FRAUD DETECTION IN INDONESIA NATIONAL HEALTH INSURANCE IMPLEMENTATION: A PHENOMENOLOGY EXPERIENCE FROM HOSPITAL

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Abstract: National Health Insurance (NHI) is one of policy that being implemented in many countries in the world in order to gain Universal Health Coverage (UHC). In Indonesia, National Health Insurance or known as Jaminan Kesehatan National (JKN) is performed by Badan Penyelenggara Jaminan Sosial (BPJS). Despite the new policy aim to protect people from unpredictable condition that threaten in health, it also brings a challenge. Implementation of NHI in Indonesia with INA-case based group's prospective system payment that involves BPJS as insurance agency, hospital as a health care provider, and the patient as a customer led to fraud and moral hazard condition. The fraud and moral hazard condition caused the BPJS deficit financing in the first year of implementation in 2014. The objective of this study is to detecting fraud that occurs in hospital on implementing NHI. This was a qualitative research with phenomenology-interpretive approach. Data was collected through Interview with manager of BPJS, Internal Stakeholder of the hospital, and BPJS Patient. This study was conducted in one of private hospital in Indonesia in Mei-August 2015. This study suggested that fraud and moral hazard could occur in BPJS-provider relationship as well as in provider-patient while delivering health care. Government must improve the policy by strengthening the controlling and evaluation function in National Health Insurance Implementation. Considering of the important of case-mix team suggested as the way to reduce fraud and moral hazard in this concern.

Keywords: Fraud, Moral Hazard, and phenomenology-interpretive approach

1. Introduction

Establishing a reform agenda for the World Health Organization (WHO) requires understanding its role within the wider global health system and the purposes of the wider global health system. National Health Insurance (NHI), called JKN in Indonesia, has been implemented in January 2014 as a realization of government law No.40/2004 National Social Insurance System and become one of policy to establish WHO agenda. NHI is a proof of government responsibility to protect people from unpredictable condition that threaten in health and aimed to gain Universal Health Coverage (UHC) (Indonesian MoH, 2010).

UHC is widely recognized as essential to enhancing health, social cohesion, and sustainable human and economic development (WHO, 2010; Palmer, 2014). UHC is health system that ensure people in the population having equitable access in health care, promotive, preventive, curative, and rehabilitative, with good quality and affordable prices. It contains two core

elements, equitable access to health services and quality and financial risk protection when people use health services.

Inadequate and inequitable health financing is a challenge a global health treaty must address. Health financing is something important in NHI. The purpose of health financing is to encourage quality improvement, patient-oriented services, efficiency treatment by reducing over treatment or under treatment, and team services (Miller, 2007). There are two methods of NHI payment in the hospital, retrospective payment and prospective payment. Retrospective payment method is payment method based on health care activities that brought to patient. Fee For Services payment system is an example of retrospective payment method. The much health services received the much cost that have to be paid. Prospective payment method is a payment method on health services wich amount is already known before the health care given. The examples of this method are global budget, capitation system, and case based payment system. Prospective payment method is a payment system that implemented in NHI with case based groups system payment called Indonesian Case Based Groups (INA-CBGs). The advantages and disadvantages of this payment system is given in table 1.

Table 1. The Advantages and Disadvantages of Prospective Payment Method

	Advantages	Disadvantages
Provider (Hospital)	Equity payment based on complexity of services	Low qualification in coding makes differentiation in case grouping
	Efficiency claim process	
Consumer (Patient)	High quality of health care	Reducing quantity of services
	Opportunity to choose the best quality of health care	Provider referring to other hospital
Insurance Agency (BPJS)	Sharing of financial risk with provider	Establish prospective concept and its implementation
	Lower of administrative cost	Monitoring pasca-claim
	Encourage information system development	

Prospective payment that performed by INA-CBGs is regulated in Minister of Health Regulation No. 27/2014 and No.59/2014. There are 155 cases that already agreed for the services cost. The aim of INA-CBGs is to gain the effectiveness services with reducing and over treatment (Indonesian MoH, 2014). Treatments for chronically ill, like diabetes, stroke, heart attack, and kidney failure is helped by this policy. NHI in many countries bring advantages for people as a social health insurance. Research shows that implementation of NHI in India bring the advantages especially for lower and middle economic income because it improve productivity with health assurance (Virk and Atun, 2015). In Taiwan, NHI is a form for gaining UHC could reduce curative services due to maximalization of preventive and promotive services (Chen, Peng, Lee, and Liu, 2015).in addition, in Korea NHI also covered people in traditional medicines, such us acupuncture, cupping, and herbal preparation (Lim, Byungmook, 2013). The purpose of the UHC is for humanity so it need humanity efforts (Ooms, Marten, Hammond, Mulumba, 2014).

However, in the first year of NHI implementation, January 2014, BPJS faced deficit financing with amount about 2,6 Billion. It came from the activity of fraud and moral hazard that detected during and after health care services between the provider, consumer, and insurance Agency it self. As state in table 1 that NHI with prospective payment can bring the reducing quantity of services because of the relationship between doctor and patient. Provider referring to other hospital which mean the first provider do not take the lost from cases that low cost than the actual cost. NHI also need monitoring in pasca-claim process, it means that there is opportunity to manipulate accounting in claim process.

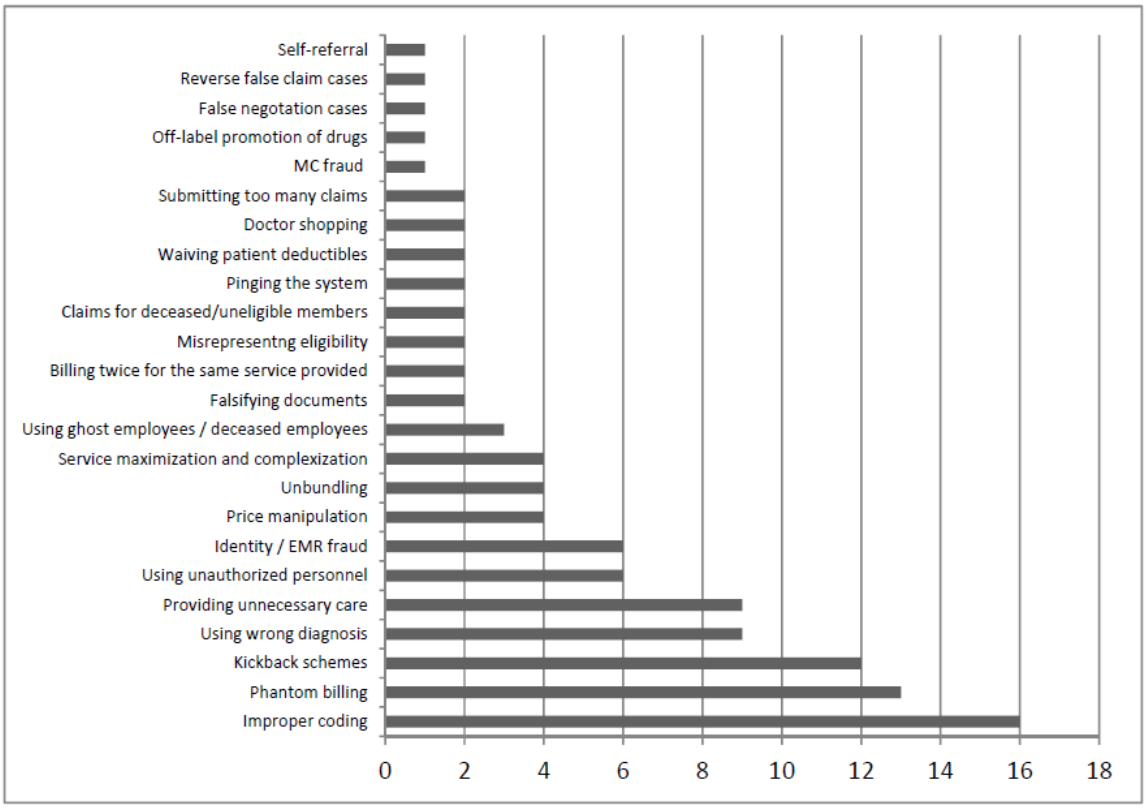
The purpose of this paper is to interpret the fraud phenomenon comes from NHI implementation. The authors first discuss what NHI means, or should mean from a right to health perspective, with a focus on health financing. In the next section the relationship between BPJS as an insurance agency, hospital as a health provider and patient as a customer is discussed. Finally the fraud detection in the implementation of NHI between the subjects is in the next discussion.

2. Literature Review

Fraud is the phrase used to describe a situation when an employee of business entity steals, misappropriates or embezzle money or other resources. Anybody in the position of stealing ranging from unit managers to accounting clerks or chief financial officer can perpetrate this kind of fraud (Rasuli, 2000). Categories or types of accounting fraud there are; (1) payroll fraud, this fraud whereby payroll staff create dummy or ghost worker that receives pay regularly. This type of accounting fraud is common in regularly. (2) Invoice fraud, here employees duplicate the invoice of their employer and occasionally issue them in the name of legitimate customer or services provider.(3) Accounts payable fraud, this is an extension of invoice fraud. The difference is that the perpetrator of the accounting fraud connives with fake company or creates a dummy company that never existed, and then make claims for payment and goods services that were never delivered. (4) accounts receivable fraud, this is situation where one or more employees arrange to divert money or cheque that is meant to go in to the company accounts in to their personal account. It is important to note that this type of fraud is much more difficult than others as it is not easy to perpetrate. (5) Financial statement fraud, it is a high level fraud that is mostly perpetrated by top management staff. The main motive behind this type of fraud is to present a falling company as being profitable as this will greatly influence the perk that the managers will receive at the end of the day. (6) tax fraud, it is a type of accounting fraud whereby directors of company misrepresents financial facts in the bid to hide profit. The ultimate aim is to avert paying taxes to the appropriate tax authority. According to Cressey (1973) fraud can be occurred with three factor, it is called fraud triangle, perceived unsherable financial need, perceived opportunity, and rationalization.

Extent of accounting fraud; the scale and optimal size of conspiratorial networks; the authorities‟ willingness to penalize it and the political and social factors that secured leniency; and inefficiency in the socialist market where managers competed for political credit (Harrison, 2011). Fraud also can be seen in all insurance types including health insurance. Fraud in health insurance is done by international deception or misrepresentation for gaining shabby benefit in the form of health expenditures (Kirlidog and Asuk, 2012). In health services, fraud exist in many forms: from dishonest provider, organized criminals, colluding patient, and patients who misrepresent their eligibility for health insurance coverage. A healthcare program run by states with cost-share from the federal government, is

particularly susceptible due to its patient population and limited payer oversight as compared with commercial insurers. Sometimes the fraud may take place by the collaboration of the different entities. It may even been committed by the insurance company employees. In turkey experience, fraud is occur in claim process, whose payable amounts are greater than the invoice amounts that insurance company will pay. The types of health care fraud is shown in figure 1.



Source; Thornton, Brinkhuis, Amrit, and Aly, 2015
Fig.1 Incidence of health insurance fraud types in literature

3. Method

This research was a qualitative case study of NHI in Indonesia in micro environment, private hospital, and used phenomenology-interpretive approach. Phenomenology-interpretive approach is interpreting the phenomenon that occurs with the timing, history, and mapping. There are six phases in the interpretive process; (1)framing the research question, (2) deconstruction and critical analysis of prior conceptions of the phenomenon, (3) capturing the phenomenon, including locating and situating it in the natural world and obtaining multiple instances of it, (4) bracketing the phenomenon, reducing it to its essential structures and features may be uncovered, (5) construction, or putting the phenomenon back together in terms of its essential parts, pieces, and structures, and (6) contextualization, or relocating the phenomenon back in the natural social world (Denzin, 1989). This interpretive paper draws on in-depth interviews of key informants and active participation. The key informants are manager of NHI-patient services, internal stakeholder in hospital, and NHI-Patient. Interviews were tape-recorded and transcribed after obtaining consent from interviews. This research was conducted in one of private hospital in Indonesia in Mei-August 2015.

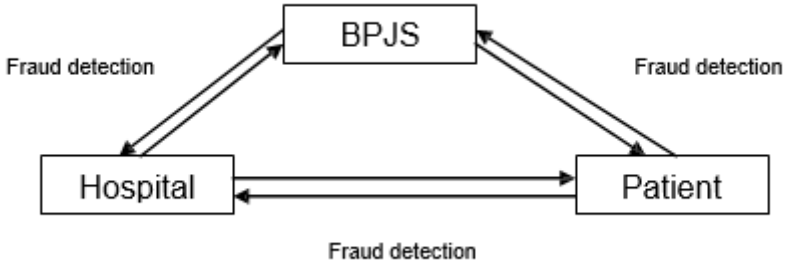


Figure 2. Theoritical Framework

Figure 2 inform the theoretical framework of this research. Fraud was detected in the relationship between hospital and BPJS, BPJS and patient, and also Hospital and Patient. They have their own interest at this point of fraud. But in this paper the researcher focus on detecting fraud in Hospital-BPJS relationship. Fraud is a multifaceted phenomenon, whose contextual factors may not fit into a particular framework. Consequently, the fraud triangle should not be seen as a sufficiently reliable model for antifraud professionals (Lokanan, Mark, 2015)

4. Result and Discussion

The relationship between BPJS and Hospital is a provider and insurer relationship. As a provider, hospital will claim health care services cost to the insurer, BPJS. Fraud may occur when the hospital wants to take profit from the quarrel of INA-CBGs cost and actual cost. However, BPJS will pay as a stated in INA-CBGs whether the actual cost is lower or higher. This condition may led fraud such us limitation of the services to patient, self - referrals, and improper coding.

The limitation of the services is one of NHI fraud. Because of fix cost is already given in INA-CBGs, hospital take the policy for saving it from loses including make a limitation of the healthcare services. This limitation make patient unsatisfied with this condition, the researcher also found that there are 36,4% out-care patient is satisfied with this limitation and 63,6% is unsatisfied. As said by the informant, patient (Lh, 43)

"there is a quota for the patient in a day for the some specialist doctor. It makes me have to come over again in the day after and again till I get the permit to see the doctor. And also in a day we just allowed to take the health services not more than Rp. 400.000 in a day. I don't know why, so if there is a receipt that in amount more than the limit, we have to make it in different day"

Self-referrals "referring the patients to a clinic, diagnostic service, hospital etc. with which the referring physician has a financial relationship." This might involve a kickback scheme if the referred-to party pays a commission back to the physician, but other financial relationships are conceivable. For example, many physician groups and hospitals are sustaining through growing. While some economies of scale are achievable through growth, referrals within the same financial organization are becoming normal and accepted practices that typically elude significant audit scrutiny.

Improper coding, sometimes called upcoding, is one of the most discussed and prevalent fraud topics. Upcoding as a "billing for a more expensive service or procedure than the one performed." improper coding, which differentiates as due to an administrative error versus a

malicious attempt to increase revenue. When it comes to submitting claims not only improper coding practices can be fraudulent, but also care providers can try to submit the same claim multiple times, in order to get paid two times for performing one action. Double-billing as "billing multiple times for the same service." Automatic acceptance of claims is mostly done to improve processing speed, however, for true efficiency not only speed matters. Tests for legitimacy are just as important. According to INA-CBGs and regulation of Indonesia Ministry of Health No.27/2013 there are two types cases in coding activity, primer diagnosed and secondary diagnose that can disappear one another in different cases (Indonesian MoH, 2013). As stated one of coder in claim unit (Sr, 28):

"There are so many regulation especially about this payment system through INA- CBGs. There is different cost depend on the individual cases. In addition, if the services of in-care patient is higher from the NHI-Class they has paid, there will be a charge to them."

It may also happen that more healthcare is provided than was actually needed to heal the patient; thus providing unnecessary care. Sometimes certificates are falsified to show the medical necessity of certain actions in order to justify payments. Maximizing the number of services and claims. The fee-for-service model means that physicians get paid based on the services they provided – maximizing the number of services means maximizing their pay. Outlier detection techniques have shown promise in detecting providers that differ from their peer groups. Other examples of unnecessary care include Rolling labs" which administer tests provided by health care providers that temporary visit shopping centers or retirement houses. These are simple test, but billed as expensive tests to insurance programs. Furthermore sometimes care providers use unproven treatments, which might not work in the end and thus result in unnecessary care provided.

Prospective payment as a managed care, as opposed to fee-for-service, represents a growing proportion of the US health insurance market. Within Medicaid, Managed Care Organizations (MCOs) now cover the majority of patients. This type of insurance mechanism theoretically passes risk from the primary payer to an intermediary insurer, which is paid on a capitated rate for the population they insure. Doctors participate either at-risk, also taking a capitated rate for their patients for certain services, or in a fee-for- specific-services arrangement. These changed incentives provides for new areas of fraud, including denial of services to patients, providing substandard care and creating logistical and/or administrative obstacles for patients in order to receive the care they need.

5. Conclusions

Fraud is the phrase used to describe a situation when an employee of business entity steals, misappropriates or embezzle money or other resources. Anybody in the position of stealing ranging from unit managers to accounting clerks or chief financial officer can perpetrate this kind of fraud. Fraud also can be seen in healthcare services. In NHI Implementation fraud probably happen in the triangle relationship of provider, BPJS, and Patient it self. Type of fraude are Self-refferals, Improper Coding, Over treatment, and Managed Care Fraud. Government must improve the policy by strengthening the

Controlling and evaluation function in National Health Insurance Implementation. Considering of the important of case-mix team suggested as the way to reduce fraud and moral hazard in this concern. In addition the existence of auditor will also considerable for the importance. Research found that The citizen as user of the financial information argues that the accountant and the auditor should take more responsibility for detection and dissemination of illegal acts to improve the efficiency and effectiveness of the audit process

(Abreu, 2015).Improve audit quality caused by fraud has been detected (Wang and Dou, 2014). It is also found that companies audited by large audit firms are less likely to commit financial statement fraud (Lisic, Silveri, Song, Wang, 2015).

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