Ayushman Bharat – National Health Protection Mission
Providing Universal Health Coverage to 500 million people
Executive summary

The healthcare in India is largely underpenetrated, with government expenditure at around 1.25% of the GDP and an underperforming public healthcare ecosystem. It is extremely worrying that nearly 55–60 million Indians are pushed into poverty every year because they are unfortunately compelled to shell out half of their annual household expenditure to meet medical needs, especially for hospitalisation. Even after 70 years of independence, there is no real health insurance scheme for 80% of the Indian population.

One of the major government’s policy initiatives has been the announcement of the Ayushman Bharat – National Health Protection Mission (AB-NHPM) for the vulnerable section of the Indian population which, if implemented effectively, will help the nation move closer to the Sustainable Development Goal of ‘Universal Health Coverage’.

It is expected that the scheme will have a far-reaching impact on the entire Indian healthcare and insurance landscape. The scheme envisages the adoption of standard treatment guidelines and defined package rates for surgical procedures, and the widespread use of IT and data analytics to monitor scheme implementation and manage fraudulent claims. All these measures taken together will help in regulating the hitherto unregulated hospital and healthcare sector and in making the health insurance sector a sustainable one. The scheme will help in generating large volumes of data which may be used later for designing better and targeted health programmes. This will assist in effective medical management; in studying the impact of including or excluding specific diseases, populations or coverages; and in optimising cost and improving efficiencies.

The scheme will also help in enriching the database of hospitals registered with the Registry of Hospitals in Network of Insurance (ROHINI) System and the human capital captured under the National Health Resource Repository (NHRR) project. This can later be used innovatively for improvement of access to and quality of healthcare services in the country. The scheme will have a multiplier impact on the healthcare and allied sectors like pharmaceutical, diagnostics and medical devices and the overall Indian economy by way of employment generation.

The execution of the scheme, however, will be a big challenge since it would involve identifying and focusing on the right critical success factors, allocating the optimum budgetary support, incentivising all stakeholders appropriately (e.g. insurance companies, third-party administrators, healthcare providers) and acting speedily to cover all the beneficiaries.

In the long run, AB-NHPM should envision strengthening of primary care, inclusion of out-patient treatment and a public healthcare delivery system, and expanding the scope of coverage to the entire population in order to make the government’s transition from provider to payer a successful one and achieve Universal Health Coverage in the true sense.
Section 1 UHC and past learnings
The coverage cube: Three dimensions of Universal Health Coverage (UHC)

**UHC is a dynamic process that should be responsive to** constantly changing demographic, epidemiological and technological trends. The changing nature of health systems has significant implications for UHC monitoring.

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**UHC goes much beyond health insurance for 100% of the population**

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Adapted from Tracking Universal Health Coverage: First Global Monitoring Report: WHO and World Bank
UHC extends beyond curative care and has direct implications on health outcomes

Investments in UHC and its projected impact

<table>
<thead>
<tr>
<th>Category</th>
<th>No.</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of healthy life years gained:</td>
<td>535 million</td>
<td>PwC research and WHO report on ‘Together on the road to universal health coverage: A call to action’</td>
</tr>
<tr>
<td>Average life expectancy gained by 2030:</td>
<td>5 years</td>
<td>WHO modelled projections for 67 low- and middle-income countries (2016–2030)</td>
</tr>
<tr>
<td>Unintended pregnancies averted due to use of modern contraceptive methods:</td>
<td>400 million</td>
<td>WHO modelled projections for 67 low- and middle-income countries (2016–2030)</td>
</tr>
<tr>
<td>Child deaths averted (0–4 years):</td>
<td>41 million</td>
<td>WHO modelled projections for 67 low- and middle-income countries (2016–2030)</td>
</tr>
<tr>
<td>Non-communicable disease (deaths averted):</td>
<td>20 million</td>
<td>WHO modelled projections for 67 low- and middle-income countries (2016–2030)</td>
</tr>
<tr>
<td>Additional people with access to clean water in 2030 (above 2015 baseline):</td>
<td>226 million</td>
<td>WHO modelled projections for 67 low- and middle-income countries (2016–2030)</td>
</tr>
<tr>
<td>Additional number of people accessing treatment for depression:</td>
<td>94 million</td>
<td>WHO modelled projections for 67 low- and middle-income countries (2016–2030)</td>
</tr>
</tbody>
</table>
Government-sponsored insurance schemes are critical for UHC

Adopted from M. Kimball et al. (2013), ILO
While multiple government-sponsored insurance schemes exist in India:

<table>
<thead>
<tr>
<th>State</th>
<th>Scheme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Himachal Pradesh</td>
<td>Mukhya Mantri State Health Care Scheme</td>
</tr>
<tr>
<td>Punjab</td>
<td>Punjab Government Employees and Pensioners Health Insurance Scheme</td>
</tr>
<tr>
<td>Rajasthan</td>
<td>Bhamashah Swasthya Bima Yojana, State Insurance and Provident Fund Department, Rajasthan Chief Minister’s Relief Fund</td>
</tr>
<tr>
<td>Madhya Pradesh</td>
<td>MP Swasthya Suraksha Yojana</td>
</tr>
<tr>
<td>Uttar Pradesh</td>
<td>Mukhyamantri Swasthya Bima Yojana and U-Health Card</td>
</tr>
<tr>
<td>Arunachal Pradesh</td>
<td>Arunachal Pradesh Chief Minister Universal Health Insurance Scheme (APCMUHIS)</td>
</tr>
<tr>
<td>Assam</td>
<td>Atal Amrit Abhyan, Assam Aarogy Nidhi, Sneha Sparsha</td>
</tr>
<tr>
<td>Tripura</td>
<td>Tripura Health Assurance Scheme for Poor</td>
</tr>
<tr>
<td>Jharkhand</td>
<td>CM’s Health Insurance Scheme, Sarva Swasthya Mission</td>
</tr>
<tr>
<td>West Bengal</td>
<td>West Bengal Scheme, Swasthya Sathi, Mabhoi Scheme</td>
</tr>
<tr>
<td>Odisha</td>
<td>Biju Krushak Kalyan Yojana</td>
</tr>
<tr>
<td>Gujarat</td>
<td>Mukhyamantri Amrutum and Vatsalya Yojana, Chiranjeevi Yojana</td>
</tr>
<tr>
<td>Goa</td>
<td>Chief Minister’s Comprehensive Health Insurance Scheme</td>
</tr>
<tr>
<td>Kerala</td>
<td>Comprehensive Health Insurance scheme</td>
</tr>
<tr>
<td>Telangana</td>
<td>Arogyashree (co-branded with RSBY)</td>
</tr>
<tr>
<td>Andhra Pradesh</td>
<td>Arogya Raksha Health Scheme, Dr. NTR Vaidya Seva Scheme</td>
</tr>
<tr>
<td>Tamil Nadu</td>
<td>Chief Minister’s Comprehensive Health Insurance Scheme</td>
</tr>
</tbody>
</table>
... the overall penetration is still relatively low

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Lives covered</th>
<th>Number of policies issued</th>
<th>Average amount per claim</th>
<th>Claim settlement</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013-14</td>
<td>~450 million</td>
<td>13 million</td>
<td>25,000 INR</td>
<td>40% cashless, 47% reimbursement and 13% via both cashless and reimbursement</td>
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</tr>
</tbody>
</table>

Despite the increase in annual growth, more than 80% of the population still does not have any significant health insurance coverage.

Health insurance in India

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Lives covered under health insurance (in lakhs)</th>
<th>Annual growth rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013-14</td>
<td>2162</td>
<td>13%</td>
</tr>
<tr>
<td>2014-15</td>
<td>2880</td>
<td>15%</td>
</tr>
<tr>
<td>2015-16</td>
<td>3590</td>
<td>22%</td>
</tr>
<tr>
<td>2016-17</td>
<td>4375</td>
<td>24%</td>
</tr>
</tbody>
</table>

Source: IRDA annual reports
More than two-thirds of healthcare spend is out-of-pocket expenditure

Healthcare financing schemes for India

- Household out of pocket expenditure: 67%
- Government-sponsored health insurance (Union, state): 22%
- Local bodies and other schemes: 7%
- Private health insurance: 4%

More than 2/3rd of expenditure on healthcare is out of pocket

Private health insurance accounts for <5% of total healthcare financing

Health insurance covers mostly in-patient treatment

It is imperative for any UHC scheme to cover OPD/medicines/diagnostics

Source: National Health Accounts (2014-15)
### Significant gaps in current health insurance schemes

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Insurance schemes</strong></td>
<td>Mostly tax funded and non-contributory</td>
</tr>
<tr>
<td></td>
<td>Non-incentivised nature of insurance scheme</td>
</tr>
<tr>
<td><strong>Quantum of insurance cover</strong></td>
<td>Largely provides a coverage of &lt;1 lakh INR</td>
</tr>
<tr>
<td></td>
<td>Coverage is insufficient in comparison to total cost incurred annually on treatment</td>
</tr>
<tr>
<td><strong>Population coverage</strong></td>
<td>A majority of these schemes are targeted at below poverty population</td>
</tr>
<tr>
<td></td>
<td>Minimal inclusion of above poverty population in government schemes</td>
</tr>
<tr>
<td><strong>Number of schemes</strong></td>
<td>Multiple state government health insurance schemes</td>
</tr>
<tr>
<td></td>
<td>Fragmented and each offering a different benefit package</td>
</tr>
<tr>
<td><strong>Spectrum</strong></td>
<td>Usually covers only-in-patient expenses and don’t cover wellness and rehabilitative care</td>
</tr>
<tr>
<td></td>
<td>Mostly excludes OPD, diagnostic and pharmaceutical expenses</td>
</tr>
<tr>
<td><strong>Pricing of packages</strong></td>
<td>Highly skewed</td>
</tr>
<tr>
<td></td>
<td>No standardised package</td>
</tr>
<tr>
<td><strong>Treatment protocols</strong></td>
<td>Subjective medical decisions</td>
</tr>
<tr>
<td></td>
<td>No defined clinical protocols</td>
</tr>
<tr>
<td><strong>Market penetration</strong></td>
<td>Broadly confined in tier 1 and 2 cities</td>
</tr>
<tr>
<td></td>
<td>Limited penetration to tier 3 and 4 cities</td>
</tr>
</tbody>
</table>

Source: PwC research
AB-NHPM is now poised to become the world’s largest sponsored health insurance scheme

- **Budgetary announcement**
- **100 million family beneficiaries**
- **500,000 INR cover per family**
- **Families identified as per Socio-Economic Caste Census 2011**
- **Funded 60:40 by Centre and state**
- **To be merged with other state schemes**
- **To be implemented through an insurance company or directly through a trust/society or a mixed model**
- **Driven by strategic purchasing from private sector**

Over 500 million Indians to be covered in AB-NHPM
AB-NHPM is a step towards UHC on different parameters

<table>
<thead>
<tr>
<th>Population coverage</th>
<th>In-patient coverage</th>
<th>Diagnostics</th>
<th>Pharmaceuticals</th>
<th>Out-patient coverage</th>
<th>Wellness</th>
<th>Rehabilitation</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1" alt="Population coverage icon" /></td>
<td><img src="image2" alt="In-patient coverage icon" /></td>
<td><img src="image3" alt="Diagnostics icon" /></td>
<td><img src="image4" alt="Pharmaceuticals icon" /></td>
<td><img src="image5" alt="Out-patient coverage icon" /></td>
<td><img src="image6" alt="Wellness icon" /></td>
<td><img src="image7" alt="Rehabilitation icon" /></td>
</tr>
</tbody>
</table>

Source: PwC research
Section 2 Putting in the building blocks
A well-designed UHC scheme can result in positive outcomes

**Sources of funding**
- Analyse the fiscal space
- Identify additional sources of funding

**Insurance mechanisms**
- Design and implement the UHC scheme
- Define: Target population and service coverage
- Consider: Public vs private, contributory vs non-contributory, mandatory vs non-mandatory nature of scheme

**Payer–provider relationship**
- Fortify payment mechanisms
- Introduce disease coding and EMR
- Reduce fraud
- Introduce standard treatment protocols

**Health priorities and outcomes**
- Widening of population coverage, OPD, drugs and diagnostics; progress towards preventive and rehabilitative care
- Monitor the health outcomes

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National Health Protection Scheme
AB-NHPM promises to bring about a tectonic shift in the healthcare ecosystem

<table>
<thead>
<tr>
<th><strong>Standardised treatment guidelines (STGs)</strong></th>
<th><strong>Standardised package rates</strong></th>
<th><strong>Updating ROHINI</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandate adoption of STGs for standardised treatment and billing.</td>
<td>The scheme identifies approximately 1,350 treatment/surgical procedures for which package rates will be fixed.</td>
<td>It will benefit the health insurance sector in the management of claim costs through reduction in fraudulent claims.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Enrichment of National Health Resource Repository (NHRR)</strong></th>
<th><strong>IT integration and data generation</strong></th>
<th><strong>Employment generation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Generation of repositories on hospitals, providers and other human resources for health.</td>
<td>Will create data for improved operational, financial and medical management effectiveness via IT-enabled systems.</td>
<td>The scheme will have a multiplier effect on the Indian economy through employment generation and promoting the healthcare industry in tier 3 and 4 cities.</td>
</tr>
</tbody>
</table>
Standardised treatment guidelines (STGs) and package rates

**Standardisation**

- **Quality of care**
  Improved quality of services received by patient

- **Health outcomes**
  Increase in evidence-based medicine treatments, leading to improved health outcomes

- **Consistency of care**
  Improved consistency of care

**Package rates**

- **Claims management**
  Uniformity of surgical expenses, thereby enabling efficient management of claims

- **Uniformity**
  Helps in curbing tendency to overcharge

- **Price optimisation**
  Helps in standardising prices of treatment across the country for similar type of institutions
Enrichment of ROHINI system and NHRR creation

Registry of Hospitals in Network of Insurance (ROHINI) is a registry of unique hospitals in the health insurer and third-party administrator (TPA) network in India. It acts as an authentic data repository of hospitals which may be utilised for geography-specific trend analysis and curbing leakages arising due to fake hospital information.

NHRR is country’s first ever healthcare establishment census to collect data of all public and private healthcare establishments. The project aims to strengthen evidence-based decision making and develop a platform for citizen- and provider-centric services by creating a repository of India’s healthcare resources.

Enriching the ROHINI system through large-scale empanelment and registration of hospitals

...by removing inefficiencies like non-reporting, under-reporting and delays in transmission of public health data.

Improved user experience by enabling choice of best suited provider

This will help in leveraging private sector health infrastructure in service delivery.

Better fraud management at provider level due to generation of unique IDs for each hospital and improving claim efficiencies

It will also address the issue of unavailability of private sector health resource data, health infrastructure, equipment and other important data points.
Data creation and employment generation

**Improving disease profile**
Improvement of national health and disease prevention, prognosis of National urban health mission (NUHM) and National rural health mission (NRHM)

**Process efficiencies**
Bringing in operating efficiencies and improving financial performance and future cost predictions and budgeting

**Capability building**
Identifying utilisation patterns and their distribution or variation amongst different states and of healthcare resources accordingly

**Fraud management**
Predicting, preventing, detecting and managing frauds

<table>
<thead>
<tr>
<th>Services</th>
<th>Transportation</th>
<th>Data management</th>
<th>Hospitality</th>
<th>Operations and general admin.</th>
<th>Quality accreditation</th>
<th>Human resource management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Industries</td>
<td>Pharma and diagnostics</td>
<td>Insurance</td>
<td>TPAs</td>
<td>Hospitals</td>
<td>Medical devices and supplies</td>
<td>Infrastructure</td>
</tr>
</tbody>
</table>


This will positively impact the current healthcare ecosystem

<table>
<thead>
<tr>
<th><strong>Hospitals</strong></th>
<th><strong>Pharmaceuticals and diagnostics</strong></th>
<th><strong>Insurance</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Push for package rates</td>
<td>• Focus on low-cost, good-quality drugs and on centralised procurement</td>
<td>• To build capacities for effective claims management, actuarial capacities, clinical audit capacity and hospital scrutiny</td>
</tr>
<tr>
<td>• Focus on quality</td>
<td>• Focus on supply side shortages</td>
<td>• Negotiate package rates, improve system automation</td>
</tr>
<tr>
<td>• Focus on accreditation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Focus on operational improvements to reduce costs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Digital and IT service providers</strong></th>
<th><strong>Government</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Develop IT architecture to link patient data, hospital data and insurance companies with Socio-Economic Caste Census (SECC) and Aadhaar data</td>
<td>• Identify additional sources of financing</td>
</tr>
<tr>
<td>• Digitisation trends will further help in reduction of costs, etc.</td>
<td>• Build in system automation for monitoring and grievance redressal</td>
</tr>
<tr>
<td></td>
<td>• Regulators to ensure fair competition</td>
</tr>
</tbody>
</table>

Digitisation trends will further help in reduction of costs, etc.
Section 3

Imperatives for success
## Right implementation

<table>
<thead>
<tr>
<th>Key parameters</th>
<th>Immediate term</th>
<th>Medium term</th>
<th>Long term</th>
</tr>
</thead>
</table>
| **Institutional structures** | • Identifying and setting of State Health Agency (SHA) and District Implementation Units (DIUs)  
• Building contracts with insurance companies/implementation support agency | • Operations support in stabilising and issue resolution  
• Scale up implementation across states | • Capacity building of officers at regular intervals  
• Strengthening of SHAs and institutional structures |
| **Identification and verification of beneficiaries** | • Updating Socio-Economic Caste Census (SECC) list  
• Creating multiple service location  
• Develop unique list of beneficiaries | • Linkage for approval to insurance company  
• Issuance of e-card | Monitor training of all stakeholders involved in beneficiary identification |
| **Hospital empanelment** | • Setting of State and District Empanelment Committee  
• Online empanelment of hospitals via PMRSSM interface (registration and application, tracking, follow-up, etc.)  
• Signing of contracts | • Appointment of nodal officer for administrative and medical purposes  
• Hospital transactions for treatment procedures | • Hospital quality strengthening (nudging towards entry-level National Accreditation Board of Hospitals [NABH] or higher)  
• Evolve hospital rating system for further usage |
| **Information technology** | Deployment of requisite hardware, software, allied infrastructure and IT team across states | • Assess Information Technology (IT) team for readiness  
• Track readiness of state’s IT platform for scheme and it’s integration with central software | • Monitor deployment of IT hardware, software and allied infrastructure at empanelled hospitals  
• Monitor and reporting of deployment of kiosks  
• Develop standard operating procedures (SOPs) |
| **IEC and capacity building** | • SOPs need to be defined for all key processes  
• Development of Information, Education and Communications (IEC) strategy and guidelines  
• Develop and devise training methodologies | Strengthening of SOPs and guidance documents and implementation of IEC campaign | • Ongoing capacity building and Institutional strengthening  
• Incorporation of DRGs, disease coding and electronic medical reports (EMRs) |

Identification of critical success factors, their seamless execution and evolution over the course of implementation will be the pillar for effective implementation.
Right pricing strategy

Pricing of key medical procedures

Variation in pricing

Market rates in INR

Trend line

Line of price parity

Procedures with high demand (high market price) but low supply (high price variation and low empanelment)

*Ratio of market price and NHPS price

Difference between market price and NHPS price is higher for costly procedures, thereby limiting the availability of these procedures. It is imperative to follow the right pricing strategy for the scheme to make maximum impact.

Difference between market price and NHPS price is higher for costly procedures and this might limit the availability of these procedures. Hence, it is imperative to follow the right pricing strategy for the scheme to make maximum impact.
## Right costing considerations

<table>
<thead>
<tr>
<th></th>
<th>RSBY</th>
<th>AB-NHPM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coverage</strong></td>
<td>30,000 INR</td>
<td>500,000 INR (16–17 times that of RSBY)</td>
</tr>
<tr>
<td><strong>Services covered</strong></td>
<td>Limited</td>
<td>Cover high-end procedures</td>
</tr>
<tr>
<td><strong>Premium</strong></td>
<td>300–400 INR</td>
<td>?</td>
</tr>
<tr>
<td><strong>Population covered</strong></td>
<td>18 crore</td>
<td>50 crore</td>
</tr>
</tbody>
</table>

Premiums should be appropriately benchmarked to insurers so that they can be engaged constructively.
Right budgetary considerations

<table>
<thead>
<tr>
<th></th>
<th>Current estimate</th>
<th>Case 1</th>
<th>Case 2</th>
<th>Case 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage of target population</td>
<td>100%</td>
<td>60%</td>
<td>60%</td>
<td>100%</td>
</tr>
<tr>
<td>Increase in incidence rate due to coverage</td>
<td>30%</td>
<td>20%</td>
<td>70%</td>
<td>100%</td>
</tr>
<tr>
<td>Percentage of total hospitalisation in private hospitals</td>
<td>54%</td>
<td>60%</td>
<td>75%</td>
<td>90%</td>
</tr>
<tr>
<td>Reduction in private cost due to introduction of package rates</td>
<td>NA</td>
<td>50%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Total scheme cost (crore INR)</td>
<td>~23,000</td>
<td>~8000</td>
<td>~24,000</td>
<td>~40,000</td>
</tr>
</tbody>
</table>

Source: PwC simulation based on NSSO report

* Assuming 15% administrative expenses
Right pooling strategy

Multiple schemes lead to:

- Duplication of beneficiaries across multiple schemes
- Inefficiencies in scheme management and roll-out
- Insurance frauds
- Poor beneficiary targeting
- Dual premium for same services

<table>
<thead>
<tr>
<th>Scheme</th>
<th>State</th>
<th>Population covered</th>
<th>Premium payment</th>
<th>Coverage limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sarva Swasthya Mission</td>
<td>Jharkhand</td>
<td>Entire population of Jharkhand • BPL (&gt;25,000 INR), offered Health security by affordable pricing of standardised services</td>
<td>Family pays the premium: • 20 INR per family member and 170 INR as subsidy • Total premium: 190 INR</td>
<td>Public and private hospitals coverage: up to 30,000 INR Private hospitals coverage: up to 30,000 INR</td>
</tr>
<tr>
<td>Chief Minister’s Comprehensive Health Insurance Scheme</td>
<td>Tamil Nadu</td>
<td>1. Families (residents of state) with income less than 72,000 INR per annum 2. Sri Lankan refugees 3. Orphans 4. Migrants on fulfilment of certain conditions</td>
<td>Government of Tamil Nadu pays the entire premium</td>
<td>Based on ailment/procedure: 1,00,000 INR or 2,00,000 INR per family per year and grants for follow-up treatment</td>
</tr>
<tr>
<td>Mukhyamantri Amrutum and Vatsalya Yojana</td>
<td>Gujarat</td>
<td>1. BPL (part of district BPL list) – for Amrutum 2. Families with income of 1.5 lakh INR and below – for Vatsalya</td>
<td>Government of Gujarat pays the entire premium</td>
<td>2 lakh INR/family for tertiary medical cover and 300 INR transportation charges</td>
</tr>
</tbody>
</table>

Existing schemes have seen a significant rise in financial costs due to systemic inefficiencies and fraudulent behavior across stockholders.
Right infrastructure

Hospital bed requirement

<table>
<thead>
<tr>
<th>Population to be covered</th>
<th>50 crore</th>
</tr>
</thead>
<tbody>
<tr>
<td>New population (no previous health insurance coverage)</td>
<td>33%</td>
</tr>
<tr>
<td>Hospital admission incidence rate</td>
<td>6%</td>
</tr>
<tr>
<td>Average length of stay (ALOS)</td>
<td>3 days</td>
</tr>
<tr>
<td>‘New’ hospital beds required*</td>
<td>1.6 lakh</td>
</tr>
</tbody>
</table>

* From new population which comes under coverage for the first time, and also from increased demand from previously covered population due to higher coverage

Demand for new beds to be met by:

- Capital investments
- Changing status of non-functional beds to functional
- Public-private collaboration
- New business models
- Focus on preventive health care

Right infrastructure strategy required to meet new bed capacity demand from AB-NHPM
Appropriate institutional mechanisms would be needed for strategic implementation support and programme management.
Right leakage management

**Foreseeable fraud challenges in NHPS**

- Enrolment of genuine/ghost beneficiaries
- Impersonation in connivance with cardholders and hospital, leading to fraudulent admissions
- Conversion of OPD patient into an IPD patient
- Showing medical management cases as day care procedures
- Deliberate blocking of higher priced package or multiple packages to claim higher amounts
- Treatment of diseases which a hospital is not equipped for
- Non-payment of transportation charges
- Hospitals/doctors not following standard protocols
- Doctors performing procedures needlessly
- Hospitals charging money even though it’s a cashless scheme

**Analytical activities**

- Hospital analytics
- Doctor-level analytics – by specialisation
- Package-level analytics
- Disease profiling
- Fraud analytics based on diagnostics
- Analytics on consumption patterns of drugs, from a fraud and predictive standpoint
- For states where the insurance programme is self-managed, we can do a solvency analysis based on claim ratio
- Time to settle – one of the key KPIs; it should be analysed by insurer, because it is a major dampener for participating hospitals
- Deduplication algorithms to prevent duplicate enrolments

PMRSSM will create a need for various system analytics for risk mitigation in implementation/operations.
### Right scheme monitoring indicators

#### Identification and verification of beneficiaries
- Families eligible in SECC
- Beneficiaries identified via valid Government ID
- Household covered
- Families migrated
- Families found with no change
- Families that could not be contacted
- Families currently enrolled in RSBY
- Families enrolled in state health insurance schemes

#### Hospital empanelment
- Hospital registered but application submission pending
- Application submitted with documents verified and under scrutiny by DEC/SEC
- Application sent for field inspection
- Application approved and contract pending

#### Treatment availed
- Qualified staff missing
- OT notes and daily monitoring chart not available
- Proof of payment of transportation charges missing
- Help desk missing
- Patients presenting complaints that do not match with package blocked
- Treating doctor’s details not shared
- Package blocked without patient being admitted

#### Pre-authorisation and claims processing
- Percentage of pre-authorisation raised
- Percentage of pre-authorisation approved
- Percentage of pre-authorisation declined
- Time to pay hospitals after submission of claims
- Percentage of pre-authorisation settled within TAT
- Percentage of re-imbursement claims reported
- Percentage of claims paid/rejected
- Percentage of claims paid within 30 days

#### Fraud
- Beneficiary fraud: Enrolment of in genuine/ghost beneficiaries
- Beneficiary fraud: Impersonation in connivance with cardholders and hospital, leading to fraudulent admissions
- Hospital fraud conversion of OPD patient into an IPD patient
- Hospital fraud: Showing medical management cases as day care procedures

#### Complaints
- Qualified staff missing
- OT notes and daily monitoring chart not available
- Indoor case papers incomplete
- Proof of payment of transportation charges missing
- Help desk missing
- Patients presenting complaints that do not match with package blocked
- Treating doctor’s details not shared
- Package blocked without patient being admitted
Identification and verification of beneficiaries
- Percentage of families currently enrolled in RSBY: 20%
- Percentage of families eligible in SECC: 34%
- Percentage of households covered: 16%
- Percentage of families covered under state insurance schemes: 10%

Hospital empanelment
- Percentage of hospitals empanelled: 20%
- Percentage of verification of the empanelment application by the insurance company and approval by state: 9%
- Percentage of applications rejected: 16%
- Percentage of applications submitted with documents verified and under scrutiny by DEC/SEC: 15%

Treatment availed
- Discrepancy between patient’s ID and smart card: 20%
- Package blocked without patient being admitted: 9%
- Proof of payment of transportation charges missing: 16%
- Investigation report/ corroboration diagnosis not available: 15%
- Qualified staff absent: 10%

Claims
- Pre-authorisation of claims approved: 20%
- Claims rejected: 15%

Fraud
- Beneficiary fraud: 35%
- TPA fraud: 17%
- Hospital fraud: 10%
- Diagnostic fraud: 23%

Complaint
- Total complaints received: 32
- Total complaints resolved: 28
- Complaints resolved within defined timeperiod: 12
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