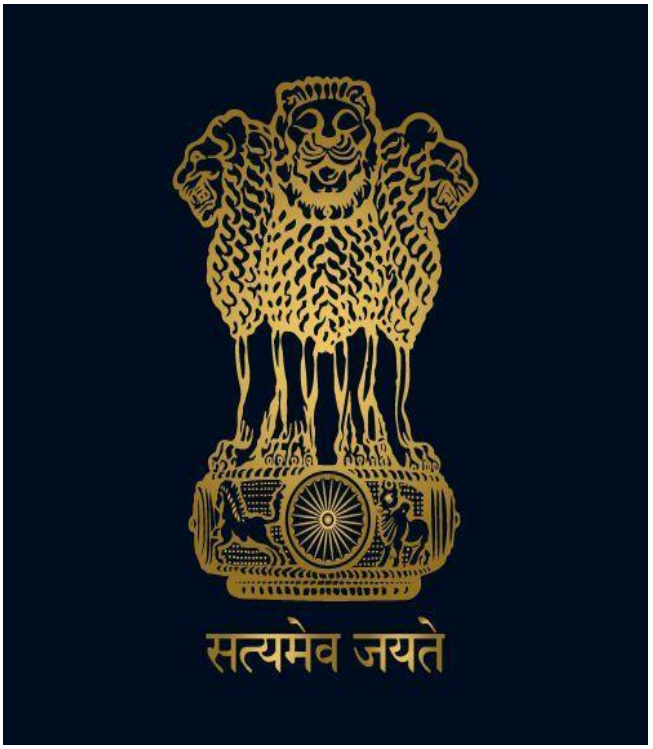


POLICY DRAFT

AYUSHMAN BHARAT SCHEME [PMJAY]

Changes suggested to bring reforms in the Ayushman Bharat Scheme (PMJAY) to address the situation of COVID-19 outbreak in India and improvements to health infrastructure in India

INDIAN CONSTITUTIONAL AID ASSOCIATION

ICAA
Indian Constitutional Aid Association

NOTIFICATION

The Government of Tamil Nadu hereby proposes to make the following policy, namely, -

AYUSHMAN BHARAT (PMJAY) YOJANA, 2021

Chapter I

INTRODUCTION

1. Medical care and insurance benefits are the cornerstones of a welfare state. The state has an inevitable responsibility to provide medical care benefits and other incentives owing to its social contract with the citizens.
2. Ayushman Bharat yojana – National Health protection scheme which has now been renamed as Pradhan Mantri Jan Arogya Yojana, plans to make secondary and tertiary healthcare complete cashless.
3. The 71st round of the National Sample Survey Organisation reveals that a staggering 85.9% of rural households do not have access to any healthcare insurance or assurance. Additionally, 24% of rural families' access health care accesses health care facilities by borrowing money.
4. Prime minister Narendra Modi rolled out this health insurance scheme on 23rd September 2018 to cover about 50 crore citizens of India. The PM Jan Arogya Yojana beneficiaries get an E- card which can be used to avail services at an empanelled hospital, private or public, anywhere in the country. With it you can walk into a hospital and obtain cashless treatment. The coverage includes 3 days of pre hospitalisation and 15 days post hospitalisation expenses.
5. Around 1400 procedures, with all related costs like OT expanses are taken care of. The e- card provides a coverage of Rs. 5 Lakh, per family, per year.
6. The aim of PM Jan Arogya Yojana aims to help the rural sector avoid debt traps and avail services by providing yearly assistance of Rs. 5 lakhs. The coverage of Rs. 5 lakhs could be utilised, not just by individuals but also by their families in general.
7. Under the Ayushman Bharat Scheme, Health ID will be given to every Indian. This health account will contain details of every test, every disease, the doctors visited, the medicines taken and the diagnosis. This information will be very useful as it is portable and easily accessible even if the patient shifts to a new place and visits a new doctor.
8. National digital health mission is a holistic, voluntary healthcare programme which will integrate doctors, hospitals, pharmacies, insurance companies and make a digital health infrastructure. The health ID card is created with details like Aadhar and mobile number and generates a unique ID for each individual. The national digital health mission includes health ID, Digidoctor, telemedicine, ePharmacy, healthcare registry and personal health records digitally stored.

9. **PMJAY Challenges:**

9.1. This lump sum is enough to cover both medical and surgical treatments in 25 specialities which include cardiology, neurosurgery, oncology, orthopaedics etc. However, it states that medical and surgical treatments cannot be reimbursed simultaneously, which may be a cause of worry for families that have more than one patient.

9.2. Keeping in mind the knowledge of technology and Due to lack of education, not every person in a rural area would be able to access the card without any trouble. To make the health care services cashless it becomes essential to first help them understand its usage.

9.3. If multiple surgeries are necessary, the highest package cost is paid in the first instance, followed by a 50% waiver for the second and a 25% discount for the third.

9.4. A report claimed that a family in Gujarat had obtained a 1700 Ayushman Card through fraud. Reacting to this report, the National Health Authority (NHA) has said that the matter was detected by National Anti-Fraud Unit (NAFU) in August 2019 and shared with the Gujarat Health agency which disabled the cards.

9.5. An FIR was lodged by the State on November 8, 2019. An NHA official told FE Online that the health authority has been proactively detecting suspect e-cards with the help of algorithms developed by NAFU. The detected frauds are shared with states for due diligence and action. The media report on the fraud in Gujarat was based on the same information shared by NAFU with the state.

9.6. The official said that there is no possibility of a 'Farzi' (fake) e-Card being generated automatically by the System. Explaining the reason, he said: "The e-card generation process requires a go-ahead by the authorised persons based on supporting documents and final approval of the State Health Agency officials to not just create an e-Card, but also to add any additional family members."

9.7. Covid-19 pandemic has put hospitals and health officials under heavy stress with millions testing positive. However, the medical fraternity had taken up the challenge valiantly and have reduced the fatality rates drastically making the death rate much lower than many developed countries.

9.8. Drawback of PMJAY is the limited network of empanelled hospitals and the request by private hospitals to pay upfront which they promise to reimburse upon payment received by the government. This negates the policy goal of cashless treatment.

CHAPTER II

POLICY CHANGES FOR EFFECTIVE IMPLEMENTATION

1. POLICY GOALS

The goal of this policy is to ensure medical care for the marginalised sections of the society. Key policy changes are to clarify certain discrepancies in the scheme.

1.1. **E-Health Cards:** Health cards are provided to every individual covered under PMJAY to avail medical insurance for payments of hospital bills owing to surgery, and contains details of every test, every disease, the doctors visited, the medicines taken and the diagnosis. This information will be very useful as it is portable and easily accessible even if the patient shifts to a new place and visits a new doctor.

1.1.1. Wider Accessibility of E-Health cards to the rural communities and increase in scope of benefits received from the usage of cards.
1.1.2. Accessibility can be increased through monitored deployment of mobile vans to distribute e-health cards after successful registration in every village of a district
1.1.3. District teams have to be setup under central administration to monitor and assess the distribution and usage of E-health cards
1.1.4. Transparent database has to be maintained by the district team under the aegis of the National Digital Health Mission
1.1.5. Cashless treatment in practice has to be ensured through pre-coverage of hospital bills after the treatment
1.1.6. Reimbursement post treatment leads to payment of full cost of hospital bills by the patient which leads to negation of cashless treatment under PMJAY
1.1.7. Coverage of healthcare costs during treatment through E-health credit card system to enable cashless and efficient transaction/treatment
1.1.8. Subsidization of healthcare costs based on income level of the family as described by the beneficiary at the time of treatment determined through the E-health card.
1.1.9. No patient would be kept under hold of treatment/surgery covered under PMJAY in lieu of pre-authorisation clearance from the national insurance company or its subsidiaries listed for PMJAY that work under the direct command of the Ministry of Health and Family Welfare.

1.1.10. Submission of the E-health card would be sufficient to initiate treatment of the patient as delay due to pre-authorisation clearance should not put the life of the patient in risk which can be impunitive.

1.2. **Insurance expenses and payment:** Claim of medical insurance and coverage of hospital bills are the main policy goals of this scheme that need rectification.

1.2.1. COVID-19 is a special emergency situation globally and India is arguably the worst hit country. This scheme should introduce a 'wartime' clause to tackle pandemic-like situations.

1.2.2. 'Wartime' governance calls upon public healthcare institutions to share costs with centre and state to cover costs of hospital expenditure for individual well-being and state welfare.

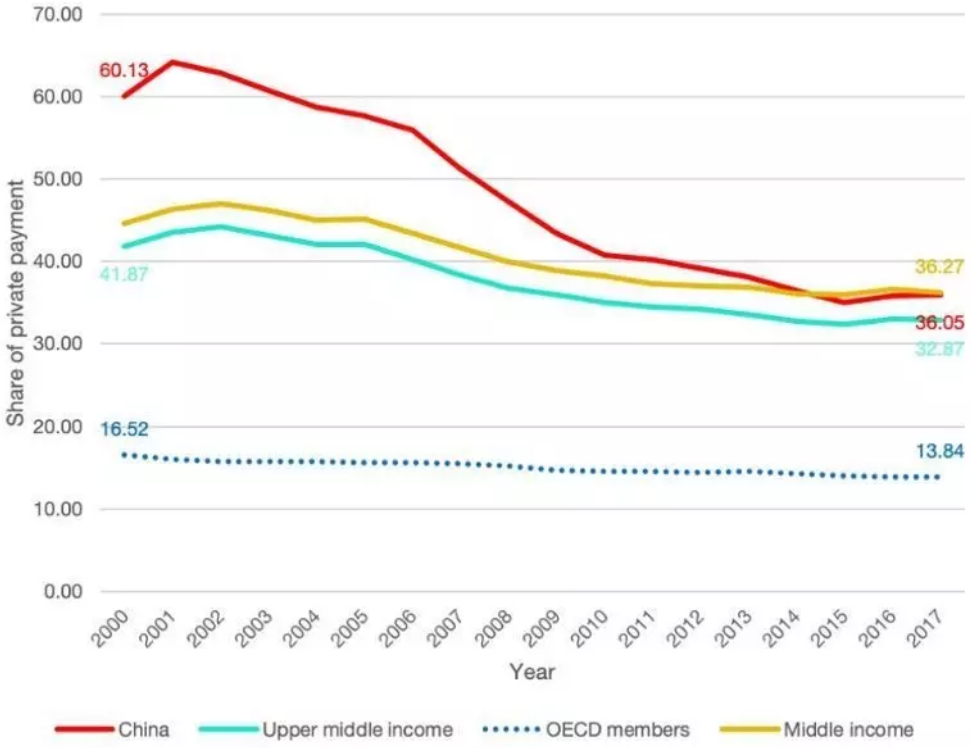
1.2.3. PMJAY needs to act as an emergency socialised medical insurance policy for every individual of the country seeking hospital treatment owing to COVID-19.

1.2.4. Public finance and fiscal policies need to utilise taxes collected and increase healthcare expenditure with reallocation of resources in the economy to fulfil the requirements of public healthcare infrastructure.

1.2.5. Contextualised through China's case, the share of out-of-pocket payments towards healthcare expenditure in China was 36.05%, slightly better than the middle-income country average and just behind the higher-middle income country average in 2017[1].

1.2.6. An individual's payment liability declined to virtually zero when facing the COVID-19 bill, which is attributable to a further welfare expansion in response to a public health crisis[2].

[1] https://www.weforum.org/agenda/2020/12/how-china-pays-for-its-covid-19-medical-bills/
[2] https://www.weforum.org/agenda/2020/12/how-china-pays-for-its-covid-19-medical-bills/



[3]

1.2.7. The outbreak has been a thought-provoking lesson in risk management for all of society. Its rapid spread, the government's bleak response, and citizens' reaction, have aroused public awareness of risk coverage, especially of health risks[4]

1.2.8. Insurers who rely heavily on traditional channels and tools of insurance took the hardest hit by the virus outbreak. It is imperative these small and mid-sized insurance providers develop themselves digitally through government support to avail digital proposals and e-contract signing.

1.2.9. Internet channel building and introduction of blockchain is essential to streamline information to increase engagement, analyse affordability, fragmentation as millions seek help from the government.

1.2.10. This can be done in three stages:

1. strengthen partnerships with 3rd-party internet platforms through product innovation to gain share of internet traffic;
2. advance development of self-owned digital channels to attract private domain traffic from customers of other third party and self-owned channels, creating a platform for online customer management and operation; and

[3] *World Bank Data*

[4] Extraordinary service COVID-19 and China's Insurance Industry

3. compete in the digital insurance platform sector through strategic alliance, self-built or acquired platforms[5].

1.2.11. Medical insurance can be broken down into three subcategories under nationalised healthcare insurance with improved digital distribution channels:

1. basic cover for urban enterprise employees,
2. basic cover for other urban residents, and
3. rural cooperative medical insurance for the farming population.

1.2.12. Disease control research support to hospitals and communities: Insurance claim and customer behaviour data combined with hospital diagnosis and treatment data can provide insights into pandemic prevention and control, vaccine research and development, value-based medicine, innovative diagnosis and treatment methods[6].

1.2.13. Health intervention for individuals: Within legal boundaries, insurance companies can collect health data through smart home equipment, wearables and online communication devices to help policyholders be more compliant with treatment instructions and provide meaningful health interventions for individuals and families[7].

[5] Improve channel management capacity: Extraordinary service COVID-19 and China's Insurance Industry

[6] Improve Med-Tech capability and assist public health system development: Extraordinary service COVID-19 and China's Insurance Industry

[7] Supra, Note 6