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Hospital Fraud in the National Health Insurance Program from a Legal and Governance Perspective

Lalu Jamiri, Mujito, Sarwo Waskito

Universitas Sunan Giri Surabaya, Indonesia

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ABSTRACT

This study examines hospital fraud in the implementation of the National Health Insurance (JKN) from the perspective of public law and administration, with the aim of assessing the adequacy of regulations, enforcement mechanisms, and dispute resolution patterns. The method used is normative legal research with a legislative and conceptual approach, based on an analysis of the National Social Security System Law, BPJS Health regulations, Presidential Regulations on Health Insurance, and Minister of Health Regulation No. 16 of 2019 concerning the prevention and handling of fraud. The results of the study show that hospital fraud occurs in various forms, such as claim manipulation, data falsification, provision of unnecessary services, and irregular tariff arrangements, which in many cases constitute criminal fraud according to the Criminal Code. The driving factors behind fraud can be explained through the Fraud Diamond, which emphasizes the interaction between pressure, opportunity, rationalization, and the perpetrator's ability, reinforced by weak internal controls and a culture of legal compliance. From an enforcement perspective, Minister of Health Regulation No. 16 of 2019 still focuses on administrative sanctions, so the deterrent effect on perpetrators is limited and criminal prosecution is highly dependent on law enforcement officials' interpretation of the provisions of the Criminal Code. Dispute resolution is possible through mediation or lawsuits in district courts, but its effectiveness is highly dependent on the quality of the complaint unit, the transparency of procedures, and accessibility for JKN participants. This study emphasizes the urgency of strengthening regulations, governance, and legal culture to reduce fraud incidents and protect the rights of JKN participants. These findings provide an argumentative basis for policymakers to design comprehensive interventions in line with the mandate of national social security in the constitution.

INTRODUCTION

An understanding of healthy living as one of the fundamental prerequisites for individuals to be able to function normally occupies a central position within the conceptual framework of basic human rights. Health is regarded as an essential component of well-being and as an integral part of human rights that must be realized in accordance with the ideals of the Indonesian nation as stipulated in the 1945 Constitution of the Republic of Indonesia and Pancasila (Budiono et al., 2022). In Indonesia, the normative foundation of health development is anchored in the Second Amendment to the 1945 Constitution, Article 28H paragraph (1), which stipulates that "Every person shall have the right to live in physical and spiritual prosperity, to have a place to live, and to enjoy a good and healthy environment, and shall have the right to obtain health services." This provision is reinforced by Article 34 paragraphs (2) and (3) of the 1945 Constitution, as well as Article 4 paragraph (1) of Health Law No. 17 of 2023, which affirms the right of every individual to live in a proper physical, mental, and social condition. These legal foundations constitute the basis for the formulation of regulations in Indonesia governing the implementation of social security in order to give effect to constitutional mandates, among others through Law No. 24 of 2011 on the Administration of Social Security and Law No. 40 of 2004 on the National Social Security System, which are implemented by the Social Security Administration Agency (BPJS) for Health in the form of the National Health Insurance (JKN) scheme (Daisahbeny, 2023).

** Corresponding author, email address: dr.sarwowaskito@gmail.com*

Prior to the implementation of the National Health Insurance, public access to health services at Health Facilities was severely constrained, as only specific groups with sufficient financial means or coverage, for example through insurance schemes, were able to utilize such services. The relatively high cost of health care rendered formal health facilities difficult to access for economically disadvantaged groups, who consequently often postponed or even neglected treatment for illnesses. In many cases, these groups preferred to seek care from alternative health providers perceived as more affordable, although such services did not necessarily comply with formally regulated health care standards. Within this framework, the strengthening of the health insurance system through JKN and BPJS Kesehatan is expected to expand access to quality health services, provide more inclusive social protection, and realize the constitutional mandate that an adequate standard of health is a right of all citizens without exception (Dewi & Israhadi, 2021).

The formulation of policies and regulations related to JKN requires a careful understanding of membership dynamics, fiscal sustainability, and vulnerabilities to fraud in its implementation. The number of JKN Participants has increased very significantly; however, the growth trajectory of this program faces various challenges, one of which is fiscal deficit pressure. Since its operationalization in 2014, JKN has often been in a deficit position and within a red-zone status for several subsequent years. In the course of JKN implementation, many Participants, particularly those from low-income groups, have benefited from broader access to health services. Nonetheless, various forms of dissatisfaction continue to emerge among JKN Participants and stakeholders, partly due to the existence of opportunities for fraudulent practices that cause harm to other parties.

The concept of fraud as formulated in Minister of Health Regulation Number 16 of 2019 on the Prevention and Handling of Fraud and the Imposition of Administrative Sanctions for Fraud in the Implementation of the Health Insurance Program refers to intentional acts carried out to obtain financial gain from the National Social Security System in the Health Insurance program through conduct that deviates from statutory provisions. In the implementation of the National Health Insurance, fraud may potentially be committed by various actors, including health care providers or Health Facilities, BPJS Kesehatan, and Participants. Efforts to ensure quality control and cost control in health insurance programs require concrete measures to minimize the potential for fraudulent practices. The 2018 report to the Association of Certified Fraud Examiners (ACFE) indicates that losses due to fraud in health services amount to approximately 5% of total health care expenditures. The obligation to manage health benefits effectively and efficiently is explicitly regulated in Law Number 40 of 2004, which designates BPJS Kesehatan as the Social Security Administering Body responsible for paying health benefits to health institutions (Law No. 40 of 2004). Through Presidential Regulation Number 82 of 2018 on Health Insurance, the notion of Fraud in the Health Insurance program is further reaffirmed as intentional conduct aimed at obtaining financial gain from the National Social Security System that is contrary to statutory provisions (Sadikin, 2016). In the health sector, fraud is understood as deceitful conduct encompassing the falsification of statements and the misuse of assets, and may be perpetrated by various parties involved in the delivery of services.

The forms of Fraud that may be committed by health care providers in hospitals are highly diverse, including falsification of Health Facility Operational Licenses and Health Worker Practice Licenses, receipt or provision of gratuities or bribes related to Health Insurance, collection of fees from Participants that contravene statutory provisions, billing for services that were not actually provided, manipulation of room charges, prolonged length of stay without sufficient medical indication, repeat billing, self-referrals, separate billing for several procedures that should be claimed as a service package, submission of separate invoices for the same diagnosis by providers, splitting of episodes of care to increase the number of claims, inflated bills in the form of exaggerated costs of medical devices or medicines, falsification of claims, cloning of claims by copying other patients' data, and manipulation of procedures or diagnoses. In light of these various problems, a legal analysis of hospital Fraud in the implementation of the National Health Insurance becomes crucial in order to examine the legal framework governing fraudulent acts by hospitals and to assess the extent to which the effectiveness of existing provisions is reflected in practice.

Accordingly, research on hospital fraud in the National Health Insurance program is expected to contribute to the strengthening of regulation and law enforcement, so that the implementation of JKN can proceed in a more accountable and equitable manner and remain aligned with the original objectives of establishing the national social security system in the health sector.

RESEARCH METHOD

The discussion of methodology in legal research constitutes a crucial foundation for ensuring the accuracy of the analysis of fraud in the implementation of the National Health Insurance (JKN) by hospitals. This study employs a normative juridical legal method, namely a type of research based on the examination of primary and secondary legal materials. The main focus is directed toward legal norms governing the administration of JKN and the mechanisms of law enforcement against fraudulent practices committed by hospitals. The primary legal materials used comprise Law Number 40 of 2004 on the National Social Security System, Law Number 24 of 2011 on the Social Security Administering Body, Presidential Regulation Number 82 of 2018 on Health Insurance, various Minister of Health Regulations, BPJS Regulations, and other regulations that specifically govern hospital fraud. Secondary legal materials are obtained from books, law journals, scholarly articles, and other analytical documents considered relevant for strengthening the argumentative basis and normative interpretation.

To clarify the analytical framework, this study adopts two types of approaches, namely the statute approach and the conceptual approach. The statute approach is employed to systematically examine regulations related to JKN, hospital governance, and the imposition of sanctions for fraud in health insurance programs. The conceptual approach is utilized to formulate and interpret the notion of fraud within the frameworks of health law and administrative law, so that the juridical characteristics of fraudulent acts can be constructed in a structured manner and made consistent with the prevailing doctrinal developments. Through the selection of these methods and approaches, the study is expected to produce a rigorous analysis that is academically defensible in support of strengthening legal governance of fraud in hospitals under the JKN scheme.

RESULT AND DISCUSSION

The discussion of health financing constitutes a key element in the study of public policy, as it is directly related to the capacity of the health system to provide quality services for the population. Efforts to improve the quality of health services are strongly determined by the existence of an adequate, well-structured, and sustainable financing system. Health financing is positioned as a principal instrument for enhancing and maintaining societal welfare, which simultaneously serves as the foundation for the capacity of the health system. Accordingly, a clear assessment of the range of indicators used to evaluate and monitor the performance of health system financing in comparison with the intended expectations is required.

Conceptually, health financing refers to the function of the health system in meeting the health needs of individuals and communities through processes of allocating, pooling, and mobilizing funds. The primary objective of health financing is to ensure that all segments of society are able to access effective public and private health services, to guarantee the availability of required resources, and to regulate financial incentive mechanisms for health service providers so that they remain oriented toward service quality. Thus, well-organized health financing management becomes a determining factor in the success of the health system in achieving an optimal and equitable level of population health. Within this framework, the design of health financing must take into account the principles of equity, efficiency, and protection for vulnerable groups in order to prevent exclusion from services due to financial barriers. Appropriately designed financing schemes can reduce the risk of catastrophic health expenditure that has the potential to push households into poverty. In addition, a transparent and accountable financing structure is a prerequisite for preventing budget leakages, moral hazard, and fraudulent practices that may erode public trust in the health system. Financing instruments such as capitation payments, diagnosis-based claims, and performance-based budgeting must be carefully regulated so that they are able to promote efficiency without compromising the quality of clinical care. The regulation of tariffs and rational payment patterns for health facilities contributes to maintaining the sustainability of hospital and primary care operations, while at the same time reducing tendencies toward overutilization or underutilization of services. The integration of financing from various sources, including taxes, social security contributions, and other forms of funding, requires strong institutional coordination in order to avoid program fragmentation and overlapping allocations. In the long term, health financing policies that are formulated consistently and on the basis of evidence will determine the capacity of the state to achieve high-quality universal health coverage. In this manner, health financing functions not merely as a technical mechanism for resource collection, but as a strategic instrument for realizing social justice and the continuous improvement of population health status.

Analysis of Types and Causes of Fraud

The analysis of fraud in the implementation of the National Health Insurance (Jaminan Kesehatan Nasional, JKN) constitutes a critical agenda for strengthening health system governance and safeguarding the sustainability of social health insurance financing. Fraudulent practices in the delivery of health services represent a serious problem that requires targeted intervention, particularly within the framework of the JKN Program. Fraud is understood as an intentional act committed to obtain financial gain from the National Social Security System in the health insurance program through conduct that deviates from statutory and regulatory provisions. This definition indicates the presence of three essential elements, namely the intention to obtain financial benefit, the element of deliberateness, and deceitful actions that contravene established rules and thereby cause harm to other parties. Within the JKN scheme, fraud may be perpetrated by beneficiaries, BPJS Kesehatan officers, health care providers, as well as pharmaceutical and medical device suppliers through various forms of conduct that violate applicable regulations (Hartati, 2016). In Indonesia, the potential for fraud in the health service sector has become increasingly prominent, among others due to the relatively recent nature of the financing system, pressure on service providers, rationalization of deviant behavior, and weak oversight in practice. Therefore, strict regulatory enforcement accompanied by consistent supervision constitutes a key strategy to reduce the risk of fraud in the JKN Program and to maintain the sustainability of the national health financing system.

Fraud in health service delivery poses a serious threat to the integrity of financing systems, the quality of services received by beneficiaries, and the stability of health institutions as service providers. In practice, fraud manifests in various forms of irregular conduct, such as intentional keystroke mistakes in tariff input for billing in order to secure reimbursement above the amount that should legitimately be paid, or manipulation of length of stay through the unjustified extension of inpatient days in health facilities to increase claim values, which is often accompanied by unnecessary treatment in the form of medical procedures or therapies that are not clinically indicated for the patient. Furthermore, there are practices categorized as no medical value, namely the provision of services that do not yield tangible benefits for diagnostic processes or clinical management, yet are still charged as part of the service costs, as well as cancelled service, referring to services that are in reality not provided but are nonetheless submitted as claims within the financing system. Another pattern is observed in the practice referred to as standard of care, in which the pattern and intensity of services are adjusted solely to conform to the INA CBG tariff structure, giving rise to concerns about a decline in clinical quality standards. In addition, service unbundling or fragmentation is carried out by deliberately arranging services so that procedures that should be claimed as a single package are split into several separate services to increase the total claim value, while inflated bills are reflected in invoices that list service costs, medical devices, or pharmaceuticals at amounts exceeding actual expenditures. Phantom billing occurs when hospital billing units submit claims for services that have in fact never been provided to JKN participants, whereas upcoding is performed by assigning diagnostic or service codes that suggest a higher level of complexity or intensity than the services actually rendered, or conversely, in order to obtain certain advantages for the health care institution. The diversity of forms and patterns of fraud illustrates the complexity of the challenges faced in the oversight of health services within the JKN framework, thereby necessitating robust internal control systems, continuous auditing, and firm regulatory enforcement to ensure that the principles of equity, efficiency, and accountability in the provision of health services are preserved.

The theoretical examination of the causes of fraud frequently refers to the Fraud Diamond Theory proposed by Wolfe and Hermanson, which constitutes an extension of Cressey's Fraud Triangle Theory (1973). The Fraud Triangle emphasizes three core elements, namely rationalization, opportunity, and incentive or pressure. The Fraud Diamond adds a fourth element, namely capacity or capability, and thereby provides a more comprehensive depiction of the drivers of fraudulent behavior. Rationalization is understood as a process of self-justification undertaken by perpetrators prior to engaging in deviant acts, through which such behavior is perceived as acceptable or reasonable from a psychological and moral standpoint. Through rationalization, perpetrators regard their actions as normal, for example by assuming that many others engage in similar practices without facing significant sanctions, so that the misconduct is perceived as something that can be tolerated (Zulaikha & Hadiprajitno, 2016). This portrayal underscores that fraud is not merely a matter of regulatory violation, but is closely related to the way perpetrators think and their attitudes toward ethical values and legal norms.

In legal and management studies, fraud is conceptualized as deviant conduct that is illegal and involves an element of deception (Elisabeth & Simanjuntak, 2020). Opportunity refers to conditions that enable individuals to commit irregularities, which are generally supported by strategic positions, weak supervision, and ineffective internal control systems. In addition, incentive or pressure relates to internal or external forces that drive individuals to engage in fraud, such as work-related stress, lifestyle demands, detrimental habits, and economic hardship (Ruankaew, 2016; Wijayani, 2016). Such pressures may originate from personal circumstances or the work environment, which subsequently encourage perpetrators to seek shortcuts through unlawful conduct. Capability or capacity denotes the competence of individuals to exploit system weaknesses, understand procedures in detail, and circumvent internal control mechanisms, so that acts that should be prohibited appear legitimate within the organizational structure. Accordingly, the occurrence of fraud often represents the combined effect of pressure, opportunity, rationalization, and the technical capabilities of perpetrators, which together create sufficient space for the emergence of fraudulent practices in health care organizations.

By attaining a clear understanding of the forms of fraud that frequently occur in hospitals and the causal factors as articulated through the Fraud Diamond Theory, stakeholders in the health sector are expected to be able to design more effective oversight mechanisms, internal control systems, and sanction regimes. In this way, the potential for fraud in the implementation of the National Health Insurance can be minimized, and the objectives of delivering health services that are fair, transparent, and sustainable can be achieved in a more optimal manner. A more precise diagnosis of typical fraudulent patterns enables policymakers to formulate targeted prevention strategies that address concrete vulnerabilities rather than relying on generic compliance measures. Knowledge of the pressures, opportunities, rationalizations, and competencies that drive fraudulent behavior helps institutions to recalibrate incentives, refine standard operating procedures, and close procedural gaps that facilitate abuse. When such analytical insights are integrated into organizational governance, hospitals and insurers can establish clearer lines of accountability, measurable performance indicators, and explicit thresholds for intervention in suspected fraud cases. A structured understanding of fraud dynamics further supports the development of training programs for health personnel that emphasize ethical decision-making, awareness of legal consequences, and professional responsibility toward patients and public funds. In addition, a more accurate mapping of fraud risks assists in prioritizing resource allocation so that monitoring efforts are concentrated on areas with the highest likelihood of irregularities, thereby improving the efficiency of supervision. The refinement of sanction regimes based on empirical evidence of recurring violations can enhance their credibility, since penalties that correspond to the gravity and pattern of misconduct are more likely to be perceived as fair and preventive rather than merely punitive. Moreover, systematic learning from fraud cases that have been uncovered can inform continuous regulatory adjustments, allowing the National Health Insurance system to evolve in response to emerging schemes and to maintain its ability to safeguard the integrity of health financing over time.

Law Enforcement on Fraud

Within the dynamics of modern health care systems, law enforcement cannot be separated from efforts to safeguard integrity, accountability, and justice in the provision of services to the public, particularly when confronted with complex regulatory frameworks and the diverse interests of stakeholders in the health sector.

The effectiveness of law enforcement in the field of health services must be understood as the outcome of interaction among regulatory structures, institutional governance, and the legal culture that prevails in society. Within the theoretical framework of law enforcement, several key factors influence its effectiveness. The first factor concerns the legal instruments. Legal instruments encompass the entire set of normative provisions that guide the conduct of individuals and institutions, including statutes, government regulations, court decisions, and social norms whose validity is socially recognized. Viewed from the perspective of their sources and functions, legal instruments are divided into substantive law and procedural law. Substantive law serves to provide guidelines on how citizens should act and which types of conduct they must avoid, whereas procedural law regulates the methods for filing, examining, adjudicating, and enforcing legal decisions.

In cases of fraud in the administration of JKN health services, relevant legal instruments include, among others, the Regulation of the Minister of Health Number 16 of 2019 on the Prevention and Management of Fraud and the Imposition of Administrative Sanctions for Fraud in the

Implementation of the Health Insurance Program. This regulation stipulates that the authority to impose sanctions on perpetrators of fraud lies with the Heads of District or City Health Offices, the Heads of Provincial Health Offices, and the Minister of Health. Administrative sanctions that may be imposed include verbal warnings, written warnings, orders to return financial losses resulting from fraud, and, for service providers, fines of up to 50% of the losses that must be reimbursed. For health professionals, sanctions may ultimately lead to the revocation of their license to practice. Beyond administrative sanctions, perpetrators of fraud may also be subject to criminal liability under Articles 379, 379a, and 381 of the Indonesian Criminal Code (KUHP), which classify fraud as a form of deception.

Nevertheless, objections have emerged from health care facilities, hospitals, and professional colleges, which argue that the implementation of anti-fraud regulations remains insufficiently firm and tends to function merely as a normative threat, even though it is still perceived as being within tolerable limits. From the perspective of those who support the strengthening of law enforcement, BPJS Kesehatan, the Corruption Eradication Commission (KPK), and professional organizations are regarded as influential entities in promoting the implementation of anti-fraud programs, although, in theoretical terms, BPJS Kesehatan also has potential to act as a perpetrator of fraud, albeit to a lesser extent compared to health facilities and beneficiaries. In response to these objections, proponents of firmer regulation emphasize that the current arrangement risks normalizing irregular practices as routine administrative deviations rather than as violations of legal and ethical standards that undermine public trust. They argue that clear thresholds for classifying conduct as fraudulent, supported by transparent investigative procedures, are indispensable to dispel perceptions that sanctions are arbitrary or driven by institutional interests. A calibrated framework of consequences that differentiates between negligence, systematic abuse, and intentional deception is also required so that disciplinary measures are viewed as fair and proportionate by health workers and managers. In addition, structured guidance from supervisory authorities can assist health facilities in aligning their operational procedures with anti-fraud norms, thereby reducing resistance that arises from uncertainty or fear of punitive treatment for honest mistakes. Advocates of stronger enforcement further maintain that coordinated action among BPJS Kesehatan, KPK, and professional bodies can produce a more coherent regime of oversight, in which each institution contributes specific expertise in claims assessment, investigation of financial irregularities, and enforcement of professional standards. The articulation of explicit ethical commitments within professional associations, coupled with credible follow-up mechanisms when violations are detected, is viewed as essential to prevent corporate or collegial solidarity from shielding offenders. Ultimately, the debate surrounding the firmness of anti-fraud regulation reflects a broader struggle to reconcile the need for legal certainty and accountability with concerns about overregulation, and it underscores the importance of designing enforcement strategies that are rigorous, predictable, and at the same time conducive to continuous improvement in the governance of health services under the JKN scheme.

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Second, the governance factor. Within health care facilities, the implementation of Good Clinical Governance and Good Corporate Governance principles is imperative for establishing an effective system for the prevention and management of fraud. This encompasses the application of mechanisms for the resolution, detection, and prevention of fraudulent practices, as well as the development of service delivery that emphasizes quality control and cost management. The role of internal auditors and fraud prevention teams or committees is particularly crucial as the technical front line responsible for safeguarding the integrity of the claims process. Health care facilities must conduct early detection of potential fraud in every claim submitted to BPJS Kesehatan. Regulation of the Minister of Health Number 16 of 2019 stipulates that the implementation of Good Clinical Governance and Good Corporate Governance in hospitals includes the determination of authority and job descriptions for both health and non-health personnel, the establishment and enforcement of Standard Operating Procedures (SOPs) for clinical services that refer to the National Guidelines for Medical Services (Pedoman Nasional Pelayanan Kedokteran, PNPK) and/or other guidelines issued by the Minister of Health, as well as the establishment of internal procedures related to claim submission. In the absence of robust governance, weaknesses in procedures and oversight will create opportunities for systematic fraudulent practices.

Third, the law enforcement actors. The government, through various regulations, has established the National Health Insurance Fraud Prevention and Management Team (Pencegahan dan Penanganan Kecurangan Jaminan Kesehatan Nasional, PK-JKN) as a collective instrument for preventing and addressing fraud, while also coordinating the imposition of administrative sanctions in the implementation of the Health Insurance Program. PK-JKN teams are formed at multiple levels, ranging from health care facilities and districts or municipalities to provinces and the national level. At the national level, the composition of the team involves BPJS Kesehatan, the Corruption Eradication Commission (Komisi Pemberantasan Korupsi, KPK), the Financial and Development Supervisory Agency (Badan Pengawas Keuangan dan Pembangunan, BPKP), and the Ministry of Health. At the regional level, similar teams include health care facility organizations, health facility associations, BPJS Kesehatan, district or municipal health offices, and other supporting entities. At the level of health care facilities, the prevention of fraud in JKN is implemented through Quality Control and Cost Control Teams (Tim Kendali Mutu dan Kendali Biaya, TKMKB), which are responsible for coordinating anti-fraud programs, evaluating their implementation, and monitoring the achievement of their objectives. Hospitals are encouraged to optimize the performance of fraud prevention teams as the spearhead in the design, implementation, and development of systems for detecting and preventing fraudulent practices.

Regulation of the Minister of Health Number 16 of 2019 requires that fraud prevention teams within health care facilities include coders, medical committees, internal audit units, and other relevant elements. The mandate of these teams covers the early detection of fraud based on claim data submitted to BPJS Kesehatan, dissemination of regulations that prioritize cost control and quality assurance, routine reporting of fraudulent practices, the implementation of monitoring and evaluation activities, and active support for sound clinical and organizational governance. These teams are also tasked with fostering organizational habits that reject fraud and promoting values that prioritize integrity, cost control, and quality control (Susanti et al., 2022).

Although fraud prevention teams have been formally established, their effectiveness is considered suboptimal. Strengthening is therefore recommended through the formation of specialized teams with specific expertise in fraud prevention, so that the knowledge and skills of team members can be continuously enhanced and the focus of their work becomes more targeted. According to the American Institute of Certified Public Accountants (AICPA), there are three main prerequisites for organizations to

be able to prevent fraud, namely a strong culture of honesty and ethics, commitment and exemplary conduct on the part of management, and the presence of an effective audit team (Susanti et al., 2022).

Fourth, the societal and cultural factor. The influence of society on law enforcement in Indonesia is substantial and can be observed from several aspects, including the level of legal awareness, public participation, cultural values and social norms, the degree of trust in legal institutions, access to justice, and the role of the media and information. Legal awareness determines the extent to which citizens understand their rights and obligations, as well as their willingness to seek justice and report violations. Communities that are legally informed tend to be more proactive in reporting corrupt practices or fraud to law enforcement authorities. Public participation, for example through the provision of information or willingness to serve as witnesses, contributes to strengthening the law enforcement process. Forms of such participation include reporting suspected criminal acts occurring in the surrounding environment. Trust in legal institutions and the ease of access to justice mechanisms are also crucial determinants of the public's willingness to engage. The media and information channels can function as instruments of social control and public education. Accordingly, community involvement has a significant impact on the effectiveness of the legal system, which implies that the government and law enforcement agencies need to establish close and responsive relationships with citizens. In line with this view, Darusman and Wiyono, as cited in Pakpahan et al. (2021), emphasize that law enforcement must be carried out firmly and must generate a deterrent effect on perpetrators of fraud in health services so that the objective of protecting the public can be realized in a concrete manner.

Legal culture occupies a strategic position as the principal driving force of the legal system, because without a strong understanding of and respect for legal norms, the implementation of rules risks becoming ineffective. Legal culture is often likened to an engine that propels the system, such that its neglect may result in the failure of the modern legal system. Symptoms of this problem include the dissemination of inaccurate information to the public regarding the content of regulations and a wide gap between social practices and the objectives mandated by legislation. Under such conditions, members of society tend to act on the basis of guidelines, values, and habits they personally embrace, without reference to the applicable legal norms. Reform of a nation's legal behavior therefore cannot be confined to the technical domain, for example through formal legal education alone, but must extend to broader dimensions of education and social guidance, including the behavior of law enforcement officials. A reordering of the legal culture among officials is required, given that an individual's decision to use or disregard the law is closely related to the surrounding legal culture (Wijayani, 2016; Junaedi & Dikrurahman, 2023). The internalization of a strong legal culture among both the public and law enforcement authorities thus constitutes an essential precondition for the successful implementation of law.

In the practical implementation of the JKN program, the risk of fraud committed by health professionals and beneficiaries is a reality that cannot be overlooked. This phenomenon is closely linked to the prevailing legal culture, in which some perpetrators of fraud do not perceive themselves as guilty and justify their actions by invoking allegedly inadequate capitation tariffs or INA-CBGs, thereby claiming to protect the financial condition of the health care facilities where they work, even though the methods employed are contrary to the law. On the part of JKN participants, not all victims of fraud submit complaints to BPJS Kesehatan. This may be due to a lack of knowledge regarding reporting procedures, concerns about discriminatory treatment by health care facilities that they continue to depend on, or reluctance to engage with law enforcement agencies and legal procedures that are perceived as time-consuming and costly. Under these circumstances, the enforcement of anti-fraud regulations faces both structural and cultural challenges.

Accordingly, reform measures are required for the Regulation of the Minister of Health Number 16 of 2019 on the Prevention and Management of Fraud and the Imposition of Administrative Sanctions for Fraud in the Implementation of the Health Insurance Program, particularly to address gaps in the regulation of criminal provisions and to strengthen reporting mechanisms. Ideally, such regulatory reform should be accompanied by intensive dissemination efforts and the design of complaint procedures that are more accessible to JKN participants, so that efforts to prevent and address fraud can proceed more effectively, with greater participation and sustainability. Through the strengthening of legal instruments, institutional governance, regulatory enforcement capacity, and active community involvement supported by a sound legal culture, law enforcement within the JKN program is expected to operate consistently and to reduce the incidence of fraud that harms the public

interest. In addition, regulatory reform must be harmonized with developments in health financing schemes, advances in information technology, and emerging fraud patterns that arise as perpetrators adapt to regulatory loopholes. The regulation of reporting procedures that guarantees the confidentiality of whistleblowers, provides protection for good-faith reporters, and ensures clarity regarding follow-up actions on complaints will enhance public trust and encourage the emergence of whistleblowers within health care facilities. The revised regulation must also include detailed standard operating procedures for early detection, investigation, and prosecution of fraud, so that supervisory bodies, BPJS Kesehatan, and health care facilities have uniform references for interpreting and implementing the rules. Furthermore, integration of claims and medical record information systems with analytical features capable of identifying atypical transaction patterns in real time is required, as these can serve as the basis for risk-based audits. Strengthening the capacity of disciplinary bodies and law enforcement agencies through specialized training on the JKN scheme, fraud typologies in the health sector, and medical as well as financial audit techniques will enhance the quality of case handling from the earliest stages. Clearly regulated incentive and disincentive schemes for health care facilities and health professionals, such as compliance incentives and graduated sanctions based on the severity of violations, will foster a more orderly and accountable financing environment. Inter-institutional cooperation among the Ministry of Health, BPJS Kesehatan, the Financial Services Authority, and law enforcement agencies must be reinforced through cooperation agreements and data sharing to ensure that fraud enforcement is coordinated, consistent, and supported by robust evidence. Ultimately, carefully designed regulatory reform that takes into account juridical, technical, and operational dimensions will provide a strategic foundation for the development of a JKN system that is more transparent, characterized by integrity, and oriented toward the protection of participants' rights.

Criminal Liability for Fraud Committed by Hospitals

A comprehensive understanding of the normative and juridical dimensions of fraud mitigation in the National Health Insurance (Jaminan Kesehatan Nasional, JKN) program constitutes an essential precondition for the realization of an accountable and equitable health insurance system. Law enforcement authorities function as the primary instruments for preventing and sanctioning all forms of fraud occurring in the implementation of JKN, since law enforcement is concerned with measures taken to address any deviation from or violation of applicable regulations that is classified as an unlawful act (Wulandari & Zaky, 2016).

In Indonesia, the normative framework for combating fraud in the field of health insurance is regulated, among others, in the Regulation of the Minister of Health Number 16 of 2019 on the Prevention and Management of Fraud and the Imposition of Administrative Sanctions for Fraud, which replaced Minister of Health Regulation Number 36 of 2015 and entered into force in April 2019. This regulation was formulated as a legal basis for measures aimed at preventing and addressing fraud in the implementation of the JKN program, encompassing the strengthening of awareness, reporting mechanisms, detection systems, investigative procedures, and the imposition of sanctions. The subjects covered by this regulation include health care facilities, BPJS Kesehatan beneficiaries, providers of medicines and medical devices, JKN administrators, and other related parties. In relation to the implementation of health insurance, Articles 6, 7, and 8 of Minister of Health Regulation Number 16 of 2019 stipulate that fraudulent acts are subject to administrative sanctions in the form of verbal warnings, written warnings, orders to return losses incurred as a result of fraud to the aggrieved party, and, in certain circumstances, may be followed by revocation of licenses pursuant to statutory provisions, as well as the imposition of fines paid to the injured party. However, the substance of these provisions is limited to administrative sanctions and does not explicitly regulate criminal sanctions. This limitation has implications for the coercive force of the regulation, so that the sanctions imposed often fail to generate a deterrent effect and fraudulent practices continue to recur (Silapurna, 2022).

To date, the handling of fraud in health insurance programs in Indonesia has, in practice, largely relied on the general provisions of the Indonesian Criminal Code (KUHP) and the aforementioned sectoral regulation as references for law enforcement authorities in classifying and processing fraud cases in the implementation of the JKN program (Solehuddin, 2023). Consequently, the effectiveness of law enforcement against fraud in the JKN program depends heavily on the clarity of regulatory provisions, the rigor of the sanctioning framework, and the consistency of their implementation by law enforcement officials.

From a normative perspective, fraud in the National Health Insurance program can, in principle, be qualified as an act subject to criminal liability, as it involves an element of unlawful conduct (actus reus) accompanied by intent or deliberation (mens rea). The Criminal Code requires the presence of both an unlawful act and culpability for a particular conduct to be classified as a criminal offense (Presetyo, 2020). In general, the elements of a criminal offense consist of subjective and objective elements. The subjective elements include: (a) intent (dolus) or negligence (culpa); (b) voornemen or intent in the context of attempted offenses as set out in Article 53 paragraph (1) of the Criminal Code; (c) oogmerk or specific intent inherent in certain crimes such as forgery, extortion, fraud, and theft; (d) voorbedachte raad or premeditation, for example in the case of premeditated murder as regulated in Article 340 of the Criminal Code; and (e) vrees or fear as stipulated in the formulation of offenses in Article 308 of the Criminal Code. The objective elements encompass: (a) wederrechtelijkheid or the unlawful nature of an act; (b) a specific quality or status of the perpetrator, for example "the position as a hospital employee" in occupational offenses as regulated in Article 415 of the Criminal Code or "the position as a manager or director of a hospital" in the conduct referred to in Article 398 of the Criminal Code; and (c) causality, namely the causal relationship between the perpetrator's act and the resulting consequence (Presetyo, 2020). When these elements are projected onto fraudulent practices within the JKN framework, it becomes apparent that there is scope for the imposition of criminal liability insofar as it can be proven that there was an intention to commit an unlawful act that harms beneficiaries or the financial resources of the health insurance system.

From the perspective of criminal law, any fraudulent act committed within the National Health Insurance (JKN) scheme may give rise to criminal liability insofar as it fulfills the elements of an unlawful act and/or the element of intent on the part of the perpetrator. In essence, criminal sanctions constitute a reaction of the state to violations of the law that is intended to generate a deterrent effect, both for the perpetrator and for other parties who might potentially emulate such conduct (Natih et al., 2022). Within this framework, several provisions of the Indonesian Criminal Code (KUHP) are relevant, in particular Articles 378 and 381.

Article 378 of the Criminal Code provides that: "Any person who, with the intent to unlawfully benefit himself or another, by using a false name or false capacity, by deceit, or by a series of lies, induces another person to hand over any property to him, or to grant a loan or to cancel a debt, shall be punished for fraud with imprisonment for a maximum of four years." The elements contained in this article may be elaborated as follows. The subjective elements include: (a) "any person" as the legal subject, which may be any individual; and (b) the presence of an intent to unlawfully benefit oneself or another. The objective elements include: (a) the use of a false name, false capacity, deceit, or a series of lies; and (b) the act of inducing another person to hand over property, grant a loan, or cancel a debt.

Applied to cases of fraud in the JKN scheme, the element of "any person" may refer, for instance, to staff at a health care facility who fail to provide prescribed medicines to JKN participants, even though such medicines form part of the participants' entitlements. The element of "with the intent to unlawfully benefit oneself" is evident when staff or health care facilities deliberately fail to fulfill participants' rights as protected under Law Number 7 of 2023 and Regulation of the Minister of Health Number 28 of 2014 in order to obtain financial gain. The element of "by deceit or a series of lies" may be illustrated by situations in which staff inform participants that prescribed medicines are unavailable or not covered by BPJS Kesehatan, whereas in reality such medicines are covered and can be dispensed. Under these circumstances, participants have a basis for bringing the matter into the criminal domain, while health care facility staff may be subject to imprisonment for up to four years pursuant to Article 378 of the Criminal Code.

Article 381 of the Criminal Code states: "Any person who, by deceit, misleads an insurer regarding circumstances related to the insurance coverage, thereby causing the insurer to consent to an agreement which it would certainly not have consented to, or at least not under such terms, had it known the true circumstances, shall be punished with imprisonment for a maximum of one year and four months." The subjective elements in this provision include: (a) "any person" as the perpetrator; and (b) the use of "deceit". Its objective element is the act of misleading the insurer concerning circumstances related to the insurance coverage, resulting in the insurer's consent to the agreement, whereas, if the true circumstances had been known, the agreement would not have been concluded, or at least not on the same terms.

Within the JKN scheme, practices such as falsification of data, fabrication of medical conditions, or manipulation of claims that mislead BPJS Kesehatan as the insurer may satisfy the

constituent elements of Article 381 of the Criminal Code (Hutahaean, 2022). The characteristics of fraudulent conduct in JKN indicate that the elements of a criminal offense, both subjective and objective, are in principle fulfilled, such that perpetrators may be subject to criminal sanctions in accordance with the provisions of the Criminal Code. With strengthened regulation and consistent law enforcement, it is expected that fraud control within the National Health Insurance system can be implemented more effectively and equitably, thereby providing optimal protection for the public interest. A firm criminal law response in such cases functions as a corrective mechanism that reaffirms the inviolability of participants' rights and reinforces the principle that public funds dedicated to health must be managed with integrity. Clear and operational legal provisions, supported by detailed implementing guidelines, are essential to prevent interpretive ambiguities that might weaken the prosecution of fraud and erode public confidence in the justice system. At the same time, effective coordination among supervisory bodies, health care providers, and investigative authorities is required to ensure that indications of fraud are promptly detected, accurately documented, and systematically followed up through appropriate legal channels. Investment in capacity building for auditors, claim reviewers, and law enforcement personnel is equally crucial, so that they possess the technical competence to identify sophisticated fraud schemes that exploit regulatory gaps or information asymmetries. The use of data analytics, electronic claim verification, and integrated information systems can further support the evidentiary process, enabling more precise tracing of irregular patterns in billing behavior and clinical documentation. In addition, transparent reporting mechanisms and accessible complaint channels for JKN participants can strengthen external oversight, as beneficiaries are often the first to experience the consequences of fraudulent behavior at the service delivery level (Solehuddin, 2023). Finally, a consistent pattern of enforcement, in which sanctions are imposed in a predictable and proportionate manner, contributes to a stronger deterrent effect, encourages ethical conduct among health care providers, and gradually fosters a legal culture that treats fraud in health insurance as a serious violation of both legal norms and public trust.

Dispute Resolution Practices

The regulation of dispute resolution mechanisms arising from fraudulent practices committed by hospitals in the implementation of the National Health Insurance (JKN) program constitutes an important component of efforts to ensure legal protection for participants and to safeguard the integrity of health insurance administration. Disputes arising from fraud may be resolved through non-litigation channels, such as mediation or negotiation, as well as through litigation before the courts as a means of law enforcement recognized by statutory provisions. In the non-litigation sphere, Law Number 24 of 2011 provides a normative basis for resolving disputes related to the implementation of health insurance by BPJS, particularly through Article 49, which stipulates that if a complaint submitted by an aggrieved party cannot be resolved at the complaints unit, the matter shall be referred to mediation. This provision is reinforced by Law Number 30 of 1999, which regulates arbitration and alternative dispute resolution, including mediation, as a consensual settlement mechanism facilitated by a neutral third party. In mediation, the mediator acts as a facilitator who maintains communication, assists the parties in identifying their interests, and helps formulate settlement options, without possessing the authority to impose a decision. Mediation in JKN-related fraud cases is generally positioned as the final forum for dialogue between the parties to reach a voluntary agreement before the dispute is brought before the courts. If mediation reaches an impasse or fails to produce an agreement acceptable to the aggrieved party, the avenue to file a lawsuit in court becomes available.

Litigation, on the other hand, is based, among others, on Article 50 of Law Number 24 of 2011 on BPJS, which stipulates that if a complaint cannot be resolved by the service quality control and participants' complaint handling unit, and mediation does not take place or fails, the dispute may be submitted to the district court in accordance with the domicile of the applicant. The district court, as part of the general judiciary, has the authority to examine, adjudicate, and decide civil disputes concerning losses suffered by JKN participants as a result of fraudulent acts committed by health care facilities. Thus, the sequence of available mechanisms establishes a graduated structure that begins with persuasive settlement through mediation and extends to the judicial enforcement of rights before the district court. The coexistence of these two avenues affords the parties flexibility in selecting a mode of dispute resolution that is most proportionate to the characteristics of the dispute, while also ensuring the availability of a forum empowered to issue binding decisions when negotiations fail. Mediation has the potential to

reduce the caseload of the courts, expedite resolution, lower costs, and maintain the relationship between participants and health care facilities, particularly when the care relationship remains ongoing. Litigation, by contrast, provides legal certainty through enforceable judgments and is especially important for addressing fraud that has wide-ranging effects or involves substantial financial losses. Clear procedures for lodging complaints, conducting mediation, and accessing the district courts help to prevent gaps in legal protection for JKN participants and simultaneously foster a climate of regulatory compliance among health care facilities. In the long term, the combined use of non-litigation and litigation mechanisms is expected to strengthen the accountability of the JKN program, enhance public trust in the health insurance system, and reduce the incidence of fraud that harms participants and the state's finances.

CONCLUSION

This study demonstrates that hospital fraud in the implementation of the National Health Insurance (JKN) program constitutes a structural problem rooted in a combination of weaknesses in the legal framework, governance gaps, an underdeveloped culture of compliance, and pressures inherent in the health financing system. Fraud manifests in various forms, including claim manipulation, data falsification, provision of unnecessary services, and tariff engineering, which in many cases satisfy the elements of the criminal offense of fraud under the Indonesian Criminal Code (KUHP). The existing normative framework, particularly Minister of Health Regulation Number 16 of 2019, remains predominantly oriented toward administrative sanctions, so that its coercive power over perpetrators is relatively limited, and the imposition of criminal liability depends heavily on the construction of relevant provisions in the Criminal Code as well as the resolve of law enforcement authorities. Analysis using the Fraud Diamond concept confirms that pressure, opportunity, rationalization, and the technical capability of perpetrators mutually reinforce one another in generating fraudulent practices in hospitals. On the other hand, although dispute resolution mechanisms through mediation and litigation are available, their utilization has not yet fully safeguarded the rights of JKN participants against fraudulent conduct. Overall, the findings of this study underscore the need to strengthen regulations, reorganize internal governance within hospitals and BPJS Kesehatan, enhance the capacity of law enforcement agencies, and cultivate a more stringent legal culture toward fraud in the health insurance system.

The findings of this research have important implications for legislators, health sector regulators, hospital management, and BPJS Kesehatan. First, it is necessary to redesign the regulatory framework of JKN by recognizing fraud as a serious threat to the sustainability of health insurance financing and the protection of participants' rights, so that administrative and criminal sanctions are regulated in a more proportional and coherent manner. Second, hospitals must strengthen internal control systems, claims auditing, and clinical oversight in order to narrow the scope for data manipulation and service engineering. Third, law enforcement authorities need to develop more progressive interpretative practices regarding the Criminal Code and sectoral regulations related to health care fraud, so that case resolution does not remain confined to administrative measures. Fourth, BPJS Kesehatan as administrator must improve the quality of its claims systems, early detection mechanisms, and monitoring of billing patterns from health care facilities, supported by the use of information technology to identify anomalies. Fifth, the regulation of mediation and access to district courts requires complaint procedures that are more transparent and accessible for JKN participants, so that dispute resolution pathways function effectively as instruments for the restoration of rights.

Based on the analysis, several recommendations can be proposed to strengthen the response to hospital fraud in the implementation of JKN. First, Minister of Health Regulation Number 16 of 2019 should be revised to incorporate more explicit references to criminal provisions in the Criminal Code, to regulate the types of fraudulent conduct in greater detail, and to clarify the relationship between administrative and criminal sanctions. Second, the Ministry of Health and BPJS Kesehatan should require hospitals to establish specialized fraud prevention teams supported by regular training on claim coding, clinical auditing, and professional ethics. Third, the development of reporting systems and complaint channels for JKN participants should be directed toward procedures that are simple, secure, and technology-based, so that participants are encouraged to report indications of fraud without fear of reprisal. Fourth, the capacity of judges, prosecutors, and investigators must be strengthened in understanding the specific characteristics of health care fraud through

specialized training and case-handling guidelines. Fifth, professional organizations for physicians and other health workers should develop codes of ethics governing their relationship with the JKN system that explicitly condemn fraudulent practices, complemented by internal disciplinary mechanisms that are aligned with administrative and criminal sanctions.

REFERENCES

Budiono, A., Absori, A., Zuhdi, S., Kurnianingsih, K., Inayah, I., Bangsawan, Moh. I., & Yuspin, W. (2022). National Health Security Policy in Indonesia: A Narrative Review from Law Perspective. *Open Access Macedonian Journal of Medical Sciences*. https://doi.org/10.3889/oamjms.2022.8142

Daisahbeny, D. (2023). The Construction of the Welfare State in Human Rights in Law Number 36 of 2009 concerning Health. *Law Research Review Quarterly*. https://doi.org/10.15294/lrrq.v9i4.76266

Dewi, R., & Israhadi, E. (2021, May 5). *Legal Aspects of BPJS as National Health Insurance*. https://doi.org/10.4108/EAI.6-3-2021.2306412

Elisabeth, D. M., & Simanjuntak, W. (2020). Analisis Review Pendeteksian Kecurangan (Fraud). *Methosika*, 4(1), 14-31.

Hartati, T. S. (2016). Pencegahan Kecurangan (Fraud) dalam Pelaksanaan Program Jaminan Kesehatan pada Sistem Jaminan Sosial Kesehatan (Sjsn) (Studi di Rumah Sakit Umum Daerah Menggala Tulang Bawang). *Fiat Justisia: Jurnal Ilmu Hukum*, 10(4), 715-732.

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

Indonesia. (1945). *Undang-Undang Dasar Republik Indonesia Tahun 1945.* Sekretariat Negara. Jakarta.

Indonesia. (2004). *Undang-Undang Nomor 40 Tahun 2004 tentang Sistem Jaminan Sosial Nasional.* Lembaran Negara Republik Indonesia Tahun 2004 No. 150; Tambahan Lembaran Negara No. 4456. Kementerian Hukum dan Hak Asasi Manusia Republik Indonesia. Jakarta.

Indonesia. (2011). *Undang-Undang Nomor 24 Tahun 2011 tentang Badan Penyelenggara Jaminan Sosial.* Lembaran Negara Republik Indonesia Tahun 2011 No. 116; Tambahan Lembaran Negara No. 5256. Kementerian Hukum dan Hak Asasi Manusia Republik Indonesia. Jakarta.

Indonesia. (2014). *Peraturan Menteri Kesehatan Republik Indonesia Nomor 28 Tahun 2014 tentang Pedoman Pelaksanaan Program Jaminan Kesehatan. Berita Negara Republik Indonesia Tahun 2014 No. 859.* Kementerian Kesehatan Republik Indonesia. Jakarta.

Indonesia. (2018). *Peraturan Presiden Nomor 82 Tahun 2018 tentang Jaminan Kesehatan*. Lembaran Negara Republik Indonesia Tahun 2018 No. 165. Kementerian Sekretariat Negara Republik Indonesia. Jakarta.

Indonesia. (2023). *Undang-Undang Nomor 17 Tahun 2023 tentang Kesehatan*. Lembaran Negara Republik Indonesia Tahun 2023 No. 133; Tambahan Lembaran Negara No. 6885. Kementerian Hukum dan Hak Asasi Manusia Republik Indonesia. Jakarta.

Indonesia. (n.d.). *Kitab Undang-Undang Hukum Pidana (KUHP).* Pemerintah Republik Indonesia. Jakarta.

Junaedi., & Dikrurahman, D. (2023). Membangun Budaya Hukum Pancasila Di Era Reformasi. *Jurnal Cahaya Mandalika* ISSN 2721-4796 (online), 4(1), 709-722.

Natih, I. M. G. A. A., Dewi, A. A. S. L., & Pritayanti, I. G. A. A. G. (2022). Sanksi Pidana bagi Pelaku Penipuan dengan Modus Investasi Online. *Jurnal Preferensi Hukum*, 3(3), 501-507

Pakpahan, E. S. F., Valentine, T., Arixson, A., & Batubara, S. A. (2021). Analisis Hukum terhadap Tindakan Pidana Penipuan yang Menyalahgunakan BPJS Kesehatan berdasarkan KUHP. *Syntax Literate; Jurnal Ilmiah Indonesia*, 6(10), 4967.

Presetyo, T. (2020). *Hukum Pidana*. Rajawali Press, Depok.

Ruankaew, T. (2016). Beyond the *Fraud* Diamond. *International Journal of Business Management and Economic Research*, 7(1), 474-476.

Sadikin, H., & Adisasmito, W. (2016). Analisis Pengaruh Dimensi *Fraud* Triangle dalam Kebijakan Pencegahan *Fraud* terhadap Program Jaminan Kesehatan Nasional Di RSUP Nasional Cipto Mangunkusumo. *Jurnal Ekonomi Kesehatan Indonesia*, 1(2), 4.

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*, 4(1), 55-75.

Stowell, N. F., Schmidt, M., & Wadlinger, N. (2018). Healthcare Fraud Under the Microscope: Improving Its Prevention. *Journal of Financial Crime*, 25(4), 1039-1061.

Susanti, D. S., Arifin, P., Rahma, D., Fahmi, M., Julaeha, L., & Putri, W. A. (2022). *Tackling Fraud and Corruption in Indonesia's Health Insurance System*. U4 Issue.

Wijayani, D. R. (2016). Insider Trading dalam Perspektif *Fraud* Diamond. Proceeding SENDI_U (pp: 633-642).

Wulandari, S., & Zaky, A. (2016). Determinan Terjadinya Fraud di Instansi Pemerintahan (Persepsi pada Pegawai BPK RI Perwakilan Provinsi NTB). *Jurnal Ilmiah Mahasiswa FEB*, 3(2), 10-20.

Zulaikha, Z., & Hadiprajitno, P. B. (2016). Faktor-Faktor Yang Memengaruhi Procurement *Fraud*: Sebuah Kajian dari Perspektif Persepsian Auditor Eksternal. *Jurnal Akuntansi Dan Keuangan Indonesia*, 13(2), 5.

*** Jamiri, L., M. Mujito, & S. Waskito. (2023). Hospital Fraud in the National Health Insurance Program from a Legal and Governance Perspective, Journal of Social Science Studies, 3(2), 259 – 272.**