**Ministry of Labour and Employment**

**Rashtriya Swastha Bima** **Yojana :**

**An answer to India’s health needs**

**Getting to know RSBY**

Studies reveal that risk owing to low level of health security is endemic to workers, especially those in the unorganized sectors. The vulnerability of those workers increases when they have to pay for their medical care put of their own pockets without any subsidy or support. While on the other hand, a worker may not have the financial resources to bear the cost of medical treatment, on the other, the public owned health infrastructure itself leaves a lot to be desired. Many people have to resort to borrowing money or selling of assets to pay for treatment for hospitals. Thus, health insurance is one way of overcoming financial handicaps, improving access to quality medical care and providing financial protection against high medical expenses.

RSBY was launched by the Ministry of Labour and Employment, Government of India, to provide health insurance coverage to Below Poverty Line (BPL) families. This was subsequently extended to certain other categories of unorganized workers and their families. The objective of RSBY is to provide protection to identified households from financial liabilities arising out of health issues that involve hospitalization.

Beneficiaries under RSBY are entitled to coverage within a limit for most health problems that require hospitalization. The coverage extends to five members of the family which includes the head of the household, spouse and up to three dependents beneficiaries need to pay Rs.30 as registration fee, while Central Government and State Governments pay the premium to the insurer selected by a State Government on the basis of a competitive bidding for identified beneficiaries.

**How it began: history and genesis of RSBY**

The government in the past years had developed a number of schemes to provide a health insurance cover to selected beneficiaries both at the state as well as the national level. However, most of the schemes were unable to achieve their intended objectives due to issues pertaining to either their design and /or implementation.

The Government of India thereby decided to develop a health insurance scheme that would provide a world class model base3d on lessons learnt from previous schemes implemented in the country. Rashtriya Swasthya Bima Yojana was designed by incorporating good practices and elements of existing schemes, with particular focus on beneficiaries and their requirements.

Rastriya Swasthya Bima Yojana or RSBY was launched on 1st April 2008.

**Salient features of RSBY**

**Unit of Enrollment** - The unit of enrolment for RSBY is a family with a total size up to five members who are enrolled in the schemes. A family comprises the head of the family, spouse, and up to three dependent family members. The dependent family members are identified by the head of the household and accordingly listed in the RSBY beneficiaries’ database. In the event of the spouse not featuring in the beneficiaries’ lists, four such dependent members can be identified for enrolment and listing in the RSBY beneficiaries database. However, if the spouse is part of the identified family list, then it is mandatory to enroll the spouse.

**Package of benefits**- the benefits within this scheme to be provide to the beneficiaries are the following:

1. Cashless health insurance cover for meeting expenses of hospitalization for medical and/or surgical procedures including maternity benefits ,to the enrolled families for up to Rs.30,000 per family per year subject to limits, in any of the empanelled hospitals across India. The benefits to the family is on floater basis i.e., the total reimbursement of Rs.30, 000 can be availed individual or collectively by members of the family per year.
2. Pre-existing conditions/diseases are covered.
3. Coverage of health services related to surgical nature for defined procedures is provided on a day care basis.
4. Provision for transport allowance of Rs.100 per hospitalization is a part of the package.
5. Pre and post hospitalization cost up to 1 day prior to hospitalization and up to 5 days from the date of discharge from the hospital, is part of the package rates.
6. Maternity care and care of the newborn child is also covered in the scheme. This includes the treatment taken in the hospital or nursing home arising out of childbirth, including normal delivery or a caesarean section procedure, and /or miscarriage or abortion induced by accident or any other medical emergency. The newborn child is automatically covered from birth up to the expiry of the policy for that year for all the expenses incurred in availing treatment at the hospital as an in-patient.

**Financing**

The majority of the financing, about 75 percent of the premium amount, subject to a maximum of Rs.565 per family per annum, is provided by the Government of India (GOI), while the remainder is paid by the respective State Governments. In the case of the north eastern states and Jammu and Kashmir, the Government of India’s contribution is 90 percent.

Scheme beneficiaries pay only Rs. 30 as the registration fee. This amount is retained by the State Nodal Agency that is implementing body for RSBY. The State Nodal Agency uses this amount for incurring administrative expenses under the scheme.

For some categories of beneficiaries who are not below the poverty line, premium financing may be different depending on the occupational category of the workers.

**How it works: process flow RSBY**

1. Identifying State Nodal Agencies

Any State Government that wants to implement RSBY needs to set-up or identify an independent body for the implementation of RSBY in the State. In most of the cases, this body is either in the form of a Society or Trust or an Agency set up by the State Government under law.

1. Creating the beneficiary data

The State Nodal Agency prepares the data of beneficiary families in the format specified in the scheme. An electronic version of the prepared data is sent to the Ministry of Labour and Employment, Government of India, uploads this data on the RSBY website after the data verification is completed.

1. Selecting the insurer/insurance company

State Governments engage in a competitive public bidding process to select a public or private insurance company licensed to provide health insurance by the Insurance Regulatory Development Authority (IRDA) or enabled by the Central legislation. One insurance company is selected for each district, with a district being the unit for implementation of RSBY.

1. Setting up support services

Once an insurance company is selected for a particular district, it is mandated to set up an office in the district and also establish a District Kiosk and a Toll Free Call Centre to provide the benefits proposed under the scheme to beneficiaries in the district.

District Kiosk- the insurance company is required to set up a district kiosk in the district before the commencement of the enrolment process. A district kiosk serves as a centre where a beneficiary can get any post issuance modification done in the smart card issued to him or her. For instances, in the event of damage or loss of smart card, a new card can be made at the district kiosk for a prescribed fee.

The State Nodal Agency provides the space for setting up the district kiosk while the insurance company provides the necessary hardware and manpower. The software to operate the district kiosk is provided by the Ministry of Labour and Employment, Government of India.

Toll Free Call Centre – the insurance company is required to provide toll free telephone services and information related to the scheme.

1. Empanelling health care providers

The insurance company empanels both public and provides hospitals in the project district and nearby districts. The empanelment of hospital is done based on prescribed criteria provided by the Government. The insurance company organizes trainings on RSBY and the utilization of smart cards for empanelled hospitals to enable effective provision of services. It is important for the insurance company to effectively communicate about the empanelled hospitals to program beneficiaries. A list of the empanelled hospitals is prepared and is given to the beneficiaries in a brochure at the time of enrollement.The insurer is required to empanel enough hospitals in the district so that beneficiaries need not travel very far to get the requisite health care services.

The empanelled hospitals install the necessary hardware and software so that smart card transaction can be processed and set up a special RSBY desk with trained staffs to ensure proper implementation of the scheme. A unique number is assigned by the Mole to each empanelled hospital along with a Security Smart Card. The Security Smart Card enables the hospital to process the smart cards of beneficiaries when they visit the hospital for treatment.

1. Enrolling beneficiaries

An electronic list of eligible households is provided to the insurer by the Government through the RSBY website, using a pre-specified data format. An enrolment schedule for each village is prepared by the insurance company in consultation with the district and the block administration. Mobile enrolment stations are set up at local centers such as public schools and Panchayat offices.

These enrolment stations are equipped by the insurer by the hardware and software required to collect biometric information (fingerprints) and photographs of the members of the household covered, as well as printers to print smart cards with a photo. The smart card, along with information pamphlet describing the scheme and carrying the list of empanelled hospitals, is provided on the spot. The enrolment process continues for a maximum period of four month in a district.

A government officer, called the Field Key Officer (FKO), is assigned with an independent smart card to verify the enrolment process. The FKO needs to be present at the enrolment station during enrolment and the FKO‘s smart card is inserted to verify the legitimacy of the enrolment. The premium is paid to the insurance company of the basis of the data of families enrolled, download from the KFO card.

1. Utilization of services by beneficiaries

Once a beneficiary is enrolled in a scheme, he/she can enroll any of the hospitals across the country to seek treatment under the scheme. The transaction process begins when a member visits the empanelled hospital. The RSBY help desk up at the hospital verifies the beneficiary’s identity through his/her photograph and fingerprints that are stored in the beneficiary’s smart card.

If a diagnosis leads to a hospitalization, the assistant at the help desk checks whether the procedure is in the list of pre-specified packages. If the procedure is not listed, the help desk assistant checks with the insurer regarding the price for that procedure. At the time of the beneficiary’s discharge from the hospital, the card is again swiped and the fingerprints are verified once again. The pre-specified cost of the procedure is deducted from the amount available on the card and the beneficiary is paid Rs. 100 by the hospital as transportation expense at the time of discharge.

**A look at primary stakeholders**

RSBY is a good example of how a scheme can evolve successfully through the cooperation of different stakeholders. The initial stages of the scheme was supported by the World Bank and Deutsche Gesellschaft Fur Internationale Zusammenarbeit(GIZ) GmbH. While GIZ has been working with the Ministry of Labour and Employment through the Indo –German Social Security Programme for the implementation of RSBY, both organizations have been instructed in developing the design as well as outlining the processes for the scheme.

 There are six primary stakeholders in the scheme: the Central Government, State Governments, State Nodal Agencies, Insurance Companies, Hospitals and NGOs. The roles of each of these stakeholders are represented in the chart below:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Central Government | State Government | State Nodal Agency | Insurer/TPA | NGOs/Other partners | Providers of Care |
| Design and reversion of scheme | \* |  | \* |  |  |  |
| Oversight of scheme | \* |  |  |  |  |  |
| Setting up of nodal agency |  | \* |  |  |  |  |
| Financing of scheme | \* | \* |  |  |  |  |
| Setting parameters (benefits package, empanelment criteria, beneficiary criteria etc) | \* | \* |  |  |  |  |
| Hardware specification(e.g. systems, smart card etc) | \* |  |  |  |  |  |
| Tendering process of selection of Insurance Company |  |  | \* |  |  |  |
| Contract management with insurer |  |  | \* |  |  |  |
| Accreditation/empanelment of providers |  |  |  | \* |  |  |
| Collecting registration fee |  |  |  | \* |  |  |
| Enrolment |  |  | \* | \* | \* |  |
| Financial management/planning | \* |  | \* |  |  |  |
| Actuarial analysis of claims data from hospitals |  |  |  | \* |  |  |
| Setting rate schedules for health services/reimbursement rates | \* |  | \* |  |  |  |
| Claims processing and payment to the hospitals |  |  |  | \* |  |  |
| Outreach, marketing to beneficiaries |  |  | \* | \* | \* |  |
| Service delivery of health care |  |  |  |  |  | \* |
| Developing clinical information system for monitoring/evaluative | \* |  | \* |  |  |  |
| Monitoring state level utilization and patient information | \* |  | \* | \* |  |  |
| Monitoring national RSBY information | \* |  |  |  |  |  |
| Customer service |  |  |  | \* | \* | \* |
| Development of standardized training materials for enrolment teams and hospitals | \* |  |  |  |  |  |
| Organization of training for enrolment teams and hospitals | \* |  | \* | \* |  |  |

**What makes RSBY unique**

The RSBY scheme is not the first attempt to provide health insurance to low income workers by the Government in India. The scheme, however, differs from the other schemes in several important ways and they are the reasons for its success in reaching out effectively to a large population in a relatively brief period of time.

* Empowering the beneficiary- RSBY gives the participating BPL households the freedom to choose from public and private hospitals, making them potential clients worth attracting for the empanelled hospitals on account of the significant revenues that these hospitals stand to earn through the scheme.
* Self-sustaining business model/business model for all stakeholders- the scheme has been designed as a model for the socio sector with incentives built in for each stakeholder. This design is conductive to self- growth, both in terms of expansion of the scheme, as well as for its sustainability in the long run.
* Insurers – The insurer is paid a premium for each household enrolled under RSBY. Therefore, the insurer has the motivation to enrol as many households as possible from the BPL list. This will result in better coverage of targeted beneficiaries.
* Hospitals – A hospital has the incentive to provide treatment to the maximum number of the beneficiaries possible, as it is paid per beneficiaries treated. Even public hospitals have the incentives to treat beneficiaries under RSBY as the money from the insurer will flow directly to the concerned public hospital which they can use for their own purposes. In order to build a checking mechanism to prevent unnecessary procedures or fraud resulting in excessive claims, insurers, in turn, monitor participating hospitals.
* Intermediaries – the scheme ensures the inclusion of intermediaries such as NGOs and MFIs which have a greater stake in assisting BPL households. The intermediaries are paid for the services they render in reaching out to the beneficiaries.
* Government – by paying only a maximum sum of up to Rs. 750 per family per year, the Government is able to provide access to quality health care to the population that lives below the poverty line. The scheme will also lead to a healthy competition between public and private providers which in turn will improve the functioning of the public health care providers

* Forward looking approach by harnessing information technology – for the first time, IT applications are being used for a social sector scheme on such a large scale. Every beneficiary family is issued a biometric enabled smart card containing their fingerprints and photographs. All the hospitals empanelled under RSBY are IT enabled and connected to the server at the district level. This enables a smooth data flow at the regarding service utilization.
* Smart, safe and foolproof- the use of biometric enables smart card and a key management system makes this scheme safe and foolproof. The key management system of RSBY ensures that the card reaches the correct beneficiary and the there remains accountability in terms of issuance of the smart card and its usage. The biometric enabled smart card ensures that only the real beneficiary can use the smart card.
* Pan India usability – the key feature of RSBY is that a beneficiary who has been enrolled in a particular district will be able to use the smart card in any RSBY empanelled hospitals across India. This makes the scheme truly unique and beneficial to the poor families that migrate from one place to the other. Cards can also be spilt for migrant worker families to carry a share of the coverage with them separately.
* Cashless, paperless – a beneficiary of RSBY gets cashless benefits in any of the empanelled hospitals. The beneficiaries just need to carry the smarty card and provide verification through the finger prints. For participating providers, it is a paperless scheme as they do not need to send all the papers related to treatment to the insurer. They send online claims to the insurer and get paid electronically.

**RASHTRIYA SWASTHYA BIMA YOJANA**

**GUIDELINES**

1. INTRODUCTION

The workers in the unorganized sector constitute about 94% of the total work force in the country. One of the major insecurities for workers in the unorganized sector is absence of health cover for such workers and their family members. Insecurity relating to absence of health cover, heavy expenditure on medical care and hospitalization and recourse to inadequate and incompetent treatment is not only a social and psychological burden borne by these workers but there are significant economic costs resulting from loss of earning and progressive deterioration of health. Thus, with a view to providing health insurance cover to Below Poverty Line (BPL) workers in the unorganised sector and their families, the Central Government has announced the “Rashtriya Swasthya Bima Yojana”.

2. HOUSEHOLD ELIGIBILITY CRITERIA

* 1. Coverage under the scheme would be provided for BPL workers and their families [up to a unit of five). A family would thus comprise the Household Head, spouse, and up to three dependents. The dependents would include such children and/or parents of the head of the family as are listed as part of the family in the BPL data base. If the parents are listed as a separate family in the data base, they shall be eligible for a separate card. The definition of BPL would be the one prescribed by the Planning Commission for the purposes of determining the eligible BPL population in each State/district. It would be the responsibility of the respective State Government to verify the eligibility of specific BPL workers and their family members who would be the beneficiaries of the scheme, and to share such information with the insurance provider. To this end, an authenticated BPL list [or lists where the covered area includes urban and rural areas] providing the details of each BPL family will be prepared by the State Government/Nodal agency. The data would be provided in the prescribed electronic format to the insurer. The State Governments may, if required, seek the assistance of an outside agency for the task of data entry. However, the responsibility for providing the correct data shall be that of the State Government and it would be expected of the State Government that it shall put in place a foolproof system of supervision and authentication of the data.
	2. Proof of the eligibility of BPL households for the purposes of the scheme will be provided by issuance of smart cards to all beneficiary households.
1. ENROLMENT OF BENEFICIARIES

 The enrolment of the beneficiaries will be undertaken by the Insurance Company selected by the State Government and approved by the Government. The Insurer shall enroll the BPL beneficiaries based on the soft data provided by the State Government/Nodal Agency and issue Smart card as per Central Government specifications through Smart Card Vender and handover the same to the beneficiaries at enrolment station/village level itself during the enrolment period. Further the enrolment process shall continue at designated centers agreed by the Government /Nodal Agency after the enrolment period is over to provide the smart card for remaining beneficiaries. Insurer in consultation with the State Government/ Nodal Agency shall chalk out the enrolment cycle up to village level in a manner that representative of Insurer, Government/Nodal Agency and smart card vender can complete the task in scheduled time. The process of enrolment shall be as under:

(a) The data relating to BPL families in the selected districts shall be entered into prescribed software by the concerned State Government/Nodal Agency.

(b) A soft and hard copy of this data shall be provided by the State Government/Nodal Agency to the INSURER selected by the State Government/Nodal Agency.

(c) The Insurer will arrange for preparation of the smart card as per the prescribed stipulation.

(d) A schedule of programme shall be worked out by the Government/Nodal Agency in consultation with the Insurer for each enrolment station/village in the district.

 (e) Advance publicity of the visit of representatives of the State Government and the Insurance Provider shall be done by the State Government/Nodal Agency in respective villages.

 (f) List of BPL should be posted prominently in the enrolment station/village by the Insurer.

 (g) The representatives shall visit each enrolment station/village in the selected district jointly on the pre-schedule dates for purpose of taking photograph of the head of the family and the thumb impression of the head of the family and the other eligible member of the family, enrolment and issuance of smart card.

(h) The software to be used by the Insurance Company for the purpose of enrolment and thereafter for the purpose of transaction at the hospitals and data transmission there from shall be the ones approved by the Central Government.

(i) At the time of enrolment, the government official shall identify each beneficiary in the presence of the insurance representative.

(j) At the time of handing over the card, the INSURER shall collect the registration fee of Rs.30/- from the beneficiary.

(k) This amount will be adjusted against the amount of premium to be paid to the INSURER by the Nodal Agency.

(l) The Insurer’s representative shall also provide a pamphlet along with Smart Card to the beneficiary indicating the list of the networked hospitals, the availability of benefits and the names and details of the contact person/persons. To prevent damage to the smart card, a plastic jacket should be provided to keep the smart card.

(m) The beneficiary shall also be informed about the date on which the card will become operational (month).

1. IMPLEMENTATION SCHEDULE

The scheme will be implemented by the State Government in a phased manner in the next five years. The entire country will be covered by 2012-13. In districts where the Scheme is introduced, it would

Supersede the Universal Health Insurance Scheme (UHIS). State wise coverage of the number of districts is at Annexure-I.

1. FINANCING FOR THE SCHEME

 Financing of the scheme would be as follows:

 (a) Contribution by Government of India: 75% of the estimated annual premium of Rs.750, subject to a maximum of Rs.565 per family per annum. Additionally, the cost of the smart cards will also be borne by the Central Government @ Rs.60/- per card.

 (b) Contribution by the respective State Governments: 25% of the annual premium, as well as any additional premium in cases where the total premium exceeds Rs.750.

(c) The beneficiary would pay Rs.30 per annum as registration/renewal fee.

(d) Any administrative and other related cost of administering the scheme in each State, not otherwise included in the premium cost, shall be borne by the respective State Governments.

1. HEALTH SERVICES BENEFIT PACKAGE

 6.1 The beneficiary shall be eligible for coverage of the financial costs of such inpatient health care services as would be negotiated by the respective State government with the insurer(s), as well as agreed daycare procedures not requiring hospitalization. However, the following minimum features of the health insurance plan would be as follows:

 (a) Total sum insured of Rs.30, 000 per BPL family per annum on a family floater basis.

(b) Pre-existing conditions to be covered, subject to minimal exclusions. An indicative list of exclusions is provided in Annexure II.

(c) Coverage of health services related to hospitalization and services of a surgical nature which can be provided on a daycare basis. Annexure-III contains an indicative list of daycare treatment.

 (d) Cashless coverage of all health services in the insured package.

(e) Provision for a smart-card based system of beneficiary identification/verification and point of service processing of client transactions.

 (f) Provision for reasonable pre and post-hospitalization expenses for one day prior and 5 days after hospitalization, but subject to a maximum share of the total costs of the hospitalization.

(g) Provision for transport allowance (actual with limit of Rs.100 per visit) but subject to an annual ceiling of Rs.1000. 6.2 In addition to the above minimum, in their proposals, States should specify in detail the proposed package of health services to be covered under the Scheme, as well as the proposed exclusions.

7. PAYMENT OF PREMIUM

 Payment of registration fee and premium installment will be as follows:

a) The registration fee of Rs.30 by the beneficiary to the insurance company.

b) The first installment will come from the State Nodal Agency to the insurance company in the nature of 25% of (X-60)-30. (X being the premium amount per beneficiary).

 c) The second installment will be paid by the Central Government through the State Nodal Agency as per the following formulation: 75% of (X-60)+60 (Subject to a maximum of Rs.565/- + Rs.60/-) {Any amount beyond the contribution by the Central Government will be borne by the State Government.}

 8. ELIGIBLE HEALTH SERVICES PROVIDERS

 Both public (including ESI) and private health providers which provide hospitalization and/or daycare services would be eligible for inclusion under the insurance scheme, subject to such requirements for empanelment as agreed to between the State Government and insurers.

 9. REQUIREMENT OF TENDER TO SELECT INSURANCE PROVIDER

 The State Government will be required to select one or more health insurers on a periodic basis according to a tender process which would take account of both the price of the insurance package and technical merit of the proposal. The tender should be open to both public and private sector health insurers who meet the relevant IRDA standards. If the period of the contract with the successful bidder exceeds one year, the State should provide for performance indicators or other mechanisms to extend the contract annually.

10. SUBMISSION AND APPROVAL OF THE PROPOSAL

10.1 The proposals of the State Governments will be considered by the Approval and Monitoring Committee set up by the Central Government. The elements that States would need to address in their proposals include the following:

(a) Tendering and contracting procedure for insurer/partners.

(b) Overseeing arrangements (e.g. district and block monitoring bodies). Representatives of civil society, including Panchayati Raj institutions, should be adequately represented on relevant State, District and Block level overseeing bodies.

(c) Status of BPL data and its conformity with the prescribed standards, readiness for provision to insurer and estimates of BPL population in covered districts.

 (d) Training plan of State Government, insurers and others to ensure adequate capacity for Scheme implementation.

(e) IEC/awareness raising mechanisms (start-up and ongoing), including any special/extra channels for harder-to-reach groups. Role of intermediaries/NGOs/MFIs/Cooperatives therein.

(f) Enrollment and renewal procedures, including identification of beneficiaries.

 (g) Empanelment/accreditation of health providers, including minimum requirements for health facilities to be included in the Scheme and administrative capacity. An indicative list of requirements is provided in Annexure IV.

(h) Process for smart card provision and operation.

(i) MIS and database management, including collection of data on patients/providers and its use.

(j) Evaluation of impact and performance, including provision for baseline survey(s). (k) Grievance redressal mechanisms.

(l) Financing plan for State Government premium contributions and other administrative expenses to be incurred in Scheme operation.

(m) How the proposed Scheme would interact with any existing health insurance schemes in the proposed district(s).

10.2 The Central Government Approval and Monitoring Committee would assess all State Government proposals to ensure that credible implementation arrangements were in place for all of the above.

 11. RESPONSIBILITIES OF GOVERNMENT OF INDIA

 In addition to its financing commitment outlined in Point 4, the Government of India shall undertake the following actions in order to operationalize the Health Insurance scheme:

 (a) Issuance and periodic revision of guidelines for the Scheme.

 (b) Establishment of an Approval and Monitoring Committee to assess health insurance proposals submitted by State Governments for Government of India financing contribution.

(c) In consultation with the States, development of such protocols and common standards as may be necessary to ensure effective functioning of the Scheme on a national basis. This would include determination of the protocol for nationally unique identification numbers for BPL families, specification of the minimal technical standards of the smart card, ensuring timely transfer of the Central financing share of insurance premia, establishment of common reporting protocols for States as part of Scheme monitoring and such other design and implementation issues considered necessary for the functioning of a coherent national system.

(d) Establishment of a Technical Support Cell within the Ministry of Labour and Employment which would provide expert inputs to Central and State Governments on matters pertaining to the design, implementation and monitoring/evaluation of the Scheme. The Cell would be headed by a Senior Advisor, who would be assisted by two Advisors, database management team, support staff, and such other expert personnel as determined from time to time to be necessary to support effective implementation of the Scheme. The Cell would carry out the following functions, inter alia:

 i. Provide technical support to States in development of health insurance schemes for submission to the Central Government.

 ii. Provide ongoing support to State Governments (coordinating with similar Cells at State level) on technical issues in implementation of the Scheme in individual States, including monitoring and evaluation.

iii. Provide the Approval and Monitoring Committee with such financial estimates as may be necessary to assess the budgetary implications of both Central and State Government commitments under the Scheme.

iv. Provide technical inputs to the Approval and Monitoring Committee which will allow it to carry out its monitoring and evaluation functions effectively. v. Undertake and/or commission detailed evaluation studies on Scheme functioning.

 12. DISTRICT SELECTION BY STATES

 States would be responsible for proposing selected district(s) for inclusion in the Scheme, subject to the phased maximum number of districts per State as outlined in Annexure I. In proposing districts for inclusion in the Scheme, States should ascertain that districts have:

(a) An adequate network of hospitals/health facilities which meets minimum standards for service delivery and operation of transactions related to the Scheme.

(b) Adequate presence of potential intermediaries which can partner with health insurers to ensure effective outreach and grassroots support to beneficiaries in various aspects of operation of the Scheme.

 (c) Other basic infrastructure necessary to ensure successful implementation of the Scheme (e.g. electricity; roads).

ANNEXURE -I

SUGGESTED IMPLEMENTATION SCHEDULE

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| SL NO. | STATE  | NO. OF DISTRICTS | (2008-0901 | (2009-10)2 | (2009-10)3 | (2010-11)4 | (2011-12)5 |
| 1. | ANDHRA PRADESH | 23 | 5 | 5 | 5 | 4 | 4 |
| 2. | ASSAM | 23 | 5 | 5 | 5 | 4 | 4 |
| 3. | ARUNACHAL PRADESH | 14 | 2 | 3 | 3 | 3 | 3 |
| 4. | GUJARAT | 25 | 5 | 5 | 5 | 5 | 5 |
| 5. | BIHAR | 37 | 8 | 7 | 7 | 8 | 7 |
| 6. | HARYANA | 19 | 4 | 4 | 4 | 4 | 3 |
| 7. | HIMACHAL PRADESH | 12 | 2 | 2 | 2 | 3 | 3 |
| 8. | JAMMU AND KASHMIR | 14 | 2 | 3 | 3 | 3 | 3 |
|  9. | KARNATAKA | 27 | 6 | 6 | 5 | 5 | 5 |
| 10. | KERALA | 14 | 2 | 3 | 3 | 3 | 3 |
| 11. | MADHYA PRADESH | 48 | 10 | 9 | 10 | 9 | 10 |
| 12. | MAHARASHTRA  | 35 | 7 | 7 | 7 | 7 | 7 |
| 13. | MANIPUR | 9 | 1 | 2 | 2 | 2 | 2 |
| 14. | MEGHALAYA | 7 | 1 | 1 | 1 | 2 | 2 |
| 15. | MIZORAM | 8 | 1 | 1 | 2 | 2 | 2 |
| 16. | NAGALAND | 8 | 1 | 1 | 2 | 2 | 2 |
| 17. | ORISSA | 30 | 6 | 6 | 6 | 6 | 6 |
| 18. | PUNJAB | 17 | 3 | 3 | 3 | 4 | 4  |
| 19. | RAJASTHAN | 32 | 7 | 6 | 6 | 6 | 7 |
| 20. | SIKKIM | 4 | 1 | 1 | 1 | 1 |  |
| 21. | TAMIL NADU | 29 | 6 | 6 | 6 | 5 | 6 |
| 22. | TRIPURA | 4 | 1 | 1 | 1 | 1 |  |
| 23. | UTTAR PRADESH | 70 | 14 | 14 | 14 | 14 | 14 |
| 24. | WEST BENGAL | 19 | 3 | 4 | 4 | 4 | 4 |
| 25. | DELHI | 9 | 1 | 2 | 2 | 2 | 2 |
| 26. | GOA | 2 | 1 | 1 |  |  |  |
| 27. | PONDICHERRY | 4 | 1 | 1 | 1 | 1 |  |
| 28. | LAKSHDWEEP | 1 | 1 |  |  |  |  |
| 29. | DAMAN & DIU | 1 | 1 |  |  |  |  |
| 30. | DADRA & NAGAR | 1 | 1 |  |  |  |  |
| 31. | CHANDIGARH | 1 | 1 |  |  |  |  |
| 32. | ANDAMAN & NICOBAR | 2 | 1 | 1 |  |  |  |
| 33. | UTTARANCHAL | 13 | 2 | 2 | 3 | 3 | 3 |
| 34. | JHARKHAND | 22 | 4 | 5 | 4 | 4 | 5 |
| 35. | CHHATTISGARH | 16 | 3 | 3 | 3 | 3 | 4 |
|  | **TOTAL** | **600** | **120** | **120** | **120** | **120** | **120** |

 ANNEXURE –II

INDICATIVE LIST OF BASIC EXCLUSIONS:

In line with the financial protection objective of the Scheme, there should be minimum exclusions. The list of exclusions would be negotiated between State Government and insurers, and be subject to assessment by the Approval and Monitoring Committee to ensure that it was not overly wide. Common exclusions that would be expected would include:

 1. Conditions that do not require hospitalization

2. Congenital external diseases

3. Drug and Alcohol Induced illness

 4. Sterilization and Fertility related procedures

5. Vaccination

6. War, Nuclear invasion

 7. Suicide

 8. Naturopathy,Unani, Siddha, Ayurveda

ANNEXURE- III

 INDICATIVE LIST OF DAY CARE TREATMENT

 Given advances in treatment techniques, many health services formerly requiring hospitalization can now be treated on a day care basis. Examples of such services which States should consider negotiating in their coverage package with health insurers include:

1. Haemo-Dialysis

2. Parenteral Chemotherapy

3. Radiotherapy

4. Eye Surgery

5. Lithotripsy (kidney stone removal)

 6. Tonsillectomy

7. D&C 8. Dental surgery following an accident

 9. Surgery of Hernia

10. Surgery of Hydrocele

11. Surgery of Prostrate

12. Gastrointestinal Surgery

 13. Genital Surgery

14. Surgery of Nose

 15. Surgery of Throat

16. Surgery of Ear

17. Surgery of Appendix

18. Surgery of Urinary System

19. Treatment of fractures/dislocation (excluding hair line fracture), Contracture releases and minor reconstructive procedures of limbs which otherwise require hospitalization

20. Laparoscopic therapeutic surgeries carried out in day-care

21. Any surgery under General Anesthesia

22. Any disease/procedure mutually agreed upon.

 ANNEXURE IV

 GUIDANCE FOR ENROLLMENT OF HOSPITALS

 Hospital and other health facilities with desired infrastructure for inpatient and daycare services will need to be empanelled. It is essential to have a proper system of empanelment. The process will be carried out by the Insurer. However, States may assist to complete the task.

All Government hospitals (including Primary and Community Health Centres) and ESI hospitals can be empanelled provided they possess they facility to read and manage smart cards. The criteria for empanelling private hospitals and health facilities would be as follows:

1. At least 10 inpatient medical beds for primary inpatient health care.

b) Fully equipped and engaged in providing Medical and Surgical facilities, including diagnostic facilities, i.e. pathology testing and X-ray, E.C.G. etc for the care and treatment of injured or sick persons as in-patient.

c) Fully equipped Operating Theatre of its own where surgical operations are carried out.

d) Fully qualified doctors and nursing staff under its employment round the clock.

e) Maintaining of necessary records as required to provide necessary records of the insured patient to the Insurer or his representative/Government/trust as and when required.

 f) Registration with Income Tax Department.

 g) Telephone/fax and internet facilities, and machine(s) to read and manage smart card transactions. \* \* \*