Study to Review Existing Mass Health Insurance Schemes and Designing an Ideal National Health Insurance Scheme in India

By

Himanshi Batheja

Dissertation submitted for the partial fulfillment of the

MBA Hospital and Health Management

Academic year, 2016-2018

The IIHMR University, Jaipur

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INSTITUTE OF HEALTH
MANAGEMENT RESEARCH
(WHO Collaborating Centre for District Health System Based on Primary Health Care)

IIHMR UNIVERSITY

TO WHOMSOEVER MAY CONCERN

This is to certify that Dr. Himanshi Batheja student of MBA Hospital and Health Management from The IIHMR University, Jaipur has undergone internship training at AXA FRANCE VIE-INDIA REINSURANCE BRANCH from 05-02-2018 to 05-05-2018.

The Candidate has successfully carried out the study designated to her during internship training and her approach to the study has been sincere, scientific and analytical.
The Internship is in fulfillment of the course requirements.

I wish her all success in all her future endeavors.

Dean, Academics and Student Affairs
The IIHMR University, Jaipur

Piyusha
15/5/18

Professor
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Date: 10th May 2018

TO WHOM IT MAY CONCERN

The certificate is awarded to **Himanshi Batheja**, Management Trainee in the Claims and Investigation Department at AXA France Vie – India Reinsurance Branch in recognition of having successfully completed her dissertation from February 5th 2018 to May 5th 2018,

She has successfully completed her Project on "**Study on Different Mass Health Schemes and Designing an Ideal National Health Insurance Scheme in India**".

During the period of her dissertation programme, she was found punctual, hardworking and inquisitive.

We wish her good luck for all her future assignments.

For and on behalf of **AXA France Vie – India Reinsurance Branch**

Pankaj Tomar
Chief Underwriting Officer

DECLARATION

I do hereby declare that I am a student of MBA in Hospital and Healthcare management, IIHMR University, Jaipur, Rajasthan session 2016-2018.

I would like to state that I have carried my dissertation on the topic "A Study to review existing Mass health insurance schemes and designing an Ideal National Health Insurance scheme in India at Claims and Investigation department of AXA France VIE-India Reinsurance Branch for the fulfillment for the degree of MBA in Hospital and Health Administration.

This project work is my own and has not been submitted to any of the other Institute or University for the purpose of award of any degree or diploma.

Himanshi

Dr. Himanshi Batheja

IIHMR University

(2016-2018)

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Dr. Himanshi Batheja

IIHMR University

(2016-2018)

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Introduction: If one is to compare the health indicators of India from those that are present worldwide, the picture that will emerge is going to be dismal. The progress in health from the weak starting position in 1947 has been tremendous but still not enough. The government has recognized the need for a reform and has introduced several of these in the eleventh and the twelfth five-year plans.

Both the public and the privatesectors have played an important role today in improving access to the quality of the healthcare sector in India, but still the country lags behind than other countries. The presence of inequalities in India further exacerbates this problem. The inequalities are both demographic and geographic in the context of India. The Govt. will have to take bold steps to correct these issues. Health spending, as a proportion of the GDP will have to rise while collaboration between the public and the private sector is the only way by which the said improvements in infrastructure and general healthcare can be addressed.

Literature Review:India started on her unending quest, at the stroke of the midnight hour on 15th August 1947 and her journey since then has been one that has been carefully followed by multitudes of people across the globe. Today India stands as the 3rd largest economy (based on gross domestic product estimation in terms of purchasing power parity) and has come a long way since independence. During this time the country has seen tremendous improvements in its healthcare sector. An average Indian today, at birth has a life expectancy of 66 years, which is nearly double of that of an individual living in the decade following India's independence. India has successfully eradicated epidemic causing diseases such as smallpox, guinea worm and polio.

In the field of health infrastructure, India has come leaps and bounds, with the country today having nearly 2.5 million primary, secondary and tertiary healthcare institutions compared to the uninspiring number of 10,000 such institutes that we had in 1951.

Evolution of healthcare in India

1946	**Bhore Commission** Bhore commission was an important landmark in public health in India. It initiated the concept of integrated development & comprehensive health care.Also, the idea of primary health care owes its inception to this committee. This further led to the three-tier pattern of health care services.
1952	**Primary Health Centers (PHC)** Following the acceptance of report of Bhore Committee by rulers of

	the newly independent country, in 1952 there was an initiative to setup PHCs to provide integrated promotive, preventive, curative and rehabilitative services to the entire rural population, as an integral component of wider Community Development Programme. **National Programme Emphasizing Family Planning** In the same year, India also became the first country to launch a national Programme emphasizing family planning to stabilize the population at a level consistent with the requirement of national economy.
1970s	**Country Implements Vision of Sokhey Committee to have one Community Health Worker per 1000 people** The convulsive political changes that took place inthe 1970s impelled the Central Government to implement the vision of Sokhey Committee of having one Community Health Worker for every 1000 people to entrust 'people health on people's hand'. India has come quite close to Alma Ata (Health for All) Declaration on Primary Health Care made by all countries of the world in 1978.
1982	**National Health Policy for Architectural Correction** In 1982 the government made a major move in health politics by coming up very sharply against the health work done in the country in last 35 years. National Health Policy gave a general exposition of the policies, which required recommendation in the circumstances prevailing at that time in the health sector.
1985	**Universal Immunization Programme (UIP)** This program was to provide universal coverage of infants and pregnant women with immunization against identified vaccine preventable diseases.
1992	**UIP strengthened becomes Child Survival and Safe Motherhood (CSSM) Project** The strengthened UIP was to sustain the high immunization coverage level reached by the UIP, and augmenting activities under Oral Rehydration Therapy, prophylaxis for control of blindness in children and control of acute Respiratory infections. Under the Safe Motherhood component, training of traditional birth attendants, provision of aseptic delivery kits and strengthening of first referral units to deal with high risk and obstetric emergencies were taken up.
1997	**Reproductive and Child Healthcare Program (RCH)** This program incorporated child health, maternal health, family

	planning, treatment and control of reproductive tract infections and adolescent health.
2005	**RCH Phase II** RCH Phase II aimed at being a sector-wide, outcome-oriented program with an emphasis on decentralization, monitoring and supervision, to bring about a comprehensive integration of family planning into safe motherhood and child health. There was a differential approach for Empowered Action Group (EAG) and non-EAG states with improved ownership among states with dedicated structural arrangements to improve program management. **National Rural Health Mission** The National Rural Health was a program undertaken by the Government to honor it's political commitment to rural health and access to primary health. NRHM was also a strategic framework to implement the National Health Policy 2002. It adopted key guidelines given in National Health Policy 2002, e.g. equity, decentralization, involving Panchayati Raj Institutions (PRIs) and local bodies in owning primary health care management, strengthening primary health care institutions and suggestions for generating an alternate source of financing. The NRHM subsumed key national programmes, namely, Reproductive and Child Health-2 (RCH-2), National Disease Control Programmes and Integrated Disease Surveillance Project. The mission covered the entire country, with a special focus on 18 states, which had a relatively poor infrastructure. These included all 8 Empowered Action Group (EAG) states viz. Uttar Pradesh, Madhya Pradesh, Rajasthan, Bihar, Orissa, Uttaranchal, Chhattisgarh and Jharkhand; 8 North East States besides Jammu and Kashmir and Himachal Pradesh
Since 2005	**Multiple health schemes by India for the health sector** • Setting up for department of AYUSH (Ayurveda/Yoga/Unani/Siddha/Homeopathy) (2003) • The Entire country being covered under DOTS since 2006 (Direct Observed Treatment-Short course) by the RNTCP (revised national tuberculosis plan 1992) • National AIDS Control Programme Department of Aids Control (National AIDS Control Organization) • National Cancer Control Programme • National Filaria Control Programme • National Iodine Deficiency Disorders Control Programme • National Leprosy Eradication Programme • National Mental Health Programme • National Programme for Control of Blindness

	• National Programme for Prevention and Control of Deafness • National Tobacco Control Programme • National Vector Borne Disease Control Programme (NVBDC) • Pilot Programme on Prevention and Control of Diabetes, CVD and Stroke
2008	**Rashtriya Swasthya Bima Yojna (RSBY)** RSBY launched by Ministry of Labour and Employment is a health-financing scheme to provide health insurance coverage for Below Poverty Line (BPL) families. The objective of RSBY is to provide protection to BPL households from financial liabilities arising out of health shocks that involve hospitalization. Beneficiaries under RSBY are entitled to hospitalization coverage up to INR 30,000/- for most of the diseases that require hospitalization. The Government has fixed the package rates for the hospitals for a large number of procedures. Pre-existing conditions are covered from day on e and there is no age limit. Coverage extends to five members of the family which includes the head of household, spouse and up to three dependents. Beneficiaries need to pay only INR 30/- as registration fee while Central and State Government pays the premium to the insurer selected by the State Government on the basis of a competitive bidding.

While statistically, India has progressed well on some basic health indicators during the last 60 years since Independence, it lags very much behind other developed and emerging economies like the BRICS countries. In the World Health Organization's rankings of National Healthcare Delivery Systems , India finds itself a very low rank of 112 along with Sub-Saharan countries and even behind Bangladesh that is at position 88.

Health & demographic indicators of India

	1951	1981	2000	2012
Demographic Indicators				
Life expectancy [years]	36.7	54.0	64.6	66.0
Crude birth rate [per mile]	40.8	33.9	26.1	19.9
Crude death rate [per mile]	25.0	12.5	8.7	7.9
Infant mortality rate [per mile]	146.0	110.0	70.0	44.0
Maternal mortality rate [per 0.1 million]	–	470.0	390.0	190.0
Epidemiological Shifts				
Malaria [millions]	7.5	2.7	2.2	1.1
Leprosy [millions]	38.1	57.3	3.7	1.1
Smallpox	>44,887	Eradicated	Eradicated	Eradicated
Polio	NA	29,709	265	Eradicated
Infrastructure improvement				
SC/PC/CHC	725	57,363	1,63,181	1,76,820
Dispensaries and Hospitals	9,209	23,555	43,322	66,870
Beds (Pvt. and Public)	1,17,198	5,69,495	8,70,161	13,76,013
Doctors (Allopathic)	61,800	2,68,700	5,03,900	61,20,000
Nursing Personnel	18,0 54	1,43,887	7,3 7,000	9,00,000

World Health Organization, Health Indicators 2013

According to WHO, 35% of the population has no access to essential drugs while 45% of the children below five years of age are malnourished. 3% of the population slides under the below poverty line every year due to the crushing burden of healthcare costs. There are many other indicators that paint a very grim picture of the healthcare in India.

Thus, India has a long way to go in the area of healthcare, and for achieving the millennium development goals and universal health coverage a lot more has to be done in the country.

Objectives:

1. To compare the existing state mass health scheme running in the country.
2. To study the type of frauds occurring in the different mass health schemes which reduces its scope of operation and recommending strong Fraud mitigation methods to reduce the same.
3. To determine the need for health insurance and proposing an Ideal Health Insurance Scheme in the country.

Methodology:

1. Study Design: The study is descriptive and exploratory in nature. In this study a comparative analysis was undertaken by comparing the National Health Insurance scheme of various states. Process of implementation, current challenges, types of frauds existing with the insurance schemes and designing of ideal universal health insurance scheme
2. Setting: Axa France branch office, New Delhi
3. Duration: February to May 2018(3 months)
4. Data collection procedure: Secondary data was collected on individual schemes from the various respective records, tender guidelines, RFP and Addendum, official records, various publications by researcher and electronic data from respective official website of various health insurance schemes.
5. Data analysis: Data was analyzed with the help of advanced Microsoft excel function on the type of frauds seen in different mass health insurance schemes.

Observations and Findings:

Health Insurance Model: A Budding Seed in India

Health insurance is insurance against the risk of incurring medical expenses among individuals. By estimating the overall risk of healthcare and health system expenses, among a targeted group, an insurer can develop a routine finance structure, such as a monthly premium or payroll tax, to ensure that money is available to pay for the health care benefits specified in the insurance agreement. The benefit is administered by a central organization such as a government agency, private business, or not-for-profit entity.

Over a period of last few decades, health insurance has tremendously evolved in India. In order to gauge the evolution of health insurance in India, important milestones achieved in the sector since its inception are indicated.

Evolution of health insurance in India

1938	Insurance act recognizes two categories: life and non-life insurance
1954	Central Government Health Scheme providing health coverage to employees of central government employees
1986	General Insurance Corporation of India (GIC) introduced medi-claim insurance policy
1999	Insurance Regulatory and Development Authority (IRDA) Act passed
2001	IRDA introduced provisions for TPA system in health insurance. Nine private general insurance companies get registered with IRDA
2003	IRDA sets up a National Health Insurance Working Group to identify existing problems in health Insurance industry
2006	First Standalone Health insurance company came into the business with a capital requirement of Rs100 crore
2007	The insurance market was de-tariffed. Earlier 70 percent of the General Insurance business was driven by various tariffs. In a tariff driven market, the leverage for taking flexible decisions regarding the pricing based on the merit of individual risk was virtually nil
2010	Offers cashless medical treatment to bring discipline to the pricing of hospital services. The health insurance market continues to be dominated by the four state-owned general insurers, which together

	accounted for almost 60 percent of the premiums
2011	Portability of health insurance policies by IRDA allowing policyholders to switch providers on the same policy terms, particularly without losing the credit gained for pre-existing conditions in terms of waiting period

Health insurance is protection against the financial damage caused by illness. In India, health insurance are broadly of 2 types -

I. Retail Health Insurance

Individual or family health product is purchased by an individual on the payment of a premium. The medical risk covered is for self or for a family on floater basis. Group health products are purchased by the employer for its employees and/or for their families. It is a broker and client-driven market.
To increase the market penetration different insurance companies have come up with different innovative features, some of them are illustrated as below-

Cardiac Care
The product aims at providing protection against the risk of damage caused by any cardiac ailment.
Policy Benefits

- Hospitalization Cover Protects insured for in-patient expenses for a minimum of 24 hours.
- These expenses include room rent, nursing and boarding charges, Surgeon, Anesthetist, Medical Practitioner , Consultants, Specialist Fees , Cost of Medicines and Drugs
- Ambulance charges for emergency transportation to the hospital as per specified limits
- Pre-hospitalization expenses up to 30 days prior to admission in the hospital
- Post-hospitalization paid as lump-sum upto the limit specified
- 101 Day-care treatments covered
- Cardiac ailments covered after 90 days.

Senior Citizen Care
The product aims at providing coverage against financial damage caused by diseases specific to old age.
Policy Benefits

- Hospitalization Cover Protects the insured for in-patient hospitalization expenses for a minimum of 24 hours.

- These expenses include room rent, nursing and boarding charges, Surgeon, Anesthetist, Medical Practitioner , Consultants, Specialist Fees, Cost of Medicines and Drugs
- Post-hospitalization paid as lump-sum upto the limit specified
- Pre-existing diseases are covered after 12 months
- Co-payment - 30% for other than claims for Pre-Existing Diseases and 50% for Pre-Existing Diseases claims.

Automatic Restore Plan

The policy automatically reinstates the basic Sum Assured, if exhausted. Also, basic sum insured increases by 50% for first, claim free year and if second-year also goes claim free, the company doubles the basic sum assured.

Policy benefit

- Pre/Post Hospitalization
- 100% Lifelong renewal
- No sub limits on room rent and no geography based sub-limits
- No claim based loading & health line support for any time medical assistance.
- Pre-hospitalisation covered up to 60 days and post-hospitalization covered up to 180 days
- Enlisted 140-day care procedures covered.

Comprehensive Health Product

This is a comprehensive healthcare product.

Policy Benefits

- 101 day-care procedures covered.
- Maternity expenses covered for delivery, treatment of newborn and vaccination expenses.
- Covers expenses for outpatient dental and ophthalmic treatment.
- Health check-up benefit becomes payable if the policy is continued for 3 claim free years.
- Cover to HIV positive Individuals provided the CD. 4 count at the time of entry is above 350.

Add on covers

- Automatic restoration of sum insured if exhausted, once by 100% for the remaining policy period.
- 20% of co-payment is applicable for the insured above 61 years of age.
- Claim loading clause - If the claim ratio exceeds 100% in two consecutive years, premiums may increase by 20 to 50% in the subsequent years.

Distribution Channels of health insurance

1. **Agents & Brokers**

   Among all the distribution channels, to large extent agents take the lion's share and shows a high level of penetration in several countries. Recent Trends show a

slight decrease in the market share of agents in most markets. This is closely linked to diversification by insurers: on one hand, there are new distribution channels such as bancassurance and the internet and, on the other hand, insurers have embarked on a multichannel strategy that is eroding the market share of the leading distribution channels. The proportion of tied and multi-tied agents varies widely from country to country according to local practice and national legislation. Brokers remain much less important than agents in most countries.

2. Bancassurance

The provision of insurance products by banks or lending institutions. The bank or lending institution may act as an insurance agent, bank employee or insurance broker.

Bancassurance is not very well developed in non-life insurance and represented less than 10% in all countries.

However, the development of bancassurance in life insurance does not guarantee the success of this channel in the non-life market

3. Internet and telemarketing

The development of new channels such as internet and call centers in parallel with the retention of traditional networks such as agents and brokers demonstrates the desire of insurers for multichannel strategies to reach clients. This strategy is made necessary by the growing volatility of purchasing by customers

II. Micro health insurance schemes for BPL families sponsored by Government

Micro health insurance schemes are sponsored by government and are for the poor population of the country. India currently does not have expertise in OPD coverage under such schemes. Currently, the country lacks the capacity for drug procurement so the cost for OPD cannot be controlled. In the United States, OPD coverage was the major reason for the failure of Government insurance scheme. Insurance schemes globally have never been a successful partner to efficiently manage OPD.

Evolution of Micro Health Insurance

Year of inception	Micro insurance Policy
2003	• UHIS - Universal Health Insurance Scheme • Yashashvini Health Insurance Scheme (Karnataka)
2006-07	• Weavers and Artisans scheme (Textile Ministry) • Rajiv Aarogyasri Scheme (Andhra Pradesh)
2008	• RSBY (Rashtriya Swasthya Bima Yojana)

2009	• Kalaignar Scheme (Tamil Nadu)
2010	• RSBY Plus (Himachal Pradesh) • Vajpayee Arogyasri Scheme (Karnataka)
2011	• CM's Comprehensive Health Insurance Scheme (Tamilnadu) • Rajiv Gandhi Jeevandayee Arogya Yojana (Maharashtra)

Reach of Health Insurance

Total penetration has been markedly better since 2000. Life industry penetration level is on the downward path since 2010; 5.10 percent in 2010 to 4.10 percent in 2011. However, throughout 1990 to 2011 non-life insurance has remained remotely stagnant and ranged around 1% for these years.

Approximately 6% of insured householdshave health insurance with much about 1.3 % difference between urban and rural backdrops. Only 5.27% of insured rural households have health insurance despite the prevalence of government health insurance mass schemes. Amongst the uninsured population, a meager 0.49% has opted for health insurance. Interestingly, motor insurance remains a key preference for both insured and uninsured households with 30.90 % and 6.13 % of the group opting for it, respectively.

The increased penetration with the opening up of the sector in 2000 gives a clear indication that the private and the foreign players & re-insurers have the ability to enhance the size, structure and participation in the insurance market worldwide. India has one of the lowest penetrations of non-life insurance when compared internationally, with little to no growth since 2010-11. Sitting at 0.7% penetration rate, such a low and uneven development of insurance implies high risk in economic decisions taken by individuals and firms, therefore, fastening up the insurance sector to make it competitive at global level.

The hallmark of Indian healthcare industry has been the formation of various healthcare delivery services both at the state level and national level. Its main objective is to have one central healthcare organization to deliver a wide range of health services. From the standpoint of integration, major players or participants in healthcare delivery system are hospitals, insurers and Government.

Awareness of Health Insurance

The proportion of households aware of health insurance is a little more than half, both in rural and urban areas. Awareness regarding health insurance remains a challenging issue and one that provides huge scope for improvement if tackled properly. There is also no significant difference in perception between rural and urban households. In general people aware of health insurance understand that it covers benefits for illnesses.

A particularly disturbing observation is the lack of knowledge of the cashless facility. Penetration remains limited, policyholders' knowledge about insurance policy remains constrained. Level of awareness of health insurance is limited in Rajasthan, Bihar, Sikkim, Karnataka, Haryana, Himachal Pradesh, while is satisfactory in Uttarakhand, Mizoram and Andhra Pradesh. However, there are many impediments such as lack of awareness and financial illiteracy, which are hampering the growth of the insurance industry.

Why insurance?

India has made significant gains in terms of health indicators - demographic, infrastructural and epidemiological, it continues to struggle with newer challenges. The country is now in the midst of a dual disease burden of communicable and non-communicable diseases. This is coupled with spiraling health costs, high financial burden on the poor and erosion in their incomes.

Treatment cost of an unexpected hospitalization might result in significant dwindling in a person's wealth and even lead to the bankruptcy of patient and family members in some cases. In the absence of risk pooling, individuals are exposed to the dangers of sudden illnesses swiping the bank accounts clean.

Healthcare systems across the globe can be assessed using the **Iron Triangle**: cost, quality and access. Prioritizing costs can lead to deterioration of quality and access and upgrading quality (an actual impediment in India) can increase cost burden. For putting in place an effective healthcare policy, India requires a sound balance in all three components of the Iron triangle.

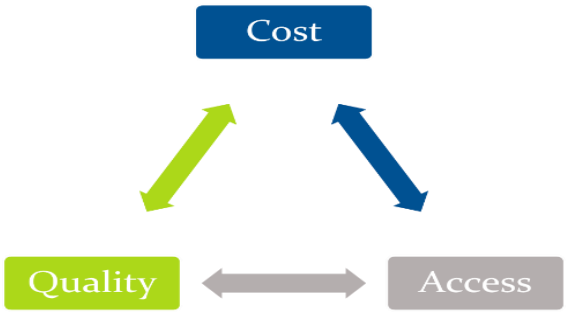

Figure 1: Iron Triangle

India stands at a critical juncture where it must realize the strengths and weaknesses of its delivery models and opt for a path that is a coalition of the best traits of both. While private hospitals boast quality world-class treatments, these treatments come with a price tag not affordable to most of the population.Contrarily, public hospitals provide accessibility at multiple levels and house affordable services but are plagued with dangerously low-quality medical services.

Only 25% of the population is presently covered with health insurance, giving huge scope of penetration to blanket untoward expenses arising out of unexpected ailments. It will be a win-win situation for beneficiaries, public and private companies. Significant upliftment in BPL will only occur if -patient costs and drug expenses are covered under health insurance.

Private healthcare systems provide high-quality services but involve equally high treatment cost. On the other hand, multiple levels in the organizational hierarchy of public health system lead to consultations on multiple levels for the same episode. This further augment cost and quality concerns. Moreover, issues with medical procedures account for a large share of adverse drug events. Overall deaths in India due to adverse drug reactions are estimated to be 400,000 annually. Given its high premiums, most medi-claim and similar policyholders belong to the middle and upper class.

Mass Health Schemes in India

All countries across the globe, both highly industrialized as well as low- and middle-income economies, clearly demonstrate the importance of achieving universal health coverage through. tax-based, social health insurance or a mixed of both. India has mostly adopted the mix approach. This section throws light onthe comparison of different mass health insurance scheme floated across the country and the key learnings of each scheme.

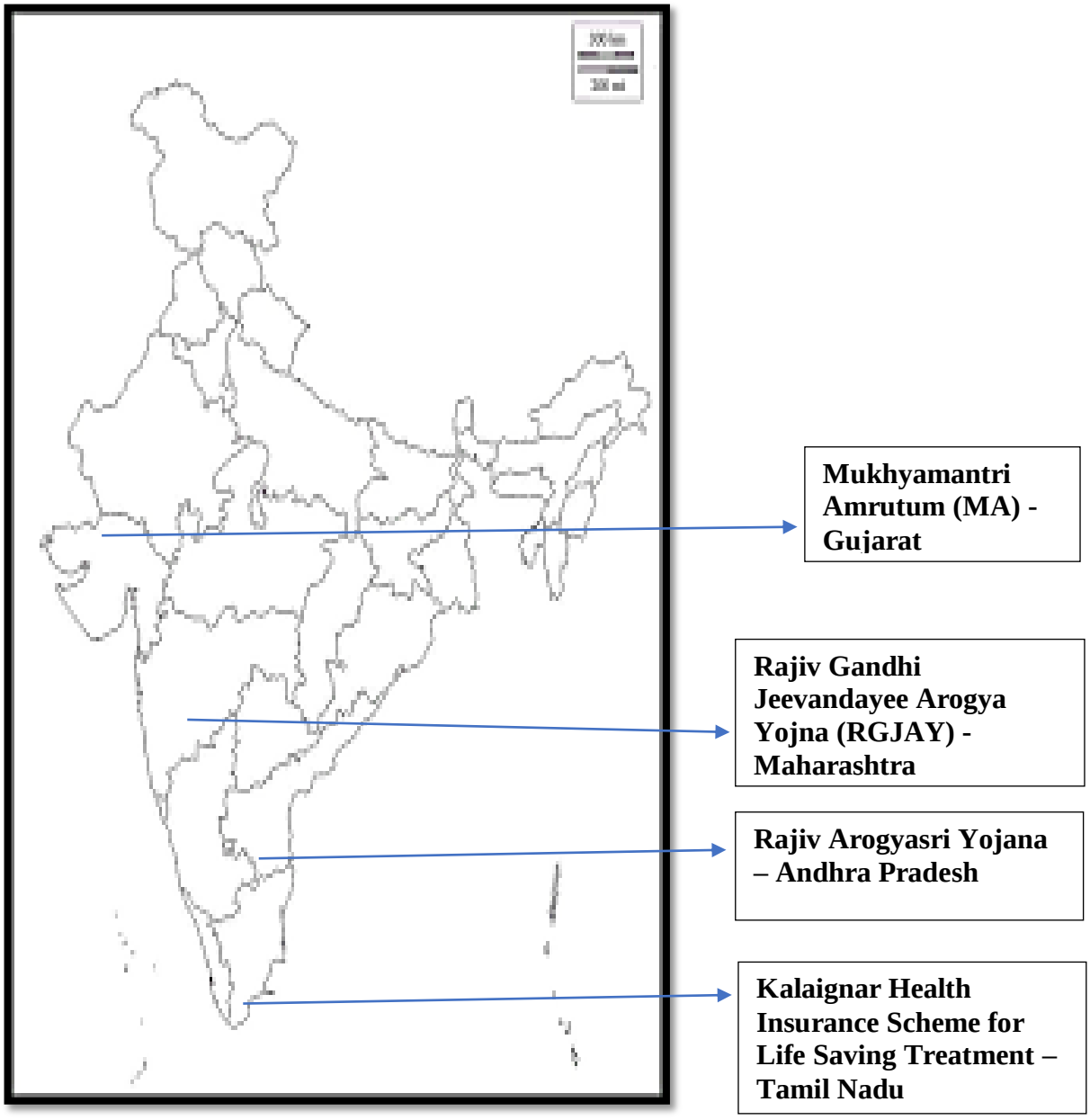

Figure 2: Map showing mass health policies running in different states

State health insurance scheme	Population covered	Sum insured	Enrolment process	Claim process	Grievance redressal system	Strength	Pitfall
Rajiv Arogyasri Yojana – Andhra Pradesh	233 lakh BPL families	1.5 lakh per annum with 50K buffer	BPL database of the civil supplies department of Governmen t of Andhra Pradesh	1. Aarogyamitra (health coordinator) appointed at each network hospitals 2. pre-authorization request sends to the Aarogyasri Health Care Trust 3. preauthorization request approved if the conditions are satisfied.4. The network hospital extends cashless treatment and surgery to the beneficiary.	Registration of the grievances online in the Aarogyasri module	Government restricted package	1.Exclusion of the most marginalized population such as the destitute, street dwellers and migrant laborers with no residential address and therefore ineligible for inclusion in the BPL population 2. Inability and inefficiency of the AHCT
Kalaignar Health Insurance Scheme for Life Saving	1.4 Cr families	1 lakh per annum (cardio thoracic surgery for	all members and families of various welfare boards as	pre authorisation send to the insurance company and	Absence of grievance redressal system	1.Everyone was covered under the scheme 2. Robust Enrolment process	1.The sum insured per family was too low to cover

Treatment – Tamil Nadu		INR 1.25 Lakh, double valve replacement & renal transplant with immune-suppressive therapy for INR 1.5 Lacs, polytrauma 2 Lakhs)	well as families having an annual income of less than INR 72,000/- per annum	claim processing done by medical approvers			treatment for critical illness2. There were excessive numbers of hospitals empaneled under the scheme3.Poor quality data
Rashtriya Swasthya Bima Yojana (RSBY) – India	3.5 Cr Families	30,000 per family per annum	1.The Insurer will get the BPL database from the state government 2. Enrolment schedule is prepared by insurance company and smart card is given to the enrolled beneficiary after	1.Beneficiary can visit any of the empanelled hospitals and avail treatment after verification2. The card is swiped and the treated package amount is deducted from the card	3 committees are formed DGRC,SGRC and NGRC	1.Cashless and paperless scheme2.High technology involved in enrolment and claim transaction	1.Coverage is too small, leaving the beneficiary exposed to the damage cause by advanced or critical illness2.Quality of enrolment data is not good leading to low enrolment and creating loophole for fake enrolment

			biometric identification and photograph				
Rajiv Gandhi Jeevandayee Arogya Yojna (RGJAY) - Maharashtra	2.13 Cr families	INR 1.5 Lakh(Renal Transplant INR 2.5 Lakh per operation as an exceptional package exclusively for this procedure)	All the families in the state holding yellow ration card, Antyodaya Anna Yojana card (AAY), Annapurna card and orange ration card are covered under the scheme	1.Beneficiary are identified by the health card at the empanelled hospital2.E-pre authorisation request sends to the insurer3.Payments are made to the hospital within 7 days after the reciept of the documents	Nil	1.121 follow up packages encourage the poor to complete the treatment for the disease and not to leave it before complete cure2.empanelment procedure based of NABH which focusses on improving the quality of healthcare received by the poor.	The scheme does not cover the secondary care due to which most of the secondary illness could not be addressed and the objective of financial protection of the poor remains unachieved
Mukhyamantri Amrutum (MA) - Gujarat	21 Lakh families	INR 2 Lakhs per BPL Family	For enrolment and updation of card taluka kiosk has been established	1.Beneficiaries would be identified by the Mukhyamantri Amrutum Plastic Card2.After the verification of the patient, the treatment will be cashless for all the covered procedures	3 committees are formed DGARC,MCAGRC and SEGRDC	1.Robust grievance redressal system for beneficiaries2. Limited number of hospitals3.Enrolments are done by Government subsidiaries or agencies	1.Provides only tertiary treatment2.Only limited specialties are covered

One of the biggest flaw in all the above-mentioned state mass health policy is that no strong measures for fraud mitigation was implemented in order to curb the malpractices done by the hospitals.

On reviewing the Government internal reports,it was found that the Fraud can happen at any step of the scheme implementation.

- At Enrolment Phase
  Printing of fake cards
    1. Involvement of hospitals in the issuance of smart card
    2. Issuance of smart card with same URN to more than one person with same name.
    3. Cards printed but not distributed to the actual beneficiaries, but sold to hospital
    4. Purchase of cards by the hospitals, directly from the beneficiaries
    5. Charging extra money for enrolling beneficiaries whose name is not in the data shared by Government

- At the level of Hospital empanelment

Various state/district officials have their vested interests for the empanelment ofhospitals even if sufficient numbers are already empaneled.

- At the level of Claims
    1. Surgical Packages blocked but no performance of operation.
    2. Card of a patient blocked but the patient was not found in the hospital
    3. Smart cards found in the custody of hospital without patient being admitted.
    4. Patients charged for diagnostics and medicines
    5. Claims are not uploaded by the hospitals within a stipulated time, in order to misguide the insurance company

Data was analyzed and following conclusions are made:

Most common Type of Frauds seen in Mass Health Policies at the time of claim submission are:

1. Impersonation
2. Fake Admission
3. Fake Surgical package/ Billing for services not rendered
4. Multiple Package Blocking/ Unbundling of Services
5. General Ward to ICU Conversion
6. Govt. Reserved Surgery done by Pvt. hospital under other allowed packages
7. Claiming higher package surgery but performing lower package surgery/Upcoding of services
8. Open to laparoscopic conversion for higher claim amount
9. OPD to IPD conversion
10. Admission in two different hospitals at the same time
11. Advance booking of surgical packages which are diagnosed during surgery / treatment(Ex: Adhesiolysis, Package of neonatal care)
12. Policy Violation by charging money from patient

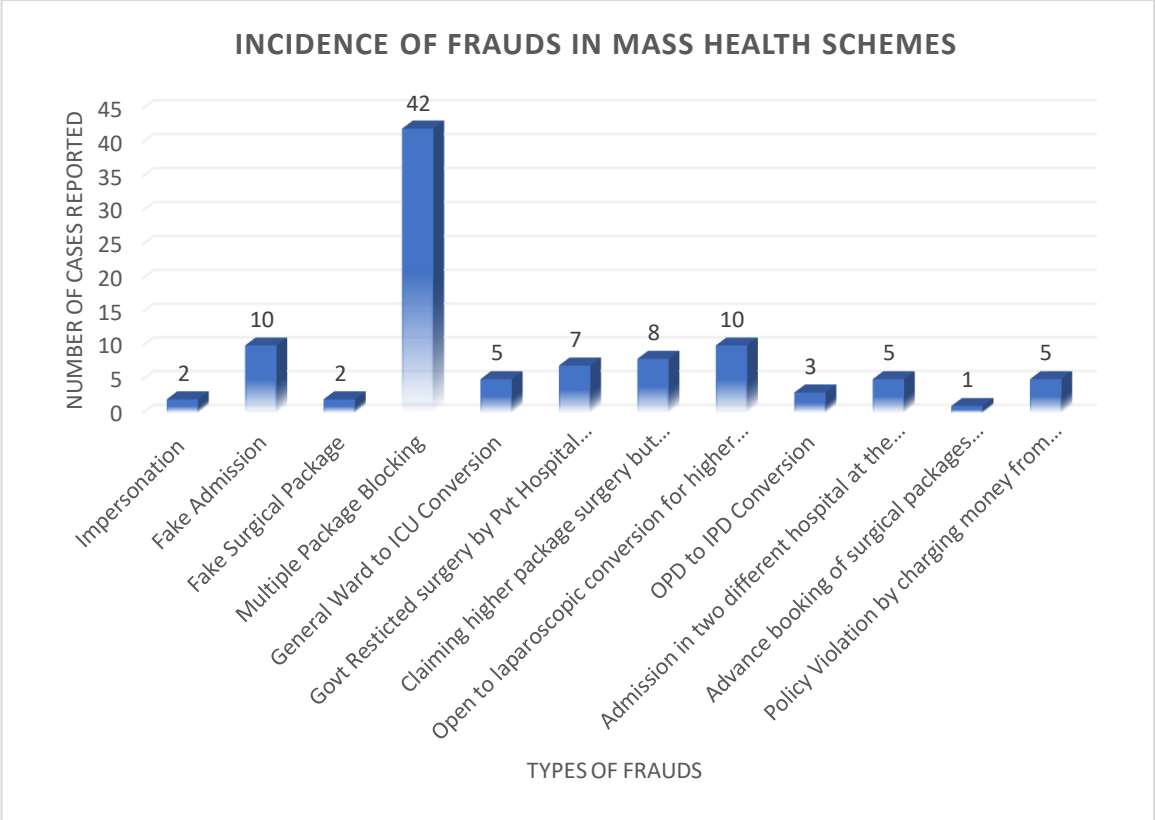

Figure 3: Chart showing the types of Fraud prevalent in Mass Health Schemes

INFERENCE: The Chart reveals that multiple package blocking is the most common fraud seen in Mass health Scheme.

Overview of Ideal Scheme

Below is the scheme, which if implemented can result in providing the much needed financial assistance in the time of crisis for the entire family and can act as a pivot of financial upliftment of the family.

Name of the Scheme	**National Comprehensive Health Insurance Scheme**
Policy period	The scheme to be enforced for 5 years All beneficiaries would have a common expiry date so that scheme performance could be monitored
Term of the cover	The contract of insurance to be in force for two years from the date of commencement of the scheme
Proposing & funding authority	Government of India
Beneficiaries	Universal healthcare coverage but to start with BPL population of the country 6.73 crore families (approx.)
Proposed definition of family	Family shall include the eligible members as detailed below: • Legal spouse of eligible person • Children of the eligible person till they get employed or married or attain the age of 21 years, whichever is earlier • Dependent parents of the eligible person Provided that if any person, in any of the categories above finds a place in NPR, then it shall be presumed that the person is the member of the family & no further confirmation shall be required Maximum number of family members should not exceed 5, and inclusion of members should be with the priority order of spouse, children & then parents
Indicative sums insured	• Secondary Treatment: INR 50,000 per family per annum • Tertiary Care: INR 2,00,000 per family per annum
Proposed benefits	• Secondary & Tertiary care treatment, with the minimum hospital stay of 24 hours should be covered • Pre-existing diseases covered - all diseases under the scheme will be covered from its inception

	• Pre- & post hospitalization is covered- 2-day pre-hospitalization and 3 days post-hospitalization • Cashless transactions • Travel allowance of INR 100 for the beneficiaries, maximum up to INR 1,000 as part of the overall limit and not in addition • Dialysis covered only upto the limit of INR 15,000/ family/year • Snakebite covered • AIDS patients covered for tertiary healthcare hospitalization
Implementing agency	Public sector insurance company only
Payment of premium	• 50% of the premium for total targeted families will be paid to the insurance company at the inception of enrolments • Remaining premium to be adjusted against enrolment done at the end of three months
Implementation strategy	• **Phase 1** covers only the BPL population covered • **Phase 2** covers APL population or the households with annual income less than INR 2, 00,000/annum" • **Phase 3** would cover households with annual income less than INR 5,00,000 • **Phase 4** would cover rest of the population
Maternity benefits	• All the empanelled hospitals to provide Janani Suraksha Yojana benefits under NRHM
Enrolment	Unique ID health cards, having biometric data (iris, fingerprint and voice), provided by the government agencies making use of the existing UIDAI and NPR data
Main exclusions	• Injury/disease directly or indirectly caused by or arising from or attributable to war, invasion, an act of foreign enemy, warlike Operations (whether war be declared or not) • Cost of spectacles & contact lenses, hearing aids, walkers, crutches, wheelchairs & such other aids • Convalescence, general debility, run-down condition or rest cure, congenital external diseases or defects or anomalies, sterility, venereal diseases, intentional self-injury and use of intoxicating drugs/alcohol • Injury or disease directly or indirectly caused by or

	contributed to by nuclear weapon/ materials
Technology	As far as possible, web-based software to be used (end to end) from enrolment to claims/call center management/generation of various reports etc. The Benefit of software are as below • Error-free transactions • Online access to each stakeholder • Real-time status available • Environment-friendly • Cost & time saving than the manual process

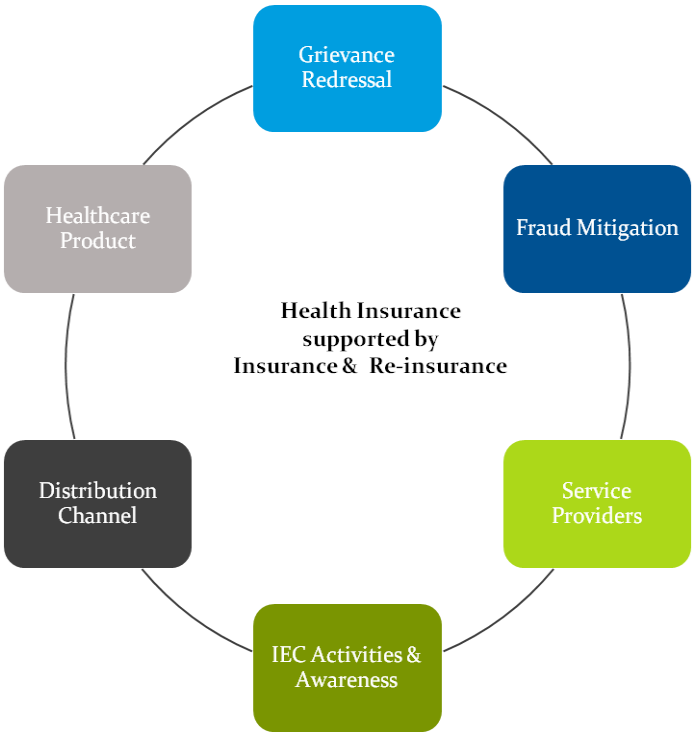

Figure 4: Components of a Successful Scheme

Strategy for Implementation and Role at each step

- Distribution Channel- Enrolment Process

- The enrolment process as a whole would be the responsibility of the government.
- For the same, NPR / UIDAI (Aadhar) to be linked with enrolments of the scheme. As three of them are government initiatives, it would be easy for the government to manage and monitor the process.
- A proper quality check to be carried out for the data pertaining to from NPR/ UIDAI, including printing of hard copies of enrolment form with the unique family ID of each family, along with beneficiary details like name of head of family, age, gender, complete address.
- NPR/UIDAI representatives would visit the beneficiary's door to door for enrolments. By Using the biometric details already captured for UIDAI, family would be allotted unique number.
    - Possibility 1- If the beneficiary is already holding a UIDAI number, details already captured for UIDAI would be used and entire family would be allotted a unique family number. Against that unique family number, biometric details of all the enrolled family members would be registered
    - Possibility 2- If the head of the family is holding a UIDAI but the family members he intends to enroll under the scheme are not registered in NPR or UIDAI, then the biometrics including retinal scan and other details would be recorded and registration would be done on the spot. Post registration the individual would be allotted his/her UIDAI number. Then after, unique family number would be issued to the family
- For availing health benefits, the beneficiary has to just produce his unique family number or UIDAI number at the help desk in the hospital. For cross verification and to ensure zero tolerance for fraud, beneficiary's biometrics (retinal scan & finger print) would be matched with the biometrics registered against the unique family id.
- At the time of enrolment, the beneficiaries would also be provided with a guidebook containing policy features, network hospitals, toll free numbers etc.
- This would save cost to Government and would lead to universal health insurance coverage as the government will be able to move to complete digitization of the beneficiary data
- Government will be able to analyze the scheme in a better manner. The categories to be added can be added within a short span of time using the UIDAI number
- The time duration required for the enrolment will be reduced

- IEC activities & Awareness

Awareness is an important component for the success of the scheme as the success ofparticular scheme can only be defined with beneficiaries being aware of the scheme benefits and having access to the same. This is contrary to the popular perception; the more aware beneficiary would help prevent leakages and frauds by various stakeholders
To increase the utilization of the scheme, well-structured awareness activities would be organized
The Information Education Communication activities would include

- Distribution of pamphlets describing scheme benefits
- Miking and announcements
- Focused group discussions
- Advertisements on radio & televisions
- Street plays
- Display of banners of the scheme

- Service Providers

Hospital Empanelment

- Geographically evenly distributed hospitals ensuring maximum penetration and enough volumes to an empanelled hospital in order to keep them motivated.
- The hospitals would be empanelled on the basis of score they get on the grading format.
- They would be categorized into 3 categories A, B & C on the basis of the specialty offered.
- Package rates would be negotiated with the hospitals and would reduce the cost to Government
- It would ensure transparency between all the stakeholders
- It would make the claim processing hassle-free and volumes would be quite high

- Cashless Claims Process

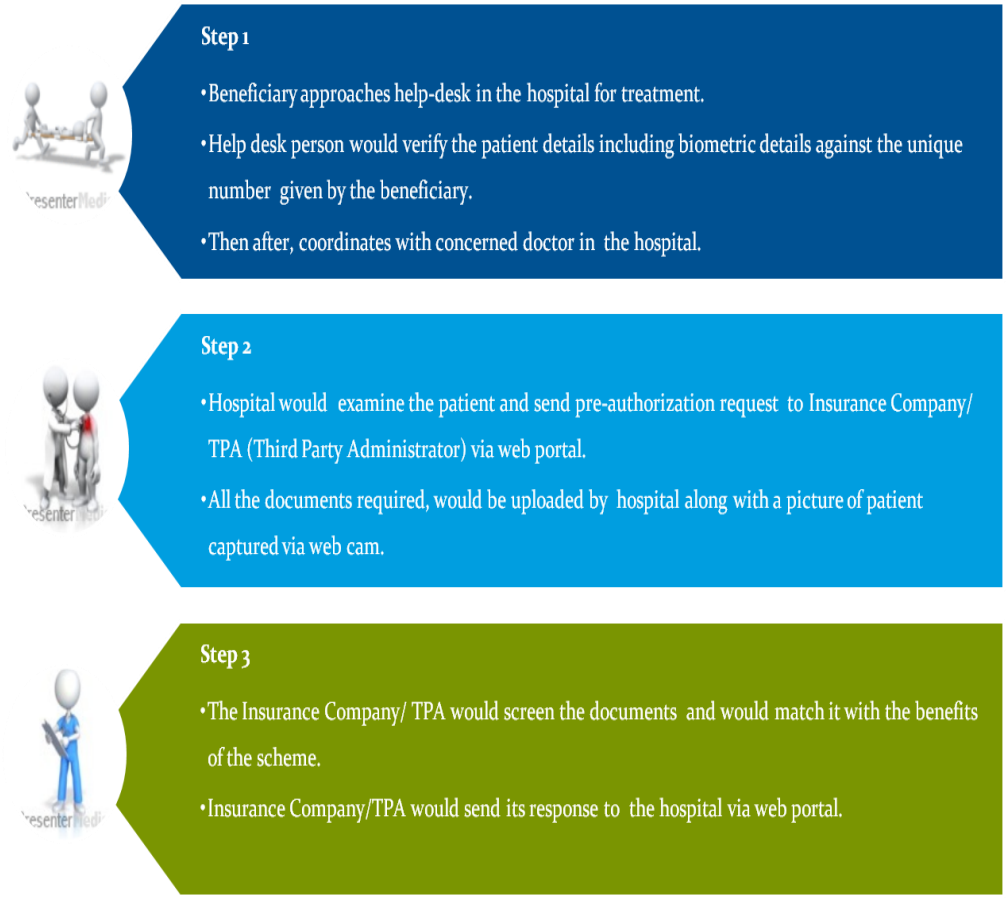

Figure 5: Claim Process Flow

- Fraud Mitigation

Frauds in healthcare insurance schemes can be defined as making money by deceitful ways. Defrauding beneficiaries and insurance company for making undue profit is a common purpose of fraud. Fraud is harming the health system across the world.

IRDA guidelines classify various insurance frauds as under:

- **Policyholder Fraud and /or Claims Fraud** - Fraud against the insurer in the purchase and/or execution of an insurance product, including fraud at the time of making a claim.
- **Intermediary Fraud** (Healthcare provider, agent, broker etc) Fraud perpetuated by an intermediary against the insurer and/or policyholders.
- **Internal Fraud** - Fraud / misappropriation against the insurer by a staff member.

As relevant to health insurance, the type of fraud committed by the customer, intermediary-agent, broker, healthcare provider either individually or jointly or in connivance with an internal staff of insurance company/TPA vary in nature and modus operandi.

Fraud Management & Prevention

- With the support of industry, regulatory and government bodies Autonomous anti-fraud bureau to be formed
- All TPAs and insurers should maintain and share their own lists of blacklisted providers
- Investigator training program should be conducted
- Ethics training should be imparted to all stakeholders
- Medical protocols and treatment guidelines should be formed
- Punishment should include
    - Banishment
    - Loss of reputation
    - Explanation of benefits (EOB) to the insured
- Public awareness regarding fraud should be made

Techniques to Detect & control fraud

- Data Analysis- Technology can be used for data analysis e.g.:
    - Automated fraud detection - red flags
    - Pattern recognition
    - Predictive modeling
- Medical Investigation
- Ground inspection

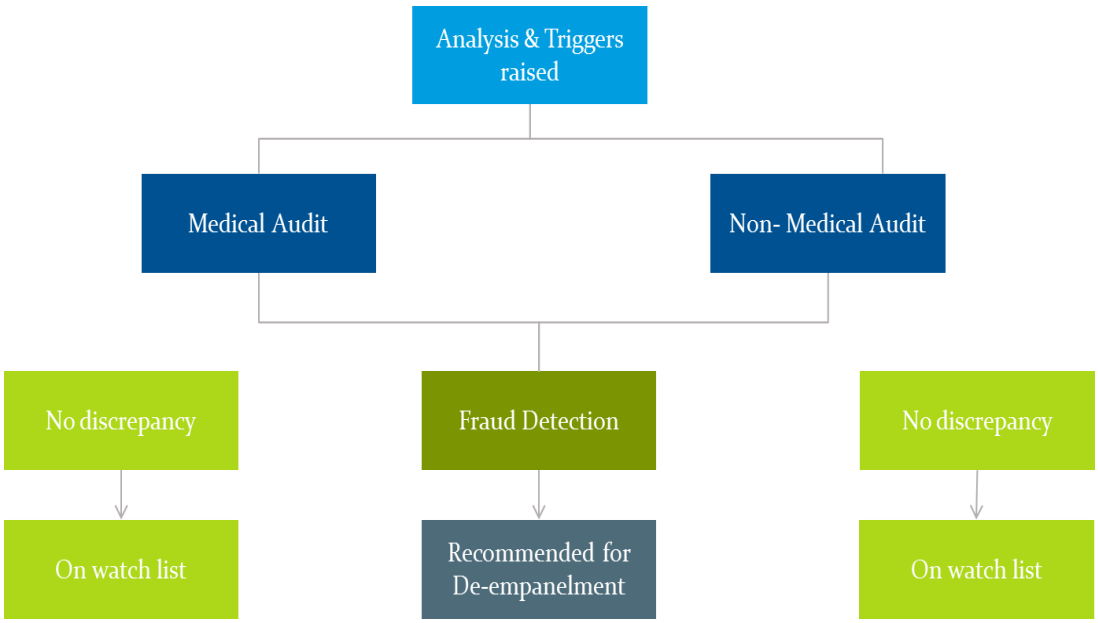

Figure 6: Fraud Mitigation Process Flow

- Management Information System
  Web based software will be used (end to end) from enrolment to claim, for call center management and generation of various reports

Benefit of web-based portal

- Error-free transactions
- Online access to each stakeholder
- Real-time status available
- Cost & time saving then manual process
- Tracking of all inbound calls received from insurer, customer or any other source
- Health insurance software generates different types of reports for stakeholders
- Claim status tracking and reports

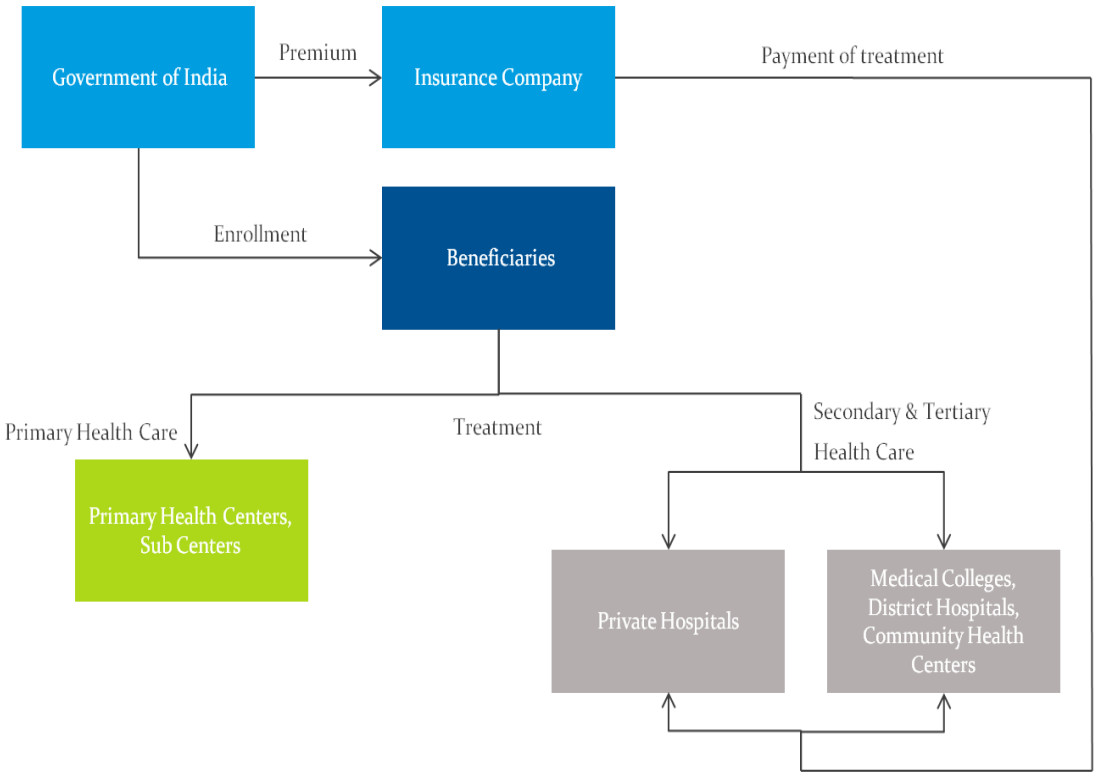

Figure 7: Bird's eye view of Process Flow

Wish list of Key Stakeholders of the scheme

Beneficiaries

- Accessible and affordable medical services
- Coverage for maximum family members
- Good hospitality and treatment at the hospital
- Covered for both inpatient and outpatient medical services
- Completely informed about the benefits and about the treatment being provided
- No exploitation
- Alternative medicines (AYUSH) is covered
- Strong grievance mechanism and his/her voice is heard

Service Providers

- Consensus on reasonable package rates
- Annual revision of package rates in consideration with medical inflation
- Maximum footfall of patients
- Receiving of timely payment from the insurance company
- Tax benefit for participation in the scheme, ensuring financial viability and sustainability
- Levi of minimum tax on the revenue generated via social scheme
- Access to subsidized drugs and implants

Government

- Coverage of maximum population for maximum ailments
- Establishment of goodwill
- Proper awareness and publicity of the scheme
- Minimum cost
- Positive impact on health indicators
- Minimum leakages and frauds
- Minimum beneficiary grievance
- Standardized process and system
- Flawless and self-sustainable scheme over a period of time

Insurance Company

- Clear policy framework with standard operating procedures in place
- Strong mechanism and Government support in combating fraud
- Financial sustainability of the scheme with profit generation
- High acceptability of the scheme and maximum enrolments
- Lack of subjectivity in implementation of the scheme
- Transparency and free hand in the implementation of the scheme
- Upfront payment of premium as per IRDA guidelines
- Preference to cover IPD and at the right price

Four Pillars of Scheme

The below mentioned table shows main highlights of the scheme under four heads namely enrolments, unique health cards, negotiable package rates & PPP model.

Enrolments	**Unique health cards**	**Negotiated package rates**	**PPP model**
Entire Poor Population to be covered	Plastic card with a unique identification number	Comprehensive treatment package for each ailment	Empanelment of private & public hospitals
Biometric details to be recorded	Biometric details, information of family and treatment would be captured and would be available on real time	Package Rates would freeze a periodand thus will take care of medical inflation	Private hospitals would be motivated - Better reach in rural areas
Mobilize civil society (NGOs, support groups, community leaders) for ensuring issuance of health cards		Annually govt. should look to increase the premium and package rates by a fixed percentage to accommodate for inflation and foreign exchange rate fluctuations	Additional revenue – Development of public healthcare infrastructure & resources

Figure 8: Pillars of the scheme

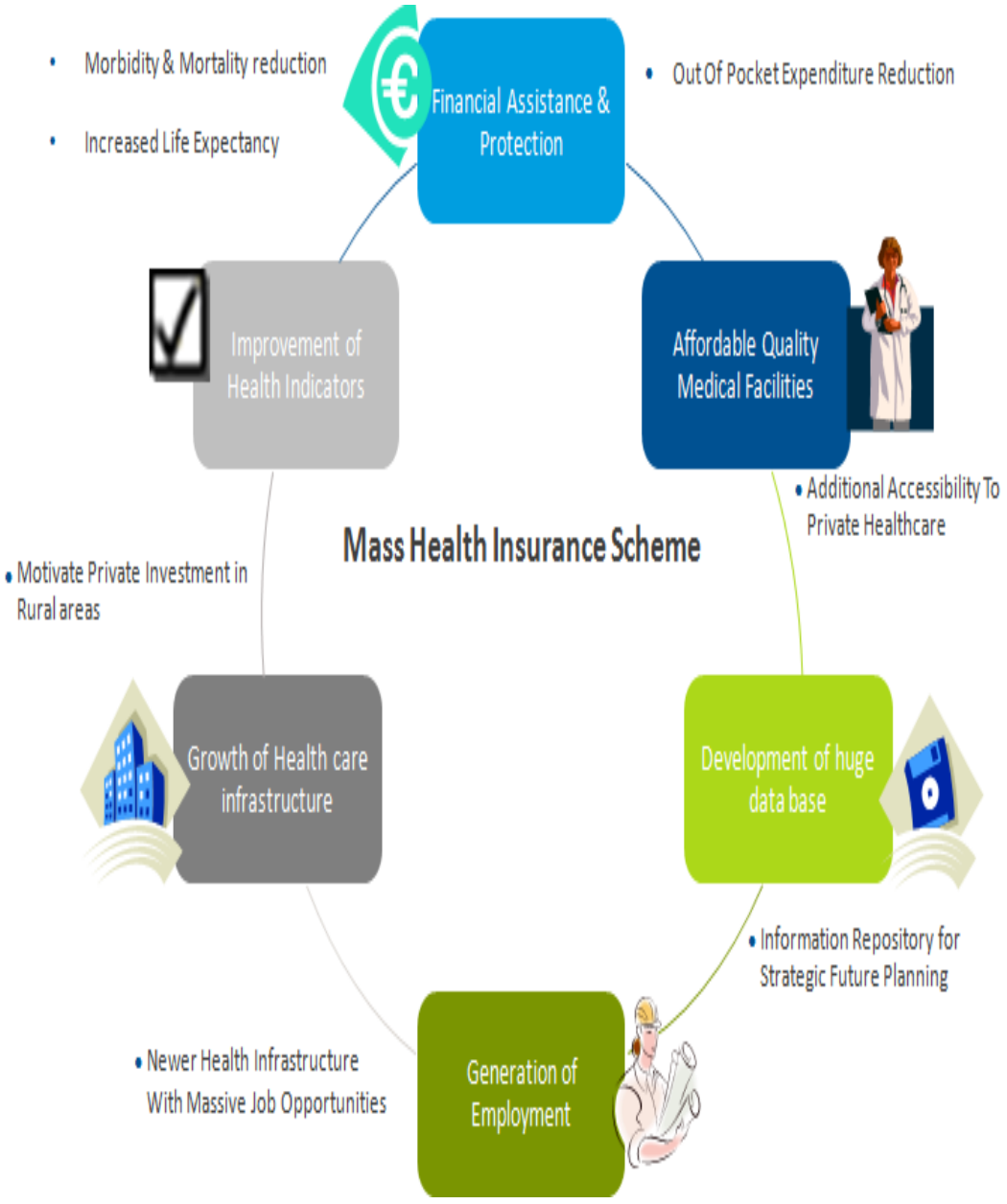

Figure 9: Impact of the Scheme

Success factors/ USP of the proposed scheme

- Simplicity & comprehensive of the product
- Cost-effectiveness and transparency of distribution channel
- Regular awareness campaign via a variety of media
- Geographical coverage of network hospitals with cashless facilities.
- Implementation of measures so that the beneficiary gets the benefits
- Grievance redressal mechanism so that the beneficiary gets a voice
- Political backing

Summary of Recommendations

- **Insurance Products in Place of Self-Funded Schemes**

Insurance companies already have retail/corporate insurance policies in place with hospitals thus they can help with accreditations and standardization of the tariff as far as possible for the similar pattern of healthcare providers. With this prior experience insurance companies can also help reduce admin costs.

- **Tax Exemption on Health Insurance**

To increase the penetration of health insurance in India, Tax exemption should be applicable for the policyholders. This would motivate the people to cover themselves against the unforeseen damage caused by hospitalization.

- **New Innovative Customized Healthcare Products**

India is a peculiar puzzle with high variations in working age population, which further contribute to a complex structure of individual needs and expectations. Companies need to understand that there is **no 'one-size-fits-all'** that can be applied to the workforce and employers must **adjust policies** with respect to age, location and understanding of issues. Wellness initiatives can be directed towards the younger working populace as they would be better aware of the importance of a healthy lifestyle. Broadly, all strata of the working population should be encouraged to adopt defined contribution plans and employers should be persuaded to **gradually diminish life-long benefit strategy practices.**

- **Changing Policy with Changing Conditions**

As the life expectancy of the country is on an increasing trend, the geriatric population is also increasing. Considering the same, innovative and new policies for geriatric population should be designed.

- **Creating more awareness regarding health insurance**

Government should persuade awareness generation in rural and urban areas. Government can appoint 'insurance promoters' trained to promote greater outreach of insurance schemes via catchy communication and selling skills.
For health scheme promotion including street plays, songs, pictorial descriptions etc. must be reviewed, encouraged, and spread by the mechanism. Mode of communication should ideally be in local language and coverage of both females and males should be encouraged.

- **Health Corpus to be Created for HIV**

HIV infection is on an increasing trend in the country and till date there is no social scheme, which provides protection against the financial damage caused by the treatment of the disease. The most vulnerable group is the work-force of the country and this illness directly affect productivity and growth of our country. Therefore, a corpus should be created which should fund the treatment of this dreadful disease.

- **Monitoring and Evaluation Mechanism to be in Place**

A proper and strict monitoring mechanism should be in place so as to ensure that the designated benefits are reaching the beneficiaries. Close monitoring would also ensure that leakages resulting due to various frauds are out of the system and are controlled by keeping a firm check on possible avenues of fraud.
The government must establish an evaluation committee, which conducts system evaluations periodically, with a pre-determined frequency to ensure a sound balance of administrative, functional, financial and institutional viability. Effectiveness and impact remain key focus areas to evaluate the scheme. Evaluation would also help to assess the gaps in the existing scheme and would create a scope for improvements.

- **Retail & Social Health Insurance**

With special Focus on the corporate health products the retail and Social/ Mass health insurance products are side-lined and out of focus. Considering the needs of the masses and increasing out of pocket spending on health, the social insurance sector should be encouraged.
Service Tax should not be levied on any stakeholder of any mass or retail health insurance product or scheme. This will motivate the stakeholders at various levels to actively participate in Mass schemes.
Time taken by IRDA to approve any retail product should be reduced.

- **Corporate Health Insurance Sector**

In India currently, the entire focus of the Government and the market is on the corporate insurance. All the insurance companies are competing against each other, in the process of which the premium rates are crashing

The health products are being sold at subsidized rates, which are affecting the insurance industry adversely

To maintain a healthy competitive environment and to keep health insurance industry sustainable, as rule none of the insurance company should be allowed to quote below the burn cost.Standard package rate list should be developed based on the city tier

Miscellaneous Recommendations

Government must recognize health insurance as a separate line of business. It must also introduce capital monitoring and product level norms for private health insurance. Accreditation and benchmarking of health providers are essential and there should be some quality standards and protocols for follow-ups.

Budget should be directed to training doctors, providers, health economists, cost accountants, epidemiologists, hospital managers, record keepers in computerization etc.

The Government should facilitate public–private partnership in a competitive environment via self-controlled health trusts.

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