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ANALYSIS OF THE IMPLEMENTATION OF THE NATIONAL HEALTH INSURANCE FRAUD PREVENTION PROGRAM

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ABSTRAK

Program Jaminan Kesehatan Nasional (JKN) yang diselenggarakan oleh Badan Penyelenggara Jaminan Sosial (BPJS) Kesehatan merupakan salah satu upaya strategis pemerintah Indonesia untuk mewujudkan sistem kesehatan yang *inklusif* dan merata bagi seluruh masyarakat. Program ini menghadapi berbagai tantangan serius, salah satunya adalah masalah fraud atau kecurangan. Penelitian ini bertujuan untuk menganalisis pelaksanaan program pencegahan fraud dalam JKN, mengidentifikasi hambatan yang dihadapi, dan mengevaluasi efektivitas strategi yang diterapkan. Penelitian ini bersifat kualitatif dengan menggunakan teknik pendekatan sistematik review. Artikel yang digunakan dalam penelitian ini merupakan teks full artikel dengan desain studi observasional yang dipublikasikan dari tahun 2016 hingga tahun 2024. Variabel independen meliputi program ansuransi jaminan kesehatan nasional, dan variable dependen yaitu kecurangan *fraud* ansuransi. Pengumpulan data artikel dilakukan dengan mencari artikel pada search database database Google Scholar, ProQuest, dan Science Direct**.** Negara Indonesia telah Membentuk tim anti-*fraud*, namun belum berfungsi maksimal karena kurangnya pengetahuan mengenai pencegahan penipuan dalam program JKN. Masih banyak yang belum melaksanakan program pencegahan (FRAUD) dengan optimal, dari berbagai dilayah di Indonesia.

Kata Kunci : Kecurangan Asuransi, JKN, Indonesia

ABSTRACT

The National Health Insurance (JKN) Program The National Health Insurance (JKN) organized by the Social Security Administration Agency (BPJS) Kesehatan is one of the Indonesian government's strategic efforts to realize an *inclusive* and equitable health system for all people. This program faces various serious challenges, one of which is the problem of fraud or fraud. This study aims to analyze the implementation of fraud prevention programs in JKN, identify the obstacles faced, and evaluate the effectiveness of the strategies implemented. This research is qualitative using a systematic review approach technique. The article used in this study is a full article text with an observational study design published from 2016 to 2024. Independent variables include the national health insurance insurance program, and the dependent variable, namely insurance *fraud* fraud . Article data collection is carried out by searching for articles on Google Scholar, ProQuest, and Science Direct database search databases**.** The Indonesian state has formed an anti-fraud team, but it has not functioned optimally due to the lack of knowledge about fraud prevention in the JKN program. There are still many who have not implemented the prevention program (FRAUD) optimally, from various programs in Indonesia.

Keywords: Insurance Fraud, JKN, Indonesia

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BACKGROUND

The National Health Insurance Program (JKN) organized by the Social Security Administration Agency (BPJS) Kesehatan is one of the Indonesian government's strategic efforts to realize an *inclusive* and equitable health system for the entire community. This program faces various serious challenges, one of which is the problem of fraud or fraud. Regulation of the Minister of Health (PMK) Number 16 of 2019 concerning the Prevention *of Fraud* in the National Health Insurance Program (JKN) as a replacement for the Regulation of the Minister of Health Number 36 of 2015 still requires. Evaluation and Study in its Implementation. There is still the potential *for fraud* in the implementation of JKN that has not been proven and followed up by the Fraud Prevention Team (TPF) in accordance with the mandate of PMK Number 16 of 2019.

Fraud related to JKN (national health insurance) can be in the form of false claims, data manipulation, and various other forms of misuse of funds carried out by health care providers and participants. Fraud is not only economically detrimental but also reduces the quality of services and endangers the sustainability of the JKN program itself. Based on BPJS Kesehatan data (2020), the potential for losses due to fraud is quite large, indicating the need for more effective prevention efforts. Fraud committed by health services throughout Indonesia related to the service system, such as changing the main diagnosis or making additional diagnoses so that they get large tariffs. Various fraud issues in health services, including claiming services that were never provided, claiming services that cannot be covered by insurance, falsifying service times, service locations, claiming bills that should be paid by patients and unnecessary drug prescriptions (Charles, in Adisasmito 2016). The JKN program began running in Indonesia in 2014. With the increase in the number of JKN participants and health facilities, many complaints have emerged from various parties, including from JKN providers, namely health centers, hospitals, and private clinics regarding alleged fraud (Yaslis, in adisasmito 2015). Allegations of *fraud* do not only occur in Indonesia, which has not been neatly organized in the health service system and financing system, but also occurs around the world, which has an impact on various aspects. The impact that arises from *fraud* is that it can affect aspects of good name, quality of clinic services, and finance (Rahma 2019, in Putri 2019).

BPJS Kesehatan noted that the health insurance costs paid in 2023 are around IDR 158.85 trillion. The cost of health insurance paid this year is predicted to increase. The President Director of BPJS Kesehatan explained, in a decade of implementing national health insurance (JKN), participant coverage as of December 31, 2023 was 267.31 million or 95.75%. BPJS Kesehatan's commitment is to ensure that all Indonesians receive quality services without discrimination. BPJS Kesehatan has also collaborated with health service facilities that are able to provide health services according to the set standards. As of December 2023, more than 23,000 FKTPs (first-level health facilities) and 3,120

FKRTLs (advanced referral health facilities) or hospitals have cooperated. Data on Indonesian insurance fraud cases, BPJS Kesehatan has found false claims reaching billions of rupiah. For example, there are *fictitious* claims and increased diagnoses to inflate claims. In 2023, the cost of controlling inefficiencies in financing the JKN program is estimated to reach IDR 866.8 billion at the time of the review and IDR 397.9 billion after the review. Efforts to deal with it include the formation of an anti-fraud team consisting of nearly 2,000 personnel spread throughout Indonesia. On the other hand, private insurance companies also face various forms of fraud. For example, manipulation of fictitious medical documents and reports is a common method used to make false insurance claims. Cases such as falsification of medical care documents and claims of inappropriate treatment costs are also common. This research is expected to make a meaningful contribution to improving the supervision and fraud prevention system in JKN (national health insurance), as well as ensuring the sustainability and integrity of this program for the welfare of the Indonesian people (PMK, 2019; BPJS 2023).

Through this research, it is hoped that a clearer picture of the implementation of fraud prevention programs can be obtained, as well as policy recommendations to improve the efficiency and effectiveness of the program. To overcome this problem, BPJS Kesehatan has implemented various fraud prevention strategies, including the use of information technology to monitor claims, strengthening the internal audit system, and cooperation with law enforcement. However, there are still many challenges faced in its implementation, such as limited human resources, regulatory complexity, and resistance from several related parties. The large number of companies engaged in the insurance sector requires proper supervision and more focus on each insurance company in carrying out health services, especially in preventing fraud. Therefore, this study aims to analyze the implementation of fraud prevention programs in JKN, identify the obstacles faced, and evaluate the effectiveness of the strategies implemented.

METHOD

1. Research Design

This study uses *a systematic review* study design. The articles used in this study are articles that have been published from 2016-2024 and obtained from the Google Scholar database, and *Science Direct*. The keywords used in searching for articles are "Insurance fraud, insurance and Indonesia". This research has been carried out in March-May 2024. The article used in this study is an article text with an observational study design published from 2016 to 2024.

2. Population and Sample

The research sample is the JKN insurance institution (national health guarantee). The population in this study is all Indonesian insurance institutions.

3. Research Variables

The dependent variable in this study is insurance fraud and the independent variable in this study is the national health insurance (JKN) program.

4. Operational Definition

Insurance fraud or (fraud) is an act carried out deliberately by participants, BPJS Kesehatan officers, health service providers, and providers of drugs and medical devices, to obtain financial benefits from the health insurance program (PMK, 2019).

This study is a literature study with the Systematic Literature Reviews (SLR) method which comprehensively summarizes the studies that have been conducted on the effects of hypnotherapy on problems experienced by mothers during pregnancy both in Indonesia and in various other countries.

Articles are assessed using a Critical Appraisal checklist and the article screening process is carried out with a PRISMA diagram. The data bases used in this literature study are ProQuest, Pubmed and Google Scholar with keywords; hypnotherapy and pregnancy, hypnotherapy and maternity, hypnotherapy and anxiety and pregnancy, hypnotherapy and pain and labor, hypnotherapy and hyperemesis and pregnancy, hypnosis and anxiety and pregnancy, hypnosis and anxiety and labor, hypnosis and pain and labor and pregnancy, hypnosis and anxiety and pain management and labor. The literature search has been carried out since January 2024. Seven articles were selected based on inclusion criteria such as articles with Cross sectional, Clinical Trial, Randomized Controlled Trial, Pre-experimental, English or Indonesian, full text, free full-text and are academic journals.

RESULTS

A. Result

An article search related to Analysis of the Implementation of the National Health Insurance Fraud Program using the keywords: "Insurance Fraud, Health Insurance and Indonesia, "insurance fraud" and "health insurance" and "indonesia", "insurance fraud" or "health insurance" or "indonesia" resulted in up to 2870 articles on the Google Scholar database, and *Science Direct*. The articles were then selected according to the inclusion criteria in the form of insurance institutions, using an observational study design discussing insurance fraud, the journals taken had a span of the last 8 years between 2016-2024. Have a fraud *prevention outcome* (FRAUD). 13 articles were found that met these criteria.

Author (Year)	Heading	Purpose	Research methods	Results
Rizka zafira et al (2018)	Analysis of the implementation of the national health insurance fraud prevention program at the Semarang Health Center.	Analyzing the implementation of PMK RI no.36 of 2015 in the Implementation of the JKN fraud prevention program at the Semarang City Health Center.	Qualitative	That the formation of the JKN fraud prevention team was delayed due to the weakness of the legality of the DKK Decree regarding the JKN fraud prevention team, and the commitment of team members.
Adisastimo et al (2016)	Analysis of the influence of the Fraud Triangle dimension in fraud prevention policies on the national health insurance program at the Cipto Mangunkusum National Hospital.	Analyze the influence of the fraud triangle dimension in fraud prevention policies on the National Health Insurance program.	Qualitative	Get an analysis of pressures, opportunities, and rationalization of the risk of fraud incidents and present how policies have had an impact on the DR Cipto Mangunkusumo National Hospital.
Hartati et al (2016)	Prevention of fraud in the implementation of the health insurance program in the health insurance system at the Menggala Tulang Bawang	Creating a Fraud Prevention Team, based on the Decision of the Technical Director of Menggala with Decree No. 800/876/III.12/ TB/IX/2015	Qualitative	Create a fraud prevention team based on the decision of the technical director of Manggalang.

	Regional General Hospital	concerning the Prevention Team Deceit.		
Marasabessy et al (2016)	The effect of internal control on the prevention of fraud (FRAUD) in the implementation of health insurance at the Bhayangkara Kindergarten IV Hospital of the Maluku Police.	Determine the influence of internal control on the prevention of fraud in the implementation of health insurance.	Random Sampling	The influence of the internal control variable was 0.882 and the remaining 11.8% was influenced by other variables outside the research model
Solehudin et al (2023)	The urgency of criminalizing fraudulent acts in the implementation of health insurance programs in Indonesia	Knowing the urgency of the crime of fraud in the health insurance program in Indonesia.	Normative Law	Handling Fraud in the Implementation of the Health Insurance Program aims to provide a reference for Participants, BPJS Kesehatan, Health Facilities
Thaifur et al (2021)	How to detect healthcare fraud, systematic review	Investigate/detect cases of fraud that occur in the health sector or other related sectors.	Systematic review	Most of the fraudsters are carried out by medical personnel (doctors) and service providers. Many types of fraud occur such as insurance, claims or medical procedures that are not managed at all.
Soputan et al (2018)	Risk Analysis of Fraud in the National Health Insurance Capacity Fund Management System in the	Analyzing the Risk of Fraud on the National Health Network Capacity Fund Management System in Bitung City	Content analysis	The risk of fraud in the health insurance capacity fund management system in Bitung City occurs due to a weak fund management system that is not in accordance with regulations.

	Bitung City Government			
Fatimah Nurul et al (2021)	Determinants of the potential *for FRAUD* in the JKN program at the health center x	Knowing the driving factors of potential fraud in the implementation of JKN at the Health Center in City X.	Qualitative	The driving factor for potential fraud can be reviewed from the opportunity factor, namely the lack of internal and external audits at the Health Center.
Indrawan et al (2023)	The role of the health office in preventing and handling fraud in the implementation of the health insurance program based on the regulation of the Minister of Health of the Republic of Indonesia in Buleleng Regency	Inform the public that the health office has created a fraud prevention program based on the regulation of the Indonesian minister of health	Qualitative	There are still many people who allegedly do not know the registration procedure, still do not realize the importance of participating in the JKN program.
Bramastoro et al (2022)	Fraud prevention with internal audits and internal controls	In order to prevent the possibility of fraud, and limit the losses that may arise if the fraud occurs.	Descriptive and verifiable	Internal Audit has an effect on Fraud Prevention. Internal Control affects the Prevention of Fraud,
Budiantoro et al (2022)	The effect of the implementation of Gcg, anti-fraud awareness and employee integrity on fraud prevention	Examining the influence of Good Corporate Governance (GCG), Anti-fraud Awareness and Employee Integrity on fraud prevention.	Saturated Sampling or Questionnaire	That the implementation of Good Corporate Governance (GCG) and anti-fraud awareness has a significant effect on fraud prevention. And employee integrity has no effect on fraud prevention.

Putri Prima et al (2019)	Health services in the era of national health insurance as a program of the health social insurance implementation agency	Organizing social health insurance programs	Qualitative	Injustice and legal uncertainty and the possibility of triggering fraud on various sides.
Wulandari et al (2018)	The influence of external control, anti-fraud awareness, integrity and professionalism on fraud prevention.	Obtain evidence of the influence of internal control, anti-fraud awareness, integrity, independence, and professionalism on fraud prevention in the audit of state financial management and responsibility.	Purposive Sampling	Internal control, integrity, independence, and professionalism have a positive effect on fraud prevention. Meanwhile, anti-fraud awareness does not have a positive effect on fraud prevention.

Table 1. Research included in the Systematic Review

Fraud in the implementation of the health insurance program data shows that the national health insurance (JKN) fraud is an act carried out by BPJS personnel, health workers, drug and medical device providers deliberately to obtain personal benefits through fraudulent acts that are not in accordance with the provisions. This study aims to analyze the implementation of fraud prevention programs in JKN, identify the obstacles faced, and evaluate the effectiveness of the strategies implemented. Through this research, it is hoped that a clearer picture of the implementation of fraud prevention programs can be obtained, as well as policy recommendations to improve the efficiency and effectiveness of the program. Regulation of the Minister of Health of the Republic of Indonesia Number 16 of 2019 explains the settlement of fraud in the implementation of JKN by the Fraud Prevention Team of the Regency/City Office, the Fraud Prevention Team at the Regency/City Health Office solves fraud cases found from detection, or reported by Health Facilities.

As for several regions in Indonesia, one of the studies is that the implementation of the fraud prevention policy at Diponegoro National Hospital has not been running optimally due to the Covid-19 pandemic, so the fraud prevention team has not carried out its duties in accordance with the Minister of Health Regulation Number 16 of 2019. The Fraud Prevention Policy does not yet have a clear and measurable measure of indicators and objectives of policy managers that are used as a benchmark for success. The HR team needs to be increased and must be improved again with good training.

This is in line with research conducted by adisasmito (2016) There are many factors that cause employees to potentially commit fraud against JKN at the DR Cipto Mangunkusumo National Hospital. The causative factors themselves consist of high unmet needs and low salaries received which can result in employees committing potentially fraudulent actions. In addition, the government sets a salary increase once a year. If the policy does not change, if the leader assesses the employee's work for a year as unsatisfactory (individual performance index assessment), then the salary will not be increased. Although the anti-fraud team has been formed, it has not functioned optimally due to a lack of knowledge about fraud prevention in the JKN program. This presents challenges for healthcare teams and hospital fraud shows that the challenge in controlling fraud lies in the lack of knowledge of the various parties involved in the problem of healthcare fraud. In fact, leaders of healthcare organizations often have minimal knowledge of fraud anti-fraud strategies.

This has an impact on the less optimal prevention system and leads to an increase in fraud incidents. In some regions in Indonesia, there has not been any education about FRAUD control for related parties. Education can be done by providing an understanding of the importance of

compliance with standards for cheating that occurs in health. Article 11 of BPJS Kesehatan Regulation Number 6 of 2020 explains that BPJS Kesehatan carries out the detection of potential fraud committed by participants by ensuring that participants get services through health utilization data analysis, the implementation of cyclical data analysis or patterns of health service utilization through participants, the implementation of data analysis on the misuse of membership identity cards in the use of health services and the use of information from whistleblowers (whistleblower).

The Regency/City Health Office is included in the institution that collaborates with BPJS Kesehatan, professional organizations, and health facility associations to build a JKN fraud prevention system. According to Laksono Trisnantoro, Professor of Gajah Mada University (UGM), DKK and the Ministry of Health become third parties when there is a dispute between BPJS Kesehatan and health facilities when there is an allegation of fraud, so it is necessary to have qualified human resources to be able to identify claim and *fraud* techniques, and detect fraud committed by the perpetrators. In addition, the DKK aims to receive complaints about fraud.

Fraud in health insurance in Indonesia can have a significant impact on various aspects, both in terms of the economy, health services, and public trust. Here are some of the impacts, namely; For Insurance Companies Fraud, such as false claims or inflated treatment costs, causes insurance companies to suffer large financial losses. This can reduce the company's ability to provide optimal service. For customers, to compensate for losses due to fraud, insurance companies may increase premiums. This increases the financial burden for honest customers. Fraud can lead to inefficient allocation of resources, where funds that should be used for health services that are really needed are diverted to pay for false or invalid claims. This can have an impact on decreasing the overall quality of health services. Increasing Administrative Burden, Insurance companies must increase efforts to detect and prevent fraud, which requires additional resources in the form of manpower and technology. This can increase the operational costs of insurance companies.

AUTHOR CONTRIBUTIONS

Auliya Safitri is the main researcher who plays a role in research data collection, research article formulation, and data processing. Karlinda and Tiara Nurchikita played a role in the procedure for writing journals and research discussions.

CONFLICT OF INTERESTS

There is no conflict of interest in this study.

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