Legal Liability of Hospitals for Fraud in the National Health Insurance Program

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A R T I C L E I N F O

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A B S T R A C T

This research aims to analyze law enforcement against fraudulent acts committed by hospitals in the implementation of the National Health Insurance (JKN) program. The research method used is normative juridical legal research with statutory and conceptual approaches. Primary legal materials consist of various laws and regulations governing JKN and fraud prevention, while secondary legal materials include books, legal journals, scientific articles, and related study documents. The results of the research indicate that fraud in JKN consists of various deviant practices such as phantom billing, upcoding, inflated bills, and unnecessary treatment, which are driven by the factors of rationalization, opportunity, pressure, and capability based on the Fraud Diamond theory. Law enforcement against fraud is regulated under Minister of Health Regulation Number 16 of 2019, which provides administrative sanctions, but its implementation is not yet optimal because the regulation does not explicitly regulate criminal sanctions. Criminal liability can be imposed through Article 378 and Article 381 of the Criminal Code (KUHP) upon fulfilling the elements of unlawful acts and intent. Dispute resolution can be pursued through non-litigation channels in the form of mediation pursuant to Law Number 24 of 2011 and litigation channels through district courts based on Article 50 of the same law. This research recommends amending Minister of Health Regulation Number 16 of 2019 by adding criminal sanction provisions, strengthening the role of anti-fraud teams, and increasing public legal awareness.

INTRODUCTION

The National Health Insurance (JKN), implemented through the Health Social Security Administering Body (BPJS Kesehatan), is one of the government's strategic programs in realizing social protection in the health sector. This program is mandated by Law Number 40 of 2004 concerning the National Social Security System and Law Number 24 of 2011 concerning the Social Security Administering Body, with the aim of ensuring the availability of quality healthcare access for all Indonesian residents (Jabbar, 2020). As a program that involves a large budget and reaches almost all layers of society, the implementation of JKN demands accountable governance and strict supervision to maintain its sustainability (Putra et al., 2024). In the realm of public law and healthcare facility services, the refinement of governance frameworks and the limits of hospitals' legal responsibility are crucial to anticipating potential fraud in the implementation of the national health insurance (Harianto et al., 2024).

The implementation of the JKN program cannot be separated from the potential occurrence of deviant acts in the form of fraud that threaten the effectiveness and sustainability of the program. Fraud in healthcare services is defined as intentional acts committed to obtain financial benefits by violating statutory provisions, thereby harming other parties, whether participants, administrators, or the state. These actions not only result in the waste of the national health budget but also reduce the quality of service and harm the rights of JKN participants who should be entitled to benefits according to provisions (Safitri et al., 2024). Legal irregularities and claim abuses at the hospital level can damage public trust in the quality of health insurance (Issalillah, Rachmawati, et al., 2021; Khayru & Issalillah, 2022), as well as affect public perception regarding the reliability of health financial risk protection (Issalillah, Darmawan, et al., 2021).

Based on the provisions in laws and regulations,

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fraud in the implementation of JKN can be committed by various parties involved in the health insurance system, including JKN participants, BPJS Kesehatan officers, providers of medicines and medical devices, and health facilities. In the context of healthcare services, fraudulent acts encompass various deviant actions that contradict prevailing regulatory provisions (Purwandari et al., 2024). The scope of health facilities' accountability includes oversight of ethical violations and criminal forgery of medical documents by healthcare professionals (Hartika et al., 2023), as well as the prevention of governance violations in drug distribution and pharmaceutical claims within the hospital environment (Hartono et al., 2024). A comprehensive understanding of the forms of fraud is an essential first step in designing effective prevention and enforcement strategies.

Various forms of fraud in healthcare services have been identified in legal and health management studies, among others phantom billing (billing for services not rendered), upcoding (coding diagnoses or procedures as more complex than they actually are), inflated bills, unnecessary treatment (providing care not needed by patients), length of stay extended without medical indication, keystroke mistakes (intentional billing errors), no medical value (services providing no benefit to the patient), cancelled services that continue to be billed, and service unbundling or fragmentation of services. These forms of fraud indicate gaps in the supervision and internal control system that can be exploited by individuals to gain financial benefits (Syakurah, 2023). These loopholes frequently arise due to a lack of understanding among hospital management and staff regarding the legal procedures for submitting health insurance claims (Hakim et al., 2024).

To understand the factors causing fraud, the Fraud Triangle theory proposed by Cressey and later developed into the Fraud Diamond theory by Wolfe and Hermanson provides a comprehensive analytical framework. The theory identifies four elements causing fraud: rationalization, opportunity, incentive/pressure, and capability/capacity. Rationalization occurs when the perpetrator is able to formulate a justification for deviant behavior so that it is considered morally acceptable (Suryandari et al., 2023). Opportunity arises due to conditions that allow individuals to execute fraudulent actions, typically caused by strategic positions, poorly controlled supervision, or weak internal controls. Pressure refers to internal or external drives motivating individuals to commit irregularities, while capability represents an individual's competence in exploiting circumstances and loopholes in the organization's control system (Muhammad, 2023). These four elements interact and reinforce the likelihood of fraud occurring.

The government has responded to the potential threat of fraud by issuing Minister of Health Regulation Number 16 of 2019 concerning the Prevention and Handling of Fraud as Well as the Imposition of Administrative Sanctions Against Fraud in the Implementation of the National Health Insurance Program. This regulation replaces Minister of Health Regulation Number 36 of 2015 and governs various aspects of prevention, awareness raising, reporting, detection, investigation, and the imposition of administrative sanctions. The targets of this regulation include providers of medicines and medical devices, health facilities, BPJS Kesehatan participants, and other related parties. The administrative sanctions stipulated include oral warnings, written warnings, order warnings, restitution of losses, fines of up to 50% of the loss amount, and revocation of practice licenses for healthcare professionals (Firmansyah et al., 2022). Nevertheless, the substance of the regulation only governs administrative sanctions and does not explicitly regulate criminal sanctions.

The success of law enforcement against fraud in the JKN program is influenced by various interrelated factors. Based on the law enforcement theory proposed by Soerjono Soekanto, these factors include legal framework factors, governance factors, law enforcement officer factors, as well as community and legal culture factors (Safitri et al., 2024). The legal framework refers to the regulatory instruments and norms governing individual and institutional behavior, including material and formal law. Governance encompasses the implementation of Good Clinical Governance and Good Corporate Governance in hospitals, including the definition of authority and job descriptions for healthcare and non-healthcare personnel, the establishment and implementation of Standard Operating Procedures (SOPs), and internal claim submission procedures (Jamiri et al., 2023). Enforcement officer factors include the role of the Fraud Prevention and Handling Team (PK-JKN) at the health facility, district/city, provincial, and national levels, as well as the Quality Control and Cost Control Team at health facilities (Hidayati et al., 2022). Meanwhile, community and legal culture factors cover public legal awareness, public participation, social culture and norms, trust in legal institutions, access to justice, and the role of information media (Prasada, 2022). In addition, the existence of internal monitoring systems and social support for medical institution

governance also determine the legal compliance of hospitals in providing services to all patient groups (Khayru, 2022). All these factors must be integrated consistently so that law enforcement is not merely formalistic, but truly effective in preventing and prosecuting fraud within the JKN program.

Criminal liability for fraud in the implementation of the JKN needs to be examined based on the provisions of the Indonesian Criminal Code (KUHP). Fraudulent acts in the JKN can be categorized as a criminal offense if they fulfill the elements of an unlawful act (actus reus) and intent or deliberateness (mens rea). The subjective elements of a criminal act include deliberateness or negligence, intent to attempt, various intents as listed in crimes of fraud and extortion, premeditation, and feelings of fear. The objective elements include the unlawful nature, the quality of the perpetrator, and causality between the act as the cause and the resulting effect (Priscilia et al., 2025). The provisions of the Criminal Code that can be applied in JKN fraud cases are Article 378 concerning fraud and Article 381 concerning the misleading of insurance underwriters, which threaten perpetrators with imprisonment. Thus, perpetrators of fraud in the JKN can not only be subjected to administrative sanctions based on Minister of Health Regulation Number 16 of 2019, but can also be held criminally liable in accordance with the provisions of the Criminal Code if the elements of the criminal act are fulfilled.

Dispute resolution for cases of fraud committed by hospitals in the implementation of the JKN program can be pursued through two channels: non-litigation and litigation. Based on Law Number 24 of 2011 concerning BPJS, Article 49 regulates that dispute resolution is carried out through mediation if complaints cannot be resolved at the complaint unit. Mediation regulated in Law Number 30 of 1999 concerning Arbitration and Alternative Dispute Resolution is a mechanism involving a neutral third party as a facilitator who helps the parties resolve issues persuasively, although the mediator does not have the authority to make a decision (Alawiya et al., 2023). If the mediation channel is unsuccessful, Article 50 of Law Number 24 of 2011 stipulates that the dispute may be submitted to the district court in the domicile area of the applicant as a litigation channel. The district court referred to is a judicial power within the general court environment, so that dispute resolution regarding fraud in the JKN can be pursued gradually starting from persuasive channels to legitimate legal channels when necessary.

The urgency of this research lies in its contribution to strengthening the legal system that protects the interests of JKN participants, ensuring the sustainability of the program, and guaranteeing accountability in the implementation of the national health insurance. Using a normative juridical approach that examines primary and secondary legal materials through statutory and conceptual approaches, this research examines three main issues. First, an analysis of the types and causes of fraud frequently committed by hospitals in the implementation of the JKN. Second, the identification of factors influencing law enforcement against hospital fraud in the implementation of the JKN. Third, an examination of criminal liability for fraud committed by hospitals as well as dispute resolution practices for fraud cases in the implementation of the JKN program. The results of this research are expected to provide a deep understanding of legal loopholes in anti-fraud regulations and offer alternative solutions for strengthening law enforcement in the health insurance sector.

RESEARCH METHOD

This research uses the normative juridical legal method as the main framework in examining the issues raised. The normative juridical method is a legal research approach conducted through the examination of legal materials, sourced both from laws and regulations and from relevant legal literature. The focus of the study in this research is directed toward the legal norms governing the implementation of the National Health Insurance (JKN) as well as law enforcement efforts against fraudulent acts committed by hospitals as healthcare facility providers.

The legal materials used in this research consist of two main categories. Primary legal materials encompass all laws and regulations that serve as the normative foundation for the implementation of JKN and the handling of fraud, including Law Number 40 of 2004 concerning the National Social Security System, Law Number 24 of 2011 concerning the Social Security Administering Body, Presidential Regulation Number 82 of 2018 concerning Health Insurance, Minister of Health Regulations, BPJS Kesehatan Regulations, and various related regulations governing fraud in hospitals. Meanwhile, secondary legal materials are obtained from textbooks, legal journals, scientific articles, and study documents related to the subject matter being researched.

To obtain a comprehensive analysis, this research applies two main approaches. The statute approach is used to thoroughly examine various regulations governing JKN, hospital operations, and sanctions that can be imposed for fraudulent acts. This approach allows researchers to understand the

normative structure and hierarchy of applicable regulations. In addition, the conceptual approach is applied to explore and understand the legal concepts underlying the definition of fraud, both from the perspective of health law and administrative law, thereby providing a solid theoretical foundation for the analysis conducted.

RESULT AND DISCUSSION

Analysis of the Types and Causes of Fraud Frequently Committed by Hospitals in the Implementation of the National Health Insurance Program

Fraudulent practices in healthcare services represent a critical issue that demands a comprehensive response, particularly within the operational framework of the National Health Insurance (JKN) Program. Conceptually, fraud is defined as an act committed intentionally to obtain financial benefits from the National Social Security System through actions that deviate from prevailing legal norms (Safitri et al., 2024). There are three main pillars in defining fraud: the effort to obtain economic benefits, the element of intent in acting, and the deceptive act that contradicts regulations, thereby causing losses to other parties. Within the realm of JKN, fraud can be committed by participants, BPJS Kesehatan officers, healthcare providers, or pharmaceutical and medical device distributors, all of whom are motivated by financial gain through unauthorized actions that violate rules (Muliarta et al., 2023). Such deviations not only undermine financial governance but also threaten the legal protection of patients' rights to obtain safe and quality healthcare services (Tampil et al., 2023).

Indonesia faces serious challenges with the increasing indication of fraud in the healthcare sector, largely triggered by the implementation of a financing system that is still relatively new. This condition gives rise to three triggering factors: perceived pressure experienced by perpetrators, moral justification for deviant actions, and open opportunities due to loose supervision (Fatimah et al., 2021). Consequently, strengthening regulations and optimizing supervision mechanisms are crucial steps to suppress potential fraud in the JKN program while safeguarding the sustainability of the national health financing system. Preventive measures against these deviations are vital to ensure the fulfillment of the juridical rights of underprivileged patients to continue accessing healthcare services without claim manipulation (Noor et al., 2023).

Various modi operandi of fraud in healthcare services can be identified, beginning with the keystroke mistake, which involves the manipulation of billing data input into the tariff system to obtain unreasonable reimbursements (Bauder et al., 2017). Furthermore, there is length of stay, which refers to the extension of inpatient care without clinical justification aimed at increasing claim amounts, as well as unnecessary treatment in the form of providing medical procedures or prescriptions not needed by the patient. No medical value appears as providing services that offer no diagnostic or therapeutic benefit, while cancelled service is the practice of submitting canceled services while still claiming costs through the system (Li et al., 2022). In addition to administrative claim fraud, vulnerabilities in hospital services also encompass potential disruptions to health information systems that can hinder the validation of claim data and trigger the legal responsibility of management (Yatno et al., 2023).

Other modi operandi include standard of care, which links service tariffs to the INA-CBG scheme, thereby potentially lowering the quality standards of service in pursuit of cost efficiency. Service unbundling or fragmentation is an administrative manipulation that breaks down a single service unit into multiple separate components to be reimbursed individually. Inflated bills describe the practice of inflating hospital billing values beyond actual costs, while phantom billing represents fictitious billing for services that were never provided to JKN participants (Triyudawati et al., 2023). Upcoding constitutes a fairly sophisticated form of fraud by manipulating diagnosis or procedure codes to appear more complex than actual clinical reality, or conversely, downgrading codes for specific purposes. Such practices of service manipulation and excessive cost efficiency frequently harm patients with special conditions, including rare disease patients whose access rights to therapy are limited within the BPJS system (Rahmawan et al., 2024), as well as palliative care patients who require the accountability of terminal services in accordance with health law regulations (Wahyusetiawan et al., 2024).

The Fraud Diamond theory introduced by Wolfe and Hermanson presents a more holistic analytical framework compared to its predecessor, Cressey's Fraud Triangle (Septian & Ratnawati, 2023). While the earlier theory only highlighted three elements rationalization, opportunity, and pressure the Fraud Diamond adds a fourth dimension in the form of the perpetrator's capability. Rationalization occurs when an individual successfully creates a narrative of justification that

makes fraudulent actions feel morally valid. Perpetrators frequently believe that such deviant behavior is commonplace because others also do it and escape sanction (Aphek & Cojocaru, 2024). Strengthening supervisory governance becomes a necessity to protect service quality and shield all stakeholders from potential losses. The transparency of hospital governance serves as a key pillar in maintaining patient perception and satisfaction regarding the reliability of service quality and location (Mardikaningsih, 2022).

Opportunity in this theory depicts a situation that enables an individual to commit irregularities, generally stemming from strategic positions held, weaknesses in the oversight system, and loose internal controls (Sun & Chen, 2022). Pressure represents a psychological or material drive that compels an individual to commit deviations. The combination of opportunity and pressure indicates that fraud is not merely a product of system failure, but also a reflection of the psychological burden bearing down on the perpetrator (Suryandari et al., 2023). Consequently, prevention interventions must not only focus on structural aspects but also touch upon the humanitarian dimensions of the perpetrator. This condition is likewise influenced by environmental characteristics and the social determinants of urban society, which impact interaction patterns and norm compliance in public service institutions (Warin, 2023).

Pressure that triggers involvement in unethical actions can originate from various factors, ranging from excessive work demands, deeply rooted bad habits, to economic desperation (Sooter et al., 2024). Rationalization acts as a moral shield that legitimizes fraudulent acts, and its effectiveness grows stronger if fraud is committed repeatedly. Meanwhile, capability refers to an individual's proficiency in exploiting the situations they face, which is ultimately used to justify violations through manipulation against internal control mechanisms (Rashid, 2022). A deep understanding of the four elements within the Fraud Diamond theory serves as an essential foundation for organizations to formulate more resilient control strategies to significantly suppress fraud risks.

Factors Influencing Law Enforcement Against Hospital Fraud in the Implementation of the National Health Insurance Program

The effectiveness of law enforcement in the healthcare sector is determined by the complex interaction among structural, institutional, and cultural factors, which encompass legal instruments, institutional governance, the capacity of rule-enforcement officers, and the level of community awareness and participation. Referring to the legal enforcement theory developed by Soerjono Soekanto, there are four main dimensions that influence the success of law enforcement efforts: legal instruments, governance, enforcement officers, and community and legal culture. These four dimensions are interconnected and determine whether a regulation can be implemented effectively or merely remains an idle norm.

The first dimension is legal instruments, which encompass all instruments, regulations, and norms governing the behavior of individuals and institutions in society, including laws, government regulations, court decisions, and recognized social norms. Legal instruments are divided into material law, which contains behavioral guidelines for citizens, and formal law, which regulates the mechanisms for filing, examining, adjudicating, and executing decisions (Rinaldi, 2023). In cases of JKN fraud, the primary reference legal instrument is Minister of Health Regulation Number 16 of 2019 concerning the Prevention and Handling of Fraud and the Imposition of Administrative Sanctions in the Implementation of the National Health Insurance Program. This regulation grants the authority to impose sanctions to the Head of the District/City Health Office, the Head of the Provincial Health Office, and the Minister of Health, with types of administrative sanctions ranging from oral warnings, written warnings, order warnings, restitution of losses, fines of up to 50% of the loss value for service providers, to the revocation of practice licenses for healthcare personnel. In addition, perpetrators of fraud can also be subject to criminal sanctions under Article 379, Article 379a, and Article 381 of the Criminal Code (KUHP); although these articles do not explicitly mention JKN fraud, such actions can be classified as fraud (Purwandari et al., 2024). The completeness of these legal instruments also requires a criminal construction that synergizes with financial sector regulations to anticipate the risk of claim payment failures caused by administrative fraud (Ambarwati et al., 2024).

Nevertheless, the implementation of anti-fraud regulations still faces resistance from various parties, particularly healthcare facilities and colleges, who consider their application inadequate despite remaining within tolerance limits. Healthcare facilities are the primary target for eradication efforts due to their dominant contribution, so the imposition of strict sanctions is expected to create a deterrent effect. In reality, however, the administrative sanctions in Minister of Health Regulation Number 16 of 2019 have

not been enforced with adequate firmness, leading some parties to view them merely as symbolic threats. To optimize eradication efforts, after sanctions are imposed, perpetrators need to receive ongoing guidance and supervision to cultivate awareness so they do not repeat their actions (Kalza et al., 2023). On the supporting side, the entities that play the most significant role in implementing anti-fraud programs are BPJS Kesehatan, the Corruption Eradication Commission (KPK), and professional organizations, although BPJS Kesehatan theoretically also has the potential to become a perpetrator, its probability is smaller compared to healthcare facilities and participants (Safitri et al., 2024).

The second dimension is the governance factor, which emphasizes the importance of implementing Good Clinical Governance and Good Corporate Governance principles in healthcare facilities. These principles encompass steps for prevention, detection, and resolution of fraud, as well as the development of services oriented toward quality control and cost management. The presence of effective internal audit teams and fraud prevention committees is recognized as a key element in prevention efforts, where healthcare facilities are obligated to conduct early detection of potential fraud on every claim submission to BPJS Kesehatan (Probowati et al., 2024). Minister of Health Regulation Number 16 of 2019 explicitly regulates the implementation of Good Clinical Governance and Good Corporate Governance in hospitals through the determination of authority and job descriptions for healthcare and non-healthcare personnel, the establishment and implementation of Standard Operating Procedures (SOPs) referring to National Clinical Practice Guidelines, and internal claim submission procedures. The strengthening of this governance collaborates with the utilization of big data analytics to validate claims objectively, prevent discrimination, and protect participants' rights (Bashori et al., 2024).

The third dimension is the law enforcement officer factor, which is realized through the establishment of the National Health Insurance Fraud Prevention and Handling Team (PK-JKN) at the health facility, district/city, provincial, and national levels. The existence of this team is part of efforts to build a sustainable anti-fraud ecosystem within the JKN Program. The PK-JKN team consists of various components, among others BPJS Kesehatan, the KPK, the Financial and Development Supervisory Agency (BPKP), the Ministry of Health, healthcare facility organizations, healthcare facility associations, and health offices. At the healthcare facility level, prevention roles are carried out by the Quality Control and Cost Control Team, which is responsible for implementing the anti-fraud program up to the evaluation and monitoring of its implementation (Probowati et al., 2024). Hospitals are required to maximize fraud prevention teams as the spearhead for the implementation and development of fraud prevention and detection systems, with team components including coders, medical committees, internal audit units, and other components. The team's duties include data-claim-based fraud prevention and early detection, regulation socialization prioritizing cost and quality control, routine reporting, monitoring and evaluation, and support for optimal clinical and organizational governance. Nevertheless, the role of this team remains suboptimal, necessitating the establishment of specialized fraud prevention teams so they can continuously enhance their knowledge and skills while prioritizing their tasks. According to the American Institute of Certified Public Accountants (AICPA), the three main criteria an organization must possess to prevent fraud are a strong culture of honesty and ethics, managerial roles and commitment, and an effective audit team.

The fourth dimension is the community and culture factor, which exerts a significant influence on the law enforcement process in Indonesia. The aspects detailing this influence encompass public legal awareness, public participation, culture and social norms, trust in legal institutions, access to justice, and the role of media and information. The level of public legal awareness determines their understanding of rights and obligations, where a legally educated public tends to be more active in demanding justice and reporting criminal offenses, such as corruption or fraud, to law enforcement officers (Rosisca et al., 2024). Public participation in legal processes, such as providing information or testimony, can strengthen law enforcement efforts, and the active role of citizens in reporting suspected criminal activity in their environment becomes a tangible form of contribution to the protection and enforcement of the law. Thus, legal awareness, public participation, culture, trust in institutions, access to justice, and the role of media collectively contribute to the effectiveness of the legal system, prompting the government and related institutions to pay attention to these factors and build strong relationships with the community so that law enforcement is not merely a formality, but truly effective in preventing and prosecuting fraud within the JKN program. The performance of law enforcement that impacts the quality of services in

hospitals and community health centers will directly influence the satisfaction of JKN participants regarding the reliability of healthcare facilities (Darmawan et al., 2022).

Legal culture acts as a primary driver within the legal system, where without deep understanding and respect for legal norms, the implementation of rules risks failure. The neglect of legal culture can give rise to symptoms such as misinformation disseminated to citizens regarding the content of regulations, as well as the gap between public practices and the will of the statute, wherein society tends to behave based on values that serve as their guiding principles (Patiev & Alimbekova, 2024). Re-arranging the legal culture behavior of law enforcement officers is a necessity, because a person's decision to use or not use the law heavily depends on their legal culture. The internalization of legal culture within society and law enforcement officers becomes a determining factor for the overall success of legal application.

The implementation of the JKN program cannot be separated from the risk of fraud committed by both healthcare personnel and participants, one of the triggers being the legal culture in Indonesia which tends to normalize deviant actions. Perpetrators of fraud frequently feel blameless and rationalize their actions under the pretext that the capitation or INA-CBG tariffs are insufficient, leading them to attempt to prevent losses for the healthcare facility where they work, even through unlawful means (Muliarta et al., 2023). On the other hand, not all participants who become victims of fraud report to BPJS Kesehatan for various reasons, such as ignorance of procedures, fear of discrimination by healthcare facilities they still require, or reluctance to face law enforcement officers and undergo time-consuming and costly processes. This condition underscores the need for an amendment to Minister of Health Regulation Number 16 of 2019 to fill the legal vacuum concerning criminal provisions, which must be accompanied by socialization and easily accessible reporting mechanisms for JKN participants so that fraud prevention and handling efforts become more effective and participatory.

Criminal Liability for Fraud Committed by Hospitals in the Implementation of the National Health Insurance Program

Law enforcement officers play a strategic role in preventive and repressive efforts against all forms of fraud in the implementation of the National Health Insurance (JKN) Program. Law enforcement is essentially a series of actions to prosecute any deviations or violations of prevailing laws and regulations, commonly referred to as unlawful acts (Firmansyah et al., 2022). In Indonesia, the legal basis for law enforcement against fraud in JKN is regulated through Minister of Health Regulation Number 16 of 2019 concerning the Prevention and Handling of Fraud and the Imposition of Administrative Sanctions in the Implementation of the National Health Insurance Program, which was designed as a legal instrument to support fraud prevention measures and replace Minister of Health Regulation Number 36 of 2015.

The substance of Minister of Health Regulation Number 16 of 2019 encompasses various activities, ranging from awareness raising, reporting, detection, investigation, to the imposition of sanctions, targeting providers of medicines and medical devices, health facilities, BPJS Kesehatan participants, and other related parties. Articles 6, 7, and 8 explicitly stipulate that law enforcement against fraud can be subject to administrative sanctions in the form of order warnings, written warnings, oral warnings, and the restitution of losses to the injured party, which can be followed by the revocation of licenses in accordance with statutory provisions as well as additional fines. Nevertheless, the fundamental weakness of this regulation lies in its provision of sanctions that are solely administrative without touching the criminal realm, making its deterrent effect very limited and causing fraud to recur (Hutahaean, 2022). The enforcement of Indonesian positive law in prosecuting fraud and the falsification of health insurance claim documents is crucial to preventing financial losses in the health insurance industry (Setiawan et al., 2023).

Throughout the practice of law enforcement in Indonesia, fraud cases within the health insurance program largely still rely on those regulations as a precedent for law enforcement officers, yet their effectiveness is heavily determined by normative clarity, sanction firmness, and implementation consistency in the field. Regulatory ambiguity and weak officer consistency serve as major obstacles to optimal law enforcement efforts (Solehuddin, 2023). Deviations in claims and governance within hospitals also have a direct impact on the neglect of patients' legal rights within the health insurance system (Tamaka et al., 2023), including the fulfillment of service access rights for persons with disabilities groups (Subiakso et al., 2023).

From the perspective of criminal law, fraudulent acts in the JKN can be classified as a criminal offense if two fundamental elements are fulfilled: the

existence of an unlawful act (actus reus) and intent or malicious intent (mens rea). The Indonesian Criminal Code (KUHP) stipulates that an act can be categorized as a criminal offense if it fulfills the elements of an unlawful act and the element of fault (Ashar, 2023). The elements of a criminal offense are generally divided into two main categories: subjective elements and objective elements.

Subjective elements encompass aspects inherent to the perpetrator, such as intent or negligence, the intent to attempt as stipulated in Article 53 paragraph (1) of the Criminal Code, specific purposes characteristic of crimes such as fraud and extortion, premeditation as found in premeditated murder under Article 340 of the Criminal Code, and feelings of fear as formulated in Article 308 of the Criminal Code. Meanwhile, objective elements cover the unlawful nature of the act itself, the quality of the perpetrator including office or position as regulated in Article 415 and Article 398 of the Criminal Code, as well as the causal relationship between the act committed and the resulting consequence (Nasution, 2022). Thus, any fraudulent act in the JKN can be held criminally liable if all these elements are fulfilled, with criminal sanctions functioning as the state's reaction to unlawful acts aimed at providing a deterrent effect. In addition, the manipulation of service promotions or medical advertisements in hospitals must also be subject to patient protection regulations as consumers of healthcare services (Sahidu et al., 2023).

Criminal provisions that can be applied in JKN fraud cases are Article 378 and Article 381 of the Criminal Code (KUHP). Article 378 of the Criminal Code threatens perpetrators of fraud with a maximum imprisonment of four years, namely anyone who with the intent to unlawfully benefit themselves or others, uses a false name or false dignity, deceit, or a series of lies, thereby moving another person to surrender goods, provide a debt, or write off a receivable (Muharam et al., 2024). The elements of Article 378 of the Criminal Code are divided into subjective elements in the form of "anyone" and the intent to take an unlawful advantage, as well as objective elements in the form of using a false name or dignity through lies or deceit and moving another party to surrender goods, provide a debt, or write off a receivable.

The application of Article 378 of the Criminal Code in the context of JKN fraud can be observed in the element of "anyone," which refers to healthcare facility officers who fail to provide medicine rights to JKN participants; the element of intent to unlawfully benefit oneself, which is reflected in actions of withholding participants' rights as guaranteed by Law Number 17 of 2023 and Minister of Health Regulation Number 28 of 2014; and the element of deceit or lies, which is apparent when officers convey false information that prescribed medicines are unavailable or not covered by BPJS Kesehatan (Solehuddin, 2023). Consequently, participants can pursue criminal channels, and perpetrators face a maximum imprisonment of four years. This practice of healthcare facility deviation further exacerbates the health burden of marginal groups who are vulnerable to public service injustice (Issalillah & Mardikaningsih, 2022).

Meanwhile, Article 381 of the Criminal Code threatens a maximum imprisonment of one year and four months for anyone who, through deceit, misleads an insurance underwriter regarding circumstances related to the coverage, thereby obtaining the approval of an agreement that would not have been approved if the actual circumstances had been known (Rusli & Halawa, 2024). The subjective element in this article is "anyone" and the presence of deceit, while its objective element is misleading the insurance underwriter regarding the coverage conditions resulting in agreement approval. The enforcement of criminal sanctions for this information misleading is crucial to maintaining the integrity of the underwriter's brand image and sustaining public interest in becoming insurance participants (Issalillah & Khayru, 2022). Based on all these analyses, fraudulent acts in the JKN have fulfilled all elements of a criminal offense, both from subjective and objective perspectives, so that perpetrators can be subjected to criminal sanctions in accordance with the prevailing provisions of the Criminal Code.

Dispute Resolution Practices for Fraud Cases Committed by Hospitals in the Implementation of the JKN Program

Disputes arising from fraudulent practices committed by hospitals in the implementation of the JKN Program can be pursued through two main mechanisms: non-litigation channels and litigation channels. Both of these channels are legitimate legal instruments that have been accommodated within the framework of prevailing laws and regulations. Dispute resolution mechanisms in cases of hospital fraud within the JKN program are fundamentally designed to provide legal certainty while protecting the rights of injured parties (Alawiya et al., 2023). These dispute resolution efforts are rooted in the principle of legal protection for patients as recipients of healthcare services in medical facilities (Tampil et al., 2023) as well as the enforcement of

participants' juridical rights within the health insurance system (Tamaka et al., 2023).

Out-of-court dispute resolution, or the non-litigation channel, serves as the primary option available to disputing parties. Provisions regarding this mechanism are stipulated in Law Number 24 of 2011 concerning the Social Security Administering Body, specifically Article 49, which regulates that if a party suffers losses and their complaint cannot be resolved through the complaint unit, the resolution shall proceed through mediation (Ikhsan et al., 2022). In addition, Law Number 30 of 1999 concerning Arbitration and Alternative Dispute Resolution also provides a legal foundation for dispute resolution through mediation as part of alternative mechanisms outside arbitration. This deliberative channel serves as an essential instrument in maintaining hospital accountability, particularly regarding special service claims such as palliative care for terminal patients who require legal certainty (Wahyusetiawan et al., 2024), while simultaneously accommodating access protection for persons with disabilities groups (Subiakso et al., 2023).

Mediation as a non-litigation instrument has a primary characteristic in the form of the involvement of a neutral and independent third party, who functions as a facilitator rather than a decision-maker. The mediator's duty is to support the disputing parties in reaching an agreement persuasively, without having the authority to impose a verdict. Thus, mediation is a final effort pursued through deliberation before the parties decide to bring the dispute to the judicial realm. This procedure also encompasses a space for dialogue regarding losses resulting from operational constraints, such as a hospital's legal liability for service disruptions originating from information system failures (Yatno et al., 2023). If the mediation step fails to achieve a satisfactory result, the injured party may submit the dispute to court as the next step.

Dispute resolution through the courts, or the litigation channel, is a legal mechanism pursued when mediation efforts are declared a failure. The legal basis for this channel is stipulated in Article 50 of Law Number 24 of 2011, which states that if complaints cannot be resolved by the service quality control and participant complaint handling unit through the mediation mechanism, resolution can be carried out by filing a lawsuit at the district court within the legal domicile area of the applicant. The district court referred to is within the general judicial environment as part of the judicial power authorized to examine, try, and decide civil cases, including disputes arising from the implementation of the JKN program. The firm application of positive law in this litigation process is crucial for prosecuting fraud and the falsification of claim documents in order to suppress losses in the health insurance industry (Setiawan et al., 2023).

Consequently, dispute resolution regarding fraud in the implementation of JKN goes through a staged mechanism, starting from the persuasive channel through mediation that prioritizes deliberation and agreement between the parties, and if those efforts yield no results, the district court becomes a legitimate and final legal path to uphold the rights of injured parties and provide legal certainty in dispute resolution. The firmness of the legal process regarding health insurance disputes can ultimately strengthen public trust in the brand image of the insurance provider (Issalillah & Khayru, 2022), reduce the health burden of vulnerable populations (Issalillah & Mardikaningsih, 2022), and realize sustainability policies that prioritize equal access and quality of life for citizens.

CONCLUSION

Based on the discussion regarding law enforcement against fraudulent acts committed by hospitals in the implementation of the National Health Insurance (JKN) Program, it can be concluded that JKN fraud encompasses various deviant actions, including phantom billing, upcoding, inflated bills, unnecessary treatment, no medical value, cancelled service, service unbundling, standard of care, and keystroke mistakes, which are caused by four main factors based on the Fraud Diamond theory: rationalization, opportunity, pressure, and the perpetrator's capability to exploit loopholes in the internal control system. Factors influencing law enforcement against hospital fraud in JKN include legal instruments, governance, enforcement officers, and community and legal culture, wherein Minister of Health Regulation Number 16 of 2019 has regulated administrative sanctions against perpetrators, yet its application remains suboptimal because it is still regarded merely as a threat and is not followed by continuous guidance and supervision; meanwhile, Law Number 17 of 2023 concerning Health has mandated the fulfillment of JKN participants' rights to fair and equitable healthcare services and regulated criminal sanctions for health-sector violations, serving as an additional legal foundation in enforcing laws against fraud. Criminal liability for JKN fraud can be imposed based on Articles 378 and 381 of the Criminal Code (KUHP) because fraudulent acts have fulfilled the elements of unlawful acts and intent, with dispute

resolution that can be pursued through non-litigation channels in the form of mediation as regulated in Law Number 24 of 2011 and Law Number 30 of 1999, as well as through litigation channels in district courts pursuant to Article 50 of Law Number 24 of 2011.

Based on the conclusions presented, it is recommended that an amendment be made to Minister of Health Regulation Number 16 of 2019 by incorporating strict criminal sanction provisions and clarifying coordination mechanisms among law enforcement officers, using Law Number 17 of 2023 concerning Health as a more comprehensive legal foundation. Strengthening the role of the Fraud Prevention and Handling Team at every level needs to be carried out continuously through competency enhancement and the establishment of specialist teams in every hospital. Massive socialization and easily accessible reporting mechanisms for the public are essential to increase public participation in monitoring and reporting suspected fraud, while simultaneously building an anti-fraud legal culture through legal behavior education and guidance. Strengthening internal control systems in hospitals through the consistent implementation of Good Clinical Governance and Good Corporate Governance principles, including optimizing the role of the Quality Control and Cost Control Team in claim monitoring and evaluation, represents a strategic step aligned with the mandate of Law Number 17 of 2023 regarding the implementation of quality management and patient safety systems in every healthcare facility.

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