Fraud Development in the National Health Guarantee System Reviewed from Criminal Law Aspects

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Abstract: The purpose of this study was to find out and analyze the forms of fraud and falsification of documents in the Health insurance industry in terms of criminal law aspects, and to find out how to prevent fraud in the National Health Insurance System (SKJN) in Indonesia. This research is a type of legal research in relation to academic activities. This research method includes the approach to determining legal materials and critical analysis of legal materials which contain traces of thought that are tracing, in-depth assessment and interpretation. The research method used is normative juridical. Various criminal acts of fraud and forgery, in national health insurance can be done by anyone. Various parties who can commit this crime can be done by: Participants, BPJS, Health Facilities, Government and Pharmaceutical Industry. The development of the health insurance industry in Indonesia, has not been followed by legal regulation in the accommodating field, so that various crimes of fraud and fraud in the national health insurance in Indonesia are many who have escaped punishment.

Keywords: Fraud, Health Guarantee, Criminal Law.

1. INTRODUCTION

Since the enactment of the National Health Insurance, the potential for fraud in health services has become increasingly apparent in Indonesia. This potential arises and can become increasingly widespread due to pressure from the new financing system in Indonesia, opportunities due to lack of supervision, and justification for taking this action. Fraud health services have the potential to harm state health funds and reduce the quality of health services. The study shows that health service fraud has the potential, even partially proven, to occur in Indonesia. Throughout Indonesia, until mid-2015 there was a potential fraud of 175,774 hospital claims or Advanced Referral Health Facilities (FKRTL) with a value of Rp. 440 M. The potential for fraud is only from health care provider groups, not from other actors such as BPJS Health staff, patients, and medical and drug equipment suppliers. This value
also does not show the true value considering that the monitoring and detection system used is still very simple. The potential forms of fraud commonly encountered in the provider group are upcoding, inflated bills, unbundling services, no medical value and standard of care. The form of fraud standard of care besides harming the state's health costs also has a negative impact on patients. The health service fraud control system has started to run especially since the issuance of Minister of Health Regulation number 36 of 2015, but still needs to be accompanied by various activities and detailed instruments for prevention, detection and enforcement.

In a study conducted by several doctors in Germany against developed countries, it was revealed that fraud in health care was the most potential source that could harm insurance companies, especially health insurance. The fraud was done intentionally which intended to benefit from the action. In the United States the health insurance industry suffered losses of hundreds of millions of dollars in a year caused by fraudulent acts, which if estimated by the insurance industry in America suffered losses of between 3% and 7%.

The problem above was interesting when the Indonesian government launched a health financing policy reform with the concept of Social Insurance through Law No. 40 of 2004 concerning the National Social Security System (SJSN), when the Megawati government would soon end. The commitment to expand social security was followed up by the government with President Susilo Bambang Yudoyono, through a health insurance program for the poor or known as ASKESKIN which was subsequently replaced with the Community Health Insurance program (Jamkesmas) and various other guarantee programs such as the Regional Community Guarantee (Jamkesda) / City Community Guarantee (Jamkeskot) and Childbirth Guarantee (Jampersal).

In the commercial and social health insurance program there is a tripartite relationship, namely between the Insurance Company / BPJS as the organizing body (Insurer), the benefit User as the participant (Insured) and the Health Service Provider (PPK). In the implementation of health insurance claims, fraud often occurs, this has happened in the ASKESKIN program with the amount of funds that must be paid by PT. Askes as Insurer to Health Service Provider (PPK). At that time various media were often written PPK complaints that felt their rights had not been paid by PT. Askes, on the other hand PT. Askes as the fund manager feels overwhelmed to pay claims, which turns out the amount exceeds the budget quota provided by the government, and on the next side it turns out the government has difficulty finding funds to cover up the shortfall.

In the above conditions, then various statements appeared in the media that seemed to indicate a confusion due to the chaotic financing system applied to this program. One of the most prominent statements is the suspicion of "Mrs. Minister of Health" that there will be an effort to inflate the claim by the PPK, especially the Hospital. From an academic point of view, the swelling of Askeskin funds is a reasonableness, because indeed this program has many gaps / weaknesses that enable fraud. In Indonesian, the terminology of in-insurance fraud can be interpreted as fraud.

Various forms of similar fraud will be able to color the health insurance claims, which can be done by individuals or groups as well as by Health Service Providers at the first level as well as hospitals as recipients of referrals. This form of cheating can occur due to a lack of understanding of service users health or carried out by KDP because medical expenses are borne by the insurer. Theoretically there are several factors that allow fraud to occur.

Fraud is a very dominant factor causing soaring costs of health services in America. Whereas in Indonesia, although it has not been proven, the public health insurance system in the form of BPJS has shown the existence of these symptoms. The problem of fraud in Indonesia is feared to further worsen the inequality that has occurred in the BPJS. As we all know, health care facilities are still concentrated in big cities so fraud will suck BPJS funds. As for a number of other factors that took part in causing fraud, namely: perceptions of health care providers about the amount of INA CBGS that is considered low, information systems in hospitals that are not ready to obtain fraud data, eradication of fraud is still not has the legal force in which the KPK has not thought of reaching an investigation, financial service authorities are still in a situation of observation and the motivation to seek economic benefits is a basic human instinct.

From here finally there is a big concern about the state losses that are expected to increase but the evidence is hard to come by. If it is left without prevention, it is feared that fraud will become the work culture of health workers and hospital management. Therefore, fraud in the health insurance industry
can be categorized as a criminal offense that can be threatened with fraud in Article 381 of the Criminal Code (KUHP) and also Criminal Counterfeiting as stipulated in Article 21 (5) of Law Number 40 of 2014 concerning Business Insurance of the Republic of Indonesia Article 263 of the Criminal Code. This study was conducted to answer questions: (1) how the description of the potential for fraud in health services in Indonesia, and (2) efforts to eradicate the fraud of health services that have been carried out in Indonesia and the challenges.

2. RESEARCH METHOD

This research is a type of legal research in relation to academic activities. This research method includes the approach to determining legal materials and critical analysis of legal materials which contain traces of thought that are tracing, in-depth assessment and interpretation. The research method used is normative juridical.

3. RESULT AND DISCUSSION

3.1 Definition of Fraud and Counterfeiting in Health Insurance

Fraud is included in the classification of crime, namely an act carried out by someone, a group of people or a company against the law with the intention to benefit themselves (them) or other people. In Black's Law dictionary (Black, 1991) the definition of fraud is as follows:

1. A knowing of the misrepresentation of the truth or concealment of material fact to induce another to act to his or her detriment; the usual tort (esp. when the conduct is willful) it may be a crime.
2. A misrepresentation made recklessly without belief in its truth to induce another person to act.
3. A tort arising from knowing misrepresentation, concealment of material fact, or reckless misrepresentation made to induce another to act to his detriment.

Based on the above definition, there are three elements that must be fulfilled as criminal acts of fraud or fraud, namely: the existence of an element of lawlessness in the form of mistakes, concealment of material facts or carelessness with the intention of persuading others to act or act.

From that understanding, it can be compared with the National Care Anti-Fraud Association (NHCAA), an institution that specializes in dealing with fraud problems in the field of health care in America providing the following definition of fraud: "An intentional deception or misrepresentation that the individual or entity makes, knowing that the result of this misrepresentation could be some unauthorized benefit to the individual, or entity, or to another party ".

Besides that in the legal system in the State of New Hampshire the definition of Insurance fraud is as follows: "Commits with a purpose to injure, defraud or deceive any insurer, knowingly submits or helps someone else to submit any oral statements knowing that these statements contain false, incomplete, or misleading information. insurancepolicy ".

Whereas in the Dictionary of Insurance (Ali, 2002) which is a guide for insurance practitioners in Indonesia equating the notion of fraud with criminal acts of fraud, and giving the notion of fraud as: "An act of fraud, deliberate misrepresentation of important facts, meaning other people believe that fact and consequently the person suffers financial difficulties ".

In general, fraud is a criminal act using dishonest methods to take advantage of others (Merriam-Webster Online Dictionary). Whereas specifically, fraud in health insurance is defined as an action to rig or benefit health care programs in an inappropriate manner (HIPAA Report, 1996).

Based on the above definitions, it can be seen that fraud or fraud has four criteria that must be met, namely:

1. The action is intentionally carried out by the offender;
2. The existence of victims;
3. The victim obeys the wishes of the perpetrator;
4. The loss suffered by the victim.

3.2 Various Forms of Fraud Potential in Health Facilities

In health insurance there are various possibilities that are carried out by various parties in carrying out fraud or fraud. Types of Fraud in the health sector:

1. Fraud in primary service.
2. Fraud in referral services (RS).
3. Fraud in the Drug Industry.
4. Fraud at the BPJS institution.
5. Fraud in the community / as BPJS participants.

3.3 The Dilemma Faced by Health Services vs Prevention of Fraud

Some ING CBG tariffs have not allowed clinical practitioners to provide services in accordance with 'Evidence Based Medicine' so that the possibility of Fraud forms such as a decrease in standard of care, fragmentation of care, unnecessary treatment can still occur and may occur in health services. Some hospitals with mindset profit oriented participating in the JKN-BPJS program will tend to commit intentional or not. Our system of legislation in prosecuting fraud does not yet exist specifically and specifically (still in the process of discussion at the Ministry of Health, etc.)Coder's ability or professionalism in general in Indonesia is in accordance with WHO data in terms of 'coding' diagnoses and actions based on ICD 10 and ICD-9CM, the scorecard is still below the standard value so fraud such as 'upcoding' is possible or not. Some health service institutions have been implementing a payment for service system, so the application of the casemix system and retrospective payments requires further understanding and adaptation.

But behind all the above dilemmas, JKN is still a program that we must support together but still need a lot of improvement, development and continuous evaluation. And this becomes a joint hard work of the government as a policy maker and especially those related directly to health services and to develop back the values of spirituality, nationalism and professionalism among health care providers both practitioners and management, so that fraud can be prevented and state losses can also be prevented either Doctors, Nurses, Coders, Medical Recorders, Hospital Management and Directors. Besides that, it is also necessary to develop the values of spirituality, nationalism and professionalism among health care providers both practitioners and management, so that fraud can be prevented and state losses can also be prevented.

3.4 Impact of Fraud in Health Systems

Provinces that do not have adequate personnel and health facilities will not optimally absorb BPJS funds. Residents in difficult areas in Indonesia do not have equal access to services. If they have to pay for themselves, the health costs that must be borne will be very large. BPJS funds will be sucked into developed regions and people in remote areas will find it increasingly difficult to obtain optimal health services.

3.5 Fraud Control

The important thing in implementing health insurance programs in the National Health Insurance System, BPJS Health, District / City Health Service and Health Facilities in collaboration with BPJS must establish a JKN fraud / fraud prevention system (Exsenveny, 2015).

So that control or prevention efforts can be carried out from various aspects, such as:

1. Participants
   a. The need for good socialization to the public about the BPJS pathway and the socialization of irregularities from the BPJS system, so that participants can take part. Because so far what happened in the field, participants felt less involved in this program and participants thought that JKN was a government program.
   b. Complete the identity appropriately, including the claim submission
   c. Request information / feedback about benefits that are entitled to be evaluated.

2. Health BPJS
   a. Preparation of policies and guidelines for prevention of JKN fraud in BPJS Health and dissemination to workers in the BPJS Health range.
   b. Development of a culture of prevention of JKN fraud as part of good organizational governance.
   c. The establishment of a fraud prevention and supervision team which was increased in JKN at BPJS Kesehatan. As in the case of card forgery, it can be developed with a BPJS card printed with photos or finger print.
d. Conduct routine investigations of claims submitted

e. Conduct regular consultations with MAB about the type of action and therapy provider.

f. Prospective controls and retrospective controls. Health insurance with a managed care system has not been well understood by participants and the general public, so they often interpret it as a system that is bureaucratic and troublesome. At first glance, there is a point, but this system can have a significant impact on cost control.

g. Implementation of PPATRS. The PPATRS Hospital Integrated Services Administration Program that is applied to hospitals that work with BPJS aims to provide convenience for BPJS program participants who need information or legalization relating to examinations or actions guaranteed by BPJS. Placement of officers at the Hospital is adjusted to the size of the number of participants' visits to each hospital, in line with the addition of the number of BPJS participants who utilize the Hospital which is the provider.

h. Determination of DPHO. List and Drug Price Ceiling (DPHO) aims as drug standards guaranteed by BPJS Standardization of drugs carried out by BPJS does not mean limiting the space for peers to provide therapy to patients, but rather is intended as a cost control tool for drug services for participants. Through the application of the DPHO, standard drugs will be obtained that provide great benefits for participants, because there are guarantees that these drugs have high medical effects, the side effects of the drugs are low, and have lower prices.

i. OUDD / ODDD Program. The One Unit Dose Dispensing (OUDD) and One Day Dose Dispensing (ODDD) program was carried out at the advanced inpatient drug service at the Hospital. With this program, the drug is given regularly per unit or per day for the patient's drug needs, so that there is no waste of medicine.

j. Establishment of MAB. Establishment of the Medical Advisory Board (MAB) in each work area of the Regional Office to the province. MAB members consist of specialist doctors, where together BPJS periodically discusses various matters relating to health services provided to BPJS participants. The results of this meeting / discussion will be a recommendation and second opinion for BPJS officers in conducting verification, both before and after the provision of health services to patients.

3. Health Service Facilities

a. Increasing the ability of doctors and other officers in relation to claims by maintaining the trust of insurance companies by correct claims and providing quality services in accordance with their rights

b. Improved management in an effort to early detection of prevention of JKN fraud.

c. Monitoring and fostering fraud. This can be done by forming a fraud prevention team whose job is to socialize new policies, guidelines and culture oriented to quality control and cost control, while also encouraging the implementation of good organizational governance and governance. Another task is to make efforts to prevent, early detection and prosecution of JKN fraud both in FKTP and in subsequent health facilities, resolving JKN fraud disputes, monitoring, evaluating and reporting well.

d. On issues related to the claim or financing system, it is the authority of the Ministry of Health, Health Facilities and BPJS to make the software 2 in 1 or one for all.

e. The need for the role model of JKN program implementation at the FasKes level, namely by establishing guidelines for determining the FasKes model in JKN implementation, conducting FasKes assessment activities in the implementation of JKN and compiling directors' policies regarding definitions and types of actions including fraud in hospital health services.

f. Hospitals must begin to study the calculation of 'unit cost' of health services for each diagnosis, so that they do not always think that participating in the JKN program will lose money.

g. Conduct monitoring and auditing for Coding by internal hospitals or independent parties to improve the quality of Coding and Coder.

h. All hospital staff need to develop a joint commitment to fight fraud in health services. Hospitals also need to develop a compliance program in the claims process of INA CBGs.
Various media for the prevention of fraud for hospitals also need to be arranged for staff learning materials. The hospital fraud prevention system is carried out by hospital fraud prevention units that are not ad-hoc.

i. After prevention is carried out, there is a need for internal fraud enforcement at the hospital. This action can be carried out in the form of administrative sanctions, financial sanctions, and refunds to BPJS. If an act of fraud is committed by the head of the SMF, action can be taken by the head of the SMF. If fraudulent acts are carried out by the hospital manager, then action can be taken by the board of directors. Whereas if the act of fraud is carried out by the board of directors of the hospital, action can be taken by the Supervisory Board.

4. Government
   a. Establish laws or regulations on fraud and penalties.
   b. Establish standards in health services so that there are "measures".
   c. Establish a body responsible for monitoring and evaluating the possibility of fraud.
   d. Increase socialization to the saryankes regarding the application of the casemix system and up-date the changes.
   e. Increasing Coder professionalism in general in Indonesia through training or ‘workshops' held by national / international professional organizations.
   f. Reinvesting good moral ethics for BPJS organizers, participants and all involved in health services in JKN and re-fertilizing homeland love and nationalism among health practitioners.
   g. Preparation of policies and guidelines for preventing JKN fraud.
   h. Development of health services oriented to quality control and cost control.
   i. Development of a culture of prevention of JKN fraud as part of good organizational governance and clinical governance.

5. Pharmaceutical Industry
   Encourage the compilation of technical guidelines on the procurement of medicines through E-catalogs that are integrated with the system of BPJS and health facilities.

3.6 Guidelines for Fraud Prevention and Reduction in Hospitals
   Step 1: prevention and reduction of fraud regulations
   1. Compile a list of activities called fraud
   2. Delegation of fraud supervision authority from the Ministry of Health to the Provincial and District Health Offices
   3. Collaboration between the Provincial Health Office and District Health Office with an independent team to conduct supervision.
   4. Establishment of a Special Investigation Unit at each BPJS Regional Office
   5. Strengthening the role of the internal and external supervisor of the hospital

   Step 2: socialization and training on prevention and reduction of fraud
   1. Collaboration between the Ministry of Health and universities for the preparation of materials and training
   2. Establish budget and training funding sources
   3. Implementation of the TOT program for trainers in various universities

   Step 3: Establish an anti-fraud team in the hospital
   1. Determination of members and duties of the team.
   2. Implementation of prevention programs in the form of anti-fraud education for hospital staff.
   3. Implementation of detection programs and internal investigations for fraud: monitoring and evaluating the accuracy of INA-CBG claims
   4. Implementation of action programs: reporting and refunds
   5. Implementation of research programs: use RS claim data for research on fraud.

   According to article 18 of Minister of Health Regulation No. 36 of 2015 states that:
   1. The JKN Fraud prevention team at FKRTL consists of elements from the internal inspection unit, medical committee, medical recorder, Koder, and other related elements.
   2. The JKN Fraud prevention team at FKRTL as referred to in paragraph (1) has the duty:
a. conduct early detection of JKN fraud based on data Claims of health services carried out by FKRTL;
b. socializing new policies, regulations, and cultures that are oriented towards quality control and cost control;
c. encourage the implementation of good organizational governance and clinical governance;
d. improve the ability of Koder, as well as doctors and other officers relating to Claims;
e. make efforts to prevent, detect and prosecute JKN fraud;
f. monitoring and evaluation; and
g. reporting.

3. To carry out the tasks as referred to in paragraph (1), the JKN Fraud prevention team in FKRTL coordinates with the Health BPJS both periodically and at any time.

Article 19
In the case of a primary clinic or equivalent health facility that does not yet have a JKN Fraud prevention team, prevention of JKN Fraud can be carried out by the JKN fraud prevention team in FKTP formed by the District / City Health Service.

3.7 Guidance and Supervision
Article 27 of Minister of Health Regulation No. 36 of 2015 states that:
1. Guidance and supervision of prevention of JKN Fraud shall be carried out by the Minister, Head of the Provincial Health Office, and Head of District / City Health Service in accordance with their respective authorities.
2. In the case of guidance and supervision as referred to in paragraph (1) carried out in a hospital, it can involve the hospital supervisory body, hospital supervisory board, hospital associations / associations, and professional organizations.
3. In the case of guidance and supervision as referred to in paragraph (1) carried out in the main clinic or equivalent and FKTP, it may involve the association of health facilities and professional organizations.
4. Guidance and supervision as referred to in paragraph (1) shall be carried out through:
   a. advocacy, socialization, and technical guidance;
   b. training and capacity building of human resources; and
   c. monitoring and evaluation.

3.8 Complaints and Settlement of Disputes
Complaints and control of disputes according to Minister of Health Regulation No. 36 of 2015 stated that:

Article 25
1. Any person who is aware of JKN fraudulent actions can make a complaint in writing.
2. Complaints as referred to in paragraph (1) shall be submitted to the head of the health facility, District / City Health Office and / or Provincial Health Service.
3. Complaints as referred to in paragraph (1) must contain at least:
   a. identity of complainant;
   b. name and address of agency suspected of committing JKN Fraud;
   c. reason for complaint.

Article 26
1. The head of the health facility, the District / City Health Service and / or the Provincial Health Service must follow up on the complaint as referred to in Article 25 by conducting an investigation.
2. Investigation as referred to in paragraph (1) is carried out by involving the Health BPJS, the JKN Fraud prevention team at FKRTL, or the FKTP Fraud fraud prevention team formed by the District / City Health Service.
3. The head of the health facility, the District / City Health Service and / or the Provincial Health Service after conducting the investigation as referred to in paragraph (1) must determine whether there is a JKN Fraud or not.
In the event of a disagreement over the determination of the presence or absence of JKN Fraud as referred to in paragraph (3), the Provincial Health Office or District / City Health Service may forward complaints to the JKN Fraud Prevention Team established by the Minister.

3.9 Sanctions

According to Article 28 and Article 29 of Minister of Health Regulation No. 36 of 2015 concerning Prevention of fraud in the implementation of health insurance programs on the national social security system:

1. In the framework of fostering and supervising the Minister, Head of the Provincial Health Office, the Head of District / City Health Service can provide administrative sanctions for health facilities, health workers, and providers of medicines and medical devices.

2. Administrative sanctions as referred to in paragraph (1) in the form of:
   a. verbal reprimand;
   b. written warning; and / or
   c. order to return losses due to JKN Fraud to the injured party.

3. In the event that JKN Fraud is carried out by the service provider or provider of drugs and medical devices, the administrative sanctions as referred to in paragraph (2) may be supplemented with a maximum fine of 50% of the total loss due to JKN Fraud.

4. In the event that JKN Fraud is carried out by health personnel, administrative sanctions as referred to in paragraph (3) may be followed by revocation of the practice permit.

5. Administrative sanctions as referred to in paragraph (2) do not remove criminal sanctions in accordance with the provisions of the legislation.

Article 29

1. In the case of JKN fraudulent actions carried out by Health BPJS officers, the Minister, the Head of the Provincial Health Office, and the Head of the District / City Health Service issued a recommendation to BPJS to provide administrative sanctions to BPJS Health officials who committed JKN Fraud.

2. The recommendations as referred to in paragraph (1) can be in the form of:
   a. verbal reprimand;
   b. written warning;
   c. dismissal from office;
   d. dismissal; and / or
   e. order to return losses due to JKN Fraud to the injured party.

Until now there has been no legislation that specifically regulates criminal sanctions that can be used to ensnare fraud perpetrators in the implementation of national health insurance. In order to overcome the vacuum of criminal law in health insurance, the crime of crime in health insurance, the perpetrators can be threatened with criminal fraud stipulated in Article 381 of the Criminal Code and counterfeiting criminal acts as stipulated in Article 263 paragraph (1) of the Criminal Code.

4. CONCLUSION

The development of the health insurance industry in Indonesia, has not been followed by legal regulation in the accommodating field, so that various crimes of fraud and fraud in the national health insurance in Indonesia are many who have escaped punishment. Basically fraud control for Participants, Health Facilities, BPJS, Health Service and Pharmaceutical Industry is by making policies and guidelines for prevention of JKN fraud and socialization and supervision of related parties. In order to overcome the legal vacuum in health insurance, the crime of crime in health insurance, the perpetrators can be threatened with criminal fraud stipulated in Article 381 of the Criminal Code and falsification as stipulated in Article 263 paragraph (1) of the Criminal Code.

In order to keep pace with the rapid growth of the health insurance industry, it needs a legal umbrella for the Insurers and the insured, so that the insurance industry in general and health insurance in particular can grow and develop and benefit all parties, for the realization of a just public health degree. For parties involved in the health insurance industry, it should be more sensitive if there are indications of criminal offenses to be able to use the legal umbrella of the Criminal Code in an effort to entrap the perpetrators of fraud and fraud.
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