Implementation of Indonesian Positive Law in Combating Fraud and Forgery in Health Insurance and Protection against Industrial Losses

Rangga Aditya Setiawan, Rafadi Khan Khayru, Rahayu Mardikaningsih, Fayola Issalillah, Siti Nur Halizah

Universitas Sunan Giri Surabaya, Indonesia

A R T I C L E I N F O

Article history:
Received 27 November 2022
Revised 16 December 2022
Accepted 22 January 2023

Key words:
Health insurance,
Fraud,
Forgery,
Positive law, Coverage,
Legal protection,
Deception.

A B S T R A C T

Fraud and forgery in health insurance pose a serious threat to the stability of the industry, the sustainability of financing schemes, and trust between insurers and insured parties. Various forms of fraud arise in the registration process, medical services, and claims submitted by participants, health workers, and agents. In Indonesian positive law, protection of insurance integrity is supported by civil, commercial, and criminal provisions, including the obligation to disclose material facts, the principle of absolute honesty, and criminal penalties for fraud and document forgery. This study examines how these norms work to suppress fraudulent practices and assesses the capacity of the law to provide guarantees for the health insurance industry. The results of the study show that the Indonesian legal system has provided a strong substantive framework, but its effectiveness is largely determined by administrative oversight mechanisms, the quality of medical verification, and the ability to provide evidence. Legal instruments serve to prevent, correct, and prosecute perpetrators of fraud, while minimizing potential financial losses for insurers. This study concludes that the integration of legal norms and operational control systems is necessary for optimal fraud eradication efforts.

INTRODUCTION

The development of health insurance in Indonesia has undergone a profound transformation over the past two decades, driven by structural reforms, increasing public demand for financial protection, and the growing burden of healthcare costs. Both commercial health insurance and state-administered social health insurance have expanded rapidly as the population becomes more aware of the importance of securing protection against illness, catastrophic medical expenses, and long-term health risks. The enactment of Law Number 24 of 2011 concerning the Social Security Administering Body (BPJS) marked a crucial shift by institutionalizing a nationwide social health insurance system that became fully operational on 1 January 2014. This reform placed Indonesia among countries striving to achieve universal health coverage through mandatory participation and solidarity-based health financing (Listiani et al., 2023).

The legal framework for insurance in Indonesia, articulated in Article 246 of the Commercial Code and Article 1 paragraph (1) of Law Number 2 of 1992 on the Insurance Business, emphasizes insurance as a contractual transfer of risk based on mutual trust between the insurer and the insured (Agustina et al., 2019). The insurer agrees to compensate future losses specified in the policy, and the insured commits to paying premiums and providing honest declarations. The entire system stands upon the presumption of good faith. Any distortion in this relationship threatens not only contractual fairness but also the financial integrity of the insurance sector. As health risks become more complex and the cost of care escalates, the volume and financial value of claims increase, thereby widening the potential for misuse and systematic manipulation (Saru et al., 2023).

Along with this expansion, the Indonesian health insurance industry has also experienced a significant rise in fraudulent practices (Tamaka et al., 2023). The increasing sophistication of policyholders, intensifying market competition among insurers, and economic pressures have contributed to the proliferation of fraudulent claims (Issalillah &

* *Corresponding author, email address:* ***rahayumardikaningsih@gmail.com***

Khayru, 2022). Fraud in health insurance is not restricted to a single actor. It can involve policyholders, healthcare providers, agents, brokers, or even internal staff within insurance companies and reinsurance institutions. International evidence underscores the seriousness of this problem. Research conducted in several advanced healthcare systems shows that fraudulent practices constitute one of the largest sources of financial loss in health insurance. In the United States, for example, industry-wide estimates suggest annual losses of three to seven percent of total health insurance expenditure, amounting to hundreds of millions of dollars (Muhammad & Priyono, 2023).

The Indonesian context reveals similar vulnerabilities. The government's commitment to expanding social protection through reforms such as the National Social Security System (SJSN), initiated under Law Number 40 of 2004, significantly increased public funding for healthcare. Between 2005 and 2007, public funds were allocated to cover over sixty million people, with government expenditure rising substantially as service utilization expanded. Under these schemes, the cost of essential and advanced care, including surgeries, dialysis, cardiac procedures, and maternal services, was fully covered by the state through PT Askes (the predecessor of BPJS Kesehatan). As claim volumes increased, discrepancies between expected and actual expenditures began to surface.

Tensions emerged between insurers and healthcare providers regarding unpaid claims, financial deficits, and unclear accountability. Public debates intensified when hospitals reported delayed payments, while PT Askes argued that claims submitted exceeded government budget allocations. The government, in turn, faced challenges securing additional funds to cover escalating deficits. This situation not only revealed administrative bottlenecks but also exposed the structural fragility of the financing system. Allegations of claim inflation by healthcare providers circulated widely and signaled the presence of systematic weaknesses in verification procedures. From an academic perspective, these issues highlight the inherent vulnerability of social health insurance systems when oversight, claim auditing, and regulatory enforcement are insufficient.

In both commercial and social insurance environments, the tripartite relationship among insurers, policyholders, and healthcare providers forms a complex interaction in which moral hazard and fraudulent behavior can arise at multiple points. Fraud may take the form of exaggerated claims, fictitious diagnoses, overbilling, unnecessary medical procedures, or deliberate manipulation of patient records. At the individual level, fraud may be motivated by financial distress, personal gain, or perceived opportunity. At the institutional level, it may stem from moral hazard created by third-party payment systems, weak regulatory sanctions, or the absence of transparent auditing mechanisms.

The literature identifies three fundamental drivers of fraud: need, opportunity, and rationalization. These factors align with Cressey's Fraud Triangle, a criminological framework widely used to understand white collar crime. Financial pressure creates incentives; system weaknesses provide opportunities; and cognitive justification normalizes unethical actions. In the Indonesian health insurance landscape, all three factors are evident. Economic disparities stimulate fraudulent claims; gaps in monitoring create exploitable opportunities; and the perception that large institutions can absorb financial losses encourages rationalization.

The increasing prevalence of fraud raises significant concerns for health system sustainability. Fraudulent claims undermine financial stability, distort risk calculations, increase the cost of premiums, strain government budgets, and ultimately threaten the quality and availability of health services. Fraud also erodes public trust, weakens insurer-provider relationships, and burdens administrative systems (Ndonga, 2018). In the long term, the persistence of fraud can compromise the viability of both commercial insurers and national health insurance programs.

Against this backdrop, the central problem becomes clear. Insurance fraud constitutes a violation of the law, damages the integrity of the insurance system, and produces substantial financial losses. In the context of social health insurance, these losses affect not only insurers but also the state and the broader public. Therefore, a comprehensive legal analysis is required to examine how regulatory frameworks address fraudulent practices, the effectiveness of legal sanctions, and the capacity of existing institutions to mitigate fraud. Understanding these legal mechanisms is crucial for reducing financial risks, strengthening institutional accountability, and ensuring the sustainability of the health insurance system in Indonesia.

The study is intended to analyze the legal dimensions of fraudulent practices in the health insurance industry and to understand how the current regulatory framework can mitigate the financial and operational risks posed by such actions.

The analysis seeks to investigate the legal status of insurance fraud as an unlawful act, evaluate the adequacy of statutory provisions and institutional mechanisms designed to prevent fraudulent behavior, and assess how enforcement agencies implement legal sanctions against perpetrators. Furthermore, the study aims to identify weaknesses within the existing governance and oversight systems that allow fraud to persist, and to explore how strengthened regulatory measures and more effective monitoring can enhance the stability and integrity of the health insurance sector. The overarching objective is to provide a comprehensive legal perspective that contributes to minimizing fraudulent activities, safeguarding the financial sustainability of insurance institutions, and ensuring that health insurance programs, particularly social health insurance, continue to function as reliable instruments of public protection.

RESEARCH METHOD

This research adopts a normative juridical methodology to examine fraudulent practices in Indonesia's health insurance sector and to evaluate the adequacy of the legal framework designed to prevent and address such misconduct. The normative juridical approach is appropriate because the central questions of this study revolve around the interpretation of statutory norms, institutional mandates, and the legal obligations arising within contractual insurance relationships. By grounding the analysis in authoritative legal sources, this method enables an in-depth evaluation of how Indonesian law constructs the concept of insurance fraud, delineates liability, and establishes sanctions for unlawful conduct.

The study relies on primary legal materials, including statutory instruments such as the *Kitab Undang-Undang Hukum Dagang* (KUHD), *Kitab Undang-Undang Hukum Perdata* (KUHPer), Undang-Undang Nomor 40 Tahun 2004 tentang Sistem Jaminan Sosial Nasional (SJSN), Undang-Undang Nomor 24 Tahun 2011 tentang BPJS, Undang-Undang Nomor 2 Tahun 1992 tentang Usaha Perasuransian (sebelum dicabut oleh UU No. 40 Tahun 2014), serta regulasi pelaksanaannya yang dikeluarkan oleh Kementerian Kesehatan, Otoritas Jasa Keuangan (OJK), dan lembaga terkait. Judicial decisions, particularly those addressing disputes involving fraudulent claims and contractual breaches in insurance transactions, are also examined to understand how courts interpret and enforce insurance obligations.

To enrich the interpretation of these legal norms, the study employs secondary legal materials, such as academic journals, monographs, legal commentaries, policy reports, and international literature on insurance fraud. Foundational scholarly works such as those by Clarke (2016) on insurance crime, Derrig (2002) on fraud typologies, and Heimer (2019) on compliance in health financing systems are used to provide theoretical depth and comparative insights. The integration of these materials helps clarify the conceptual foundation of fraud, the systemic vulnerabilities within insurance schemes, and the mechanisms adopted globally to strengthen fraud detection and prevention.

The legal materials are collected using documentary research techniques, which include identification, classification, and critical appraisal of statutory texts, doctrinal writings, and institutional reports. This process ensures that all materials analyzed are relevant, authoritative, and aligned with the research objectives. The selection criteria prioritize documents that explicitly address fraud, insurance operations, health financing governance, and regulatory enforcement.

Analytical procedures rely on legal interpretation, including grammatical, systematic, and teleological interpretation. These interpretive tools allow the researcher to evaluate whether the existing legal framework provides sufficient clarity in defining fraudulent conduct, allocating liabilities, and offering procedural safeguards. Doctrinal analysis connects general legal principles such as *good faith*, *equity*, *causa yang sah*, and *reasonableness* with practical issues arising in claim processing. By combining statutory interpretation with doctrinal reasoning, the research seeks to determine whether the current regulatory framework effectively deters fraud or whether structural gaps persist.

The methodological approach concludes with an evaluative synthesis that examines the effectiveness of Indonesia's legal instruments in handling fraud cases, including regulatory coherence, institutional capacity, enforcement consistency, and the alignment between legal norms and administrative realities. The final analytical outcome supports recommendations aimed at strengthening fraud prevention mechanisms, enhancing regulatory oversight, and improving the long-term integrity and sustainability of Indonesia's health insurance programs.

RESULT AND DISCUSSION

Legal Analysis of Violations of the Principle of Utmost Good Faith and Escalating Fraud in the Health Insurance Industry in Indonesia

The increase in potential and actual fraud in the health insurance industry in Indonesia is closely related to the fundamental nature of the legal relationship between the insurer and the insured, which is underpinned by the principle of perfect honesty or uberrimae fidei. This principle requires both parties to disclose all relevant material facts before the agreement is made. The normative framework of this obligation can be found in Article 1320 of the Civil Code, which regulates the validity of agreements, and is reinforced in Article 246 of the Commercial Code and Article 1 paragraph (1) of Law Number 2 of 1992 concerning Insurance Business (Imaniyati, 2011). In insurance law, the insurer always assumes that the insured provides accurate information about their circumstances, while the insured believes that the insurer will pay benefits in accordance with the policy clauses when the risk actually occurs. This relationship of mutual trust is the most vulnerable element, because any deviation from the principle of honesty will open the door to fraud.

The principle of utmost good faith requires all parties to disclose any material facts, whether requested or not, insofar as such information may influence the other party's decision to enter into an insurance agreement (Issalillah et al., 2021). In practice, however, this principle is frequently compromised within the health insurance industry. Violations take various forms that include misrepresentation, concealment of medical history, falsification of identity, and the submission of fabricated claims. Numerous cases demonstrate that such breaches are not solely committed by policyholders but also by marketing personnel, agents, healthcare providers, and institutional actors involved in the claims process. These patterns indicate that fraud arises not only from individual misconduct but from an industry ecosystem that allows information manipulation to occur (Salau et al., 2023).

Under Indonesian positive law, fraudulent behavior has long been anticipated by Article 251 of the Commercial Code, which stipulates that any concealment of material facts, even if undertaken without malicious intent, may nullify an insurance contract. This provision reflects the civil law perspective that full disclosure is an essential component of contractual validity. Nevertheless, more severe forms of fraud are classified as criminal offenses under Articles 378, 381, and 382 of the Indonesian Penal Code. These articles criminalize conduct such as the use of false identities, deceptive schemes, sequences of false statements, deliberate concealment of material information, and actions that cause loss to insurers (Chaerunnisa and Fadlian, 2022). These penal provisions illustrate that fraud in health insurance is not merely a contractual violation but a criminal act that may result in imprisonment of up to five years.

Additional insight into fraud can be found in international legal literature that enriches the domestic understanding of the concept. Black's Law Dictionary defines fraud as a deliberate misrepresentation of material fact intended to induce another party to act to their detriment. A similar definition is employed by the National Health Care Anti-Fraud Association, which characterizes fraud as the intentional presentation of false or misleading information for the purpose of obtaining unauthorized benefits. The Insurance Fraud Unit of the State of New Hampshire also emphasizes that the crime of insurance fraud involves knowingly submitting oral or written statements containing false, incomplete, or misleading information to obtain financial gain. These definitions converge on the elements of intentional conduct, the presence of a victim, actual loss, and the victim's reliance on the misrepresentation. These elements are likewise evident in various health insurance fraud cases in Indonesia (Mulhadi & Harianto, 2022).

Fraud in both national and commercial health insurance schemes is often perpetrated simultaneously by multiple actors. Hospitals frequently inflate claims by adding procedures that were never performed, recording medical interventions that did not occur, or listing fictitious patients. Laboratories may include diagnostic tests that were never requested by physicians. Pharmaceutical customers may increase the quantity of prescribed medication or intentionally substitute generic drugs with patented versions for financial advantage. Consumers may lend insurance cards to unauthorized individuals, submit fraudulent receipts, or overutilize medical services for personal resale. Moreover, insurance agents and brokers may conceal an applicant's health condition to facilitate policy issuance. These patterns demonstrate that fraud is multifactorial and may emerge at any stage of the service chain (Solehuddin, 2023).

Beyond fraudulent acts, document falsification represents another critical problem in health insurance. The fabrication of documents such as identity cards, medical certificates, receipts, hospital invoices, and patient visit records meets the criteria outlined in Article 263 paragraph (1) of the Penal Code (Gradhia, 2022). Such falsification includes creating false documents that generate rights,

obligations, or debt release, or that serve as evidentiary instruments. This practice often accompanies acts of deception, where falsified documents are used to substantiate fabricated claims. Criminal law treats this conduct with particular severity, imposing penalties of up to six years of imprisonment.

Fraud in health insurance is driven by various conditions. Financial distress may motivate policyholders to commit fraudulent acts. Legal loopholes and weak regulatory oversight create opportunities for system manipulation. Greed or moral rationalization serves as an internal factor that enables individuals to justify unethical actions. Donald Cressey's Fraud Triangle theory explains that fraud occurs when pressure, opportunity, and rationalization intersect (Awaliah, 2023).

Within Indonesia's complex health insurance ecosystem, which involves numerous actors and multilayered processes, these three factors often coexist, producing an environment where fraudulent behavior can escalate without timely intervention. The combination of administrative fragmentation and uneven digital integration amplifies the probability of inaccurate verification, allowing false claims to pass initial screening. Competition among healthcare facilities for financial reimbursement sometimes encourages inflated billing practices, especially when monitoring systems remain inconsistent. Weak internal controls in certain institutions undermine early detection mechanisms, giving perpetrators room to exploit procedural gaps. Moral hazard emerges when policyholders perceive that insurance funds can be accessed without personal consequence, especially in environments where punitive measures are seldom applied. Fraudulent conduct may also intensify when organizations lack standardized audit routines, resulting in varied enforcement across regions. Moreover, disparities in institutional capacity create imbalanced vigilance, with well resourced entities displaying higher resistance to fraud than smaller facilities. Taken together, these conditions illustrate the intricate interplay of structural and behavioral drivers that make fraud a persistent threat within national health insurance systems.

From a legal perspective, the escalating incidence of fraud in Indonesia's health insurance sector reflects weaknesses in the enforcement of the utmost good faith principle, insufficient mechanisms for the disclosure of material facts, and inadequate law enforcement against both contractual and criminal violations. Although legal instruments are available in the Civil Code, Commercial Code, Insurance Law, and Penal Code, these regulations have not yet succeeded in eliminating the systemic gaps exploited by perpetrators. Consequently, fraud remains a pervasive phenomenon that not only inflicts substantial losses on insurance companies but also threatens the long-term sustainability of the national health insurance system.

Fraud and Forgery in Health Insurance and Legal Responses in the Commercial Code and Criminal Code.

In practice, the tripartite relationship among the insurer, the insured, and healthcare providers creates multiple vulnerabilities that can be exploited through claim engineering, information manipulation, and the concealment of material facts. At the provider level, fraudulent conduct frequently manifests in the addition of diagnostic items that were never performed or the submission of laboratory examinations that were never requested by physicians, ultimately inflating the value of claims. In the pharmaceutical and optical sectors, distortions arise through the substitution of generic drugs with patented ones without medically justified indications, the inclusion of medication quantities exceeding the prescription, or the imposition of examination fees for services that were originally promoted as free. On the part of the insured, irregularities appear in the lending of insurance cards to unauthorized individuals, the submission of receipts containing nonmedical items, and patterns of excessive service utilization for personal gain (Villegas-Ortega et al., 2021).

Fraudulent schemes that originate at the initial policy stage are equally problematic. During the application phase, information regarding health conditions is frequently simplified or concealed, causing the risk profile to appear lower than it is in reality. During the eligibility phase, employment or membership status is sometimes fabricated so that ineligible individuals can be included as insured participants or so that high risk family members obtain access to coverage that should not be available to them. All of these practices revolve around the presentation of misleading facts or the omission of material information that, if known to the insurer at the time of contract formation, would influence the decision to accept, reject, or determine the terms of coverage. From a legal perspective, such conduct erodes the principle of utmost good faith, which constitutes an indispensable component of insurance agreements (Santri, 2017).

The consequences of contract nullification operate alongside the insurer's right to deny claims,

rescind the policy, or recover payments made on the basis of false information. In the criminal domain, deceptive conduct such as the use of a false identity, fraudulent schemes, sequences of false statements, or concealment of material facts falls within the parameters of fraud under Article 378 of the Penal Code. Actions that mislead the insurer into entering an agreement that would not have been concluded had the true circumstances been known are subject to sanctions under Article 381. Conduct aimed at unlawfully enriching oneself by causing harm to the insurer including within special risk categories such as fire or maritime insurance is addressed through Article 382. When fraud is executed through documents, Article 263 paragraph (1) of the Penal Code classifies the creation or alteration of documents to appear authentic despite being false as forgery subject to criminal penalties (Zulfa, 2018).

The evidentiary standard in such cases relies on establishing intentionality, the presence of a victim and actual loss, and a causal connection between the misrepresentation or concealment and the actions of the aggrieved party. Authoritative definitions in Black's Law Dictionary emphasize knowing misrepresentation or concealment of a material fact intended to induce another party to act to their detriment, while definitions used in the healthcare sector, such as those adopted by the National Health Care Anti-Fraud Association, highlight intentional deception or misrepresentation that results in unauthorized benefits to the perpetrator. These definitions underscore that the legal emphasis rests on the materiality of the concealed or falsified facts and on the perpetrator's intention at the time the act was committed (Kim et al., 2013).

This focus on intentionality reinforces that fraud is distinguished from administrative error through the presence of calculated conduct designed to obtain unwarranted gain. Courts generally require proof that the concealed information was significant enough to influence decision making, reaffirming that minor inaccuracies do not meet the threshold for criminal liability. The assessment of causation further ensures that liability is imposed only when the misrepresentation demonstrably influenced the insurer's or healthcare provider's actions. In addition, evidentiary evaluation often incorporates expert testimony to determine whether the omitted or falsified information would have altered the contractual or clinical judgment of the opposing party. Legal systems also expect a clear demonstration that the victim suffered measurable harm, whether through financial loss, undue reimbursement, or distorted risk assessment. Moreover, investigative bodies frequently analyze patterns of conduct to determine whether the misrepresentation reflects isolated misconduct or systematic fraud. Through these requirements, the legal framework assures that fraud prosecutions remain anchored in objective criteria that safeguard due process while enabling effective deterrence.

Beyond criminal sanctions, administrative and civil implications operate concurrently. Insurers possess legitimate grounds to deny claims, cancel policies, or pursue restitution for payments issued on the basis of fraudulent information (Kurniawan et al., 2020). At the provider level, the discovery of fraud may result in the termination of contractual relationships, the imposition of contractual penalties, and the initiation of formal reports to law enforcement authorities. On the policy level, the risk configurations created by widespread fraud require administrators to strengthen verification mechanisms, conduct more rigorous claim audits, enhance clinical oversight, and reinforce contractual clauses that mandate full disclosure and impose sanctions for misrepresentation. Collectively, these elements demonstrate that fraud and document falsification in the health insurance sector are not merely operational anomalies but constitute violations of the principle of utmost good faith and public order as anticipated within the frameworks of the Commercial Code and Penal Code. Consequently, their mitigation requires a combination of private remedies, criminal enforcement, and institutional reforms aimed at eliminating opportunities for recurrence.

The capacity of Indonesian positive law in handling health insurance fraud

The capacity of Indonesia's positive law to respond to fraudulent practices in the health insurance industry can be assessed through the extent to which existing legal norms are able to address the complexity of fraudulent conduct that emerges at multiple points within the legal relationships among insurers, insured parties, and healthcare providers. In this regard, the effectiveness of legal enforcement depends on the clarity of substantive rules, the adequacy of supervisory instruments, and the consistency of enforcement mechanisms that ensure perpetrators of fraud can be held accountable in a precise and proportionate manner (Silapurna, 2022). Normatively, various provisions establish a sufficiently firm foundation for addressing fraudulent acts in the health insurance sector. Commercial law regulates the duty of full disclosure regarding material facts at the time the contract is

established, while criminal law provides the framework for prosecuting acts of deception and document falsification associated with insurance claims. Nonetheless, the effectiveness of these regulatory instruments is influenced by the ability of authorities to prove manipulative conduct that often occurs within administrative processes, medical records, or internal hospital documentation. This technical complexity requires that the evidentiary burden involve not only demonstrating elements of deception or fraudulent intent but also establishing actual financial loss suffered by the insurer (Sukma et al., 2018).

The capacity of positive law is also reflected in the range of sanctions available, including policy cancellation, claim denial, and criminal liability for individuals involved in fraudulent schemes. These instruments allow insurance companies and national health administrators to respond proportionately to varying degrees of fraudulent behavior. However, challenges arise when fraud is carried out through collusion among multiple actors, such as cooperation between healthcare personnel, marketing agents, and insured participants. In such circumstances, sectoral legal structures require cross institutional coordination to prevent enforcement from being limited only to the most accessible or visible offenders (Firmansyah et al., 2022).

Beyond the clarity of legal norms, the effectiveness of the law is shaped by the administrative oversight system that governs health insurance operations, particularly within social insurance schemes. Claim verification, medical auditing, and routine evaluations by program administrators are essential to ensure that financing systems are not exploited for unlawful gain. These supervisory instruments complement the repressive character of criminal law by ensuring that fraud prevention does not rely solely on post violation sanctions but is supported by routine controls that reduce opportunities for manipulation (Ashar, 2023).

Legal instruments function to minimize financial losses in the industry through three core roles. First, they serve a preventive role by enforcing principles of transparency, mandatory disclosure, and accountability among healthcare providers and insured parties. These requirements compel all parties involved in insurance contracts to provide accurate and truthful information from the outset, thereby reducing opportunities for information manipulation (Chabra et al., 2018). The preventive structure embedded in these instruments strengthens institutional discipline by ensuring that each contractual step is supported by verifiable data and documented procedures, which reinforces trust within the insurance market. Such mechanisms discourage opportunistic behavior because every declaration must withstand legal scrutiny, creating a compliance environment that promotes fairness in risk allocation. Furthermore, preventive regulations streamline claim evaluation processes by reducing interpretive ambiguities that often trigger disputes between insurers and policyholders. In addition, these rules contribute to operational stability, since organizations are encouraged to maintain consistent records aligned with regulatory expectations. The preventive function also enhances market reliability because standardized disclosure duties make it possible for insurers to assess risks using comparable and traceable information. Moreover, the presence of clear preventive norms encourages early detection of irregularities, allowing insurers to adopt corrective measures before irregularities escalate into significant financial liabilities. Finally, the preventive force of legal instruments helps maintain the integrity of contractual relationships, ensuring that the insurance industry operates with a higher degree of predictability and legal certainty.

Second, the law provides corrective mechanisms that enable insurers to deny illegitimate claims, cancel policies, or seek restitution when manipulative practices are proven. These mechanisms help maintain the financial stability of insurance companies, which may be jeopardized if fictitious claims or fabricated diagnoses cannot be halted. In the context of social health insurance, corrective mechanisms also protect the sustainability of state funding and ensure that benefits are not misused by unauthorized parties (Yolova, 2022).

The corrective structure embedded in these regulations strengthens institutional resilience because insurers are equipped with legal avenues to respond to fraud in a proportionate and structured manner. Clear procedural grounds for rejecting unlawful claims reduce ambiguity during dispute resolution and prevent insurers from bearing costs that originate from intentional misconduct. Corrective norms also enhance operational discipline by obliging insurers to document every decision related to claim refusals or policy cancellations, creating an auditable trail that reinforces accountability. Furthermore, these mechanisms serve as a deterrent for potential offenders, since policyholders and service providers understand that fraudulent actions can trigger enforceable sanctions. The corrective dimension promotes fairness within the insurance ecosystem by ensuring that legitimate policyholders are not indirectly burdened by inflated

premiums resulting from unchecked fraud. Through this framework, insurers gain stronger bargaining capacity when adjudicating questionable claims, ultimately supporting long term system viability and reducing the financial volatility associated with fraud related losses.

Third, criminal instruments serve a repressive function by imposing deterrent effects on individuals who intentionally cause financial harm through fraudulent acts. Criminal sanctions for fraud, document falsification, or the use of false identities underscore that such conduct is not merely an administrative violation but a criminal offense that undermines the integrity of health financing structures. This deterrent function is essential, given that fraud is often motivated by substantial personal gain and systemic vulnerabilities (Hutahaean, 2022).

The incorporation of punitive measures strengthens the authority of regulatory institutions by ensuring that fraudulent behavior is met with firm and proportionate consequences. The presence of enforceable sanctions elevates the perceived risk among potential offenders, reducing the likelihood of deliberate attempts to exploit procedural gaps. Criminal enforcement also reinforces public trust, as policyholders and service providers recognize that insurance systems are safeguarded through rigorous legal protections. Furthermore, the repressive framework compels institutions to enhance internal monitoring systems, since exposure to legal liability encourages implementation of robust verification procedures. The threat of criminal prosecution fosters higher ethical discipline within organizations that interact with insurance mechanisms, including healthcare facilities, third party administrators, and independent brokers. In addition, punitive measures promote long term system stability by discouraging organized fraud networks that thrive in regulatory environments perceived as weak. Through this structure, criminal instruments contribute to a more secure and predictable insurance market, thereby reducing the overall economic strain caused by repeated fraudulent acts.

Although the existing legal instruments are relatively comprehensive, their effectiveness is closely tied to the state's ability to enforce them consistently and professionally. Strengthening the human resources of law enforcement agencies, improving information systems, and enhancing transparency across the healthcare service chain are supporting factors that determine the success of normative regulation. Without adequate operational capacity, even stringent legal provisions will not be able to prevent or combat fraud effectively.

Accordingly, the capacity of Indonesia's positive law to address health insurance fraud lies in the synergy among robust substantive rules, functional administrative oversight instruments, and effective criminal enforcement mechanisms. These three components are essential to ensure that the health insurance industry operates in a manner that upholds fairness, contractual integrity, and the protection of public funds.

CONCLUSION

The examination of fraud and falsification within the health insurance sector demonstrates that the core problem originates from deviations from the principle of utmost good faith, which constitutes the foundational basis of insurance contracts. Fraud manifests in multiple forms, ranging from identity manipulation and the fabrication of medical histories to the submission of fictitious claims involving insured participants, agents, and medical service providers. Indonesia's positive law provides a comprehensive set of instruments through civil, commercial, and criminal provisions that regulate the obligation to disclose material facts and impose sanctions on fraudulent conduct and document falsification. Nevertheless, the effectiveness of these instruments is heavily dependent on the reliability of verification mechanisms, the accuracy of supervisory procedures, and the capacity of law enforcement agencies to prove elements of intent, financial loss, and the sequence of manipulative actions undertaken by offenders. Consequently, the protection of the health insurance industry is determined not only by normative rules but also by operational capacities that ensure consistent prevention and detection of fraud.

Optimizing fraud mitigation requires significant improvements in claim verification systems through the integration of medical data, technology assisted auditing, and the enhancement of supervisory personnel competencies. Insurance companies must establish more rigorous risk assessment standards for initial participant information to reduce opportunities for manipulation. Stronger collaboration among law enforcement authorities, insurance supervisory bodies, hospitals, and insurance companies is essential to ensure that evidentiary processes proceed effectively and do not stagnate at the level of administrative irregularities. Educational initiatives directed at insured participants regarding the legal consequences of falsification and deception are also necessary to foster a culture of compliance. Preventive measures will remain

ineffective without a firm commitment from insurance companies to enforce internal sanctions against agents or service partners who are proven to be involved in fraudulent activities.

The health insurance industry will achieve greater stability when substantive legal provisions operate in alignment with effective administrative control mechanisms. A reduction in fraud rates has a direct impact on the sustainability of insurance funds and the capacity of insurers to fulfill legitimate claim obligations. Consistent legal enforcement fosters a fairer business environment and enhances public confidence in insurance services. For regulators, strengthening supervisory instruments constitutes a strategic measure for closing systemic loopholes that have been exploited by fraud perpetrators. In the long term, successful fraud mitigation supports the efficiency of national healthcare financing and improves the overall governance of the insurance industry.

REFERENCES

Agustina, R., Dartanto, T., Sitompul, R., Susiloretni, K. A., Achadi, E. L., Taher, A., ... & Khusun, H. (2019). Universal health coverage in Indonesia: concept, progress, and challenges. *The Lancet*, *393*(10166), 75-102.

Ashar, A. (2023). Aspek Yuridis Penerapan Sanksi Adminisratif Bagi Pelaku Kecurangan (FRAUD) Dalam Program Jaminan Kesehatan Nasional. *Jurnal Hukum, Politik Dan Ilmu Sosial*. https://doi.org/10.55606/jhpis.v1i1.1738

Awaliah, K. N. (2023). Fraud Triangle Theory: Pendekatan Strategis Dalam Mendeteksi Korupsi dan Kecurangan pada Laporan Keuangan Publik. *Karimah Tauhid*, *2*(5), 1493-1506.

Chabra, S., Menon, R., Postolovska, I., Smith, O., Tandon, A., & Ulep, V. G. T. (2018). *Preventing, Detecting, and Deterring Fraud in Social Health Insurance Programs*. https://doi.org/10.1596/31013

Chaerunnisa, R., & Fadlian, A. (2022). Analisis Yuridis Tindak Pidana Penipuan Atas Tipu Muslihat Terhadap Pekerja Seks Komersial Berdasarkan Pasala 378 Kuhp Tentang Tindak Pidana Penipuan. *Jurnal Ilmiah Wahana Pendidikan*, *8*(15), 487-498.

Clarke, M. (2016). *The Regulation of Insurance Fraud*. Oxford University Press.

Derrig, R. A. (2002). Insurance Fraud. *Journal of Risk and Insurance*, 69(3), 271–287.

Firmansyah, Y., Haryanto, I., & Ernawati, E. (2022). Fraud Issues in the National Health Insurance (Causes, Legal Impacts, Dispute Settlement and Preventive Measures). *Jurnal Multidisiplin Madani*. https://doi.org/10.55927/mudima.v2i4.272

Gradhia, F. S. (2022). *Tinjauan Yuridis Tindak Pidana Pemalsuan Surat (Studi Kasus Perkara Nomor 96/Pid. B/2021/PN DMK)* (Doctoral dissertation, Universitas Islam Sultan Agung Semarang).

Heimer, C. (2019). *Reactive Risk and Rational Action in Health Insurance Systems*. Cambridge University Press.

Hougaard, C., & Chamberlain, D. (2011). Fraud in Health Insurance. *MicroInsurance Network Research Paper*.

Hutahaean, H. (2022). *Application of Criminal Sanctions in Cases of Manipulation of Demand and Collection of Health Services Fees for Patients Participating in the National Health Insurance Program*. https://doi.org/10.30659/rlj.1.1.16-25

Imaniyati, S. (2011). Perlindungan Hukum Terhadap Konsumen Dalam Sengketa Klaim Asuransi. *Jurnal Bisnis*, *30*(1).

Issalillah, F. & R.K.Khayru. (2022). The Effect of Insurance Premiums and Brand Image on Interest to be An Insurance Customer, *International Journal of Service Science, Management, Engineering, and Technology*, 1(3), 31–35.

Issalillah, F., D. Darmawan & R. K. Khayru. (2021). Social Cultural, Demographic and Psychological Effects on Insurance Product Purchase Decisions, *Journal of Science, Technology and Society*, 2(1), 1-10.

Kim, L. (2013). Am I liable? The problem of defining falsity under the False Claims Act. *American Journal of Law & Medicine*. https://doi.org/10.1177/009885881303900104

Kitab Undang-Undang Hukum Dagang (KUHD).

Kitab Undang-Undang Hukum Perdata (KUHPerdata).

Kurniawan, S., Disemadi, H. S., & Purwanti, A. (2020). *Urgensi Pencegahan Tindak Pidana Curang (Fraud) Dalam Klaim Asuransi*. https://doi.org/10.33561/HOLREV.V4I1.10863

Listiani, R., Dewi, K. R., Madani, J. F., & Syarif, S. H. (2023). The Comparison of Health Insurance between Indonesia and other Middle-Income Countries. *Usada Nusantara*. https://doi.org/10.47861/usd.v1i2.209

Muhammad, A. F., & Priyono, E. A. (2023). Perlindungan Hukum kepada Perusahaan Asuransi terhadap Tindakan Fraud yang dilakukan oleh Nasabah di Indonesia. *Jurnal*

Ilmiah Universitas Batanghari Jambi. https://doi.org/10.33087/jiubj.v23i2.2906

Mulhadi, M., & Harianto, D. (2022). Misrepresentation sebagai fraud dalam perkara kontrak asuransi yang dilakukan penanggung. *Arena Hukum*. https://doi.org/10.21776/ub.arenahukum.2022.01501.4

Ndonga, S. N. (2018). *Determinants of delays in the payment of private health insurance claims in Kenya* (Doctoral dissertation, Strathmore University).

Peraturan BPJS Kesehatan terkait mekanisme klaim dan pengendalian fraud.

Peraturan Menteri Kesehatan Republik Indonesia mengenai penyelenggaraan Jaminan Kesehatan Nasional.

Picard, P. (2012). Economic Analysis of Insurance Fraud. *The Geneva Papers on Risk and Insurance*, 37(1), 1–29.

Salau, A., Nnanna, N. A., & Boukar, M. M. (2023). *A Review of Fraudulent Practices in Healthcare Insurance and Machine Learning-Based Investigation Approaches*. https://doi.org/10.1109/iisa59645.2023.10345969

Santri, S. H. (2017). Prinsip Utmost Good Faith Dalam Perjanjian Asuransi Kerugian. *UIR Law Review*, *1*(1), 77-82.

Saru, A. A. A., Arifin, Muh. A., Darmawansyah, D., Razak, A., Syafar, M., & Rahmatia, R. (2023). Potential fraud and its' prevention in the implementation of national health insurance at Dadi Regional Hospita. *International Journal of Public Health Science*. https://doi.org/10.11591/ijphs.v12i3.22952

Silapurna, E. L. (2022). Fraud Prevention Legal Certainty Principle In Health Sector and Implementation of Health Insurance Program in Indonesia. *Jurnal Berkala Kesehatan*. https://doi.org/10.20527/jbk.v8i1.12855

Solehuddin, S. (2023). Urgensi Kriminalisasi Perbuatan Kecurangan (Fraud) dalam Pelaksanaan Program Jaminan Kesehatan di Indonesia. *Interdisciplinary Journal on Law, Social Sciences and Humanities*. https://doi.org/10.19184/idj.v4i1.39490

Sukma, D. P., Sulistiyono, A., & Novianto, W. T. (2018). *Fraud in Healthcare Service*. https://doi.org/10.1051/SHSCONF/20185403015

Tamaka, R. S., A. I. Wuryani, Y. N. Lethy, F. Issalillah, & R. Hardyansah. (2023). Legal Review of Patients' Rights in the Health Insurance System, *Studi Ilmu Sosial Indonesia*, 3(2), 69-84.

Undang-Undang Nomor 24 Tahun 2011 tentang Badan Penyelenggara Jaminan Sosial.

Undang-Undang Nomor 40 Tahun 2004 tentang Sistem Jaminan Sosial Nasional.

Villegas-Ortega, J., Villegas-Ortega, J., Bellido-Boza, L., & Mauricio, D. (2021). Fourteen years of manifestations and factors of health insurance fraud, 2006-2020: a scoping review. Health & Justice. https://doi.org/10.1186/S40352-021-00149-3

Yolova, G. (2022, August 30). *For certain features of the administrative control under the health insurance act*. https://doi.org/10.36997/ppdd2022.78

Zulfa, E. (2018). Menghancurkan Kepalsuan (Studi Tentang Tindak Pidana Pemalsuan Dan Problema Penerapannya). *Jurnal Hukum & Pembangunan*, *48*(2), 345-360.

***Setiawan, R.A., R. K. Khayru, R. Mardikaningsih, F. Issalillah, S. N. Halizah. (2023). Consumer Protection in the Health Sector: The Legal Responsibilities of Pharmacists, *Journal of Social Science Studies*, 3(1), 271 – 280.**