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Legal Analysis Of Fraudulent Fictitious Claims (Phantom Billing) In The Implementation Of The National Health Insurance Program In Solo Raya

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Abstract: This study aims to: (1) analyze the occurrence of fictitious claims (phantom billing) by healthcare providers in the implementation of the National Health Insurance (JKN) program in the Solo Raya region, and (2) examine the strategy of the Health Social Security Agency (BPJS Kesehatan) in preventing such fraud. This empirical legal study employs a socio-legal approach using primary and secondary data collected through interviews, document analysis, literature review, and website sources. The data were analyzed qualitatively and prescriptively. The findings indicate that phantom billing is mainly caused by weaknesses in the manual reporting system, limited supervision, and low integrity among certain healthcare personnel, compounded by financial pressures and delayed data verification. BPJS Kesehatan addresses these issues through digital transformation, including biometric authentication, integrated electronic medical records, stronger cross-sector coordination, enhanced internal verification, and continuous fraud prevention education to improve accountability and integrity in JKN services.

Keywords: Fraud, claims, health insurance, Solo Raya

INTRODUCTION

Fraud in healthcare services is a serious issue that has adverse impacts not only on the financial sustainability of health insurance programs but also on the quality of medical services and public trust in the healthcare system (Fadliana et al., 2023). One common form of healthcare fraud is fictitious claims, commonly referred to as phantom billing, which involves submitting reimbursement claims for medical services or procedures that were never actually provided. This practice can result in substantial financial losses for health insurance providers, whether public or private, while also compromising the accuracy of healthcare service data used for planning, monitoring, and evaluating healthcare delivery (Devi et al., 2020).

vidence indicates that phantom billing has become a global phenomenon affecting various health insurance systems, including Indonesia's. For example, the Indonesian

Corruption Eradication Commission (Komisi Pemberantasan Korupsi [KPK]) uncovered a fictitious claims scheme that caused losses amounting to tens of billions of rupiah to the Social Security Administering Agency for Health (Badan Penyelenggara Jaminan Sosial [BPJS Kesehatan]). In one case, three hospitals were suspected of submitting fraudulent claims resulting in estimated losses of IDR 34 billion. The scheme involved collecting patients' personal data through community social service activities and falsifying participants' eligibility certificates, complete with forged signatures of physicians who were no longer actively affiliated with the respective hospitals (Nugroho, 2024). These findings demonstrate the existence of systematic and organized fraudulent practices that threaten the sustainability of Indonesia's National Health Insurance Program.

In addition to causing financial losses, this type of fraud poses significant risks to the accessibility and quality of healthcare services for program beneficiaries. Resources that should be allocated to legitimate healthcare services are instead diverted to reimburse fictitious claims, reducing the funds available for essential medical care. Furthermore, such fraudulent practices undermine the integrity of health insurance program administration and erode public trust in the system, ultimately affecting participation rates and the long-term sustainability of the National Health Insurance (*Jaminan Kesehatan Nasional* [JKN]) program (Fajarwati et al., 2024).

Preventing healthcare fraud, particularly phantom billing, is therefore essential to ensuring the effective and efficient management of health insurance programs. In practice, fraud prevention requires a multifaceted approach, including strengthening internal oversight mechanisms, utilizing information technology for the early detection of claim anomalies, and enforcing strict legal and administrative sanctions against perpetrators. Such comprehensive strategies are necessary to minimize opportunities for fraudulent activities while maintaining the stability of the program and ensuring equitable access to high-quality healthcare services for all members of society (Fitra et al., 2025).

The implementation of healthcare services under Indonesia's National Health Insurance (Jaminan Kesehatan Nasional [JKN]) program is fundamentally based on a contractual relationship between hospitals and BPJS Kesehatan. This cooperation agreement serves as a legally binding instrument that regulates the rights and obligations of both parties, including hospitals' responsibility to provide healthcare services in accordance with established medical standards and BPJS Kesehatan's obligation to reimburse valid claims submitted by healthcare providers. The agreement also establishes mechanisms for claim verification, supervision, evaluation of service quality, and dispute resolution to ensure transparency, accountability, and legal certainty in the administration of the JKN program. Consequently, compliance with the contractual provisions is essential to prevent irregularities in the claims process and to safeguard the integrity of the national health insurance system (Setyarini et al., 2025). From the perspective of contract law, *phantom billing* constitutes not only a fraudulent act causing financial losses but also a breach of contractual obligations, as hospitals submit claims that do not accurately reflect the healthcare services delivered. Such conduct violates the fundamental principles of good faith, accountability, and legal certainty that govern contractual relationships. Consequently, in addition to potential criminal liability, *phantom billing* may also give rise to civil liability through contractual dispute resolution mechanisms between hospitals and BPJS Kesehatan (Yuswanti et al., 2026).

From the perspective of the contractual relationship between hospitals and BPJS Kesehatan, phantom billing constitutes not only a financial crime but also a breach of the contractual obligations agreed upon by both parties. Cooperation agreements explicitly require healthcare providers to submit claims that accurately reflect healthcare services actually delivered to JKN participants. Therefore, the submission of fictitious claims represents a violation of the principles of good faith, accountability, and legal certainty that underpin

contractual relationships under Indonesian law. In addition to potential criminal liability for fraudulent conduct, such violations may also give rise to civil consequences through contractual dispute resolution mechanisms, including mediation, adjudication, or court proceedings to enforce the respective rights and obligations of the contracting parties.

Alleged fictitious claims in Indonesia's health insurance program are not only a national concern but have also been identified in the implementation of the program in the Solo Raya region and its surrounding areas. Findings by the Indonesian Corruption Eradication Commission (*Komisi Pemberantasan Korupsi* [KPK]) indicate that a hospital in Central Java was suspected of engaging in *phantom billing*, involving claims valued at approximately IDR 29 billion (Tribun Network, 2024). The alleged scheme involved thousands of claims and included document falsification as well as the inflation of charges for medicines and medical devices that did not correspond to the services actually provided. These findings reinforce concerns that healthcare fraud remains a significant threat to the sustainability of Indonesia's National Health Insurance (*Jaminan Kesehatan Nasional* [JKN]) program at the regional level.

The hospital implicated in the alleged fictitious claims reportedly exploited weaknesses in the administrative and claims submission system of *BPJS Kesehatan*. The fraudulent scheme included the creation of falsified documents and the manipulation of patient records to obtain reimbursement for healthcare services that had never been delivered (Kurniawan et al., 2020). Limited and suboptimal verification mechanisms further increased the opportunity for fraudulent activities at healthcare facilities. These circumstances underscore the need to strengthen oversight mechanisms and implement more rigorous internal audit procedures to reduce the risk of phantom billing on a regional scale.

The consequences of phantom billing practices in the Solo Raya region extend beyond substantial financial losses to BPJS Kesehatan. Such fraudulent activities also disrupt the equitable distribution of healthcare resources by diverting funds that should be allocated to patients who genuinely require medical services. As a result, the quality and availability of healthcare services accessible to JKN beneficiaries may be adversely affected. Moreover, these practices raise concerns among both program administrators and participants regarding fairness, accountability, and transparency in the implementation of the National Health Insurance program, which is intended to ensure equitable access to essential healthcare services for all citizens.

METHOD

This study employs an empirical legal research method, which focuses on examining the implementation of legal provisions in practice through the collection of facts occurring within society. This approach combines an analysis of applicable legal norms with actual practices in the field to illustrate the extent to which regulations concerning the prevention and handling of fictitious claims (*phantom billing*) in the implementation of the National Health Insurance (*Jaminan Kesehatan Nasional* [JKN]) program are applied by relevant stakeholders. The empirical approach is conducted by integrating the study of primary legal materials, such as legislation and legal doctrines, with direct observations of program implementation in the Solo Raya region.

Data were collected from two main sources: primary and secondary data. Primary data were obtained through in-depth interviews with key informants, including representatives of *BPJS Kesehatan*, hospital administrators in Solo Raya, and healthcare professionals involved in claims management. These interviews aimed to explore information regarding suspected fraudulent practices and prevention strategies. Meanwhile, secondary data consisted of relevant legal regulations, such as Law Number 24 of 2011 concerning BPJS and Regulation of the Minister of Health Number 16 of 2019, as well as academic literature, scientific journals, and

official documents from related institutions that support the conceptual foundation of the research.

Data analysis was conducted using a qualitative descriptive-analytical method through three main stages. First, data reduction was carried out by selecting and filtering relevant information obtained from interviews, observations, and document studies. Second, the reduced data were presented in the form of narrative descriptions or other systematic formats to identify patterns and relationships among the collected data. Third, conclusions were drawn to formulate answers to the research questions regarding the factors contributing to fictitious claims and effective prevention strategies implemented in practice.

RESULTS AND DISCUSSION

Results

Factors Contributing to Fictitious Claims (Phantom Billing) by Healthcare Providers in the Implementation of the National Health Insurance Program in the Solo Raya Region

The occurrence of alleged fictitious claims or phantom billing in the Solo Raya region is attributed to gaps in administrative systems and economic pressures faced by healthcare facilities in maintaining operational sustainability. This phenomenon arises when there is a discrepancy between the clinical services actually provided and the data submitted within the claims management system. Such discrepancies may result from differences between service costs and reimbursement rates, as well as technological limitations in fully validating patients' physical presence, despite the continued implementation of biometric approval requirements, although restricted to less than 1% of cases. Financial incentives to overcome hospital budget deficits are often combined with weaknesses in internal control mechanisms, creating opportunities for certain individuals to manipulate medical records or add unsupported procedures without valid clinical justification. These practices are carried out to increase claim amounts beyond reasonable limits and ultimately constitute fraudulent activities that may undermine the integrity and sustainability of the National Health Insurance (*Jaminan Kesehatan Nasional* [JKN]) program.

The potential emergence of claim manipulation is often triggered by inefficient service patterns, such as unnecessary extensions of hospitalization periods and the modification of medical procedures to meet specific claim targets. Regulatory authorities have identified that discrepancies between reported diagnoses and medical actions performed serve as strong indicators of attempts to obtain unlawful financial benefits. This finding is consistent with the results of an interview with a representative of *BPJS Kesehatan* Solo Raya Branch, who stated:

"The definition of fraud refers to the Minister of Health Regulation Number 16 of 2019. Fraud in the JKN program is an intentional act carried out to obtain financial benefits through methods that are inconsistent with applicable regulations. The most frequently identified forms of fraud in the Solo Raya region are the extension of Length of Stay in First-Level Inpatient Care (RITP), as well as the manipulation of procedures and diagnoses in Advanced Inpatient Care."

The gap between hospital tariffs, including the actual operational costs incurred by hospitals, and the amount of reimbursement provided through the JKN package payment system often creates financial pressure that requires healthcare providers to carefully manage their resources to avoid losses. The inability of the government to fully cover all healthcare service costs through the health insurance package creates a dilemma for healthcare facilities in maintaining service quality without compromising institutional financial stability. This situation is consistent with an interview with a director of a private hospital in Solo, who stated:

"The government must acknowledge that not all healthcare services can be covered by the JKN package system. As a result, hospitals must continuously be cautious in managing these resources, which may affect patients' ability to receive optimal quality services. The tendency for individuals to commit deviations may arise when they face issues related to reimbursement limits that place a significant burden on hospitals."

Incomplete medical documentation and outdated mindsets that assume adding more procedures will automatically increase hospital revenue are among the root causes of inaccuracies in claim submissions. Errors in determining appropriate diagnoses often occur due to physicians documenting procedures that are not aligned with the patient's actual medical condition, making the medical coding process more challenging. This finding is consistent with an interview with the Director of a Private Hospital in Karanganyar Regency, who stated:

"Healthcare facilities must ensure that every procedure documented by physicians corresponds to the patient's actual condition, because incomplete data will make the coding process more difficult. We must abandon the old mindset that the more procedures recorded, the higher the claim value will be, because every entry must be medically valid and supported by proper evidence."

Information asymmetry between physicians responsible for patient care and internal hospital claim verification officers (*Case Mix Team*) as well as *BPJS Kesehatan* verifiers is often exacerbated by differences in interpretation of available national clinical guidelines. The lack of synchronization between treatment regulations and hospital claim management practices creates opportunities for suboptimal medical management practices that may still be submitted as claims. This finding is consistent with an interview with a *Case Mix Manager* at a hospital in Wonogiri, who stated:

"So far, BPJS has not consistently applied the National Clinical Practice Guidelines (PNPK) in therapeutic management. For example, in certain cases, the most recent guidelines are not always used. Different BPJS verifiers may produce different verification results. Problems arise when physicians responsible for patient care do not understand claim management procedures and how to provide BPJS patient services in accordance with BPJS regulations and the interpretation of their verifiers. As a result, inconsistencies in criteria occur during the claim documentation process."

The use of electronic medical record systems with automatic data input features also creates significant risks when healthcare professionals fail to adjust records following changes in patients' clinical conditions. Limited time availability and high workloads often result in inadequate cross-verification between nursing records and physician entries, causing cancelled procedures or services that were not actually performed to remain recorded and submitted as active claims. This finding is consistent with an interview with a *Case Mix Manager* at a hospital in Sukoharjo Regency, who stated:

"There are often procedures that are automatically entered into the hospital information system, but in reality, they are not performed due to changes in the patient's clinical condition. This requires careful attention from officers to adjust the information within the patient's clinical records. There are also several cases where patients actually meet the criteria for inpatient care but are forced into outpatient treatment. One example is a Neonatal Jaundice case at our hospital, which required further discussion and careful assessment between the Case Mix Team and BPJS."

Limited access for the Health Office to directly monitor information systems makes the supervision of fictitious claim practices highly challenging and tends to result in a passive

oversight approach. Without specialized tools to verify the accuracy of healthcare services in real time, regional supervisory authorities can only take action when reports or complaints regarding suspected irregularities arise. This finding is consistent with an interview with the Head of the Sragen Regency Health Office, who stated:

"Regarding specific tools for direct monitoring, we currently do not have them. Medical record supervision is not conducted directly, so if there is an indication of irregularities, clarification and monitoring are carried out afterward. So far, we have not conducted routine audits or supervision related to JKN claims due to limitations in tools and personnel to ensure that the services provided correspond to the submitted claims."

The difficulty in accurately detecting *phantom billing* stems from weaknesses in the existing reporting system at the regional level, where utilization data submitted is often limited to administrative information without comprehensive clinical details. The lack of transparency in the referral system may also increase the burden of claims, as patients may be referred to facilities that do not have the appropriate capacity, potentially resulting in duplicate billing or unnecessary additional costs. This finding is consistent with an interview with the Head of the Boyolali Regency Health Office, who stated:

"We do experience some difficulties when trying to examine the system because we can only make assumptions based on the available reports. The primary detection usually comes from BPJS, while we mainly receive public complaints, although some people are willing to report and others are not. An inappropriate referral system can ultimately increase the burden on BPJS claims."

The interview findings are generally consistent with field observations, which indicate that although biometric technology has been implemented, opportunities for manipulation remain open during the post-service medical data entry stage. Observations revealed that the high administrative workload faced by coding officers and the limited availability of independent internal medical audits often result in data anomalies being perceived merely as technical errors, despite their potential to cause significant financial losses. The collaboration between institutions, which remains largely administrative in nature, has not yet addressed the fundamental issue of individual misconduct, causing alleged fictitious claims to remain a serious threat to the accountability of National Health Insurance funds in the Solo Raya region.

Strategies of the Social Security Administering Agency for Health in Preventing Fictitious Claim Fraud by Healthcare Providers in the Implementation of the National Health Insurance Program in the Solo Raya Region

The strategy of *BPJS Kesehatan* in addressing the potential occurrence of fictitious claim fraud in the Solo Raya region is based on strengthening digital monitoring systems and cross-sector collaboration in accordance with national regulations. Prevention efforts are carried out systematically, beginning from patient registration through post-service verification processes, to ensure that every submitted claim is supported by legitimate medical evidence and can be properly accounted for. The approach includes the use of biometric identification technology to minimize the risk of false patient identities, as well as periodic medical audits to detect irregularities in healthcare service patterns at healthcare facilities. Through the integration of various monitoring systems, *BPJS Kesehatan* seeks to establish a transparent healthcare service ecosystem, ensuring that social health insurance funds are managed effectively for participants who genuinely require medical services while preventing financial leakage caused by fraudulent practices.

The implementation of facial recognition and fingerprint scanning technology serves as a primary defense mechanism in verifying patients' physical presence at healthcare facilities and preventing claims for non-existent patients. This validation system is designed to record patient visits in real time, thereby reducing opportunities for attendance manipulation through integration with population identification data. This finding is consistent with an interview with a representative of *BPJS Kesehatan*, who stated:

"The detection of suspected phantom billing is carried out in accordance with the Minister of Health Regulation Number 16 of 2019, where participant services are currently required to use facial recognition. Biometric validation approvals that indicate potential fictitious claims will immediately become a focus of system monitoring. The innovation currently being developed to strengthen fraud detection is the implementation of stricter biometric validation to ensure that healthcare services are genuinely provided to legitimate participants."

The utilization of fully integrated hospital information systems enables comprehensive monitoring of medical activities, from patient registration until the completion of treatment. The digitalization of medical records facilitates verification teams in examining the consistency between reported medical procedures and daily clinical records entered by healthcare professionals in a continuous manner. This finding is consistent with an interview with a *Case Mix Manager* at a hospital in Wonogiri, who stated:

"The hospital process is currently highly integrated through the Hospital Information System (SIM-RS), where all medical data from physicians, nurses, and registration services are interconnected. When patients are admitted through the Emergency Department or outpatient clinics, all forms are already available digitally within the system to prevent unsupported additional data entries. This integration ensures that every service provided is automatically recorded and minimizes the possibility of discrepancies caused by human error or intentional claim manipulation."

The internalization of integrity values through the development of an honest work culture within healthcare facilities is considered a more effective prevention method than relying solely on rigid administrative supervision. Healthcare facility leaders have a significant responsibility to establish a social control system in which every staff member feels obligated to remind and monitor one another when there are indications of irregularities in the claim submission process to *BPJS Kesehatan*. This finding is consistent with an interview with a hospital director in Solo, who stated:

"The main key to preventing fraud is cultivating the vision and mission of the organization and implementing a 360-degree integrated supervision system, where all staff members from every level and position continuously remind one another. The tendency for individuals to commit misconduct may exist; however, when the work environment has a strong social control system, officers will feel monitored by their colleagues. The implementation of moral values in healthcare services becomes the foundation to ensure that no medical procedures are claimed if they were never actually provided to patients."

Aligning the understanding between medical coding officers and physicians responsible for patient care is a crucial strategy to ensure that diagnoses entered into the claims system accurately reflect the actual clinical conditions of patients. The accuracy of medical record data largely depends on the honesty and completeness of medical documentation, particularly in preparing medical summaries, to prevent the inflation of procedures solely intended to increase

claim values without genuine medical necessity. This finding is consistent with an interview with a hospital director in Karanganyar, who stated:

"Healthcare facilities must ensure that every procedure documented by physicians corresponds to the patient's actual condition, because incomplete data will make it difficult for coding officers to determine the appropriate diagnosis. We must abandon the old mindset that the more procedures documented, the higher the claim value will be, because every entry must be medically valid and supported by evidence. The consistency between diagnoses and procedures in medical summaries is essential to ensure that submitted claims are not considered potential fraud that could damage the hospital's credibility."

A multi-layered verification system involving nurses and administrative personnel as internal verifiers serves as the first line of defense in detecting automatically generated procedure entries that do not accurately reflect the healthcare services delivered. While physicians have considerable discretion in completing electronic medical records, this flexibility must be complemented by factual validation through nursing documentation, which records all medical services, procedures, and supplies actually provided to patients during their hospitalization. This finding is consistent with an interview with a *Case Mix Manager* at a hospital, who stated:

"Our staff always perform a secondary verification by comparing the data entered into the electronic medical records with the nursing documentation to ensure that the recorded procedures are consistent. There are often procedures that are automatically generated by the system but, in reality, were not performed because the patient's clinical condition changed. Therefore, the role of nurses is to ensure the validity of those records. We also regularly remind physicians through Medical Committee meetings about the risks of fictitious claims and the importance of accurate coding in accordance with the policies established by BPJS Kesehatan."

Intensive coordination between healthcare providers and regional regulatory authorities serves as an important mechanism for monitoring and evaluating claim patterns that are collectively considered suspicious. Regional Health Offices function as both supervisors and facilitators, ensuring that healthcare facilities comply with established standard operating procedures while maintaining service quality and the financial sustainability of the National Health Insurance (*Jaminan Kesehatan Nasional* [JKN]) program. This finding is consistent with an interview with the Head of the Boyolali Regency Health Office, who stated:

"The Health Office plays an active role as both a supervisor and facilitator to ensure that the public receives healthcare services in accordance with their entitlements and the standards established under the JKN program. We emphasize the implementation of electronic medical records at every point of healthcare delivery as a tool to promote transparency and accountability in the medical data submitted to BPJS Kesehatan. Coordination with BPJS must continue to be strengthened so that any indication of fictitious claims can be detected at an early stage through utilization reports received within our regional monitoring system."

Continuous education and preventive field monitoring are carried out to ensure that all supervisory instruments within healthcare facilities function properly without waiting for financial losses to be identified. Indirect medical record supervision through periodic audits helps identify administrative gaps that may be exploited by certain individuals to engage in practices leading to fictitious healthcare service billing. This finding is consistent with an interview with the Head of the Sragen Regency Health Office, who stated:

"Efforts to prevent potential claim fraud are carried out through education, socialization, and monitoring activities when our team conducts direct field evaluations of compliance with existing Standard Operating Procedures (SOPs). Medical record supervision is often conducted indirectly; however, if certain indications or complaints arise, clarification and in-depth audits will immediately be carried out together with relevant teams. Our role is to facilitate communication so that challenges encountered in the field do not lead to actions that violate the agreed-upon JKN claim regulations."

The findings of this study indicate that the fraud prevention strategies for fictitious claims implemented in the Solo Raya region are oriented toward integrating technological supervision with strengthening human resource integrity. These strategies are consistent with field observations showing that biometric validation systems at each service point have successfully reduced opportunities for the widespread use of fictitious patient identities. The implementation of electronic medical records, which has increasingly become mandatory, has also improved data accuracy, although strict human supervision remains necessary to prevent inaccurate automatic entries. The synergy between hospital internal audits, systematic verification conducted by *BPJS Kesehatan*, and guidance provided by the Health Office establishes a strong framework for maintaining financial accountability in the management of public funds and supporting the overall implementation of the National Health Insurance (*Jaminan Kesehatan Nasional* [JKN]) program.

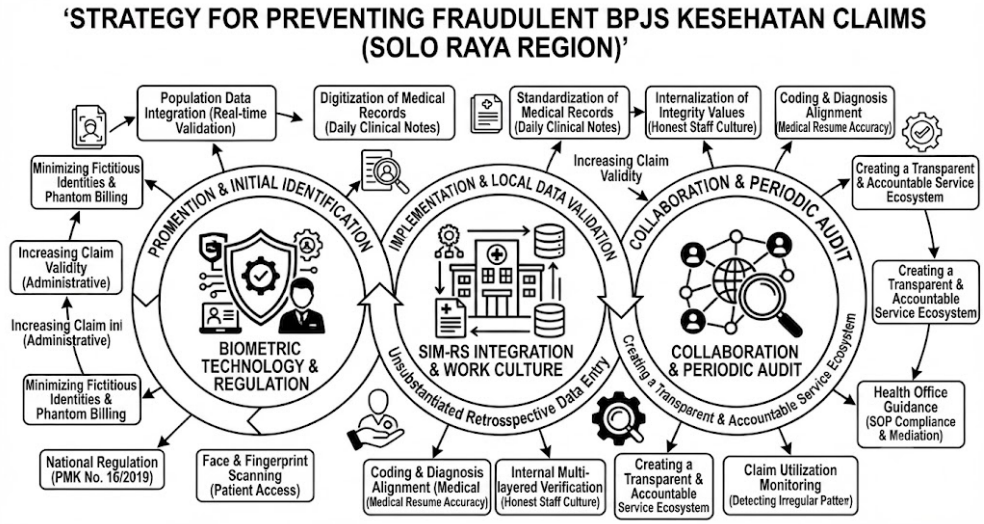

Figure 1. Flowchart Illustration of the Strategic Framework of BPJS Ketenagakerjaan in Preventing Fictitious Claim Fraud

The figure illustrates a comprehensive framework of *BPJS Kesehatan*'s strategy in preventing fictitious claim fraud in the Solo Raya region through three interconnected pillars. The first pillar focuses on Prevention and Early Identification through the implementation of biometric technology (facial recognition and fingerprint scanning) integrated with population data in accordance with Minister of Health Regulation Number 16 of 2019. This approach aims to prevent *phantom billing* from occurring at the initial stage when patients access healthcare services. The second pillar emphasizes Local Data Implementation and Validation within healthcare facilities, where the integration of Hospital Information Systems (*SIM-RS*) and electronic medical record digitalization are combined with the strengthening of an honest work culture and multi-layered verification processes. This pillar functions to minimize opportunities for manipulation, unsupported data entries, or additional documentation that lacks clinical

justification. The final pillar involves External Supervision and Guidance through collaboration and periodic audits involving multiple stakeholders. In this process, the Health Office plays a role in supervising compliance with Standard Operating Procedures (SOPs), while *BPJS Kesehatan* conducts claim utilization monitoring to identify irregular patterns. The synergy among these elements creates a transparent, accountable healthcare service ecosystem and minimizes leakage of social health insurance funds.

Discussion

Minister of Health Regulation Number 16 of 2019 emphasizes that fraud within the National Health Insurance (*Jaminan Kesehatan Nasional* [JKN]) program can be committed by various parties, including healthcare facilities as service providers. This regulation establishes fraud prevention as a collective responsibility through the establishment of dedicated teams responsible for conducting socialization, monitoring, and evaluation of healthcare service governance (Annisa, 2026). Factors such as weak system integration, administrative errors, and inadequate internal controls, as identified in the Solo Raya region, indicate that the implementation of supervisory functions mandated by the regulation has not yet been fully optimized. Fraud opportunities emerge when quality control and cost control mechanisms have not been effectively implemented at the operational level of healthcare facilities.

Minister of Health Regulation Number 36 of 2015, as the previous regulatory framework, provided an initial foundation for fraud prevention; however, it was unable to fully address the complexity of emerging issues, such as financial pressures and advancements in information technology within healthcare services. The transition to Minister of Health Regulation Number 16 of 2019 reflects the need to strengthen a more adaptive system capable of responding to various fraud schemes, including *phantom billing* driven by disparities between reimbursement rates and operational costs. Issues such as the lack of synchronization within Hospital Information Systems (*SIM-RS*), weak electronic medical record validation, and limitations among BPJS verification officers demonstrate that a purely administrative approach is no longer sufficient to address increasingly complex fraud patterns. This regulatory change reflects the government's effort to shift the focus from merely handling fraud cases toward a prevention-oriented approach based on system improvement and technological utilization (Pakpahan et al., 2021).

The relevance of Financial Services Authority Regulation Number 12 of 2024 can be observed in the aspects of governance and risk management related to the management of public funds within the National Health Insurance (*Jaminan Kesehatan Nasional* [JKN]) program. The phenomenon of financial pressure that encourages healthcare facilities to manipulate claims indicates the existence of moral hazard risks that must be controlled through the principles of prudence, transparency, and accountability. These principles are consistent with financial sector supervision, which requires strong internal control systems and accurate reporting mechanisms. Data entry errors, weak internal supervision, and passive inter-institutional coordination reflect the inadequate implementation of *Clinical Governance* principles in managing social security funds, thereby creating opportunities for irregularities that may harm state finances (Purwono, 2024).

The connection with Law Number 24 of 2011 concerning BPJS further confirms that these causes of fraud contradict the fundamental principles of social security implementation, which emphasize humanity, benefits, and social justice. As a public legal entity, BPJS has an

obligation to manage participants' entrusted funds in an accountable and transparent manner while ensuring that every claim payment is based on healthcare services that have actually been provided. Low integrity among certain healthcare personnel, weak internal social control, and limited inter-institutional coordination demonstrate deviations from the principles of accountability and prudence mandated by the law. The responsibility of BPJS to conduct supervision, compliance assessments, and even terminate cooperation with problematic healthcare facilities serves as a crucial legal instrument to address the root causes of fraud and maintain the sustainability of the JKN program (Guntoro et al., 2025).

Law enforcement within the National Health Insurance (*Jaminan Kesehatan Nasional* [JKN]) scheme in the Solo Raya region represents a systematic effort to realize the values of justice and legal certainty, ensuring that written regulations do not merely function as administrative provisions. Goldstein's law enforcement theory as discussed by Widijowati et al. (2024) divides the enforcement process into three dimensions. The phenomenon of fictitious claims demonstrates a discrepancy between substantive legal provisions (*total enforcement*) and their actual implementation in practice (*real enforcement*). Weak technological integration and the continued dominance of manual supervision indicate that supporting infrastructure and the capacity of enforcement institutions remain insufficient to effectively identify all data anomalies. The gap between automated detection capabilities and the massive volume of claims results in law enforcement that tends to be selective and often fails to identify organized fraudulent practices.

The legal structure and legal culture within healthcare facilities significantly influence the success of implementing anti-fraud programs. Pangarso (2022) emphasizes that a legal system cannot function effectively without a supportive *legal culture* or social norms that encourage compliance with regulations. The issue of certain individuals maintaining outdated practices aimed at gaining financial benefits indicates that the internalization of professional ethical values has not yet aligned with the transparency requirements of the JKN program. A permissive culture toward data entry errors or routine medical diagnosis manipulation weakens the preventive function of law in avoiding broader state financial losses.

Legal compliance among healthcare service providers in the Solo Raya region should arise from internal awareness to maintain social order, rather than merely from fear of formal sanctions. Soekanto, as cited in Marbun et al. (2021) states that compliance is highly dependent on the level of knowledge and public confidence in the function of law itself. The gap between operational costs and reimbursement rates, which creates financial pressure, is often used as a justification by hospital management to disregard legal norms in order to maintain institutional cash flow stability. Strong economic motivations may override awareness of the importance of regulatory compliance, making sustainable legal adherence difficult to achieve without systemic improvements in the healthcare financing scheme.

Although fraud prevention mechanisms within the National Health Insurance (*Jaminan Kesehatan Nasional* [JKN]) program have been regulated through Minister of Health Regulation Number 16 of 2019, the substance of this regulation remains primarily focused on administrative mechanisms and internal governance within healthcare facilities. The regulation has not specifically established a more comprehensive legal framework regarding forms of digital fraud, such as fictitious claims based on electronic system manipulation, biometric data falsification, or electronic medical record engineering, which continue to develop alongside the digital transformation of healthcare services. This condition indicates the existence of a

significant legal gap, particularly concerning technical regulations, digital evidence standards, and more specific sanctions for perpetrators of technology-based healthcare fraud.

The existence of this regulatory gap has implications for the suboptimal effectiveness of law enforcement, as the current legal instruments remain general in nature and are not yet capable of addressing the increasingly complex modus operandi of healthcare fraud. Existing regulations place greater emphasis on prevention and guidance mechanisms, while the repressive aspects of addressing modern fraud patterns still require more comprehensive normative strengthening. Therefore, it is necessary to establish new regulations or revise Minister of Health Regulation Number 16 of 2019 to specifically regulate integrated digital monitoring systems, mandatory biometric validation, electronic medical record interoperability standards, digital forensic audit mechanisms, and the classification of administrative and criminal sanctions for perpetrators of fictitious claim fraud. Strengthening these regulations is essential to create legal certainty, minimize opportunities for healthcare data manipulation, and enhance the protection of social health insurance funds as public entrusted funds. The presence of more adaptive regulations would also provide stronger legal legitimacy for *BPJS Kesehatan* in conducting supervision and taking enforcement actions against healthcare facilities proven to have committed fraudulent claims.

CONCLUSION

The causes of fictitious claims (*phantom billing*) in the Solo Raya region originate from weaknesses in manual reporting systems and the lack of integrity among certain healthcare facility personnel who exploit medical information asymmetry for personal financial gain. Internal pressure within hospital management to optimize revenue is often triggered by disparities between operational costs and claim reimbursement values, leading to the manipulation of patient visit data as a shortcut. Weaknesses in multi-layered supervision in the past also created opportunities for false data entries to pass basic verification processes due to the absence of real-time synchronization of participant identity data. The strategy of the *Social Security Administering Agency for Health* (*BPJS Kesehatan*) in addressing such fraud has shifted toward digital transformation through the implementation of biometric authentication, including facial recognition and fingerprint verification, as well as the integration of transparent electronic medical record systems to eliminate opportunities for service manipulation. Strengthening cross-sectoral coordination with Health Offices and optimizing the role of internal verifiers have become key instruments in conducting cross-validation between diagnoses and clinical evidence in the field. These efforts are further supported by continuous regulatory socialization to establish a culture of integrity across all levels of healthcare facilities and create an accountable National Health Insurance (*Jaminan Kesehatan Nasional* [JKN]) service ecosystem.

Healthcare providers in the Solo Raya region are recommended to strengthen internal monitoring systems and conduct independent medical audits to ensure that all claim data entry processes comply with standard operating procedures and professional ethics, thereby mitigating legal risks associated with fraudulent practices. *BPJS Kesehatan* is expected to improve digital security system integration and increase the frequency of collaborative regulatory guidance with relevant stakeholders to ensure legal protection for entrusted social security funds and guarantee fair healthcare access for all participants. Future researchers focusing on BPJS-related issues are encouraged to expand their analysis of the effectiveness of criminal and civil sanctions against *phantom billing* perpetrators through comparative studies

across different regions to enrich the legal healthcare literature regarding integrity enforcement within the national social security system.

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