# Analysis of the Possibility of Fraud in the National Health Insurance Program in Indonesia

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***Abstract***.
*The study focused on the purpose of finding out the effect and covering fraud in the National Health Insurance. Fraud is an act carried out intentionally to gain financial gain from the JKN program in the National Social Security System, through fraudulent acts that are not in accordance with the provisions of laws and regulations. Health fraud is a serious threat to the world, causing financial misuse of scarce resources and negative impacts on access to health, infrastructure, and social determinants of health. In Indonesia, cases of fraud continue to increase from year to year. The purpose of this study is to find out the latest studies related to the analysis of the opportunities for fraud in health insurance, and how the mechanism for effective prevention and mitigation efforts can be implemented in the implementation of the Health Insurance program in Indonesia. The method used in this journal uses qualitative descriptive through a literature study approach. Opportunities for fraud practices in JKN can be identity falsification, collusion to make false claims, unnecessary health care, excessive invoices, deviations or upcoding of diagnosis codes, document discrepancies, and duplicate claims. The reasons for fraud that usually occur are known as the fraud triangle, namely motivation, opportunity, and rationalization. Result of this study suggested systematic prevention efforts are needed together by health service providers, BPJS, and the Government by implementing the principles of a fraud prevention system, and the formation of a fraud prevention team that is adjusted to the needs for scale of the organization and national, in the future to reduce the negative impacts that occur.*

***Keywords***: *Fraud, fraud triangle, healthcare fraud, JKN and insurance concept.*

## I. INTRODUCTION

The National Health Insurance Program (JKN) is a government program that aims to provide health protection to all Indonesian people. This program is based on the principle of solidarity, where each participant pays contributions according to their ability. JKN is regulated in Law Number 40 of 2004 concerning the National Social Security System (SJSN) and is run by the Health Social Security Administering Agency (BPJS)[1]. The JKN program is a health development effort to increase awareness and also the ability of each person to be able to get used to living healthy[2] in order to achieve a high level of public health, in an effort to achieve the highest level of health, integrated, systematic, directed and comprehensive health development planning is needed, and cannot be separated from the involvement of various or all parts of the nation in its implementation[3]. Since its implementation in January 2014, the implementation of the National Health Insurance (JKN) policy has been marked by various problems[4]. One of the main problems expressed by the President Director of BPJS Indonesia in the commemoration of World Anti-Corruption Day on December 7, 2024, was the case of fraud committed by a few hospitals in Indonesia, with a total alleged fraud reaching around IDR 866 billion. According to the KPK report, since the first semester of 2015, there have been around 175,000 claims from BPJS Health Service Providers[5]. Of the thousands of claims, IDR 400 billion was detected as fraud, especially from upcoding practices. Meanwhile, according to the Indonesia Corruption Watch (ICW), health insurance is the second largest object of corruption in the health sector[6].

Fraud is an act carried out intentionally to gain financial gain from the Health Insurance program in the National Social Security System through fraudulent acts that are not in accordance with the provisions of laws and regulations.3 Fraudulent acts can be carried out by several parties, including: Participants, BPJS, Health Facilities or health service providers, drug and medical device providers, and other stakeholders (other stakeholders are all parties who carry out and or contribute to fraud)[7]. Fraud or fraudulent practices

in the implementation of the National Health Insurance are a serious threat to the sustainability of the implementation of Indonesian national health, because they can lead to financial misuse and scarcity of health resources, thus negatively impacting access to quality health services for the public. Therefore, efforts are needed to prevent, detect, and control fraud. To recognize fraud in health insurance in National Health Insurance requires a deep understanding of the availability of regulations related to the prevention and handling of fraud. In the existing regulations, it is stated that in the supervision of the Implementation of the Health Insurance Program, the Minister of Health, Head of the Provincial Health Office, and Head of the District or City Health Office can impose administrative sanctions on any person or corporation related to the implementation of JKN that commits fraud.

Administrative sanctions are in the form of verbal warnings, written warnings; and or orders to return losses due to fraudulent actions to the injured party. In the case of fraud committed by BPJS staff or officers, health service providers, providers of drugs and medical devices, administrative sanctions can be followed by additional sanctions in the form of fines. Additional sanctions in the form of fines are given to the injured party[8]. In the case of fraud committed by health workers, health service providers, and providers of drugs and medical devices, administrative sanctions can be followed by revocation of permits in accordance with the provisions of laws and regulations. The imposition of additional sanctions in the form of fines or revocation of permits must consider the continuity of health services to participants. Administrative sanctions do not eliminate criminal sanctions in accordance with the provisions of laws and regulations. In the process of conducting a literature review, the author team aspires to find out the latest reviews related to the analysis of the chances of fraud occurring, especially because in the implementation of the National Health Insurance, an evaluation is needed to assess the effectiveness of the implementation of existing policies, and in this case the evaluation aims to assess whether the objectives of the policies made and implemented have been achieved[9]. In addition, the evaluation also functions as a clarification and criticism of the values underlying the policy, helping to adjust and formulate problems in the next policy so that it can be input to optimize effective prevention and mitigation efforts to be implemented in the implementation of the National Health Insurance program in Indonesia.

## II. METHODS

This study is a literature review that is part of qualitative research, related to the research subject. Research is descriptive the social phenomena in detail. Based on this research, the research objective is to describe the factors influencing development of private fraud in Indonesia health insurance. The data collection technique used by researchers in carrying out data and information collection is by taking secondary data where the information comes from the official Indonesian website, government regulation, internet, and scientific journals, also where the data obtained in to confirm the completeness of the policy or related data involved in this research[10]. The method used in this research is a literature review of journals, which aims to describe the factors that influence the demand for private health insurance. Literature review is writing on a particular topic or issue based on a literature search or research according to research topics originating from reading books, journals, and other published publications.

## III. RESULT AND DISCUSSION

Health Fraud is an act carried out intentionally to gain financial gain from the Health Insurance program in the National Social Security System through fraudulent acts that are not in accordance with the provisions of laws and regulations. In the National Health Insurance program, the fraud prevention policy in JKN has been mandated in the Regulation of the Minister of Health of the Republic of Indonesia Number 16 of 2019.Fraud is an opportunistic infection that arises when greed and fraud meet. Fraud presents a major problem for health insurance companies and the only way to combat fraud is to use a special fraud control management system[11].Research based on a literature review conducted, it was found that fraudulent activities that are often carried out in hospitals are upcoding diagnoses. Based on a review conducted by researchers of 10 research articles, it is known that 9 out of 10 articles state that upcoding is a type of fraud that is often carried out by officers in health care facilities. Upcoding incidents are often identified with the

role of coders, because coders are the personnel tasked with entering diagnostic codes and procedures into the INA CBG application[12]. Upcoding is a form of fraud that can change claims to be higher and can be said to be fraud if there is an element of intent in doing so. The same thing was expressed by that the most likely potential for fraud to occur in a hospital environment is related to misuse of assets, unnecessary diagnostic activities by doctors, and upcoding of diagnoses[13].

Based on the Regulation of the Minister of Health Number 36 of 2015, JKN fraud actions carried out by health service providers at Advanced Referral Health Facilities or Hospitals [14]include: writing excessive diagnostic codes or upcoding; copying claims from other patients or cloning; false claims or phantom billing; inflated drug and medical device bills or inflated bills; service episode unbundling or fragmentation; pseudo referrals or selfs-referals; repeat billing; prolonged length of stay; manipulate the class of care or type of room charge; cancel mandatory services; perform unnecessary actions or no medical value; deviation from the standard of care; perform unnecessary treatment; increase the length of time using the ventilator; not perform phantom visits; not perform phantom procedures; repeated admissions or readmissions; make inappropriate patient referrals to obtain certain benefits; request cost sharing that is not in accordance with the provisions of laws and regulations; and other JKN fraudulent actions[15].According based on interviews and document reviews, it was found that the potential forms of fraud that could occur during the Covid-19 Pandemic in Hospitals were cost contributions for Covid-19 antigen screening examinations, extending the length of treatment for Covid-19 claims, adding comorbid diagnoses to Covid claims, submitting repeated claims to both JKN and Covid claims and fraud by participants in Hospitals where they use the identities of other participants to obtain guarantees[15].General there are three factors that drive someone to commit Fraud. The first is pressure which is the first factor that motivates someone to commit a criminal act of Fraud. The second is opportunity, namely a situation that allows criminal acts to be committed. The third is rationalization, namely the justification for the criminal acts committed. These three factors are often known as the Fraud Triangle[16], [17]. According to this Fraud Triangle is also a factor that drives someone to commit Fraud with the following explanation:

**Pressure**

This pressure is related to a person's intention to commit fraud. Someone who commits fraud must have their own motivation or drive. Pressure makes someone commit fraud. This pressure can come from internal or external factors. Internal factors, for example, the provision of salary and remuneration received that is not in accordance with the workload carried out. External factors are lifestyle and economic demands.

**Opportunity (opportunity, chance)**

Lack of internal supervision and no clear assignment from the leader or director regarding the work that must be done by employees will create a culture of interdependence on employees or exchanging their work. In this case, it provides opportunities for employees to carry out fraudulent actions.

**Rationalization**

The last part of the fraud triangle is rationalization. Even when people have the motivation and opportunity, most will not choose to act unless they can justify to themselves why the fraud they are committing is "okay".Rationalization is an internal conflict within the perpetrator as an attempt to justify the fraud they have committed. Rationalization allows perpetrators to justify their actions in various ways,such as:

1. "Moral Justification" is Convincing themselves that their actions are acceptable in certain situations.
2. "Dehumanization" is: if the victim of the fraud will not "
3. "Action Minimization" is: Convincing yourself that the action is only temporary or has little impact.

Losses of social health insurance funds due to fraud need to be prevented with a national fraud prevention policy so that the implementation of the national health insurance program in the national social security system can run effectively and efficiently and this is also supported by the issuance of the Minister of Health Regulation Number 36 of 2015 which in article 16 relates to good corporate governance, and good clinical governance, namely:

1. Transparency is the openness of information, both in the decision-making process and in disclosing information that is in accordance with the needs for preventing BPJS-JKN fraud.

2. Accountability is the clarity of the function of the system structure and service accountability so that management is carried out effectively.
3. Responsibility is the suitability or compliance in the management of services to the principles of a healthy organization to prevent BPJS-JKN fraud.
4. Independence is a condition where the organization is managed professionally without conflict of interest and influence or pressure from any party that is not in accordance with the principles of a healthy organization to prevent JKN fraud.
5. Fairness is fair and equal treatment in fulfilling stakeholder rights arising from the agreement to prevent BPJS-JKN fraud

Fraud prevention Based on the Regulation of the Minister of Health of the Republic of Indonesia Number 16 of 2019, the Fraud Prevention System in the Health Insurance Program[18]. The principles in the Fraud prevention system can be described as follows:

1. Preparation of policies and guidelines for preventing fraud, including:
    - Preparation of anti-fraud policies with the principles of Good Corporate Governance and Good Clinical Governance.
    - Preparation of fraud risk management guidelines consisting of at least prevention, detection and resolution of fraud.
2. Development of a fraud prevention culture, including:
    - Building a culture of integrity, ethical values and standards of behavior.
    - Educating all parties related to Health Insurance about anti-fraud awareness.
    - Creating a positive environment for implementing the Health Insurance program.
3. Development of health services oriented towards quality control and cost control, including:
    - Formation of a quality control and cost control team consisting of a coordination team and a technical team.
    - Implementation of the concept of quality management in health services.
4. Formation of a fraud prevention team that is adjusted to the needs and scale of the organization.

Fraud analysis in national health insurance in Indonesia is important to ensure the sustainability and fairness of the health system. Fraud in the national social security system has the potential to cause losses to national social security funds which will have an impact on state finances and reduce the quality of health services. Fraud is a worrying problem for all insurance companies. Some professionals even believe that during the first year of the pandemic, the number of insurance claims suspected of fraud doubled. Insurance fraud occurs when someone deliberately manipulates to gain benefits from the insurance company[19]. There are two general categories of fraud in insurance companies, namely by hiding material facts, including material facts related to a higher level of risk, with the aim of getting a lower premium value or avoiding policy closure. Another fraud that is often carried out is document falsification by engineering insurance claims. Some examples of fraud cases in health insurance are cases where an insured claims a dermatologist's fee every month. It turns out that the treatment he took was an aesthetic treatment which was not covered by insurance. Another case is where the insured spends the insurance ceiling on fictitious treatments. There are also insureds who mark up treatment costs[6].Opportunities for fraud in JKN can be in the form of identity fraud, collusion to make false claims or carry out unnecessary treatments, excessive invoices, deviations or upcoding of diagnostic codes, document discrepancies, and duplicate claims[20]. The reasons for fraud that usually occur are known as the Fraud Triangle, namely motivation, opportunity, and rationalization.

Fraud in health services has the potential to cause state financial losses and reduce the quality of health services, therefore by understanding the factors that increase the likelihood of fraud, parties involved in the administration and management of national health insurance can take appropriate preventive and detection steps to reduce the risk of fraud and maintain the integrity of the health insurance program[21]. Fraud Prevention Efforts (FPE) in accordance with the Regulation of the Minister of Health of the Republic of Indonesia Number 16 of 2019 by implementing the principles of a fraud prevention system, namely: preparation of fraud prevention policies and guidelines, development of a fraud prevention culture,

development of quality control and cost control-oriented health services and formation of a fraud prevention team that is adjusted to the needs and scale of the organization[22].Based on the results of the discussion that has been described, it can be concluded that health insurance has an important role in protecting individuals and families from the financial risks fraud with health care costs in the future. Insurance fraud prevention can be do, fraud prevention efforts have been carried out when prospective insured persons apply for a health insurance product purchase. In principle, health insurance companies will carry out the underwriting process, namely the process of identifying and selecting risks that refer to the underwriting provisions of each insurance company[23].

## IV. CONCLUSION

Fraud in the National Health Insurance program is an act carried out intentionally to gain financial, gain from the JKN program in the National Social Security System through fraudulent acts, that are not in accordance with the provisions of laws and regulations. Fraud can be carried out by: BPJS Participants, BPJS, Health Facilities (health service providers)[24], drug and medical device providers and other stakeholders[25].The underwriting process not only affects the size of the premium but also determines whether or not the prospective insured person is accepted. Therefore, when registering to purchase a health insurance product, the insurance company assesses the health condition of the prospective insured person[26]. For example, there are insurance companies that are still willing to accept insured persons with blood sugar disease with a certain level of severity, but there are also those that do not want to at all. This risk selection is usually carried out through interviews, requesting a medical check-up, providing questionnaires/forms (such as SPAJ), and verifying data before approving the SPAJ/accepting the customer as the insured person[27]. However, sometimes this process is not carried out according to procedure, thus creating the potential for fraud in the future. For example, the verification process is not carried out and later it is discovered that the insured person has a history of a disease that is actually excluded in the policy. Based on experience, from patients there are several behaviors that fall into the category of red flags and require investigation[28], including first:

- Chronic disease conditions that appear suddenly within a few months after the policy is active
- Hospitalization that is not medically necessary because it can actually be done as an outpatient
- Hospitalization in the hospital longer than medically necessary
- Providing treatment that is not in accordance with the claimed condition[29]
- Aspects of fraud investigation
- Investigations cover many aspects. Some common things that need to be investigated include ensuring that the insured is not a fictitious figure. In some cases, an insurance agent was found to have falsified the insured's figure and taken advantage of it[30].

Second, the insured's medical records. This check is to find out if the insured has a pre-existing condition that he or she did not disclose when registering to purchase an insurance product. However, finding evidence is not always easy. For example, poor management of medical records by the health facility makes it difficult for investigators to obtain them or takes a long time to obtain them or the officers are less cooperative. This usually happens in small hospitals in the regions[31]. The next aspect is to verify the purpose of treatment, for example, finding out why the insured had to be hospitalized, and no less important is to ensure whether the disease is included in the exclusions in the policy or not. Claims in the form of reimbursement are usually also red flags that need to be investigated. Usually the insured applies for reimbursement because their cashless is rejected by the health facility[32], [33]. This rejection can be due to many things, for example because of a congenital disease that is not actually covered by insurance[34]. Verify each claim and look for evidence of fraud or abuse in suspicious health insurance claims (fraud) by applying tactics and methods to reveal the truth behind fraudulent claims or insurance companies must of course be prevented in the future. Basically, investigations require honed skills to determine which approach will be used to find evidence effectively[35].

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