud prevention and handling team at the provincial level, the team will report the case to the fraud prevention and handling team at the central level.

d) Resolution by the fraud prevention and handling team at the central level: a. the fraud prevention and handling team at the central level resolve fraud cases discovered through detection or being reported by the fraud prevention and handling team at the provincial level. The resolution mechanism can be carried out through investigative examinations of the relevant parties. The resolution process can involve experts and/or professional organizations, and coordinate with the fraud prevention and handling team at the provincial level. b. The results of case resolution by the team may include recommendations for system and regulatory improvements, administrative violations investigation, code of ethics violations investigation, and/or report it to law enforcement officers.

Regarding the fraud committed by the primary health care provider (FKTP), Article 6 paragraph (1) of the Minister of Health's Regulation Number 16 of 2019 stipulates that: "For the purposes of supervision, the Minister, Head of the Provincial Health Office, and Head of the Regency/City Health Office may impose administrative sanctions on any person or corporation as referred to in Article 2 that commits fraud."

This indicates that fraud in health insurance program implementation, including that is committed by FKTP, can be subject to administrative sanctions. They having authority to impose the administrative sanctions are Minister of Health, Head of the Provincial Health Office, and Head of the District/City Health Office. Furthermore, Article 6 paragraph (2) of Minister of Health's Regulation Number 16 of 2019 stipulates about administrative sanctions.

The administrative sanctions as stipulated in paragraph (1) include a. verbal warning; b. written warning; and/or c. order to reimburse the injured party for losses resulting from fraud.

Article 6 paragraphs (3) and (5) of Minister of Health's Regulation Number 16 of 2019 stipulate that If fraud is committed by a health service provider the administrative sanction will be possibly accompanied by additional sanctions in the form of fines and license revocation. This losses reimbursement is different from compensation in civil law which is carried out by filing a lawsuit for unlawful acts and conducted in the competent district court. Instead, it is to impose sanctions in the form of a state administrative decree on any party committing fraud as stipulated by Minister of Health's Regulation Number 16 of 2019. Meanwhile, the proof of the existence or absence of fraud is carried out based on the mechanism regulated in Chapter IV on Handling Fraud in the Appendix to Minister of Health's Regulation Number 16 of 2019 in conjunction with Article 19 of BPJS Regulation Number 6 of 2020. The imposition of administrative sanctions as stipulated in Chapter V of the Attachment to Ministerial Regulation No. 16 of 2019 regulates that the categories of fraud and administrative sanctions are as follows:

a) If the fraud committed results in a loss of less than IDR 50,000,000 (fifty million rupiah), each type of fraud is categorized as a minor violation.

b) If the fraud committed results in a loss of between IDR 50,000,000 (fifty million rupiah) and IDR 500,000,000 (five hundred million rupiah), each type of fraud, or if a minor violation has already been sanctioned, it is categorized as a moderate violation.

c) If the fraud committed results in a loss of more than IDR 500,000,000 (five hundred million rupiah), each type of fraud, or if a moderate violation has already been sanctioned, it is categorized as a serious violation.

Furthermore, regarding the criminal responsibility in relation to fraud in the national health insurance program, Article 6 paragraph (7) of Minister of Health's Regulation Number 16 of 2019 stipulates that administrative sanctions as referred to in paragraph (2) do not eliminate criminal sanctions in accordance with statutory provisions. Regarding the criminal element of fraud committed by primary health care providers (FKTP), namely referring patients that is inconsistent with statutory provisions as stipulated in Minister of Health's Decree Number Hk.01.07/Menkes/1186/2022, the criminal offense that can be imposed on FKTP is a fraud criminal action as stipulated in Article 378 of the Criminal Code, namely:

Anyone who, with the intent to unlawfully benefit themselves or another person, by using a false name or false identity, or by deception or a series of lies, induces another person to hand over goods or grant a loan, which may result in loss, shall be subject to a maximum prison sentence of four years.

Regarding the element of guilt in criminal acts, Article 1, number 1 of Minister of Health's Regulation Number 16 of 2019 explains that:

Fraud is an act committed intentionally to obtain financial gain from the health insurance program of the National Social Security System through fraudulent acts that violate statutory provisions.

This can be interpreted that all fraud regulated in the Minister of Health's Regulation have an element of deliberate guilt, and by law, any act containing an element of negligence, omission, or error is not defined as fraud as regulated in the Minister of Health's Regulation. Therefore, sanctions for fraud as stipulated in Article 6 paragraph (2) of the Minister of Health's Regulation emphasize the element of deliberate error. Any negligence in implementing standard operating procedures in health services that results in harm to patients is essentially malpractice and has its own criminal provisions. However, fraud as stipulated in Minister of Health's Regulation Number 16 of 2019, the element of deliberate error is emphasized. In reality, however, though it is a case of error it is often still declared as fraud because there is no regulation differing error cases and fraud cases.

Furthermore, it should be emphasized that the Head of the FKTP is criminally responsible if, and only if it can be proven, that the criminal act was ordered by the Head or person in charge of the FKTP. The study in this research is criminal acts committed by FKTP in which the responsible party is the Head or person in charge of the FKTP. If the criminal act is committed by a functional physician (doctor) without orders or instructions from the Head or person

in charge of the FKTP then, by law, the individual committing the fraudulent act is personally responsible. This will be constituted a separate study from this research.

Fraud can result in criminal sanctions for the perpetrator while abuse does not result in legal sanctions. Examples of abuse include:[13]

a. to increase service rates or to apply service rates that do not meet standards

b. upcoding, that is to submit a claim for a service with a more expensive procedure code than it should be

c. to split claims that should be included in a single package into separate units (unbundling) to increase the cost

d. to refer health services only within one's own business environment (not based on competency)

e. to provide medication/treatment beyond what is required for a patient

3. Conclusion

Based on the research results and discussion above the following conclusions are drawn:

a. The legal responsibility of primary health care facilities for fraudulent referrals to the National Health Insurance program is regulated in Article 14 paragraph (1) of Minister of Health's Regulation Number 71 of 2013 concerning Health Services in the National Health Insurance stating that health care services for participants are implemented in stages according to medical needs, starting from primary healthcare facilities. Article 4 of Minister of Health's Regulation Number 1 of 2012 concerning referrals states that health care services are implemented in stages according to medical needs, starting from primary healthcare facilities while secondary health care services can only be provided upon referral from the primary health care facilities. The benchmark for providing referrals is regulated in Minister of Health's Decree Number HK.01.07/Menkes/1186/2022. Legal responsibility of the first level health facilities is administratively based on the provisions of Article 6 Paragraph (1) of the Minister of Health's Regulation Number 16 of 2019 stating that FKTP is administratively responsible if there is a violation of the provisions of letter C Chapter II of the Attachment to the Minister of Health's Regulation Number 16 of 2019, namely verbal warning, written warning, and/or order to return losses due to fraudulent actions to the injured party. This will not eliminate criminal and civil responsibilities if the fraud committed by FKTP causes losses to the victim concerned. Even the results of the case resolution made by the Fraud Prevention and Handling Team at the central level can be in the form of recommendations for improving systems and regulations, examining administrative violations, examining violations of the code of ethics, and/or reporting to law enforcement officials in this case to be held criminally responsible or used as written evidence in civil lawsuits. Under civil law, based on Article 1367 of the Indonesian Civil Code, primary health care facilities (FKTP) are civilly responsible for fraudulent acts in the national health insurance program committed by medical personnel, health workers, and other personnel bound by an employment relationship with the FKTP. Under criminal law, based on Article 378 of the Indonesian Criminal Code, FKTP management is criminally responsible, if, and only if, it can be proven that the crime was ordered by the FKTP management. This is contractually regulated in a cooperation agreement between Health BPJS and primary health facilities (FKTP) which stipulates that if FKTP is proven to have committed fraud, Health BPJS has the right to terminate the partnership.

b. Sanction implementation as a legal responsibility to fraud in health care services.

When fraud is indicated in healthcare services sanctions are implemented in the form of administrative, civil, and criminal sanctions. In practices fraud often occurs due to the errors in the form of upcoding therefore imposing administrative sanctions is considered far more effective in forcing people to comply with the legal provisions which

[13] P.R. Kongstvedt, Op.Cit

is expected to maintain the sustainability of the health insurance program. However, it is possible that criminal sanctions will also act as a deterrent for hospitals that conduct phantom billing in health care services.

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