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Modicare vs Medicare

Veena Satya[1*] and Vibhooti Satya Paliwal[2]
[1]Department of Botany, S.B.N. Govt. P.G. College Barwani, M.P., India
[2]Scholar of MS HSA, Madonna University, Michigan, USA
vsatya2001@yahoo.co.in

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Abstract

The Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), famous by the name of Modicare or Ayushman Bharat Yojana, is the largest health insurance scheme of the world. It is based on the health care scheme of America, started by Barak Obama in March 2010 also known as ACA or Obamacare. It is a determined approach in the reforming the health care sector in India. The Gross domestic product (GDP) in terms of health care expenditure of India is amongst the lowest in the world at just over 1%. While the United States health care spending grew to 3.9 Percent in 2017, reaching $3.5 trillion or $10,739 per person. The share of the nation's Gross Domestic Product, Health spending is accounted for 17.9 percent. Substantial shortfalls relating to infrastructure, workforce, and the quality & availability of services are the major black holes of Indian health system. There is a widespread demand for amendments across both public and private health care sectors if India is to achieve its aims in providing insurance coverage for all its population. The triumph of the program will largely be contingent on a highly organized and appropriately equipped public sector to take charge in launching, implementation, and monitoring of the scheme from the very beginning. The pace and current procedure of the program ought to be carefully evaluated to align the program to gain its objectives with assurance in a viable manner.

Keywords: Ayushman Bharat, Medicare, Pradhan Mantri Jan Arogya Yojana

Introduction

Ayushman Bharat is famous by the name of Modicare**,** Ayushman Bharat Yojana, Prime Minister Jan Arogya Yojana, is the largest health insurance scheme of the world. It was started an 25th September 2018, by PM Narendra Modi. It is believed to be inspired from the health care scheme of America and other national insurance schemes that are present in different countries of the world. The Patient Protection and Affordable Care Act or Obamacare was launched by Barak Obama in 2010. The Ayushman Bharat pursues to expand the financial health protection to the most vulnerable Indian families approximately 500 million. Another goal of this scheme is to prevent 50–60 million Indian families fall below poverty line annually due to such medical-related expenditure. The estimated cost of the scheme is 12,000 crore rupees. Out of which 60% cost will be bore by Central Govt. and 40% will be by State Govt.[1,2]. In India's economy only more than 1% of GDP is allotted for health services[3].

To provide Universal health coverage to Indian population, there are a lot of obstacles. For instance, if a required product/service is not available within the Indian manufacturing ecosystem, which is of particular concern, given that ABY will be accompanied by a substantial increase in demand for medical devices and procedures across the country. Several diseases (estimated more than 1350) even chronic diseases are also covered under this scheme. The treatment is fully cashless. And it is believed that more than 11 lakh jobs will be created[4].

According to National Health Agency (NHA), numbers of beneficiaries reached up to 3.07 crore. Aim of this scheme is to give health insurance of 5 lakh rupees annual to 10.74 crore poor families. The expenditure plan of present year is 5000 crores. Approximately 15400 hospitals are linked with the scheme among them 50% of the hospital are private[5].

There will be 6 zones all over the country: UP, East, West, North, South and central zone. Central Govt. is going to start call centers for the common people and call Centre numbers will be released very soon. It will be 14555 toll free number and by calling on this number one can get any information related to ABY. Subsequently, the amount of call centers could be increased as per the requirement of the state. These call centers will work 24hours seven days a week except 3 national holidays[4]. A treaty has been signed between ministry of health and Ministry of skill development, regarding posting of Ayushman *Mitra* to assist the patients. In each registered hospital one Ayushman *Mitra* will be appointed. For the enrollment of patients, there will be a help desk in each hospital.

Medicare- Insurance Coverage for Aged and Disabled

A federal program known by Medicare is for the elder/aged section of the population. In certain condition, those who are younger than age 65 years and who receive Social Security money assistance are also covered. As, they are considered disabled.

They become eligible for coverage after a 2-year waiting period. Medicare also includes those with permanent kidney failure[6]. Medicare has 4 parts, each of which has its own significance and employs different financing mechanisms. Part A offers Hospital insurance, inpatient care, and limited time at a skilled nursing facility. At Times it also incorporates home health and hospice care. Part B delivers supplemental medical insurance, Part C arrange for their beneficiaries for a larger array of health plan choices. That is often called as Medicare Advantage plans. Lastly, Part D is for prescription drug coverage. The role of federal government in financing this program has soared overtime. The 52% of the total medical expenditures is contained by both federal and state government[7].

Medicaid- Insurance Coverage for Low-Income group and Poor

This is a welfare program for the poor, supporting medical and long-term care above 22 percent of the population. This is commonly referred to as Medicaid. In 1985, the federal govt. spent $23 billion on the program and it was 2.4% of the federal budget. National health spending is projected to grow at an average annual rate of 5.4% for 2019-2028 which brings it up to catch $6.2 trillion by 2028 [8]. Medicaid is authorized to cover some federally mandated population sets, to be suitable for federal matching funds[7].

There are various sections in Medicaid. The first section consists; single parent families, along with those who obtain cash welfare assistance and who were initially entitled for aid to families with dependent children (AFDC). The second section encompasses low-income older people, blind, and disabled persons who meet the criteria for the supplemental security Income. The third category incorporates low-income pregnant women and children who are not eligible for the cash assistance. The fourth group contains those deemed as medically needy persons and have high medical or long-term-care expenses but not entitled for welfare programs. The last section covers low-income Medicare beneficiaries who are unable to afford the deductibles, cost sharing as well as premiums for the Medicare Part B & D. This also covers the cost of services not covered by Medicare[7].

The Patient Protection and Affordable care act (ACA) when came in 2014 brought up changes to Medicaid eligibility. Most crucial among it was expanding coverage to those who are younger than 65 years with income up to 133% of the federal poverty line (FPL)[9]. The ACA provides full federal financing to those who newly eligible (from 100 percent to 133 percent of the FPL) for the years 2014 to 2016. Given the large increase in Medicaid population the government was concerned regarding the limited access to primary physicians for this population. As, the Medicaid pays lower fee to the physicians than any other payer. Therefore, the ACA requires the federal govt. to pay the additional costs of making the Medicaid fee to primary physician equal to Medicare fees.

Salient features of Ayushman Bharat

Eligibility Criteria: According to (Bajaj Financial Services)[10], 10.74 crore families can be benefitted which are identified as poor and deprived of facilities. The Socio Economic and Caste Census (SECC) data has been used for the recognition of beneficiaries' families. The estimated distribution of families is 60% in urban areas and 80% in rural areas have been identified[4].

Aadhar card is must for each patient. Size of the family and age of the person are not included to determine the benefits of this scheme. At least 10 bedded hospitals with all basic facilities are eligible to be empaneled under ABY.

The registration of hospitals will be done step by step. In the first step all the Govt. hospitals, Govt. Medical colleges, private hospitals, and private Medical College will be registered. In the second step, community health center (CHC) and in the third and last step primary health centers (PHC) will be enrolled. The norms and regulation for private hospital will be according to govt. of India[11].

Up to financial year 2020, the largest is to register 10 crore patients under ABY scheme. The diseases covered under this scheme are Cancer, Open heart surgery, Neurosurgery, plastic surgery, Radiology etc. Dangerous and expensive diseases are also included under the scheme[12].

Package: To control the cost, package rates have been fixed by the government in advance. In ABY, the cost of medicine, diagnosis, transport, pre-treatment, post-treatment expenses will be included. 23 specialties based 1350 package, 472 reserved packages of Govt. hospital and other packages are included in ABY[13].

Financial management: The amount of expenditure will be shared between central govt. and state government. An account has been opened in ICICI bank, Center, and state, both will deposit their share.

After the completion of treatment, Govt. & Private hospital will submit the claim with all the necessary documents and inspection reports within 10 days. It will be examined online within 15 days and submitted with its recommendation to state health agency, Deen Dayal Swastha Suraksha Parishad (DDSSP). The parishad will disburse the amount within 5 days. In this way the whole process of claim payment will be completed within 30 days.

Implementation and Regulatory Authority: National Health Agency (NHA) and State Health Agency are responsible for monitoring the whole implementation process. Ayushman Bharat National Health Protection Mission Council (AB-NHPMC) at top level, chaired by Union Health and Family Welfare Minister, is proposed to establish for guiding principles and promoting harmonization between Centre and states[14].

For the implementation of the scheme, implement support agency (ISA) has been appointed. Vidal Health Insurance Company has been selected for the implementation. Primarily, its duration will be 2 years, which can be extended up to one more year for the auditing.

Appointment of Transaction Advisory Team (TAT), which includes health care expert, insurance expert, IT system analyst, Expert in public procurement and expert in contract management. Their emoluments will be as per National Informatics Centre Services Inc (NICSI)[15]. District implementation unit (DIU) have following officers and their assigned roles as indicated in Table-1.

Table-1: District Implementation Unit (DIU).

Officers	Assigned Role
Dist. Collector	President
Dist. Malaria officer	Dist. Nodal officer
National Health Mission	Dist. Program Coordinator
Dist. E- Governance manager	Dist. Information system Manager
Dist. media officer	Jan Shikayat Nivaran Prabhandhak
Dist. Community mobilizer	Dist. program coordinator

Challenges of Medicare and Medicaid

PM-JAY or Ayushman Bharat Yojana is inspired by the various health insurance scheme of America such as Medicare, Medicaid etc. This scheme is considered crucial in bringing the paradigm shift in the Indian health insurance sector. The scheme is said to be operating under two models trust and insurance namely. In the first Trust model insurance companies will not get the premiums rather the trust will collect it jointly from the state. However, in the second model insurance companies will be paid by the state governments in form of premiums. The second model will work like any other insurance plan where the insurer pays the cost of the services they accept. We can have a glance on the shortcomings of both, so in future we can adopt some reforms for the success of the world's largest democracies' healthcare scheme. Subsidies are expected to go to low income and be financed by those with high income[16].

Medicare benefits have been the same for all its beneficiaries regardless of income. Almost 96% elderly pay the same part B premium and thus receive the same subsidy. Medicare has high deductibles and no limit on out-of-pocket expenditures. Services like long- term care and home care, nursing care are not covered. Those elderly who needs home care or nursing services must rely on their own funds to cover such expenses.

Medicare system pays the cost as they occur, which makes its enrollees' contribution much less as compared to the benefits they accept from it. On the other hand, the deductible is same for all hospitals and there are no co-payments for inpatient admissions or length of a stay. Therefore, the aged have no incentive to choose less costly hospital.

Chronic conditions are priciest for Medicare patients. Hospitals were initially compensated according to their cost for caring but neither the hospitals nor physicians have a financial incentive to manage the overall cost. The absence of financial incentives for providers to coordinate care and minimize the cost subsequently, increased the cost of Medicare.

The current Medicare program without advancements is not suited for future generations of seniors and eligible disabled Americans and is unsustainable given its huge increasing financial deficit. Upcoming years hold challenges for Medicare, as the aging of the population will put great pressure on the trust fund. The 77 million baby boomers started to retire in 2011. By 2050, the number of Medicare recipients will double from 44million in 2013 to 87million[17].

65 years and older will have the medical costs risen by 5 to 6 times more in contrast to the younger Americans. Substantial number of retirees with improved lifespan in addition with expensive and cutting-edge medical technology will generate massive surges in Medicare expenditure.

The employee base subsidizing Medicare is corroding. The number of employees paying income taxes and backing the program has dropped. Consequently, increasing the tax load on each worker. In 1960, the ratio was 5.1 employees per beneficiary, which decreased to 3.3 per beneficiary currently[18].

The Medicaid program does not include a sizable portion of the population with low-income. Expanding coverage to bigger segment of low-income population necessitates maintaining incentives for low-income working group to retain their private insurance through their employment. Since income is the one and only criterion for Medicaid suitability. Once their income rises above their state's cut-off level, they lose their admissibility.

In Medicaid system, care is uncoordinated and answerability for outcomes is not present. The care for poor often ends in greater reimbursements for its providers. Hence, Medicaid, is a disjointed system. The conventional plan has demonstrated to be ineffective in enhancing its beneficiaries' health, in contrast to the uninsured.

Soaring Medicaid expenditure converted into an enormous monetary liability on both state and federal governments. Persisting to pay out huge sums from states budget portions on Medicaid would ultimately need a tax hike or a diminution of expenditures on politically popular programs such as education

and prisons. Conflicts exists between the Medicaid's goals of the expanding eligibility, improving access to care, providing coordinated and effective care, and slowing the rate of increase in Medicaid expenditures[19]. For this, the federal government will have to pay 100 percent of the expanding costs of the Medicaid, for the first three years and declining to the 90 percent Federal Medical Assistance Percentage (FMAP) thereafter. For the newly qualified population; childless adults, up to 133 percent of the FPL.

Suggestions for improvement of Medicare and Medicaid

Feldstein Medicare[7] proposed that improvement of the Medicare and Medicaid should be based on 3 criteria: Equity, Efficiency, and reduction in the rate of increase in health care spending.

Eligibility age from 65 to 67 years: Changing the age from 65 years to 67 years would match the suitable age for Social Security and Medicare. With improved life expectancy people could maintain employment-based health insurance because they could work longer.

Plummeting the rate of growth in Medicare Provider Costs: This approach was initially employed but decreasing the provider payments will ultimately reduce the provider participation and access to care by Medicare beneficiaries.

Increases in Federal Insurance Contributions Act Hospital Insurance Tax (FICA-Hi): Hospital insurance refers to a type of trust fund. This fund pays for inpatient care, skilled nursing care and services for disabled and elderly people partly. Medicare part A is another name of the Hospital Insurance trust fund. This approach which been used previously is part of any proposed solution but raising this would increase the financial burden on low wage workers[20].

Increasing the premiums for Part B and D to make them income related: The premium for Part B and Part C that most elderly people pay covers only 25% of its expenditures. To cover the higher percentage of the expenditures the cost of the premiums could be increased.

Rely on competition between Medicare health Plans: The Medicare Advantage plan is also the Part C of the Medicare. The Part C allows the aged to enroll in the health maintenance organization (HMO) or a preferred provider organization (PPO). Proposal to increase competition is referred as premium support. The competition with government-administered Medicare FFS and Medicare Advantage plans, this will allow the enrollees to select their coverage from different other options. This could provide a reason for enrollees to obtain high-value, low-cost plans and plans that compete on premiums, benefits and patient access and satisfaction.

Change Medicare to an Income related program: This will change the Medicare to an income-related program. Each enrollee would receive the premium support, but the value will be determined by the recipient's pay. The income related aid would lower the cost of Medicare and the huge intergenerational grants from low-income workers to high-income aged.

Politics of Medicare reform: Medicare among the aged among their children means that politicians who attempted to change it without the endorsement of both political parties are at great risk. Any political party proposing the decreased Medicare benefits, higher beneficiary cost sharing or premiums, or the removal of the senior's free choice of the provider would lose the votes of the aged and their children.

Medicaid managed care: Medicaid programs offers a way to reduce the rising Medicaid costs and facilitates coordinated care for its beneficiaries. Firstly, it decreases the rate of growth in Medicaid spending. Managed care produced considerable savings in private sector which are not possible in fee-for-service. Secondly, it expands Medicaid enrollees' access to care by reducing the rates paid by other insurers so that many physicians refuse to serve Medicaid patients.

Block Granting Medicaid: Federal law restricts the ability of states to change Medicaid benefits. To make such changes, a state must apply for a federal waiver, which is a time-consuming process so federal govt. The states block grants are based on a fixed amount per Medicaid beneficiary by the federal government. This would increase as a price rise index. It has been suggested as a way of curbing the financing obligation by federal and state governments.

Vouchers related to Income: Another reform proposed is to deal with the admissibility levels and instead involve those with less income by an income related voucher. The size of aid would decline as pay packet grows, and person could use the voucher to choose among the competitive managed care plans. To be effective in having health plans compete for the Medicaid enrollees, the income-related voucher should be risk adjusted for chronically ill. The enrollees should receive more valuable vouchers as compared to those in younger and better health.

Challenges of the PM-JAY

The possible shortcomings that might prove challenging in due course of the Ayushman Bharat are the lack of the infrastructure and the number of the skilled people as well as the financing options for the scheme when the usage is increased. The availability of the skilled labor force to smoothly satisfy the health needs of the people especially in the remote and rural places in India is a tedious task. As a result, for the simple procedures and normal treatment needs the people living in these places require to travel and visit nearby big cities. This in turn leads to loss of their work and added expense of the living in the city and travelling.

The number of required primary health care centers and the hospitals in such areas is limited. So, implementing the infrastructure or updating the existing one to meet the requirements is one of the main questions. Although, this scheme covers the cost of the medical treatment and the hospitalization expenditure. But, for it to reach the last person in the system it must go through a series of evolution.

For comparison between the health expenditure percentage of Gross domestic product of India and the United States of the America based on the data from the World Health Organization[21] are shown below. It shows that the in 2018 India's health expenditure was near to 3.6 percent while that if USA is of 17 percent.

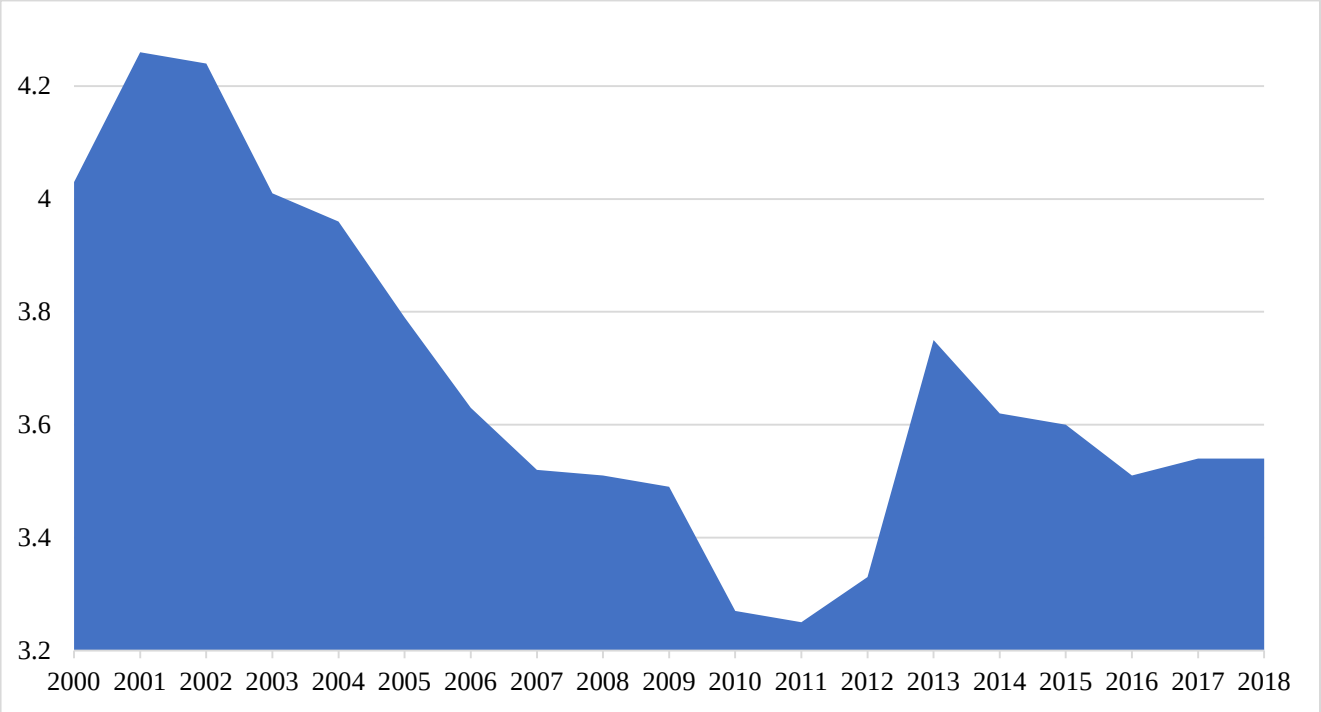

Figure-1: Current health Expenditure (CHE) as percentage of gross domestic product (GDP) (%) India.

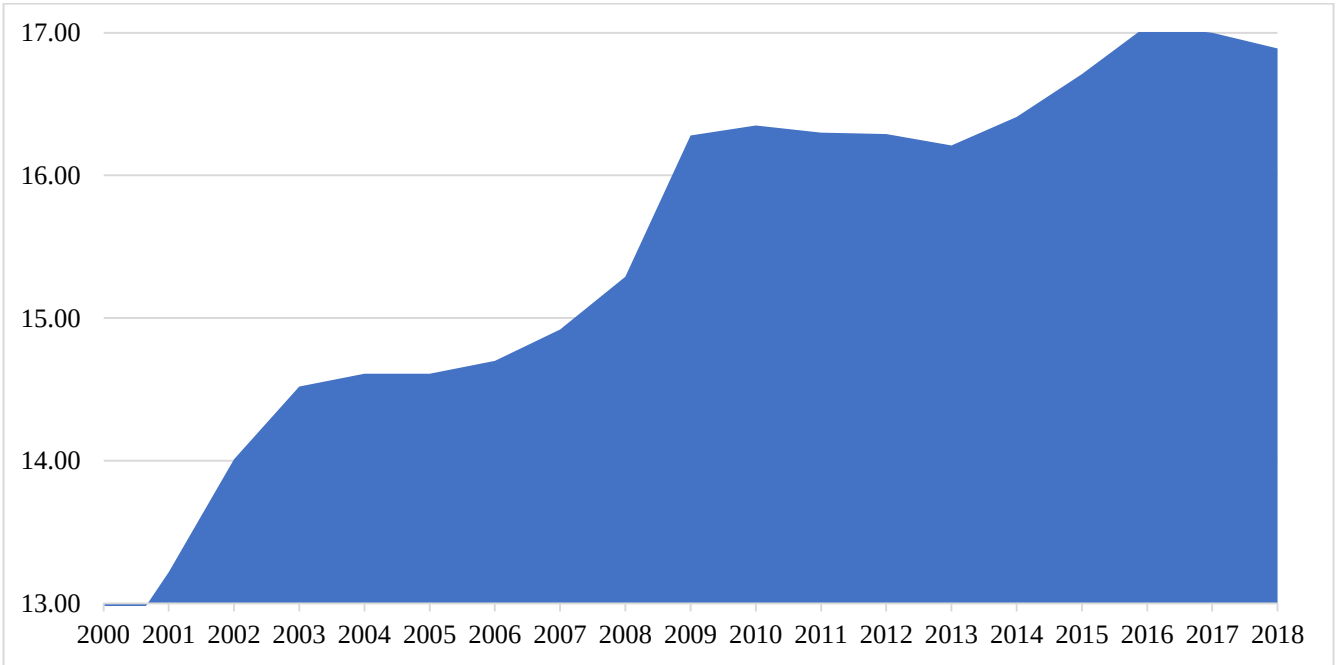

Figure-2: Current health expenditure (CHE) as percentage of gross domestic product (GDP) (%) USA.

Another aspect to consider is the expenditure on the private insurance sector. According to Prinja, Kaur, & Kumar[22] Indian health system is vastly unregulated and underutilized and mainly catered by the provate market for meeting the large number of curative treatment. The High out of pocket health expenditures poses barrier to accesss for heathcare. The health care expemnditure of India makes up to 5% of the gross domestic product but governement's involvement is only 0.96%. While the lion's share of the payment for health services are delivered out of pocket when services are being utilized. On the other hand, in the USA the government's contribution is soaring 8.51 percent. Based on the data from the World health Organization[23] global health observatory report below is the comparison of the same.

Table-2: Domestic general government health expenditure (GGHE-D) as percentage of gross domestic product (GDP) (%).

Location	India	United States of America
2018	0.96	8.51
2017	0.96	8.55
2016	0.94	8.59
2015	0.92	8.47
2014	0.86	8.24
2013	0.87	7.94
2012	0.93	7.91
2011	0.94	7.93
2010	0.86	7.95
2009	0.89	7.88
2008	0.8	7.25
2007	0.74	6.92
2006	0.75	6.81
2005	0.76	6.63
2004	0.71	6.61
2003	0.75	6.52
2002	0.77	6.32
2001	0.8	5.97
2000	0.83	5.54

Thus, to accomplish the vision of the Pradhan Mantri Jana Arogya Yojana the government's involvement must be increased mandatorily. The enrollment of wellness centers and primary health care centers must be expanded to enhance the reach of the program to the very last person standing in the queue.

Discussion

To make Medicare an impartial and proficient redistribution system, the illusion of the Medicare must be identified, and large welfare module acknowledged. Govt. subsidies should help primarily to help the low-income elderly. Health plans, including traditional Medicare should be available for the beneficiaries to compete based on price, quality, outcomes, and enrollee satisfaction. Health plans will then have the inducement to be efficient and responsive to recipients' preferences.

The purpose of affordable care act or Obama care was to make health care insurance available to more people, expand the Medicaid program to cover the adults with income below 138% of federal poverty level. Along with support to the innovative medical care delivery methods to lower the costs of health care[19].

Based on the Medicare and Medicaid insurance schemes, the world's largest democracy was determined to have the insurance for their population as well. The idea and vision of the prime minister of India was appreciable as he recognized the obstacles in the way during implementation of this scheme. The challenges that Medicare and Medicaid plans are facing even after so many years of the implementation are being addressed in the Ayushman Bharat. The incentives are given to hospitals and doctors to motivate them to address the health care issues of these patients unlike Medicare and Medicaid; Irrespective of size of the family and age limit of members, whole family is covered under the scheme; Pre and post treatment expenses and many chronic diseases are covered under the scheme, covering almost all the secondary and many tertiary hospitalizations (except a negative list).

To overcome the challenges of the skilled labor force, operation management and supply chain the govt. of India has implemented some strict measures. The bidding process to control and monitor the quality and production of the equipment to meet the standards is also believed to be having significant impact. Traditionally, nearly 80% of medical devices used in India have been imported; however, in line recent government efforts must bolster local industries, namely the "Make in India" initiative, to encouraging domestic and multinational companies to manufacture their products in India. This indicates that preference must be given to local suppliers and at least 50% of a product's value must come from a local source[23]. Although, the implementation of Ayushman Bharat has not been for a long time it is still in initial stages, so the results in terms of insurance coverage, utilization of the health care facilities and

national health expenditure needs to be monitored and is a matter of further research.

Also, in the recent times due to corona virus pandemic India has discovered its real potential and in these unprecedented times shown the world its real caliber. The corona virus pandemic made the world realize about the importance of health and having a healthy lifestyle and India is not behind in realizing it. The need of the hour was to understand the demand of the healthcare needs in this rapidly evolving situation. India as a developing nation harnessed its power in manufacturing sector in health industry. In the recent union budget the Indian government has declare to enlarge its spending in the health sector. As per the Finance ministry of India[24] announcement expenditure on Health as percentage of GDP is estimated to be 1.8 percentage for the current fiscal year. The vison of the PM Atma Nirbhar Swastha Bharat Yojana has also been put forward. Hence, under these various projects like "make in India", Pradhan Mantri Jan Arogya Yojana and many others the dream of universal health coverage could prove to be successful not only in terms of accessibility of health care but along with quality and affordability. This approach is believed to give a boost to the economy by not only creating jobs and increasing the productivity but by increasing the health of its work force and opening the market to several other insurance companies to compete in providing the benefits at lower cost. Although the out-of-pocket cost is lower in India for health services as compared to USA due to currency value, but India has the potential to create opportunities in the health sector by making it more organized. And as the population is growing in India the demand in the health care sector is going to skyrocket so need for more skilled work force, infrastructure and financing options are required. And with recent changes in the education policy and health sector financing new doors will open to establish the goal of the Ayushman bharat yojana. Also, continuous monitoring and evaluation of the utilization of the services and finance should be kept in check to avoid the financial deficit in the future years to appear.

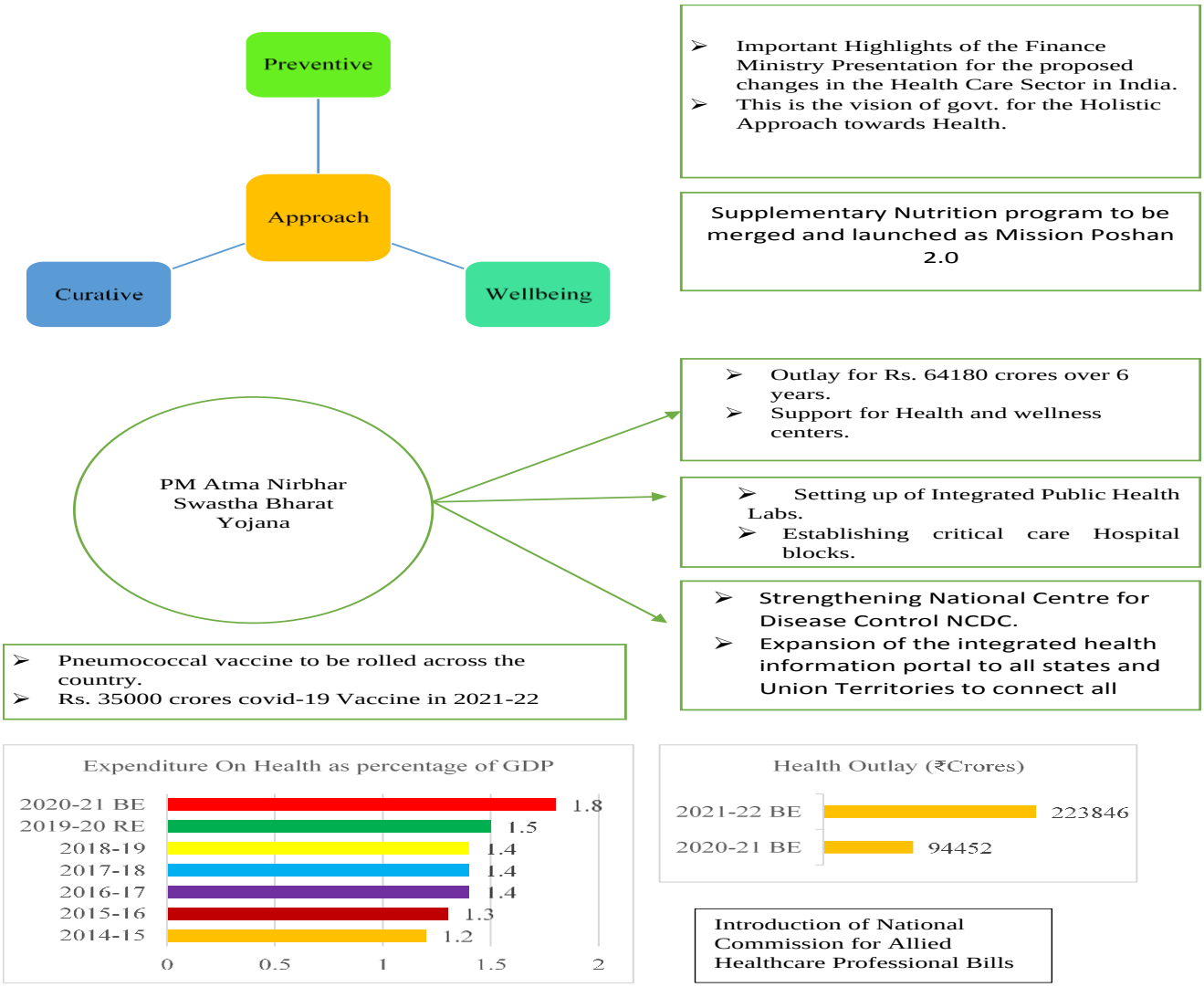

Figure-3: Holistic Approach to Health for treatment of illness and promotion of wellness.

Conclusion

Instead of significant challenges facing the program, AB-PMJAY presents a chance to gear long-term and entrenched defects in ascendency, quality control, and stewardship. It accelerates the progress of India to achieve the specified goal of UHC provision[25] by feeding the stimulus for system-wide reform.

Therefore, in nutshell we can conclude that for the success of Modicare we must learn from the challenges faced in the longer run of Medicare and Medicaid. Although, the Ayushman Bharat/ PM-JAY scheme does not consider the age or income of the population groups for its beneficiaries as of now. But the distribution of population in India and the growing demands of healthcare needs might possess as an upcoming challenge for the government to maintain the minimum financial deficit in future. So, to gain further in-depth knowledge about the measures and vision of this biggest insurance scheme further research will be required in the upcoming years.

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