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HEALTH INSURANCE IN HIMACHAL PRADESH: TRACING THE JOURNEY

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Abstract

Health Insurance as a mode of health financing is a foundation for appropriate, affordable and optimal use of healthcare services and to reduce the overdependence on out of pocket expenditure. This article attempts to trace the journey of health insurance in the State of Himachal Pradesh. With humble beginnings in 2008, when Rashtriya Swasthya Bima Yojana was launched in two Districts of the State, the Government has now scaled up the model both quantitatively and qualitatively and has set the ambitious target of universalizing the health insurance. Through flagship schemes – Ayushman Bharat and HIMCARE, every family in the State is now eligible for a health insurance cover of Rs. 5 lakh per year for indoor treatment in empanelled hospitals. However, the journey has not been without its due share of challenges and relative failures. This paper also endeavors to describe in detail the process of evidence based policy making based on past experiences which has ultimately led to the formulation of Himachal Health Care Scheme, which promises to be the panacea for health insurance in the State.

Introduction

Over the last few decades, with the availability of advanced health care facilities and better training of medical personnel, the healthcare system in India has improved considerably. This has resulted in significant increase

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in the life expectancy and improvement in various health indicators. But at the same time, the country still faces many serious problems with respect to the accessibility, affordability and quality of the health delivery system. Apart from this, any unforeseen medical need may adversely affect the financial condition of a family and may push the family into debt trap. High Out of Pocket (OOP) expenditure on healthcare financially stresses individuals and households and poses barrier to access for healthcare. This is especially true in case of poor families who cannot afford such medical treatment leading to catastrophic health expenditure and further impoverishment.

An overview of literature shows that the OOP expenditure on healthcare in India is approximately 62.6% of the Total Health Expenditure1. Only 15% of the total population in India is covered under Health Insurance. This is coupled with considerable low public expenditure on healthcare which is 1.18% (2016-17) of Gross Domestic Product. Hence, vast majority of households are pushed Below Poverty Line (BPL) because of expenditure on healthcare.

Keeping in view the above scenario, exploring the healthcare financing options becomes very critical. Health financing mechanisms are the mainstay for appropriate use of healthcare services and to reduce the overdependence on OOP payment. Universal Health Coverage (UHC) can be ensured only when there are no financial barriers to access good quality healthcare i.e. acceptable to the citizens of the State. Since, health is a fundamental right and is covered under the State list as per the constitutional scheme; it becomes duty of the State Government to cater to the health needs of its people. Health Insurance is a viable mechanism to finance healthcare to protect ones savings and avoid debts. Having Health Insurance increases the access of individuals to healthcare and protects the households from high medical expenses at the time of illness. This also prevents catastrophic OOP expenditure and impoverishment.

Health Insurance Models

There are various Health Insurance models adopted across the world. These include Social Health Insurance, Private Health Insurance and Community Based health Insurance. Social Health Insurance is based on

risk pooling and pools both the health risks of the people on one hand, and the contributors of individuals, households, enterprises, and the Government on the other. It thus protects people against financial and health burden and is a relatively fair method of financing health care. In India, there are two mandatory and contributory Health insurance schemes which include Central Government Health Scheme (CGHS) for Government of India employees and Employees State Insurance Scheme (ESIS) which is for low paid industrial workers. In addition to this, the Central Government has recently launched Ayushman Bharat- Pradhan Mantri Jan Arogya Yojna (AB-PMJAY) under which categories belonging to Socio Economic Caste Census (SECC) 2011 (D1 to D7, except D6) and families enrolled under RSBY are included without paying any extra premium cost4. Under Private Health Insurance, which is a type of voluntary health insurance, an individual can enroll and purchase the insurance product as per their requirement by paying a risk rated premium. Examples include ICICI Lombard, Max Health Insurance, Star Health Insurance etc. However, the Private Health Insurance does not allow reimbursement for pre existing conditions and has astronomical rates of premium which preclude its use by economically weaker sections of the society. Community Based Health Insurance is based on pre payment mechanism with pooling of health risks and funds taking place at the level of community or a group of people who share common characteristics like geographical or occupational characteristics. Some Community Based Health Insurance schemes5-7 in India include Vajpayee Arogyashri Scheme, Yeshaswini scheme, Rajiv Arogyasri Community Health Insurance scheme etc. However, these schemes are largely circumscribed and involve a greater degree of public mobilization to take off.

Institutional framework for Health Insurance in Himachal Pradesh

With a view to institutionalize the Health Insurance framework in the State, the Government decided to set up a Society under the Chairmanship of Administrative Secretary (Health) to the Government of Himachal Pradesh. Accordingly, Himachal Pradesh Swasthya Bima Yojna Society (HPSBYS) came into existence in 2008. The Society had provision of appointment of a Chief Executive Officer (CEO) who would look after the

operations of the Society and the functioning of various Schemes at grassroot level. As per the provisions of the Society, the CEO is being assisted by Additional Chief Executive Officer, two Consultants, Assistant Controller (Finance & Accounts), Accountant, Data Manager, Data Entry Operators and Office Assistant. The field footprint of the Society is through the existing institutions of Chief Medical Officers and District Coordinators who are on the rolls of the Society. Besides this, the Society has engaged Third Party Administrator (TPA) having institutional structure of their own at State and District levels.

Rashtriya Swasthya Bima Yojana

In India, one of the pioneer schemes launched by Government was Rashtriya Swasthya Bima Yojna (RSBY), which was a Social Health Insurance scheme, in the year 2008 to cover most poor and vulnerable groups under Health Protection. The scheme intended to provide health insurance coverage to unorganized sector workers and the families belonging to BPL and 11 more such vulnerable categories. In Himachal Pradesh, RSBY was started in the year 2008-09. Initially, it was started in two Districts i.e. Shimla and Kangra in the first phase and then was extended to the entire State from 1st March, 2010. The categories covered under RSBY in the State included BPL families, MGNREGA workers, Building & other Construction Workers, Street Vendors, Sanitation Workers, Auto Rickshaw & Taxi Drivers. Under RSBY, only basic illnesses were covered and the maximum limit for a family was Rs 30,000 per family per year. Adding on to this, the State Government started RSBY Plus (Critical Care) in the year 2010 which covered serious ailments to the tune of Rs 1,75,000. All the expenditure under Critical Care was borne by State Government and only three Government hospitals were allowed to provide services under RSBY Plus. These included Indira Gandhi Medical College (IGMC) Shimla, Dr. Rajendra Prasad Government Medical College (RPGMC) Kangra and Post Graduate Institute of Medical Sciences and Research (PGIMER) Chandigarh. In the year 2016, the State Government decided to increase the Cancer Cover under Critical Care to 2, 25,000. The last enrollment under RSBY took place in 2014-15 and total 4.84 Lakh families were enrolled by 31st March, 2015.

Mukhya Mantri State Health Care Scheme (MMSHCS) & Himachal Pradesh Universal Health Protection Scheme (HPUHPS)

Since all the vulnerable groups were not covered under RSBY, the State Government decided to launch another scheme namely Mukhya Mantri State Health Care Scheme which covered nine weaker groups including Ekal Naaris (single, widows and separated ladies), Senior Citizens more than 80 years of age, Daily Wage Workers (Government, Autonomous Bodies, Societies, Boards and Corporations), Part Time Workers (Government Autonomous Bodies, Societies, Boards and Corporations), Mid-Day Meal Workers, Aanganwari Workers and Helpers, Contractual Employees (Government, Autonomous Bodies, Societies, Boards and Corporation) and persons with more than 70% disability. The scheme was being implemented on the same analogy and had the similar benefits as of RSBY. Total families enrolled under MMSHCS were 1.05 Lakh.

The State then analyzed the existing family data8 and worked out the gap required for covering the entire population under health coverage. The details of the families can be seen at **Table -1.**

Table -1: Family data analysis and working out requirement for universalization of health coverage

Sr. No.	Scheme /Category	Families
1.	Total families	16.57 Lakh
2.	RSBY enrolled families	4.84 Lakh
3.	MMSHCS enrolled families	1.05 Lakh
4.	Regular Government Employees	2.68 Lakh
5.	Retired Pensioners	1.55 Lakh
6.	Total Families already covered	10.12 Lakh
7.	Families required to be covered for universalisation	6.45 Lakh

As can be deduced from the tabulation, around 6.45 Lakh families were required to be covered under health protection to universalize the health coverage in the State. The State then took a bold step and launched the Himachal Pradesh Universal Health Protection Scheme (HPUHPS) in August 2017 and with this launch Himachal became the first State in India to cover its entire population under Government health protection

scheme. The objective of this scheme was to improve the access of beneficiaries to quality healthcare by providing them cashless treatment for various diseases that require hospitalization. The scheme was intended for those families who were not covered under RSBY, MMSHCS or were not having any Government Medical reimbursement. The benefits under this scheme were on the same analogy as of RSBY and RSBY plus i.e. Rs 30,000 per family per year for Basic Package, Rs 1,75,000 and Rs 2,25,000 for Critical Care and Cancer respectively. An overview of the Health Insurance/Protection Schemes implemented in HP since 2008 along with their utilization is depicted in **Table-2.**

Table 2: Overview of Health Insurance schemes in Himachal Pradesh along with utilization

Name of the Scheme	Started since	Number of enrolled beneficiary families	Annual Card utilization (in percentage)	Average annual cost Per Claim (in rupees)	Per annual cost per family (in rupees)
RSBY	2008	4.84 Lakh	9.88	4737	372
RSBY Plus	2010	4.84 Lakh	0.5	40,000	207
MMSHCS	2016	1.05 Lakh	5.32	9890	380
HPUHPS	2017	1.66 Lakh	11.57	6776	784

Himachal Health Care Scheme (HIMCARE) – learning from the past

The need of improvisation in the existing system under HPUHPS and MMSHCS was multifold. The primary requirement for development of new systems was the absence of any robust Transaction Management System (TMS). Prior to the rolling out of HIMCARE, the system employed by the State was the one which was provided for by the Ministry of Labour & Employment (popularly called the MoLE software) for RSBY. The MoLE software was an IP based software and its biggest drawback was the absence of any anti-fraud controls. The system just required blocking of card as per the package prescribed and there was no provision for uploading of clinical notes and other documents which could substantiate the claim raised by the concerned hospital. Another flaw of the MoLE software was the necessity to upload the claims from the local drive to the

server, which almost always led to data loss and resulted in the under-processing of claims. This prompted to develop a state of art TMS where all these issues were addressed. The new system developed was cloud based and mandatorily provided for uploading of the clinical documents including laboratory investigations and the bills of various drugs and consumables utilized so that the claims raised can be verified before making payments to the concerned hospitals. Furthermore, as the RSBY was subsumed into AB-PMJAY, the serviceability of the MoLE software was withdrawn from the Government of India and any roll back would have adversely affected the State schemes which were solely dependent upon this system. The new TMS also provided for customized Management Information System (MIS) reports and allowed for tracking of claims, thereby enhancing the accountability and answerability of various stakeholders in the whole process of health insurance.

Another reason felt for improving the systems being followed was the problems being encountered in the enrolment of beneficiaries. The existing system entailed a two step process, starting with the uploading of documents and payment of premium and the second step being capturing of biometrics at the end of which a physical card was printed and issued to the beneficiary. This however resulted in a lot of operational difficulties. Only those family members were enrolled who presented themselves at the time of capturing of biometrics. Moreover, the Third Party Administrator (TPA) engaged under the scheme authorized Lok Mitra Kendras (LMKs) are their own level, which started conducting field camps for the first step and overcharging could not be ruled out in the absence of any legally binding document. Although the State pursued criminal cases against some of the LMKs and middlemen for overcharging in cases which came to its knowledge, the possibility of a more widespread duping could not be ruled out in the system being used back then. Furthermore, there was no facility of self-registration in the sense that even no computer literate beneficiary family could complete the registration process online. The generation of physical card also entailed a huge expenditure on the State exchequer and the cost of each card translated to around 69 rupees. If this is extrapolated to around target 6 lakh families, it turned out to be staggering estimated cost of around 4 Crores, expenditure which would have contributed virtually nothing. Keeping these issues in mind, these

two steps in process of enrolment were merged and a very convenient Beneficiary Enrollment System (BES) was indigenously developed. Now the beneficiaries could self register through the portal without the need to visit any office thereby minimizing the interface between Government and the citizens. This was further taken forward and Memorandum of Understanding (MoU) was signed with Common Service Center - Special Purpose Vehicle (CSC SPV) and all the LMKs/CSCs have started beneficiary enrollment on a nominal fee of Rs 50/- per family. Appropriate safeguards for fraud control were inserted in the tripartite MoU signed between Himachal Pradesh Swasthya Bima Yojna Society (HPSBYS), CSC-SPV and the Department of Information Technology (IT), Government of Himachal Pradesh. The new system developed was based on e-cards and was very convenient as upon the successful enrolment of the beneficiary family, SMS based facility was provided and a link to download the HIMCARE e-card was sent to the Head of family.

Another challenge posed by the system being used before HIMCARE was the authentication of the beneficiary before taking treatment. As elucidated above, the MoLE system entailed only blocking and unblocking of physical card and there was no mechanism to authenticate and identify the patient on real time basis. In the absence of such system, there was a chance of fraudulent claim raising, however miniscule it may be. To plug this loophole, the State developed Patient Registration System (PRS) wherein the beneficiaries seeking treatment are being identified through integrated database on the basis of biometrics and other particulars. This has also led to convenience for the patients, since they need not carry anything and can be simply identified on the basis of fingerprints besides ensuring a robust anti-fraud system in place.

Yet another drawback of existing system was the issue of adverse selection. It was observed that it was commonplace that the patients seeking treatment in a hospital would go to the nearest enrolment centre just before admission or even after that, and get themselves enrolled in the schemes and avail benefits. This had led to a higher card utilization rate in HPUHPS as compared to RSBY (in which no fresh enrolment was being carried out) as can be seen in Table 2. The State Government took a conscious decision to therefore, limit the time of enrolment to only three

months in a year. However, the impact of this decision remains to be seen since this is the first year of HIMCARE and the enrolment has been allowed till 31st of March every year.

Another issue which needed to be considered while framing of new policy was the sustainability of the initiative. The benefit in MMSHCS and HPUHPS was initially allowed to the tune of Rs. 30,000 per year per family for basic packages and Rs. 1,75,000 and Rs. 2,25,000 for Critical Care and Cancer packages respectively. Now, with the launch of AB-PMJAY in which around 5 lakh families of the State were entitled to claim benefits to the tune of Rs. 5 lakhs per family per year, the State Government decided to give benefits in State schemes at par with Ayushman Bharat. Therefore, it was imperative that the costs of healthcare being borne by the State Government be analysed. It was found out the cost being borne by the State Government under HPUHPS was far in excess of premium being charged. The premium being charged was Rs 365 per year whereas the annual per card cost was coming upto Rs. 784. (Table 2). Since the Above Poverty Line (APL) and other well to do families were covered under the HPUHPS, the Government decided to enhance the premium to Rs. 1000 per year from Rs. 365 per year. Also, a differential premium slab was incorporated which allowed for a greater degree of cross subsidization as the premium was kept zero for very vulnerable sections and nominal to the tune of Rs. 365 per year for other vulnerable groups. Furthermore, in order to enhance the outreach, the ambit of vulnerable groups was expanded and categories like disabled and senior citizens were relaxed to give benefit of lower premium to more individuals in these vulnerable categories. The premium slab can be seen at Table 3.

Table 3: Differential premium slab in HIMCARE

Category	Target group	Premium amount
I	BPL and Registered Street Vendors (Not covered under Ayushman Bharat)	Zero
II	• Ekal Naaris • Disabled >40% • Senior Citizens above 70 years of age • Anganwari Workers	Rs. 365 per year

	• Anganwari Helpers • ASHA workers • Mid-Day meal workers • Daily Wage Workers (Government, Autonomous Bodies, Societies, Boards & Corporations etc.), • Part Time Workers (Government, Autonomous Bodies, Societies, Boards & Corporations etc.) • Contractual Employees (Government, Autonomous Bodies, Societies, Boards & Corporations etc.)	
III	• Beneficiaries not covered under category-I and category-II or who are not Government servants or their dependent family members.	Rs. 1000 per year

To provide a uniform platform of benefits and to avoid reinventing the wheel and duplication of efforts, the State government further decided to adopt the packages in Ayushman Bharat (which had been customized by the State) and the empanelment process of hospitals. At present, the State is offering treatment under around 1800 packages including day care/critical care and cancer treatment in both Ayushman Bharat and HIMCARE, which is way above the approximately 1300 packages prescribed and being provided in other States under Ayushman Bharat.

HIMCARE- Achievements

With the launch of new system, incorporating solutions for all problems that were being faced earlier, the process of health insurance has largely become a more streamlined and effective one. The following have been the major benefits accrued from the new systems under HIMCARE:

1. Centralized monitoring of all State Health Insurance schemes.
2. Time effective solution for Hospitals for patient registration and claim raise.
3. Cost effective as plastic card replaced with e-cards.
4. Weeding out of ghost/duplicate beneficiaries.
5. Effective service delivery as citizens can track their application status online as well as they get information over SMS.

6. Accuracy in data processing as whole system is now automated and there is very less manual intervention in that.
7. Diminution of Citizen-Government interface and less footfall of citizens in Government offices.
8. Enhanced rate of registration along with porting of existing 2.7 Lakh beneficiary families under State schemes.
9. Robust anti-fraud mechanism both for enrolment and claim processing.
10. Reduction in turnaround time of claim payment to approximately 15 days.
11. Better and effective coordination between the various agencies resulting in greater penetration and better administration of the scheme.

Challenges and future course

Although, the scheme HIMCARE has been designed incorporating all the learnings of the past and promises to be the panacea for all ills in the health insurance sector in Himachal Pradesh, it still is beset with few problems which are expected to be ironed out in the initial phase. First and foremost challenge is a coordinated Information, Education and Communication (IEC) campaign. It is often said that information is power and to achieve this end, the Government has launched a coordinated and concerted effort through field functionaries of Health, Public Relations and Rural Development Departments. Nukkad nataks are being organized for clusters of Panchayats where the masses are being educated through dance and drama. The Panchayati Raj Institutions (PRIs) are being sensitized throughout the State for twin pronged objectives of saturation and minimizing fraud. Another important challenge is the optimization of packages both qualitatively and quantitatively. With the advent of modern medicine, latest treatment modalities are being incorporated in the armamentarium of the medical personnel. It is a challenge to keep the packages abreast with this advancement and more so, the process of cost determination which needs to be based on sound and logical reasons.

Conclusion

Himachal Pradesh is the first State in India to offer Universal Heath Protection through HIMCARE. The model is unique as it is largely self sustainable, being funded through the beneficiary contributed premium and the viability gap being provided by the State. Furthermore, the differential premium slab ensures cross subsidization of the economically weaker and other vulnerable groups of the society. The benefits under the scheme are at par with Ayushman Bharat. Apart from an attempt to universalize the health coverage, this scheme is operationally exceptional as it is e- card based and allows for self registration by the beneficiary through online portal or through LMK/CSC on the payment of minimal fee. The scheme will go a long way in ensuring that the affordability component of the UHC is adequately addressed.

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