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India Health Insurance Case Study

Comparison of Benefit Packages of Government Sponsored Health Insurance Programs in India

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October 2016

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Background

Financing of healthcare is one of the critical determinants of achieving better health outcomes. A government agency, National Health Accounts (NHA) that essentially monitors the flow of resources in a country's health system and provides detailed data on health finances has divided insurance into two types. Firstly, is the social health insurance which are government sponsored and secondly are the voluntary health insurance which are provided by the public sector insurance companies and private health insurance companies. Central and state funding collectively represents around twenty percent of total health spending (state funds account for the larger share of thirteen percent). This includes support for centrally sponsored schemes such as the National Health Mission as well as the government sponsored health insurance schemes that are targeted towards the poor and are non contributory by design. The national health insurance program, Rashtriya Swasthya Bima Yojana and few state sponsored programs such as the Yeshasvini Co-operative Farmers Health Care Scheme of Karnataka, Rajiv Aarogyasri Community Health Insurance Scheme of Andhra Pradesh, Comprehensive Health Insurance Scheme of Kerala are few notable examples of voluntary health insurance programs. The Central Government Health Scheme, Employees State Insurance Scheme, Ex Servicemen Contributory Health Scheme (ECHS) and the Railway Employees Liberated Health Scheme (RELHS) are mandatory programs that are multidimensional and comprehensive in nature.

The existing health insurance schemes available in India can be broadly categorized as:

Voluntary health insurance schemes including national and state funded Health Insurance Schemes

Considered to be a pioneer of sorts, the Rashtriya Swasthya Bima Yojana (RSBY) was launched by the government of India (GOI) in 2007 to provide below poverty line families with access, choice, and financial risk protection for inpatient health care, presently covering 200 million beneficiaries across India. The program provides an annual cashless coverage up to INR 30,000 per family for inpatient treatment in more than 10,000 empaneled hospitals. Over the years, the program has evolved to expand coverage beyond the Below Poverty Line to include other vulnerable sections of the society. The strong information technology system is

the highlight and backbone of this paperless and cashless program and provides for better efficiency, governance and accountability.

In addition to the national RSBY, several states have over the years launched their individual state health insurance programs, either in addition to RSBY or in exclusivity.

The Yeshasvini Co-operative Farmers Health Care Scheme run by a Trust of the Karnataka government is one of the oldest state sponsored programs. The targeted rural farmer population are eligible to avail cashless benefits from a set from a set of network hospitals for surgical procedures following a contribution of Rs.150 annually.

Andhra Pradesh launched the Rajiv Aarogyasri Community Health Insurance Scheme to provide cashless tertiary and high end surgical coverage to all persons in the state earning less than Rs.75,000 annually. Chief Minister Kalaignar health insurance program of Tamil Nadu's program design and monitoring and accountability features are inspired by the Rajiv Aarogyasri Community Health Insurance Scheme and covers all persons earning less than Rs. 72,000 a year. The eligible families avail benefits from a network of empaneled public and private facilities up to Rs. 100,000 per family over a four-year insurance period.

On similar lines, the Vajpayee Arogyashri of the Karnataka state government offers cashless treatment with a dominant focus on those requiring major surgical interventions covering the most vulnerable sections of the society.

The beneficiaries of Rajiv Gandhi Jeevandayee Arogya Yojana and Sanjeevani Kosh program of Maharashtra and Chhatisgarh respectively, can avail speciality services that require hospitalization for surgeries and therapies through their network of public hospitals.

Similar to Rashtriya Swasthya Bima Yojana, the Mukhyamantri Amrutum Yojana of Gujarat, uses the Quick Response Coded Smart Card to enroll eligible beneficiaries earning less that Rs.1.20 lacs annually to provide financial protection upto Rs.2,00,000/- per family per annum on a family floater basis through a network of empaneled hospitals.

In an ambitious effort to provide universal health coverage, Kerala launched the Comprehensive Health Insurance Scheme that attempted to cover the non RSBY population. The programmatic features of the program is similar to the RSBY. As

a special feature of the program, the above poverty line families have the choice of participating in the state program by making a beneficiary contribution that covers the entire amount of the premium including the cost of the smart card. This is in contrast to the excluded below poverty line families that are expected to pay the RSBY characteristic of Rs.30 as a per family contribution while the state government meeting the remaining expense including for the smart card in order to get the state health insurance coverage.

The Swarna Jayati Aarogya Bima Yojana is Goa's attempt towards providing universal health coverage to all residents of the state wherein the beneficiaries enjoy coverage upto Rs.60,000 annually.

Several states such as Meghala and Himachal Pradesh have designed a top up program in addition to the existing Rashtriya Swasthya Bima Yojana to expand coverage to include tertiary healthcare. The RSBY Plus and Megha Health Insurance Scheme are top up programs that have the same design features as the RSBY, follow the same enrolment process and share the technological platform for beneficiary identification and eligibility validation. However, the RSBY platform is not used for the preauthorization and claim-settlement processes mechanisms.

Mandatory health insurance schemes or government run schemes

Below is a short description of programs that essentially cover the organized workforce of the country.

The Central Government Health Scheme, popularly known as CGHS, is a centrally funded comprehensive health insurance scheme covering 3.7 million beneficiaries. It covers all central government employees and their dependants. Central Government Health Scheme operates in over twenty seven cities via its dispensaries which form the backbone of the scheme. They have certain empaneled hospitals under the scheme which provide care to the beneficiaries on a reimbursable basis. Service packages covered by the program have fixed rates. Any services not covered under the defined service packages have to be paid out of pocket by the patients. [1]

The Employees State Insurance Scheme (ESIS) is a multidimensional social security scheme providing health to the state employees and their families, presently covering 75.8 million beneficiaries. ESIS is mandatory for all employers

[1] http://www.nhp.gov.in/central-government-health-scheme-cghs-_pg

in notified areas with more than 10 employees. Employees with a monthly salary below INR 15,000 are required to join the program, and the employer through payroll deductions transmits their contributions. The insured persons are also entitled to cash benefits in times of sickness and disablement that result in loss of earning capacity. The insurance also provides a monthly pension, called dependent benefit, to dependents of insured persons who die in industrial accidents or because of employment injury or occupational hazard.[2]

The Ex Servicemen Contributory Health Scheme (ECHS) aims at providing comprehensive coverage to ex servicemen and their dependents through a network empanelled hospitals spread across the country. The program benefits about 4.4 million ex servicemen and their dependents. The program that is contributory in nature has been structured on the lines of central government health scheme and is financed by the Government of India.[3]

The Railway Employees Liberated Health Scheme (RELHS) provides comprehensive healthcare to all retired railway employees and spouses of those railway employees who die in harness. The program is contributory in nature wherein the employees make a one time contribution at the time of their retirement. There is also an option for beneficiaries to avail cashless outpatient, inpatient, home based and emergency services by applying for a smart card.[4]

However, deeper a microscopic view of the benefit packages offered by the various health insurance programs reveal differences and variations regarding their design, coverage, number of eligible treatment packages and amount of annual spending caps (Table 1). This section presents the key takeaways of the benefit packages of the various health insurance programs in India.

Focus on Higher End Healthcare and Neglect of Primary Care

As a social protection instrument, these centrally and state sponsored programs are essentially meant to cover inpatient care, specifically secondary and tertiary levels of healthcare. Primary healthcare provides the first point of contact in most health care systems for patients, and the place where most follow up for disease prevention and illness takes place. It is a well known fact that effective and sustainable interventions in primary and preventable healthcare services can have a large impact on mortality and morbidity and minimize unnecessary

[2] http://www.nhp.gov.in/employment-state-insurance-scheme-esis-_pg
[3] http://www.desw.gov.in/about-echs
[4] http://www.indianrailwayemployee.com/content/retired-employees-liberalised-health-scheme-relhs-1997

escalation of hospitalization costs. Evaluations and recent examples of health system transformations[5] have indicated that those countries that have relied on strengthening their primary healthcare services and integrated them in their financing mechanisms have experienced improvements in their health outcomes and health system efficiencies. However, it is surprising that only the nationally and older centrally sponsored programs, such as CGHS, ESIS, ECHS and RELHS include primary care services as a part of their comprehensive benefit package. The recently introduced state sponsored programs lay emphasis on covering for secondary and tertiary care only. Several factors have been attributed to the rise in the prominence of high level care in the younger health insurance programs[6]. The high costs associated with catastrophic inpatient care and limited availability of specialized human resources and poor accessibility of public facilities have lead policymakers to prioritize the private supply of secondary and high level of care. It is for this reason that many states such as Andhra Pradesh, Tamil Nadu and Himachal Pradesh have initiated special grants in addition to the health insurance to cover for costs of high end treatments. It is also noteworthy to mention that the existing network of insurers and private providers already had the services and systems to cater to inpatient care in place thereby making a high level care focused health insurance policy easier to design and implement.

Contributory Nature of Health Insurance Programs and Annual Ceiling

The benefit package of all programs are consistently defined in terms of the outpatient and inpatient care with a predefined list of treatments. The programs use the annual capping as maximum payout for each family. CGHS and ESIS provides comprehensive preventive, outpatient, and inpatient medical care as well as compensatory cash benefit programs for the loss of wages during sickness. Both these programs are non contributory in nature and don't have any annual or

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[5] Developing Primary Healthcare Delivery in Lower and Middle Income Countries: Challenges Faced and Lessons Learned. Report on the Expert Policy Consultation July 30 & 31, 2012, http://www.slideshare.net/julianelewis/overview-of-brazils-unified-health-system-sus

Thailand Universal Coverage Scheme Achievements and Challenges. An independent assessment of the first 10 years (2001-2010). -- Nonthaburi, Thailand: Health Insurance System Research Office, 2012.120p

Universal Health Coverage in Turkey: Enhancement of Equity. Lancet 2013; The Ongoing Reform in Turkish Public Health Sector: Experiences and Future Prospects, Acar, C. Taylan, 2007; OECD Reviews of Health Systems – Turkey, 2008; "Health Transformation Program in Turkey – Progress Report," Turkish MoH, 2009, European Observatory, Health Systems in Transition 2011

6 Gerard La Forgia, Somil Nagpal, 2012, Government-Sponsored Health Insurance in India : Are You Covered?

lifetime ceiling unlike the beneficiaries of state sponsored programs that are restricted by a maximum annual limit. Also, the beneficiaries of CGHS and ESIS are not burdened with any user fees, deductibles, cost sharing or coinsurance to avail the services.

Treatment Packages

Studies reveal that there is considerable variation among the different state and national health insurance programs regarding the number of eligible treatment packages and amount of annual spending caps. With the exception of RSBY that essentially covers including maternity care, all the centrally sponsored programs cover secondary and tertiary care and have therefore defined a larger number of packages than the other schemes. The list of more than 1516 and twenty two day care procedures treatment packages with fixed rates for each package is used for reimbursement to providers empanelled under the RSBY program. The treatment packages are categorized across seventeen different disease categories covering all major hospitalization episodes. CGHS and ESIS follow a list of more than nineteen hundred treatment packages developed by Central Government health scheme, which covers mostly surgical and medical packages for the specialty care. The state programs of Andhra Pradesh, Telangana, Tamil Nadu, Goa, Maharashtra and Rajasthan also cater to secondary and tertiary care..Most of these programs lay emphasis on tertiary care packages which include treatment packages for cardiovascular, renal, neurological, and cancer care problems. The annual ceiling for these programs are much higher as compared to the RSBY ceiling of thirty thousand rupees due to the high package prices for tertiary care treatment packages.

Provider Networks

All the centrally sponsored programs, apart from RSBY, deliver their services through their own network of inpatient and ambulatory care facilities. RSBY and the state programs have a list of public and private empanelled hospital providers who are responsible for the delivery of their services. Tertiary care or specialty services are usually outsourced to the private providers.

Evolution of Health Insurance Programs

Many of the health insurance programs have been undergoing some change to expand the eligible target population, treatments, outpatient care, follow up and

ambulatory services. RSBY recently expanded to cover eleven more categories of people working in unorganized sector. The outpatient care is offered as new project under a program for few categories of people including weavers. The providers get reimbursement as per the packages listed under outpatient care. RSBY has also added maternity coverage and removed the exclusion for HIV/AIDS as it attempts to stay updated with time.

Neglected Focus on Ambulatory Care

With the exception of CGHS and ESIS, no program covers ambulatory care that serves as a gatekeeper for hospitalization. With regards to post hospitalization care, RSBY and some state programs, such as those of Andhra Pradesh, Telangana, Tamil Nadu and Maharashtra, include follow up services.

Policy Recommendations

It is evident that the design of the current social protection programs in the country lay heavy emphasis on hospital and specialty care. The neglect to include primary healthcare as an integral part of the health system design leaves a significant gap in the attempt to extend universal health coverage in India. We must accentuate the need and recommend a health system where primary healthcare serves as a backbone. Moreover, the analysis also highlights the exclusion of ambulatory care as a design feature of the programs. Ambulatory care constitutes a much higher share of overall health expenditure than inpatient care. In addition, cost of the ambulatory services are usually borne out of pocket. The gate keeping function of ambulatory services coupled with primary healthcare screening of the population, can lead to curtailing unnecessary hospitalization and help in reducing the burden on the exchequer which result from costly tertiary and specialty services.

Appendix 1. Centrally Sponsored Schemes

Table 1 - Centrally Sponsored Schemes									
Scheme	Coverage			Annual Limit (INR)	Provider Network	No. of Packages	Out Patient Care	Target Group	Extended Coverage by State
	Primary	Secondary	Tertiary						
Rashtriya Swasthya Bima Yojana (RSBY)	x	✓	x	100000/Family. Top up for Senior Citizens: 30,000	Public & Private	1516 & 22 Day care procedures	x	BPL Popln & Unorganized Sector	N/A
Central Government's Health Scheme (CGHS)	✓	✓	✓	None	Own Network & Private	Comprehensive	✓	Central Govt. Employee & Dependants	N/A
Employee State Insurance Scheme (ESIS)	✓	✓	✓	None	Own Network & Private	Comprehensive	✓	Industrial workers & Dependants	N/A
Ex-serviceman's Contributory Health Scheme (ECHS)	✓	✓	✓	None	Own Network & Private	Comprehensive	✓	Ex-Defence & Dependants	N/A
Retired Employee's Liberalized Health Scheme (RELHS)	✓	✓	✓	None	Own Network & Private	Comprehensive	✓	Railway employees and spouses	N/A

State Sponsored Schemes									
Scheme	Coverage			Annual Limit (INR)	Provider Network	No. of Packages	OPD	Target Group	Extended Coverage by State
	Primary	Secondary	Tertiary						
NTR Vaidya (AP)	Limited	✓	✓	250,000/Family	Public & Private	1044 with follow up	✓	BPL Popln.	No
Rajiv Aarogyasri (TS)	x	✓	✓	200,000/Family	Public & Private	938 & 120 follow up packages	x	BPL Popln.	No
Vajpayee Aarogyasri (KA)	x	x	✓	150,000/Family + 50,000 Buffer	Public & Private	471 packages	x	BPL Popln.	No
Rajiv Aarogya Bhagya Scheme	x	x	✓	150,000/Family	Public & Private	449 packages	x	APL Popln.	No
Chief Minister's Comprehensive Health Insurance Scheme (TN)	x	✓	✓	150,000/Family	Public & Private	992 & 113 follow up packages	x	Annual Income < INR 72,000	No
Rajiv Jeevandayi (MH)	x	✓	✓	150,000/Family	Public & Private	971 & 121 follow up	x	BPL & APL Popln.	No
Mukhyamantri Amrutum (GJ)	x	x	✓	200,000/Family	Public & Private	544 packages	x	BPL & income <	No

Rashtriya Swasthya Bima Yojana Plus (HP)	x	x	✓	175,000/Family (In Addition to 30,000 from RSBY)	Public & Private	326 packages	x	BPL & Unorganized Sector	Yes
Comprehensive Health Insurance Scheme (KL)	x	x	✓	70,000/Family (In Addition to 30,000 from RSBY)	Public & Private	435 packages	x	RSBY + Low income houshold	Yes
Meghalaya Health Insurance Scheme (ML)	**Limited**	✓	✓	200,000/Family (Inclusive of RSBY)	Public & Private	1601 with 8 preventive & OPD	✓	Universal	Yes
Sanjeevni Kosh (CG)	x	✓	**Limited**	150,000/Family (Enhanced for Kidney Transplant & Head Injury)	Public & Private	1056 packages	x	BPL & Non - BPL	Yes
Swarna Jayati Aarogya Bima Yojana (GA)	x	✓	✓	60,000/Family	Public & Private	?	x	Universal for those resident >5 years	No
Bhamashah Insurance Scheme (RJ)*	x	✓	✓	30,000 for Secondary; 300,000 for Tertiary	Public & Private	1045 – General; 500 – Critical; 170 Govt. Hosp.	x	Beneficiaries National Food Social Sec	No