

An Assessment of the Trust and Insurance model of Healthcare Purchasing under PMJAY: Examining two States

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Acknowledgements:

We acknowledge with gratitude the contribution and support provided by NHA including Dr. Arun Gupta, Subhashree Patra, Shakeel Ahmad, Digvijay Sandhu, Lakshya Arora and the team; the State Health Agency officials of Uttar Pradesh and Jharkhand along with the District teams; Zubin Shroff, Vinod Varma and Lluís Vinals Torres for technical oversight and the funding support of the World Health Organization; Divya Tiwari, Research Assistant and Dr. Ajit Parulekar, Director Goa Institute of Management, for providing the necessary Institutional support to carry out this work.

Special thanks to CEO and Deputy CEO at NHA for their overall strategic guidance and facilitating the necessary approvals.

Abstract

PMJAY is being implemented across States in the Trust or Insurance mode (or sometimes a mixture of both termed hybrid). Earlier experiences with publicly financed insurance schemes, suggest limited capacities for healthcare purchasing in Trust-run schemes, and a misalignment of objectives between for-profit Insurance companies (IC) and the State in the Insurance model. A mixed methods study was carried out in Uttar Pradesh (Trust) and Jharkhand (Insurance) to determine process efficiencies and outputs of purchasing, with a focus on claims management. We report that although the Insurance model showed higher performance output, the Trust model can potentially be capacitated to purchase services with comparable efficiency, while maintaining a higher level of vigilance and alertness to fraud at this stage of the scheme. The administrative cost of the scheme per claim processed, is lower for the Trust model at current low levels of utilization. However, as awareness and utilization increase, risk sharing by the IC is likely to result in a change in claim approving behaviour of the IC, as well as premiums charged for the scheme. Ongoing assessments are required as scheme utilization increases, to ascertain the continuity of these findings.

Keywords: Trust, Insurance, Claims, Strategic purchasing

Introduction & Objectives

State governments have been provided flexibility under PMJAY to purchase services strategically through the Trust or Insurance model (and in some cases, a hybrid of both models). Earlier experiences in publicly financed health protection schemes suggest that since Trusts share the objectives of the State government, which is to improve access to hospital based care for eligible beneficiaries, they are likely to undertake fewer rejections of claims and the empanelment of more hospitals, for service delivery. On the other hand, Trusts may lack the level of expertise of an Insurance company (IC) in dealing with complex tasks, specifically related to premium pricing and claims management. They could potentially be lenient with providers and settle claims without adequate audits. The limitations of experience in a Trust could also cause inefficiencies which may make it burdensome for the providers to receive claim reimbursement on time.^{1,2} On the flip side, it may be argued that an inherent trait of insurance companies is profit maximization, leading to swift escalation of premium prices over years, or, refusal of honouring claims for insignificant reasons, or both of these, severely impacting access to beneficiaries and scheme costs.

The design of PMJAY attempts to circumvent some of these issues by setting up State Health Agencies (SHA) to ensure actions related to strategic purchasing are undertaken by government, irrespective of the model adopted.^{3,4} In the Trust model, SHAs may contract Implementation Support Agencies (ISAs) which are fundamentally Third Party Agencies (TPAs), while maintaining oversight of their performance. In the Insurance model as well, the SHA is expected to maintain adequate oversight of the Insurance Companies. The extent to which these structural features and capacities created have influenced healthcare purchasing, specifically claims management, require to be assessed alongside the expectations described above, and their ability to influence the outcomes of PMJAY. Against this background, the study aims at the following: (i) To assess the efficiencies and performance output of purchasing under each model (ii) To assess the incentives, motivations and deterrents to the agencies involved (iii) To interpret & compare the possible effects of each model on PMJAY objectives.

Methodology and data:

The study adopted a mixed methods approach using quantitative and qualitative data sources and analysis. Uttar Pradesh (UP, representing the Trust model) and Jharkhand (JH, representing the Insurance model) were selected purposively in consultation with the NHA, as examples of either model. Within UP, 8 districts were selected for study, two from each geographical cluster, assigned to one of the four ISAs operating in the State. It was ensured that one urbanized and one remote district were included for each cluster. In JH, four

districts were selected, ensuring all of the three Third Party Administrators (TPAs) contracted by the IC was represented.

Data sources and analysis

Qualitative data sources included (i) *Document review*- National guidelines relevant to the study objectives and State level documentation on purchasing functions were reviewed in detail, which included government orders, contracts with partner agencies and meeting records (ii) *Exploratory and In-depth interviews*- Based on the review of national guideline documents, exploratory and in-depth interviews were conducted with key stakeholders from the SHA, ISAs, TPAs, IC and empanelled health care providers (EHCPs) using a set of guiding questions and a semi- structured format. Additional in-depth interviews were conducted subsequently with stakeholders at the State and district level, including District Implementation Unit (DIU) offices, ISA district teams, TPA district coordinators, Hospital administrators/ owners, Ayushman Mitras (AM) and beneficiaries in hospitals. Interviews were recorded where permission was obtained to do so. Where interviews could not be recorded, detailed notes were prepared which were further used for coding and extraction of themes. Data was imported into NVivo12 and textual analysis was carried out using open coding. At a secondary level, patterns emerging from the text were identified and the most common pattern is reported. In order to understand certain processes, direct observations were carried out of the stakeholders carrying out these processes in both States. These included Beneficiary identification processes at the TPA/ISA level and hospital level; Claim processing by TPA/ISA; Beneficiary identification processes at the hospital level and uploading of claims by the AM at the hospital level.

Quantitative data was extracted from the Transaction Management System (TMS), Hospital Empanelment system and Beneficiary Identification System for the period from September 2018 to April 2019 for both States. For the analysis of pre-authorization and claims approvals, rejections, turn-around-time (TAT) and associated variables, information from hospitals within the two States from October '18 to March '19 were included, with a decision provided up to the 8th May, 2019, to allow for at least 30 days to elapse. The data was processed and initial analysis carried out in MS Excel, with further analysis undertaken using SPSS v.21. Correlations were analysed using the Spearman's Rho correlation method. Binary logistic regression was used to determine the effect of number of queries on pre-authorizations and claims.

Indicator definitions: *Pre-authorization TAT* was calculated in minutes as the period between pre-authorization initiation and approval. *Claim TAT* was calculated in days as the period between date of claim submission by hospital and payment of the claim. The time taken for response to queries is included in this calculation as the intrinsic definitions of TAT are as such. Disaggregated data for stages of the approval process was also not available, to be able to factor in these lags for each case, given the large volume of pre-authorizations and claims generated. *Claims ratio* is calculated for six months of the study period as the total claim value paid divided by the total premium value. *Hospital empanelment TAT* is the period in days between application for empanelment by the hospital and decision by the State Empanelment Committee, as recorded in the system.

Results and Findings:

Hospital Empanelment

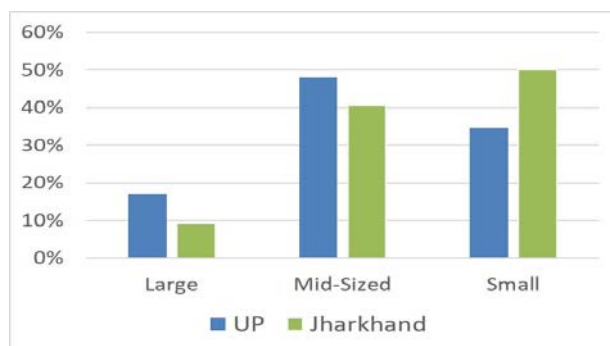
The structure and process for hospital empanelment is largely the same in both State models, with the exception that in Jharkhand, a TPA member forms a part of the District Empanelment Committee (DEC) and an IC representative is present within the State Empanelment Committee (SEC). The responsibility for

hospital empanelment however, lies with the State. In UP, all members of both Committees are State representatives.

In terms of numbers, *it was found that UP empanelled a higher number of hospitals (1724) as compared to Jharkhand (615). This includes both private and public hospitals, with the ratio of private to public hospitals being higher in UP (3:1) than in Jharkhand (1.8:1). The interpretation of these numbers however is limited in the absence of reliable data on the total number of private hospitals in the two States.*

In terms of types of hospitals empanelled, in both States, mid-sized and small hospitals formed the major proportion of hospitals empanelled, with fewer large hospitals (**Figure 1**).

Figure 1: Distribution of empanelled private hospitals by size (as percentage of total empanelled private hospitals)

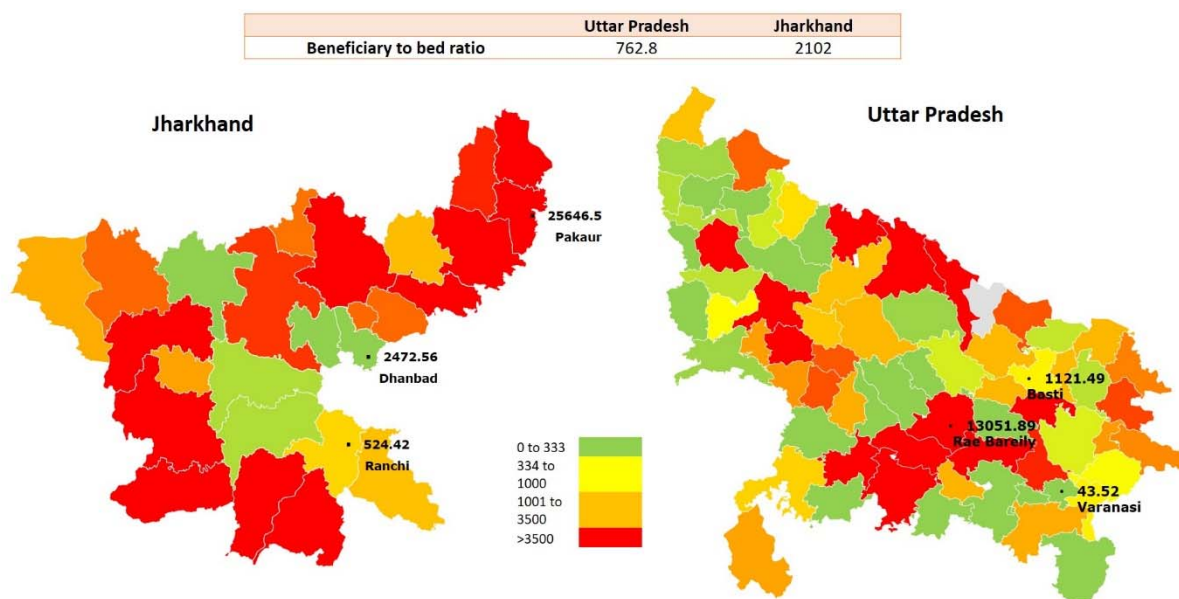


Hospitals with bed strength <30 categorized as small hospitals, 30-100 categorized as mid-sized hospitals and >100 beds as large hospitals.

Since NABH accredited hospitals are incentivized with higher payments under the scheme, the proportion of NABH hospitals empanelled was determined. *In UP, 83 of 236 listed NABH hospitals were found to be empanelled. This signifies a moderate level of participation among these hospitals in the early days of scheme implementation. Jharkhand has a total of only 10 hospitals listed under NABH, of which two were found to be empanelled.* Another four empanelled hospitals were reportedly NABH accredited, however the status of these could not be confirmed in the NABH list. The incentives provided to NABH accreditation did not appear to have a significant effect on hospital participation in the scheme, at this stage.

The geographical distribution and sufficiency of private sector beds in terms of eligible beneficiary to bed ratio was found to be better in UP as compared to Jharkhand (Figure 2). However, large scale variations are seen across districts in both States. This distribution is likely to represent better availability of hospitals in districts with higher levels of urbanization, especially in UP. The lower sufficiency in Jharkhand possibly reflects a lower infrastructure availability in the State, which can be confirmed only when accurate data on private hospital beds available in each of the districts is generated.

Figure 2: Geographical distribution of private hospital beds across districts in terms of beneficiary to bed ratios



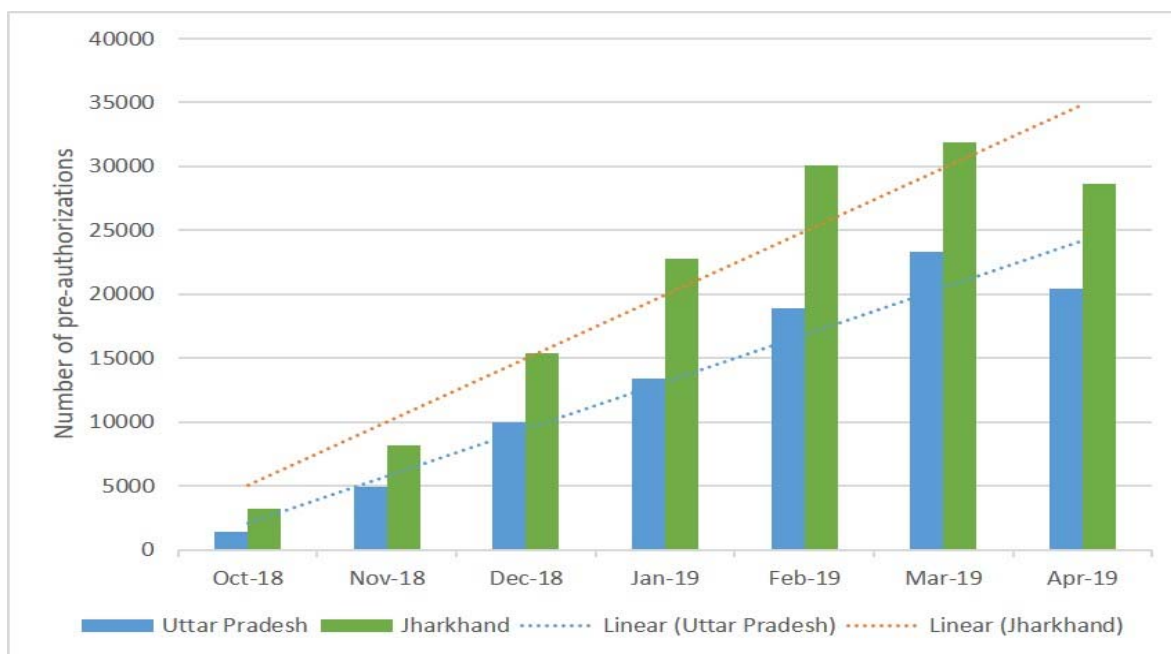
The efficiency and stringency of empanelment was determined through the TAT (30 days as per guidelines) and the rejection rate of empanelment applications. **Both States reported a mean TAT within the guideline (UP- 25 days, JH – 20 days). However, 40% of hospitals in UP and 55% of hospitals in JH were empanelled within 0-10 days. Interactions with SHA, district officials and empanelled providers revealed that in the initial days of the scheme launch, the intention was to empanel the maximum possible hospitals, therefore the quality of the hospitals might have been compromised. Data on field level verification findings is essential to accurately assess the compliance to empanelment criteria.** This data is currently unavailable in digital format. The SHA in UP reported they were now focussing on ensuring that only the right hospitals remained empanelled, and newer applications were being scrutinized more closely. **Overall, a rejection rate of 41% of specialties applied for by hospitals in UP and 33% in JH was reported. This indicates a possibly higher stringency in empanelment in UP, but would require to be further confirmed through an assessment of the reasons for rejection, or findings from field level verification, both of which are currently unavailable.**

Pre-authorization and Claim Management

The differences in the structure and processes of the two models are most relevant to pre-authorization and claim management. For pre-authorization, processing and approval is carried out by the ISA in UP and the TPA in JH. **Unspecified packages indicate those for which prices are determined at the time of pre-authorization. These require SHA approval in UP, however they may be approved by the TPA in JH.** Both States have adopted the national six hour TAT guideline. For the purpose of claims, UP had adopted a two-step process at the time of the study, which required all claims to be processed by the ISA and a 100% audit by the SHA, prior to approval and payment. The State has adopted a 30 day TAT guideline, which is a deviation from the 15 day national guidelines. JH requires only the approval of the TPA, while the IC and the SHA conduct random sample audits of claims, with the percentage of claims being audited being variable, as determined in interviews. Rejected claims are reviewed by the SHA and may be revoked where deemed appropriate. This was reportedly carried out for some claims. The State has adopted the national TAT guideline of 15 days.

Scheme utilization: Pre-authorization trends reveal that although scheme utilization increased steadily in the first seven months of implementation, the total number of pre-authorizations was 93,387 in UP and 1,40,192 in Jharkhand (**Figure 3**). The expected hospitalizations during this time in the two States was 12 lakh in UP and 5 lakh in Jharkhand for the eligible beneficiary population, assuming a 3.5% hospitalization rate (as reported by National Sample Survey, 2015)⁵. **Both States are therefore at lower than potential levels of scheme utilization at this stage, which is more so in UP than in JH (8% of expected hospitalizations in UP, 28% in JH), however this may be attributable to a number of contextual factors in the two States during this time.**

Figure 3. Assessment of Scheme utilization in the two States through Pre-authorization trends



Participation of empanelled hospitals: The low utilization reported above was further analysed across empanelled hospitals. **This revealed that 15% of hospitals in UP and 7% of hospitals in Jharkhand, had not generated any claims during the study period**, despite being empanelled under the scheme more-or-less, from the start. Across all sizes of hospitals, the average number of pre-authorizations generated per hospital was higher in JH than in UP. This low level of participation in UP requires to be further assessed, both from the point of view of hospitals, as well as eligible beneficiaries.

Efficiency and Turn-around-Times for Pre-authorization and Claim processing: In the case of pre-authorization TAT, **a higher median TAT was reported for JH (5 hours 5 minutes) than UP (3 hours 15 minutes)**. There was also a higher proportion of cases in JH that were delayed beyond six hours for approval (**Table 1**). Further, it was observed that among cases in which approval took longer than six hours, a high proportion were eventually system approved. This indicates cases wherein no response was entered by the processing authority, i.e. the TPA or ISA in the time available, and these were thus approved by default.

Claim processing was longer in UP than in JH. Despite the higher TAT guidelines adopted by the State, the mean and median TAT exceeded 30 days. In JH, the median TAT was within the 15 day guideline.

However, significant delays are seen in both States. Interactions with hospitals revealed a perception of delayed claim settlement in UP as compared to JH.

Table 1. Pre authorisation & Claims Turn- around- Time and Delays

Pre-authorisation	Uttar Pradesh (n=27068)	Jharkhand (n= 46011)
Median TAT	3 hours 15 minutes	5 hours 5 minutes
Percentage of cases in which TAT exceeds 6 hrs	33.7%	45.7%
Cases exceeding 6 hrs that were system approved	29.4%	81.6%
Claims	Uttar Pradesh (n= 44931)	Jharkhand (n= 91780)
Mean overall TAT	35 days (± 18.7 SD)	18 days (± 10.8 SD)
Median overall TAT	32 days	15 days
Proportion of claims wherein overall TAT exceeds the State guideline	52.5%	44.7%
Mean days from claim submission to approval	27 (± 18.8 SD)	10 (± 10.8 SD)
Mean days from claim approval to payment	10 (± 10 SD)	7 (± 6 SD)

Factors associated with delayed claims: It was observed that a higher proportion of delayed claim payments occurred in private hospitals, as compared to public hospitals (**Table 2**). This difference was more pronounced in UP than in JH. The value of the treatment package showed no correlation with the time taken for processing of claims, in that more expensive packages did not take longer to be approved, or vice versa. Certain specialties reported a higher TAT in both States, such as Neurosurgery, Poly-trauma and Paediatric medical management. The number of queries was most significantly associated with claim approval delays. UP reported a higher number of queries than JH. However, every additional query raised on a claim was likely to predict delay to a higher extent in JH (12.5 times) than in UP (2.3 times). This observation is due to the 100% claim audit policy adopted in UP at the time of the study, which contributed additionally to longer TATs. The policy has now been revised.

Table 2. Factors associated with delays in Claims settlement

FACTOR	FINDINGS	SUPPORTING DATA
Public or Private hospital	Higher rate of delay for private hospitals in UP. The difference is not as substantive in Jharkhand.	UP- 55% claims delayed in private, 42.2% in public hospitals JH- 45.4% in private hospitals, 41% in public hospitals.
Value of package	No correlation in either State.	UP- $r=0.076$, $n=44,931$ JH - $r=0.068$, $n=91,780$
Type of package	TAT differs as per package speciality. Neurosurgery, Poly-trauma and Paediatric medical management report highest TAT in both States.	(refer to Figure A in Annexure)
Number of Queries	Significant association. Stronger in Jharkhand than UP.	UP- Odds Ratio = 2.3 $p<0.01$ Number of queries – 0 to 6 JH- Odds Ratio = 12.5 $p<0.01$ Number of queries - 0 to 4

Rejection of Pre-authorization and Claims: *UP reported a significantly higher rejection rate for claims (5.5%) as compared to Jharkhand (1.2%).* The rejection rate in UP for private hospital claims was almost double that for public sector hospitals (6% private sector, 3.4% public sector). In Jharkhand, the rejection rate for both types of hospitals was the same (1.2% in private and public hospitals). Although rejection proportions for pre-authorization remained low, the overall rejection rate was higher for UP (2.3%) than Jharkhand (0.7%). Therefore, a higher stringency appears evident on the part of the Trust in UP in the claim and pre-authorization approval process, as compared to the Insurance Company in JH.

Fraud Management: A comparison of fraud detection and management in the two States based on aggregate data showed that *despite a lower pre-authorization volume in UP, the State generated a much higher number of cases for investigation through the application of fraud triggers (Table 3).* Although the State is known to report large scale fraud in the earlier RSBY scheme, this data does not necessarily suggest that there are a higher number of instances of fraud in UP than in Jharkhand. A higher sensitivity and motivation to detect fraudulent activity may also result in the higher number of cases generated. Further it was also seen that UP investigated 70% of the triggered cases, while JH investigated 62%. There was a difference in the percentage of cases detected as fraud in the two States.. The results on claim rejection and fraud detection require further investigation. It remains to be seen whether the higher scrutiny in UP as indicated by these quantitative and substantial qualitative observations on the orientation of SHA and DIU officials result in higher case detection, or whether the incidence of fraud is actually higher in UP than in JH. There is also the possibility that both are true. *The motivations of the trust model in ensuring public money is not wrongfully spent are clear in this case. The insurance company on the other*

hand, does not stand to gain or lose incrementally from the same level of stringency in detection and management of fraud as highlighted in their contract payment terms.^a

Table 3. Indicators for Fraud Management in the two states

Indicator	UP	Jharkhand
Period of data collection	1 month	1.5 months
Number of pre-authorizations generated during this period	20421	46173
Cases sent for investigation due to fraud triggers	8957	2116
Percentage of triggered cases investigated	70%	62%
Percentage of investigated cases confirmed as fraud	10%	4%
Number of hospitals against whom disciplinary action was taken	10	7

Cost of the scheme

The administrative cost of the scheme in the two models was determined based on the actual costs obtained from the States, at current levels of utilization (**Table 4**). It was observed that currently, the administrative cost of the scheme per beneficiary family unit, is three times higher in JH than in UP. Due to the higher claim volume, the cost per claim is lower in JH (INR 2560) than Uttar Pradesh (INR 2917). However it may be assumed that UP would show much higher claim volumes by the end of the year, therefore this unit cost is also likely to decrease. Resultantly, the administrative cost as a percentage of premium is 2% in UP. Considering the current levels of utilization and claim ratio in JH, the expected administrative cost paid to the Insurance Company will be @10% (as per terms of contract, for claims ratio less than 60%).

^a As per the contract, administrative cost that may be retained by the Insurance Company is 10% for claims ratio < 60%; 12% for 60-70%; 15% for 70-85%

Table 4. Cost of scheme based on current data

	Uttar Pradesh	Jharkhand
Total annual premium	1299 cr	513 cr
Total claim pay-out in 6 months	45.38 cr	83.05 cr
Claims ratio (6 months)	6.90%	32.35%
Total administrative cost ^a	34.7 cr	51.34 cr
Administrative cost per beneficiary family unit	29.4	90
Administrative cost per claim submitted	2917	2560
Administrative cost as a percentage of premium	2%	10%

All costs are given in Indian rupees.

^aData for UP was obtained from the SHA for HR hired specifically for PMJAY. Administrative costs for JH were calculated @10% of the premium paid to the Insurance Company assuming the current claim ratio would reach up to 60% based on the current trend of monthly claim volume.

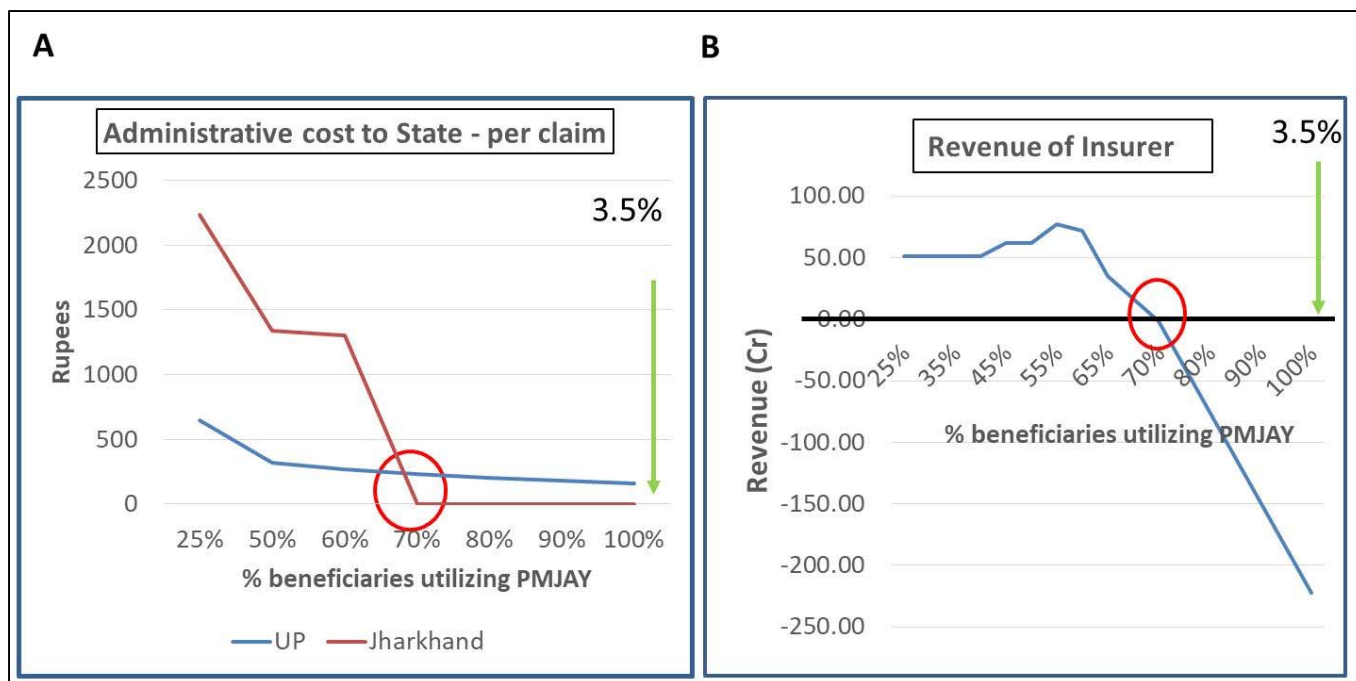
While the above data shows the cost efficiency as of March 2019 while the scheme is still in its early days, the number of beneficiaries availing benefits under PMJAY is likely to increase as awareness increases. Change in utilization would have a bearing on both, cost per claim and cost of administration. The effect of these changes in either States is different, given the two models. In case of UP, the administrative cost is not linked to the claim ratio (utilization of scheme), whereas, in Jharkhand, the administrative cost allowed to be deducted by the Insurance company, is linked to the claim ratio. Additionally in Jharkhand, if the claim ratio goes beyond 110% then the State is liable to share 50% of the excess claim amount up-to 150% claim ratio, while in case of UP, the entire claim amount has to be paid by the Trust.

Due to these differences, the cost implications in the two states will vary at different scenario depending upon what percentage of eligible beneficiaries utilize PMJAY benefits. **The projected costs at changing levels of utilization are presented in Figure 4.** The assumptions considered here are the following:

Assumption 1: Annual hospitalization rate is considered as 3.5% of the eligible population (as per NSS 71st round). Therefore, when all eligible beneficiaries (100%) utilize the scheme when they require it, a 3.5% hospitalization rate will be achieved. **Assumption 2:** Average claim value per claim is taken at Rs. 8000/- which is an approximation taken based on actual average claim value recorded for the same time period **Assumption 3:** There is no change in the contract terms with the Insurance Company in Jharkhand and ISAs in Uttar Pradesh.

It is seen that as utilization among eligible beneficiaries increases, the administrative cost to the State per claim, decreases in JH. The cost in UP remains more or less stable and is not impacted as much. However, as utilization goes to about 70%, the risk sharing of the Insurance Company ensures a reduction in the cost to the State (**Figure 4A**). It is anticipated, that at this point, or just before reaching these levels of utilization, the Insurance Company would attempt to mitigate the losses through a change in the claim approval rate, as well as the premium charged to the State for continuing its participation in the scheme. Further, **Figure 4B** shows that the revenue of the Insurer also would be maximum when utilization reaches between 55-65% of eligible beneficiaries. Beyond this, the revenue is expected to decrease and eventually, losses will be incurred by the IC.

Figure 4. Projected administrative cost to State and revenue of Insurer with evolving utilization



Incentives and deterrents to agencies

Some of the key factors influencing the agencies in either model that are associated with purchasing performance, were identified through in-depth interviews with stakeholders and the document review. These are listed below.

Implementation Support Agency:

- ISAs against whom punitive action was taken for wrongful approval of claims reported that claim audits are a matter of the opinion of ‘one doctor against another’. It is perceived by both the ISA claim processing doctors, as well as the EHCP treating doctor, as the questioning of the clinical aptitude of the treating doctor. ISAs therefore justified their actions in that, questioning the treating doctor’s clinical judgement was not within their rights and hence approved certain claims where this might be the case. In the absence of standard treatment guidelines, such issues are likely to persist and affect the motivation levels of important stakeholders.
- ISAs are paid a fixed rate per eligible beneficiary family unit served, in the geographical cluster for which they are contracted. This cost includes all functions that are to be performed by the ISA. The fixed cost payments to ISAs dis-incentivizes over-provision of services. However, there is also no incentive for ISAs to engage in awareness generation and other activities that increase uptake of services by the eligible population. Although IEC activities are not a central function of the ISA as per contract, at the State and in the districts, DIU teams utilize their services in spreading awareness of the scheme, obtaining patient feedback and attending to grievances. All these support services are covered by the fixed fee, and improved performance is not incentivized. Given that utilization levels in UP are low, these findings need to be further explored.

Insurance Company:

- In the initial days of the scheme, there appears to be no incentive to the IC to control costs, until a certain claims ratio is achieved. TPA functioning appeared to be under little oversight by the IC.
- However, at higher claims ratios, there is likely to be a change in the claim approving behaviour of the IC.

SHAs and DIUs:

- In both SHAs, key HR positions are yet to be filled. However, staff appeared motivated and performed multiple functions without a clear distribution of work. The Trust SHA was closer to the recommended staffing strength, however this included a high number of contractual staff, whose continuity in the scheme is a matter of concern.
- Most DIUs do not have dedicated office space to work, have no computer systems and access the portal on their cell phones. For the household surveys, they rely on their personal vehicles, mostly two-wheelers, which are not conducive to ride for long distances – a lot of the scheme success depends on the intrinsic motivation of contractual workers.

Empanelled Hospitals:

- The price-volume combination generated currently, appears to be attractive for low cost/small hospitals but does not appear to motivate premium hospitals to participate in the scheme.
- The assurance of payment under PMJAY (as a departure from the experience with RSBY) appears to be incentivizing hospitals to join in Jharkhand.
- However, in UP there was dissatisfaction with the number and more-so, the type and repeated nature of queries raised on claims. The questioning of clinical judgement as well as invasion of patient privacy in submitting certain video or surgery pictures, were some of the issues expressed. These findings may be a constraint to certain mid and larger sized hospitals continuing their participation in the scheme.

Conclusions and Next steps:

Our study assessed purchasing performance during the first seven months of scheme implementation in both States. Contrary to expectations, the Trust in UP was found to be more vigilant and stringent in hospital empanelment and claim approval, than the Insurance Company in Jharkhand. However, Jharkhand generated a higher number of pre-authorizations and claims as a proportion of the expected utilization, and more work was being done with fewer staff working under the scheme. Given the contract terms, it may be inferred that the IC is not likely to curb the number of claims processed, until a higher claims ratio is achieved in the State. However, in order to ensure that this does not result in wrongful approval of claims, a higher level of oversight may be required in the State. Efficiency of pre-authorization and claim processing was largely similar, with both States showing a certain proportion of delays and requiring improvements. UP had adopted a 100% claim audit policy during the study period that strengthened the robustness of the audits, and, enabled better monitoring of the ISA performance, with punitive action being taken against ISAs, when necessary. This however also resulted in delayed claim payments, and a higher numbers of queries, which was deemed as a burden by empanelled hospitals. However, due to the increasing workload and limited staff at the SHA, this policy has now been changed, and only those cases in which fraud triggers are generated, are audited by the SHA. The effect of the change in policy will have to be studied at a later date to determine if the Trust is able to retain the same level of alertness to fraud, as well as improve efficiency. The capacities built in the

Trust also must be retained and improved, which would involve ensuring retention of contractual staff, for example, through five-year/medium-term contracts and ensuring sufficient funds to DIU teams for day to day operations. Key performance indicators of the ISAs must be monitored in a more regular, structured manner. However, the audit process also remains cumbersome for the ISAs, as they continue to remain based on clinical opinion, rather than on standard treatment guidelines.

Hospital empanelment has reportedly moved from a focus on numbers, to focusing on the quality of hospitals. However, without data on the findings of field verification, this is difficult to examine and would need to be further explored. There are shortfalls in infrastructure with wide variations across districts, especially in Jharkhand. Both States need to better plan their infrastructure requirement. This would be possible if DIU teams undertake an enlistment and GPS mapping of available private sector resources, in the absence of such data. This would also enable specialty-wise planning for each district, which could better address shortfalls through targeted empanelment. In the absence of sufficient large and premium hospitals being empanelled, differential pricing may be considered in order to increase their participation, and further address shortfalls. Reasons for non-generation of claims by empanelled hospitals must be appropriately explored, and corrective action taken, as and when needed.

The cost of the scheme at this stage is lower in the Trust model of UP than in Jharkhand. With increasing levels of utilization among eligible beneficiaries, administrative costs in the Trust model which remain independent of the claims ratio, will remain more or less stable. However, it is projected that the cost to the State per claim will decrease significantly in the Insurance model. The risk sharing function of the IC will also result in a stage wherein the cost to the State may reduce in the Insurance model. However, it is also anticipated that prior to reaching this stage, the IC would likely influence claim pay-outs, as well as call for a change in premium rates charged and contract terms. This would significantly impact the future costs of the scheme to the State. Since a publicly financed health protection scheme for the poor would aim to optimize utilization, such scenarios are likely.

Our study however, is limited to the two States studied at a very early stage of implementation, and all findings and inferences are made in this context. It would be valuable to assess purchasing functions of additional States under the respective models, before generalizing the findings of the study. The issues identified however, provide early indications to policy makers, that require to be further assessed as the scheme progresses and scheme utilization evolves.

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Annexure

Figure A. Turn- around- time (TAT) for each specialty among approved claims in both States

