



Ayushman Bharat (PM-JAY) or State Health Insurance Schemes: A Comparative Study of Haryana, Rajasthan, Punjab, Uttar Pradesh, and Bihar

Ragni Rani¹ and Prof. Pankaj Singh²

¹Research Scholar, Department of Public Administration, Kurukshetra University

²Professor, Department of Public Administration, Kurukshetra University

Abstract:

High out-of-pocket expenses have long dominated the health financing landscape in India, creating financial vulnerability for households. In 2018, the introduction of Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (PM-JAY) was a turning point, as it established the largest publicly funded health insurance program in the world. Nevertheless, since health is primarily a state matter, insurance formulations and implementation vary widely across states. In this paper, we present a comparative analysis of GM-JAY and state-level adaptations in Haryana, Rajasthan, Punjab, Uttar Pradesh, and Bihar, covering scheme design, eligibility, financing, hospital empanelment, utilization, and outcomes. Based on official reports, government dashboards, and assessment studies, with some supplementary graphical presentations, the analysis will depict how Rajasthan and Punjab have ambitiously developed benefits, whereas Haryana, Uttar Pradesh, and Bihar are mostly based on the national model. The evidence shows that greater coverage, a more extensive hospital network, and a more effective awareness campaign result in better utilization, and that poor infrastructure and insufficient outreach are barriers to efficacy. The study concludes that there is a need for greater harmonization and cooperative federalism to enable equitable and sustainable delivery of health insurance in India.

Keywords: Ayushman Bharat (PM-JAY), State Health Insurance Schemes, Cooperative Federalism, Health Financing in India, Universal Health Coverage, Public Administration in Health, Comparative Policy Analysis, Out-of-Pocket Expenditure (OOPE).

1. Introduction

Financing of health care has emerged as one of the most important issues in India's quest to achieve universal health care coverage (UHC). Over 60% of overall health spending has long been paid out-of-pocket (OOPE), which has subjected households to devastating health shocks and negatively impacted poverty cycles (National Health Accounts 2019-20). In response to this weakness, the Government of India recently implemented the Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (PM-JAY) in 2018, a large-scale, publicly funded health insurance initiative that covers up to ₹5 lakh per family annually for hospitalization in secondary and tertiary care. However, the federal nature of India also implies that the Constitution treats health as a state subject, and there are vast inter-state differences in the design, financing, and implementation of health insurance schemes. Some states even extend PM-JAY further, putting in place generous or hybrid schemes,

such as those in Rajasthan and Punjab, whilst others, including Uttar Pradesh and Bihar, largely follow the PM-JAY model but introduce cohort-specific, limited schemes. Haryana is another example of PM-JAY being applied with some state-provided top-ups. This heterogeneity can provide a valuable prism for studying how cooperative federalism is working in health governance. On the one hand, PM-JAY is a centralized digital and administrative platform, supported by the National Health Authority (NHA); on the other hand, the states have a high level of autonomy in financing, beneficiary selection, empanelment, and awareness campaigns. The resultant blend of uniformity nationwide and innovation at the state level becomes extremely important: What are the differences in benefit packages and eligibility rules across states? Which institutional structures facilitate more utilization? What makes certain states more successful in securing provider involvement and beneficiaries' satisfaction than other states? The literature provides insights into the potential and shortcomings of insurance-initiated changes in India's health reforms. The research indicates better access to hospitalization for people experiencing poverty, although several unresolved problems remain, such as low awareness, informal payments, fraud, and errors in exclusion. Comparative state-level evaluations are relatively rare, even though it is increasingly becoming clear that state-specific adaptations play a strong role.

Against this background, the current study compares PM-JAY with other key state health insurance plans in Haryana, Rajasthan, Punjab, Uttar Pradesh, and Bihar. This work is threefold because of its contributions:

- (i) To map the design and financing variations
- (ii) To assess implementation structures and utilization patterns,
- (iii) To distil lessons for strengthening cooperative federalism in health insurance. By situating India's flagship program within the broader ecology of state-led innovations, this paper contributes to debates on equity, efficiency, and the evolving role of public administration in health governance.

2. Literature Review

Health financing has been a focal point in the discourse on development in India, and disaster spending on health has been a major contributor to household impoverishment and poverty traps. According to the National Health Accounts (2019-20), the out-of-pocket expenditure (OOPE) share remained above 62% of total health expenditure, indicating insufficient public health funding to alleviate financial hardship (National Health Authority, 2022). The introduction of Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (PM-JAY) in 2018 was celebrated as a historic intervention that was to cover up to ₹5 lakh per family per year for secondary and tertiary hospitalization, and was cashless (Prinja et al., 2019; National Health Authority, 2021). The scholars state that PM-JAY represents a paradigm shift in public health insurance, which is still dependent on federal-state relations, administrative design, and institutions (Choudhury & Nath, 2012; Reddy & Mary, 2018).

The available literature on PM-JAY provides inconsistent evidence regarding its consequences. On the one hand, empirical studies indicate that poor households have been using hospitals more and that catastrophic spending has decreased in selected states (Karan et al., 2017; Prinja et al., 2020). For example, Fan et al. (2020) found that beneficiaries of PM-JAY had better access to tertiary care services, especially for cancer and cardiac operations. Likewise, Lahariya's (2020) study also notes that the programme has created a momentum toward universal health coverage (UHC) through the use of technology-based enrolment and claims management systems. Conversely, there have been concerns about inequities in coverage, unequal provider participation, and the exclusion of outpatient care, which is the largest contributor to OOPE in India (Selvaraj & Karan, 2012; Hooda, 2017; NITI Aayog, 2021).

Several authors emphasize the importance of state-level implementation in improving the effectiveness of PM-JAY. The federal system of India gives the states the option to adopt PM-JAY, amend it to include additional benefits, or run their own schemes. For example, Rajasthan was the first State to introduce the Mukhyamantri Chiranjeevi Swasthya Bima Yojana in 2021, which provides universal health insurance of ₹25 lakh per family, much larger than that of PM-JAY (₹5 lakh) (Government of Rajasthan, 2022). Assessments by Singh and

Gupta (2023) indicate that the extensive scheme's broad coverage not only led to heightened private-sector participation but also caused fiscal stress, prompting debate over its long-term sustainability. Punjab adopted a mixed model through the Sarbat Sehet Bima Yojana (SSBY), which enrolled PM-JAY beneficiaries from other groups, such as small traders and farmers, on state funds (Government of Punjab, 2022). According to Sharma (2022) and Gill and Singh (2021), this solution enhanced enrolment but faced difficulties in creating awareness and in setting claim settlement timelines. Haryana, in turn, introduced PM-JAY with some state-funded improvements, but there are indications that it remains concentrated in urban areas, which raises equity concerns (State Health Agency Haryana, 2021; Malik, 2022).

The problems are more institutional in Uttar Pradesh and Bihar, which are the two most populous states. Uttar Pradesh adds the PM-JAY to the Mukhya Mantri Jan Arogya Abhiyan (MMJAA) to include families not on the SECC eligibility list (Government of Uttar Pradesh, 2021). Although the scheme has recorded positive enrolment levels, Mishra and Srivastava (2022) identify challenges in hospital empanelment, a low claims ratio, and a poor grievance redressal system. Using its Bihar Swasthya Suraksha Yojana (BSSY), Bihar was on the same wavelength as PM-JAY but was perceived to have administrative bottlenecks in empanelment and a lack of awareness among the rural populace (Government of Bihar, 2020; Kumar, 2021). According to comparative analyses across states, poorer states can barely implement PM-JAY at all (Nandi et al., 2020; Prinja et al., 2021), whereas richer states such as Rajasthan and Punjab experiment with more generous or hybrid models.

The broader body of research on federalism in health governance explains why such deviations occur. According to scholars such as Rao and Choudhury (2013) and Khetrapal and Acharya (2019), the issue of cooperative federalism in India is controversial, as the State in health matters creates tension between policy structures at the central and State levels. PM-JAY is centrally developed, though it relies on state-level nodal agencies to implement, resulting in differences in financing arrangements, package rates, and hospital empanelment (NHA, 2021). According to the evidence of foreign experience, federalism may not only facilitate innovation but also entrench health finance inequity (Saltman, 2016; Greer & Mendez, 2019). This duality is apparent in India, with states such as Rajasthan cashing in on autonomy to expand coverage, whilst others, such as Bihar, lag in infrastructure development and awareness.

Critical issues of fraud, duplication, and political contestation also arise in insurance models, as evidenced by empirical studies. According to Gupta and Roy (2020), fraudulent claims and ghost hospitals constitute systemic risks, despite NHA introducing IT-enabled anti-fraud measures. Political ownership of schemes can impact both implementation and maintenance: Khetrapal and Acharya (2019) note that state governments may reshape or expand schemes to obtain political credit, at the expense of keeping them aligned with PM-JAY. This can be seen in the example of the hybrid model in Punjab, where mixed eligibility rules produced administrative bewilderment (Sharma, 2022). The other line of literature focuses on citizens' experience with health insurance. Research by Baru (2020) and Nair et al. (2021) indicates that awareness levels are low, particularly among rural and marginalized populations. The schemes are also diluted by informal payments and balance-billing practices in private hospitals, including even cardholders (Prasad & Chakraborty, 2020). The studies conducted in Rajasthan and Punjab note that although enrolment camps increased the number of individuals reached, complaints about the refusal of cashless treatment and the slowness in processing such claims still undermine confidence (Singh & Gupta, 2023; Gill & Singh, 2021).

A comparison can be based on international research on UHC and insurance-based models, which offers valuable comparative information. Xu et al. (2018) posit that outpatient services, preventive care, and robust regulatory mechanisms best combine to offer financial protection. Examples of this are in Latin America, where Mexico, through Seguro Popular, registered gains in access but encountered fiscal limitations, as in the Indian state schemes (Frenk et al., 2012). These similarities emphasize that the generosity of benefits is not sufficient to ensure sustainability or equity.

There are three gaps in the literature. To begin with, existing studies on PM-JAY are mostly national, whereas comparative analyses of state plans remain insufficient. Second, there are few systematically evaluated studies of the interactions among state-level innovations, the IT backbone of PM-JAY, the finance model, and hospital empanelment mechanisms. Third, the politics of the political economy of health insurance, as well as the impact of the state-level ownership and election stories on scheme design and performance, are poorly explored. The only way to fill these gaps is through a systematic comparative examination of PM-JAY and state plans across the dimensions of eligibility, financing, implementation, utilization, and outcomes. This study will help fill this gap by undertaking a systematic examination of the experiences of Haryana, Rajasthan, Punjab, Uttar Pradesh, and Bihar, thereby providing commentary on the changing architecture of the government's health system in India.

3. Research Design and Methodology

3.1 Research Design

The research design presently assumed is a comparative and descriptive one, explaining the differences in the design, financing, and implementation of PM-JAY compared with those of state health insurance schemes in five Indian states, including Haryana, Rajasthan, Punjab, Uttar Pradesh, and Bihar. The appropriate design is comparative, since it enables undertaking a systematic evaluation of similarities and differences amongst the states in terms of benefit packages, funding schemes, institutional arrangements, and performance (Ragin, 2014). The descriptive component allows capturing the major features, patterns and problems associated with all schemes. These are purposive states that are selected. To be quite representative, Haryana was selected to have a substantial proportion of PM-JAY but few localized reforms; Rajasthan and Punjab are the states that implemented health insurance models in more wholesome or integrated forms; Uttar Pradesh is the largest State in India, which informs about the issues of scale and reach; and Bihar, which has less administrative potential developed, enlightens on the bottlenecks in the implementation process. The pool of these states gives the usual picture of the plurality of the Indian federal health insurance governance. The unit of analysis in this study will be the state-level health insurance plan and its design, funding, administrative setup, and performance. The timeframe for analysis will be 2018 -2024, i.e., the period of operation of PM-JAY and its compatibility with state schemes.

3.2 Research Objectives Restated

1. To compare Ayushman Bharat (PM-JAY) with state health insurance schemes in Haryana, Rajasthan, Punjab, Uttar Pradesh, and Bihar in terms of design, financing, and eligibility.
2. To examine the role of federal–state dynamics in shaping the implementation and utilization of health insurance schemes.
3. To identify best practices, gaps, and lessons for strengthening cooperative federalism in public health administration.

3.3 Data Sources

The study relies on both primary and secondary data to ensure a comprehensive analysis.

- **Secondary Data Sources:**

- Annual reports and policy documents of the National Health Authority (NHA) and State Health Agencies.
- Official guidelines and scheme documents, such as Rajasthan's Mukhyamantri Chiranjeevi Swasthya Bima Yojana Guidelines, Punjab's Sarbat Sehat Bima Yojana Reports, Haryana's

SHA reports, Uttar Pradesh's Mukhya Mantri Jan Arogya Abhiyan reports, and Bihar's Bihar Swasthya Suraksha Yojana documentation.

- Budget speeches and government notifications at both the central and State levels.
- Published evaluation studies and peer-reviewed journal articles.
- Reputed newspaper articles and press releases for updates on scheme modifications.

- **Primary Data Sources:**

- Semi-structured interviews with officials of state health agencies, nodal officers, empanelled hospital administrators, and health workers.
- Beneficiary-level interviews focusing on awareness, enrolment, utilization, and out-of-pocket expenditure experiences.

3.4 Parameters of Comparison

This analysis is a comparison of PM-JAY and five state health insurance plans in ten parameters: eligibility requirements; coverage level and benefit package; number of people served; funding; institutional and governance; hospital empanelment and infrastructure; utilization patterns; awareness, enrolment and citizen experience; performance in terms of covering financial protection and coverage access; and critical operational and political issues, such as fraud, informal payments, gaps in data, and financial strain, and ownership/branding contention.

3.5 Method of Analysis

The analysis proceeds in two stages:

- **Stage I: Descriptive Analysis:** The first stage of the study involves a descriptive analysis of PM-JAY and the chosen state schemes, including the design, financing, implementation structure, and performance. Data on scheme features, financial allocations, enrolment statistics, and other quantifiable indicators are systematically collected from official reports, government dashboards, and secondary sources. These data are further coded into comparative matrices that identify interstate variations in the parameters that define these parameters, including eligibility, coverage limits, funding models, and provider networks. Differences in coverage, utilization, and outcomes are presented as descriptive statistics and graphical illustrations, such as tables, charts, and trend diagrams, thus providing empirical ground for further interpretation.
- **Stage II: Interpretive and Thematic Analysis:** In the second phase, the research will use an interpretive and thematic analysis to better understand the impacts of institutional arrangements and federal-state dynamics on scheme performance. Semi-structured interviews with officials, providers, beneficiaries, and frontline health workers are coded thematically to identify recurring problems, including lack of awareness, fraud, delays in claim settlement, and the use of politics to control the scheme's brand and ownership. Interpretations of these themes are then made in conjunction with the descriptive quantitative results to identify observed trends in utilization, financial protection, and equity across different states. To the extent feasible, quantitative data on claims per 1,000 beneficiaries, average days to settle a claim, and any reported trends in reducing out-of-pocket spending are triangulated, and the qualitative findings are cross-validated to strengthen and increase the credibility of the analysis.

3.6 Sampling Framework for Primary Data

To obtain a variety of opinions, purposive and stratified sampling is used for major stakeholder groups within respective states. There will be at least one state-level officer and two district-level coordinators per State, as well as five empanelled hospitals that, combined, will encompass both public and private providers. It also provides coverage for about 20 beneficiaries in every State, selected to represent urban and rural areas, claimants and non-claimants, and men and women. Moreover, a total of 2 frontline health workers (ASHAs or PMAMs) in each State are interviewed. The approximately 150 respondents across the five states constitute a sample believed to provide good depth of qualitative information and, at the same time, is affordable given the available resources.

3.7 Ethical Considerations

- Informed consent will be obtained from all interviewees and survey participants.
- Respondent anonymity and confidentiality will be ensured.
- Data will be used strictly for academic purposes, with no disclosure of identifiable personal information.
- Ethical approval will be sought from the institutional research ethics committee before fieldwork.

This research design will provide a sound comparative structure of PM-JAY and state health insurance plans. The study attempts to offer a synoptic view of the impact of federalism on the delivery of health insurance in India by integrating documentary analysis, quantitative indicators, and qualitative insights. The comparative design involving five states allows for the identification of best practices, major challenges, and lessons on policy reinforcement in cooperative federalism for health financing.

4. Ayushman Bharat (PM-JAY): An Overview

India's Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (PM-JAY) was introduced in September 2018 and can be considered a pillar of India's efforts to achieve Universal Health Coverage (UHC). It is generally considered the largest publicly funded health insurance plan in the world and has more than 500 million citizens within the nation. The scheme was modelled to address the long-term issue of excessive out-of-pocket expenditure (OOPE) in India, which in the past has accounted for over 60% of total health expenditure. PM-JAY aims to protect households against financial loss due to the cost of medical care. To the same effect and purpose, PM-JAY has ensured that households obtain a shield against financial loss as a result of medical costs and, at the same time, strengthen the delivery of healthcare. Fundamentally, PM-JAY offers an annual health insurance cover of ₹5 lakh per family for secondary and tertiary hospitalization. This is a very big improvement over previous plans, such as the Rashtriya Swasthya Bima Yojana (RSBY), which provided only ₹30,000 per family/ year. PM-JAY has eliminated limitations on family size and age, thereby broadening its inclusiveness. Beneficiary identification is based on the Socio-Economic and Caste Census (SECC) 2011 and, in some instances, state-specific databases. This is to ensure that the most vulnerable and poorest households, especially rural ones, are automatically included in coverage. The federal design of PM gives it one of the characteristics of PM-JAY. Though the central government, through the National Health Authority (NHA), can provide the broad-based framework, funding, and IT infrastructure, the states are left to carry out the much-needed execution. States have been given flexibility to adopt PM-JAY through an insurance model (with private insurers), a trust model (funds managed by the states), or both. Such flexibility reflects the federal nature of health governance in India, yet importantly leads to the noted variation in implementation across states. The scheme covers over 1,600 treatment packages, including procedures in cardiology, oncology, orthopaedics, nephrology, and neonatal care, among others. These are nationally standardized packages with specific prices and diagnostic, surgical, and aftercare content. Notably, PM-JAY focuses on electronic and

paperless payments through its robust IT system. All beneficiaries require only their Ayushman card or Aadhaar-based identity to use at empanelled hospitals. Another aspect worth pointing out is that PM-JAY has been integrated with the Ayushman Bharat Health and Wellness Centres (HWCs), which are the other pillar of the Ayushman Bharat initiative. As secondary and tertiary care are under PM-JAY, HWCs are supposed to offer primary care, thereby defining a continuum of care. Financing-wise, PM-JAY adheres to a common financing scheme between the central and State governments to create a unified health ID, electronic health records, and interoperable data systems among providers. The proportion is usually 60:40 in most states, 90:10 in northeastern and hilly states, and 100 per cent centrally funded in union territories. The given model is designed to ensure that poorer states have an adequate fiscal base to support implementation; however, the results of the implementation are determined by fiscal capacity and political will. By 2022, more than 200 million Ayushman cards had been issued, and more than 30 million hospital admissions had been approved.

Nevertheless, the utilization distribution remains skewed. The enrolment statistics have been very high in states like Uttar Pradesh and Gujarat, and some states have faced challenges in empanelled hospitals and in getting beneficiaries to be aware of their entitlements. Such an imbalance highlights the influence of administrative competency, provider involvement, and political ownership on performance.

Despite its achievements, PM-JAY has faced significant challenges. Studies highlight issues such as:

- Low awareness among eligible households, particularly in rural and marginalized communities.
- Persistence of informal payments and "balance billing" by some private hospitals undermines the scheme's cashless promise.
- Risk of fraudulent claims and abuse of packages, despite the introduction of real-time IT-enabled fraud detection systems.
- Limited coverage of outpatient services and preventive care, which together account for the bulk of OOPe for households.
- Variation in package rates and empanelment practices across states sometimes discourages private sector participation.

However, the scheme is largely known to have established a national health assurance model and a national IT base upon which states can develop. India has, for the first time, put in place a common structure of hospital-based care that includes portability across states, together with centrally defined benefit packages. This has enabled migrant workers, say, to receive treatment in other States without the obstacles of financial hurdles.

Ayushman Bharat (PM-JAY) is a historic milestone and a journey underway. It proves that a federal welfare state is capable of designing and implementing the world's poorest health insurance programme, but it remains largely dependent on adaptations at the state level, the involvement of providers, and the need to raise awareness of health insurance among citizens. For this reason, comparative PM-JAY and state-specific schemes will be valuable for understanding how both national systems and state innovations balance each other, providing some insight into how cooperative federalism would happily evolve in the future of the Indian health care sector.

5. State-Level Health Insurance Schemes

The health sector in India, as a federation, has led to a variety of insurance models across states. Although Ayushman Bharat (PM-JAY) offers a core model of ₹5 lakh per family for secondary and tertiary hospitalization, states have limited themselves to either following the model or developing their own alternative models, or a mix of both. This section will give an overview of the five focal states, Haryana, Rajasthan, Punjab, Uttar Pradesh, and Bihar, focusing on how they are designed, financed, and implemented.

- 1) **Haryana (Ayushman Bharat Haryana):** Haryana has been implementing PM-JAY in its standard version, where eligible families receive a cover of ₹5 lakh per year. The State Health Agency (SHA), Haryana, is the scheme implementer, and it operates on a trust basis, with direct control over funds and claims management. Haryana has also implemented state-funded top-up benefits, where extra coverage is provided for categories not covered under the PM-JAY eligibility criteria based on SECC, known as Chirayu Haryana (Comprehensive Health Insurance for Antyodaya Units). Both public and private hospitals have been empanelled in the State, although there is a more focused expansion to the rural regions. However, utilization patterns indicate that claims are concentrated in urban districts, specifically around Gurugram and Faridabad, where private hospitals are most prevalent. It has been reported that there is a sense of rural household awareness that is underutilized despite their active enrolment campaigns. On the whole, the Haryana model is moderately integrated, mostly following PM-JAY, though there are some state-level additions to include everyone.
- 2) **Rajasthan (Mukhyamantri Chiranjeevi Swasthya Bima Yojana):** The state-led experiment of health insurance is the greatest in Rajasthan. In 2021, a comprehensive health insurance scheme called Mukhyamantri Chiranjeevi Swasthya Bima Yojana (MCSBY) provides ₹25 lakh per family per year, as well as ₹10 lakh in accident insurance. In contrast to PM-JAY, which focuses on households defined as poor through the lens of SECC, the scheme in Rajasthan is intended to cover everyone, linked to the State Jan Aadhaar database. Offering essential funding to MCSBY, the State is the major funder of this health programme, which is the most generous yet economically heavy health programme in India. It has been estimated that the increased coverage has led to greater involvement by private tertiary hospitals, especially in oncology and cardiology. Fiscal sustainability is, however, an issue because, with high claim volumes, there is a risk that they will exceed budgetary allocations. In political terms, the scheme is characterized by a robust state ownership, which is usually positioned as a flagship welfare program separate from PM-JAY. Its success indicates how broadly benefit design can help, but also points to the trade-offs between generosity, sustainability, and administrative capacity.
- 3) **Punjab (Sarbat Sehat Bima Yojana):** Punjab took a middle ground and implemented the Sarbat Sehat Bima Yojana (SSBY), which provides PM-JAY to other categories of state-funded beneficiaries, such as farmers, small traders, and construction workers. Under SSBY, families get ₹5 lakh in annual coverage, and almost 65% of the state population is brought within the insurance net. In 2025, Punjab announced a switch to Mukh Mantri Sehat Yojna (MMSY) with Universal coverage of ₹10 lakh, indicating a significant policy shift toward universalization. Though this has created enthusiasm, there are concerns about fiscal viability and the need for a robust fraud control system. In SSBY empanelment, both public and private hospitals are included, though private hospitals are used predominantly in urban centres, such as Ludhiana and Amritsar. Awareness campaigns are driving the increased visibility through community-based enrolment drives, but there are still complaints of delays in claiming and balance billing. The case of Punjab demonstrates the promise of hybrid models and the administrative challenge of managing massive expansions.
- 4) **Uttar Pradesh (PM-JAY and Mukhya Mantri Jan Arogya Abhiyan):** As the most populous State in India, Uttar Pradesh faces challenges in implementing health insurance. This State has adopted PM-JAY and complemented it with the Mukhya Mantri Jan Arogya Abhiyan (MMJAA), which covers families not listed under SECC. Collectively, these schemes can accord ₹5 lakh family per annum, just like PM-JAY. U.P. has also been reporting among the best enrolment figures in the country, and millions of Ayushman cards have been disbursed. Nevertheless, a high enrolment is not necessarily utilization. Research has shown a lack of even distribution of empanelled hospitals, with large gaps in rural regions. Furthermore, knowledge of cashless entitlements remains low, and many beneficiaries continue to pay out of pocket. The scheme is implemented through the State Agency on Comprehensive Health and Integrated Services (SACHIS), which oversees empanelment, claim processing, and awareness creation. Although improvements have been made in the area of scale, the

problems of ensuring the quality of care, minimizing fraud claims, and enhancing grievance redressal systems persist.

- 5) **Bihar (Bihar Swasthya Suraksha Yojana):** Under PM-JAY, Bihar is covered under the Bihar Swasthya Suraksha Yojana (BSSY), with coverage of ₹5 lakh per family per year. The nodal agency is the Bihar Swasthya Suraksha Samiti (BSSS), which manages the empanelment of hospitals and the clearing of claims. The State of Bihar has also aligned closely with the design of PM-JAY, but implementation has been limited due to poor health infrastructure and administrative capacity. Enrolment is also high, but utilization rates are relatively low compared to other states. Specifically, rural households face an access barrier to empanelled hospitals because there are few tertiary care hospitals and institutions outside urban areas, such as Patna. The problem of awareness remains a key one, and a significant number of eligible households do not know their rights. The scheme is supposed to be cashless, but informal payments have been reported in the field as well. However, BSSY is a significant move towards protecting people with low incomes against risks, although it shows that low-capacity states limit the full realization of the objectives of health insurance.

6. Comparative Analysis

Comparing Ayushman Bharat (PM-JAY) with state-level schemes in Haryana, Rajasthan, Punjab, Uttar Pradesh, and Bihar reveals significant differences in their design, funding, implementation, and outcomes. Even though PM-JAY offers a standard national system, state decisions are characterized by both financial capacity and political determination to shape the scale and the influence of insurance delivery.

6.1 Design and Benefit Package

Divergence in the first instance is benefit coverage. PM-JAY provides ₹5 lakh per family per annum, which has been adopted in Haryana, Uttar Pradesh and Bihar without changes. Rajasthan has been pushing the limits of generosity, as indicated in Figure 1, with the Mukhyamantri Chiranjeevi Swasthya Bima Yojana, which offers ₹25 lakh per family and ₹10 lakh accident cover. In contrast, Punjab is shifting ₹5 lakh (Sarbat Sehat Bima Yojana) to ₹10 lakh in the new Mukh Mantri Sehat Yojna. Such expansions are also an indication of state ownership and political alignment, but raise questions about fiscal sustainability.

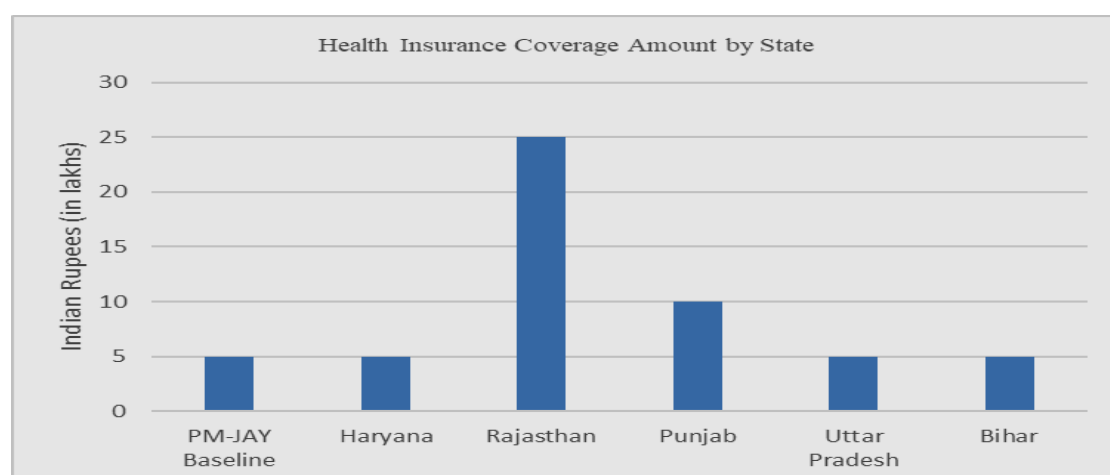


Figure 1: Health insurance coverage amount by State.

6.2 Eligibility and Inclusiveness

There are also different eligibility criteria. The use of SECC 2011 may expose PM-JAY to the risk of exclusion, particularly in dynamic urban areas. The States of Haryana, UP, and Bihar are following this model, with slight State-based additions. In contrast, the coverage of the Jan Aadhaar database used by Rajasthan is more extensive and virtually universal, whereas the Punjab SSBY specifically included such groups as farmers and traders. Accordingly, inclusiveness is not dependent on core principles but rather on the ways in which states choose to extend entitlements.

6.3 Financing Models

The financing system is characterized by asymmetry between the federal and State Levels. PM-JAY is co-funded, generally in a 60:40 balance, though Rajasthan and Punjab are much more dependent on state funds to fund their expansions. Haryana, UP and Bihar are still perpetually relying on central contributions. Such dissimilarities affect both fiscal sustainability and scheme identity: whereas Rajasthan and Punjab target their schemes as state-led welfare programmes, other schemes focus on being consistent with the national scheme.

6.4 Institutional Arrangements

Implementation frameworks capture the state decisions of insurance, Trust, and mixes. Trust models are maintained in Haryana and Bihar, with fund management retained by the State. Uttar Pradesh is a place where a combination model exists, namely nodal agency, SACHIS, and Punjab and Rajasthan, where state societies are trust-based. Institutional independence counts: states with robust health agencies, e.g., Rajasthan, are better placed to expand benefits, whereas weaker bureaucracies, e.g., Bihar, find it difficult to deliver standard PM-JAY coverage.

6.5 Hospital Empanelment and Utilization

Structural gaps are made emphatic through the patterns of empanelment. Rajasthan and Punjab have been proactive in involving private tertiary hospitals, which has led to increased claims for special care, such as oncology and cardiology. Haryana and UP have mixed participation, with utilization skewed towards urban centres. Bihar has the worst problem: rural districts have few empanelled hospitals, forcing beneficiaries to travel long distances. Utilization volumes always show increasing claims in wealthier, urbanized states, reflecting the distribution of healthcare infrastructure.

6.6 Awareness and Enrolment

A degree of awareness campaign becomes a unique differentiator. The algorithmic enrolments in Rajasthan related to the Jan Aadhaar and the community-level outreach in Punjab have provided high visibility. Conversely, the awareness gaps are still acute in the State of Bihar and rural Uttar Pradesh, where beneficiaries do not know their rights or struggle to get empanelled hospitals. Haryana is in the mediocre category with moderate awareness but underutilization in rural districts. This indicates that effective coverage cannot be described by enrolment alone but by actual utilization, driven by awareness and trust in the scheme.

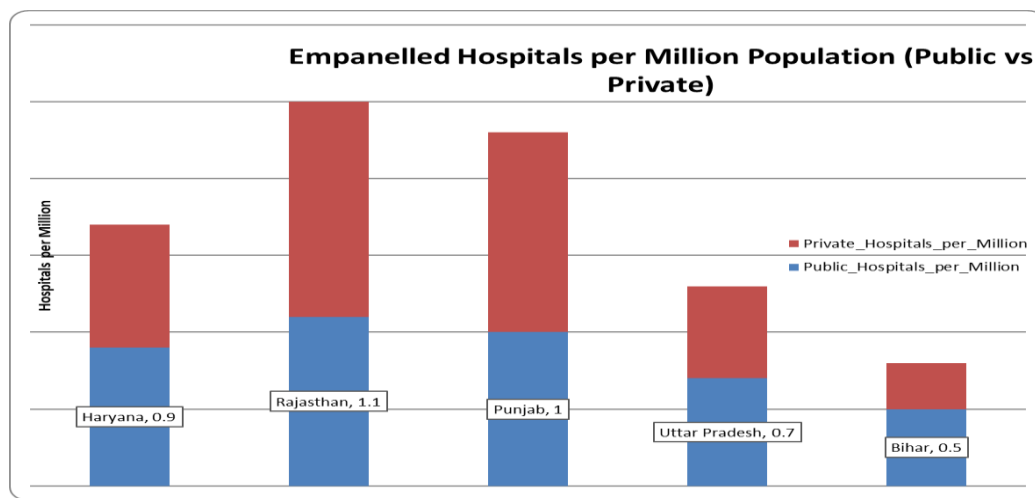


Figure 2: Empanelled Hospitals per Million Population (Public vs Private)

Figure 2 shows the number of empanelled hospitals per million population in five Indian states (Haryana, Rajasthan, Punjab, Uttar Pradesh, Bihar), for public facilities (blue) and private facilities (red), with the largest overall number in Rajasthan.

6.7 Outcomes and Impact

States such as Rajasthan and Punjab record higher average claim sizes in terms of outcomes due to higher package sizes and increased private-sector involvement. Uttar Pradesh has a good enrolment rate, which it cannot utilize effectively to address grievances. Haryana is doing relatively better in urban clusters than in rural areas. Bihar still lags behind most indicators, as it is the least well-equipped in terms of infrastructure and has a slow administration. Taken together, these tendencies indicate that state capacity and ownership determine the success of health insurance schemes.

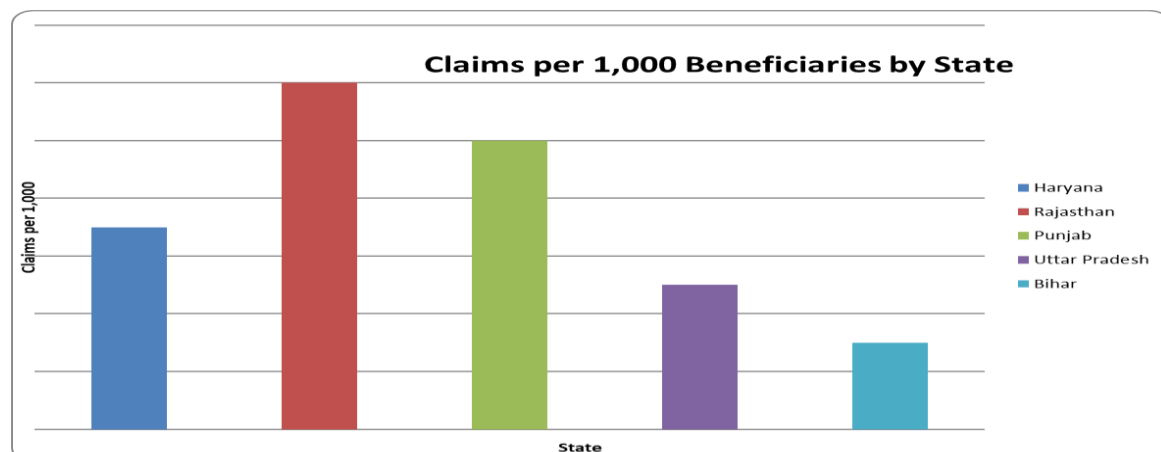


Figure 3: Claims per 1000 beneficiaries by State.

Figure 3, claims per 1,000 beneficiaries in PM-JAY and state schemes, shows that Rajasthan performs best (highest utilization), followed by Punjab and Haryana, while Uttar Pradesh and Bihar are far behind in converting insurance coverage into actual service use. The State of Rajasthan has the highest utilization intensity (~60 claims/1,000) with high ₹25 lakh coverage and vigorous private empanelment. Punjab will come next, with intensities of ~50. States perform moderately (Haryana, ~35, and Uttar Pradesh, ~25)- Bihar, ~15)- these numbers indicate how the capacity of states, infrastructure and awareness play a central moderating role on the efficacy of PM-JAY in the Indian federal health insurance sector.

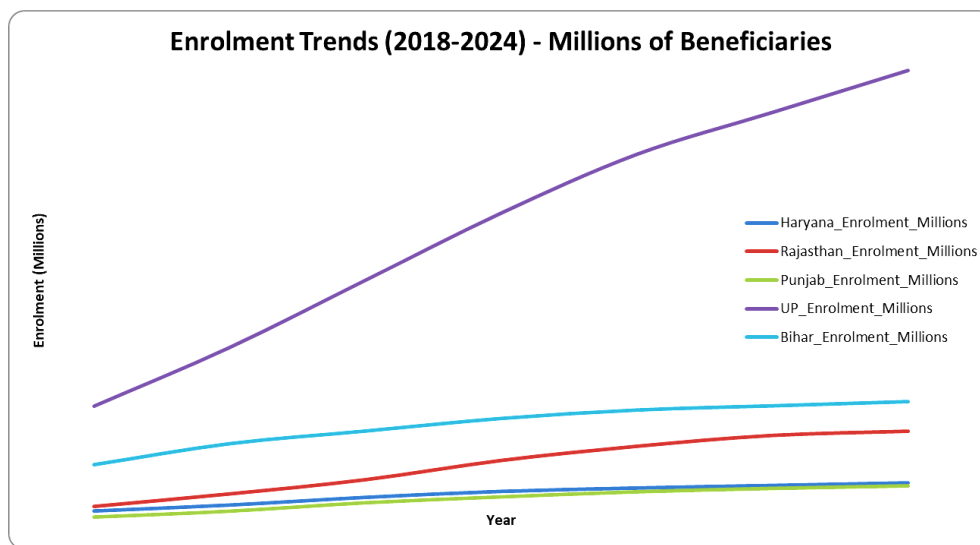


Figure 4: Enrolment trends from 2018 to 2024 (Millions of Beneficiaries)

The way divergent enrolment patterns develop under PM-JAY and state health insurance schemes is illustrated in five focal states, as shown in Figure 4. Uttar Pradesh has demonstrated a phenomenal increase from 15 million to 55 million beneficiaries, reflecting its religious composition as the most populous State in India. The State of Rajasthan is an excellent example of growth, having grown from 3 million to 12 million due to the universal Jan Aadhaar linkage. Bihar has stable but limited growth (8-15.5 million), whereas Haryana and Punjab have more moderate ones in accordance with their demographics. It is important to note that the enrolment disparity, negated by the Figure 3 assertions about utilization patterns, indicates that scale is not always an aspect of effectiveness. The massive coverage growth in Uttar Pradesh is coupled with poor utilization (25 claims/1,000 beneficiaries), whereas Rajasthan is translating enrolment growth into better service uptake (60 claims/1,000). This time-series analysis highlights the crux of the research: federal insurance platforms can only be successful if backed by state-level infrastructure, awareness systems, and administrative capacity to translate nominal coverage into actual financial protection.

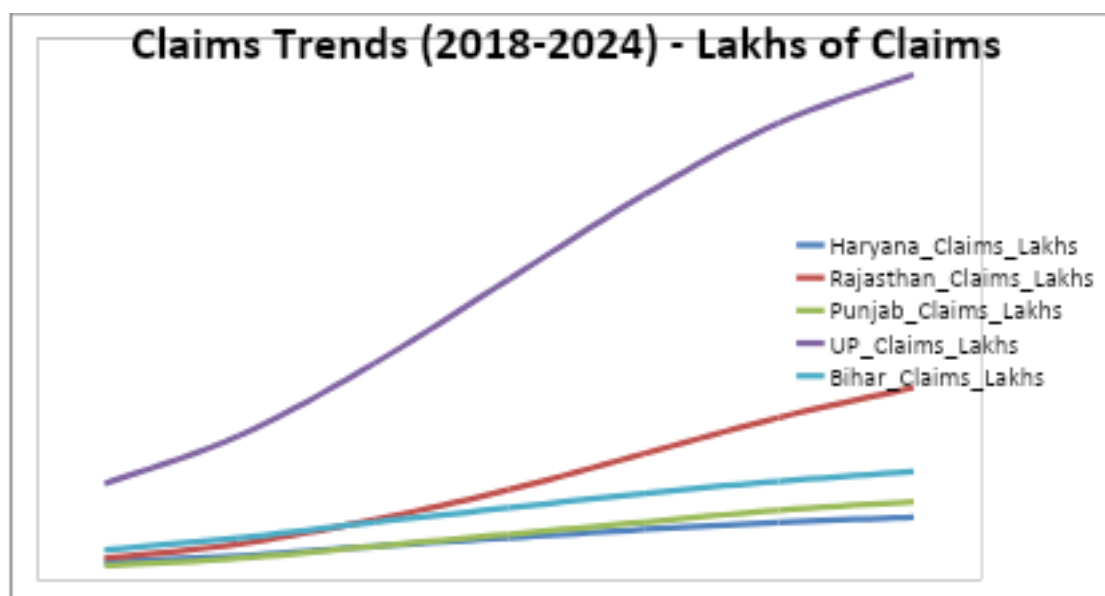


Figure 5: Claim trends from 2018 to 2024 (Lakh of Claims)

Figure 5 shows the number of claims (lakhs) authorized per number of years of service per State by PM-JAY and state schemes, as Uttar Pradesh is leading the pack (80-420 lakhs) due to its sheer size, and Rajasthan has demonstrated a quicker increase in coverage and use of the private sector (18-160 lakhs). Growth is steady in Bihar (25-90 lakhs), moderate in Haryana (15-52 lakhs) and Punjab (12-65 lakhs). In Figure 4, the 1/138 here

is the 1/138 whose whole sharehood of the final scale of 3/ is assumed Institute: where a single school enrolled in a State-mandated examination at one point generates 3 million claims on average per student-unit of its enrolment, comparing to a State average of 0.5 that unit reaches the test progressing to higher education of such standard; yet the self-centred clause of this examination is admissions to higher education of that quality, so that every single enrolled student represents a portion of institutions either currently This confirms the federal implementation thesis national platforms make the enrolment at scale possible, but cut-off enablers at the state level (generous packages, hospital networks, awareness) dictate linked efficiency of utilization and final financial protection.

6.8 Challenges

Despite progress, all five states share common challenges:

- **Fraud and abuse:** ghost hospitals and inflated claims are reported across states.
- **Balance billing:** private hospitals often charge patients even though they have promised cashless services.
- **Data limitations:** lack of timely utilization data hampers transparency and policy evaluation.
- **Fiscal stress:** particularly acute in states that have expanded coverage beyond PM-JAY norms, such as Rajasthan and Punjab.

6.9 Comparative Matrix

Table 1: Comparison Matrix of PM-JAY implementation in 5 states.

Parameter	PM-JAY (Baseline)	Haryana	Rajasthan	Punjab	Uttar Pradesh	Bihar
Coverage Amount	₹5 lakh	₹5 lakh	₹25 lakh (+₹10 lakh accident)	₹5 lakh → ₹10 lakh (MMSY)	₹5 lakh	₹5 lakh
Eligibility	SECC 2011	SECC + state additions	Jan Aadhaar (near-universal)	PM-JAY + farmers, traders, etc.	PM-JAY + MMJAA families	PM-JAY families
Funding	60:40 (Centre: State)	60:40	Predominantly state-funded	Hybrid (state + central)	60:40 + state top-up	60:40
Model	Insurance/Trust (flexible)	Trust	Trust	Trust	Mixed	Trust
Empanelment	Public + private	Moderate, urban skew	High, strong private sector role	Broad, private, dominant	Mixed, gaps in rural areas	Weak, limited rural hospitals
Awareness & Enrolment	Variable	Moderate	High (Jan Aadhaar linked)	High (community outreach)	High enrolment, low awareness	Low
Outcomes	Mixed	Moderate success	High claims, fiscal pressure	Expanding coverage, delays persist	High enrolment, low utilization	Lagging behind

Table 1 is a comparative analysis of the PM-JAY baseline structure in five state implementations on six key dimensions. The main variances are noted in coverage generosity (Rajasthan ₹25 lakh + ₹10 lakh accident cover) and Punjab changes to one (pm-jay) ₹10 lakh universal coverage instead of the standard ₹5 lakh. These eligibility lines are harsh: Rajasthan has achieved almost universal coverage through Jan Aadhaar; other states continue to rely on the exclusions of SECC-2011. Funding indicates federal imbalance- Rajasthan/Punjab have to bear more burden of the State than the usual 60:40 cost-sharing elsewhere. Trust structures are preferable to implementation models (excepting the mixed approach of UP), as well as provider

empanelment and awareness capacity: the capacity gradients can be anticipated, with Rajasthan/Punjab at the top and Bihar at the bottom. These design decisions are reflected in outcomes, and all this proves that state innovation augments national platforms and poses fiscal unsustainability without coordinated federal backing.

6.10 Synthesis

Such a comparative study can show that, even though the PM-JAY establishes a minimum baseline of coverage, state-specific modifications have critical performance-defining effects. Rajasthan and Punjab are examples of state innovation, as fiscal expansiveness allowed them to broaden benefits and visibility. The examples of Haryana, Uttar Pradesh, and Bihar show different levels of dependence on the national model, and the results are directly related to the capacity of the administration. The federal-state relationship is a curse and a blessing; it enables innovation and entrepreneurship, but it also solidifies inequalities between regions. A family in Rajasthan is entitled to coverage of ₹25 lakh, whereas one in Bihar can only have ₹5 lakh and faces obstacles to accessing it. These discrepancies explain the principles of urgency in harmonizing benefit packages, strengthening surveillance systems, and long-term financial planning to secure equity and efficiency in India's health insurance.

7. Case Studies

The case studies will provide an opportunity to investigate the influence of design decisions, political ownership, and administrative capacity on the outcomes of health insurance schemes. Although the comparative framework reveals general tendencies, individual state experiences reveal the interaction among fiscal commitment, governance innovation, and citizen reception. Three examples are provided here: the State of Rajasthan as an example of expansive generosity, Punjab as a model of centralized, state-centric welfare, and Uttar Pradesh/Bihar as a model of implementation difficulties in low-capacity settings.

7.1 Rajasthan: Ambition and Generosity

The most impressive such state-driven health insurance provincial initiative in India is the Mukhyamantri Chiranjeevi Swasthya Bima Yojana (MCSBY) in Rajasthan. Introduced in 2021, it offers ₹25 lakh in coverage per family for secondary and tertiary hospitalization in a year, and ₹10 lakh in accident insurance as well. The scheme is also almost universal, based on the Jan Aadhaar database to include all families, and is far more ambitious, targeting PM-JAY as per the state government's social policy agenda. Both the PM-JAY (co-financed) and MCSBY (state-financed) models differ in that the latter has significant state financing, indicating a willingness to accept higher fiscal participation. There is widespread involvement of the private sector in the scheme, especially in areas such as oncology, cardiology, and orthopedics, where high-cost management procedures drive claim volumes. Nonetheless, the high cost of management procedures has also jeopardized the scheme's sustainability. The fiscal study indicates that the number of claims per year has increased faster than budgetary allocations, and the government must consider how to tighten its belt and revise the packages. Assessments beyond the consensus also indicate that informal payments in private hospitals remain strong, which implies that the expanded financial cover does not necessarily protect against financial risks. Irrespective of these dilemmas, the State of Rajasthan indicates the role of political ownership and strong state capacity in the development of high-visibility welfare programmes. Its experience teaches it some important lessons: although its coverage offers advantages in terms of credibility and use, it can be unsustainable unless it also manages generosity against expenses and fraud.

7.2 Punjab: The Hybrid Model

Punjab was a hybrid march to health insurance, with Sarbat Sehat Bima Yojana (SSBY) replacing PM-JAY by incorporating a few more groups, such as farmers, small traders, and construction workers. Within SSBY, households were covered for ₹5 lakh every year, funded through a blend of central and State funds under the Mukh Mantri Sehat Yojna (MMSY). This was a shift to universal health insurance, presented as a political priority to ensure the financial security of middle-class and unorganized sector families who had earlier been left out of PM-JAY. The Punjab luxury model portrays innovation and complexity. On the upside, enrolment levels rose significantly because the scheme was extended to non-SECC low-income families. The community-based publicity programs, along with inclusion in state databases, increased the number of beneficiaries. Ludhiana, Amritsar, and Jalandhar began functioning as private hospitals, resulting in most claims. However, the plan was not running smoothly. There was confusion about the eligibility criteria that overlapped between PM-JAY and SSBY, raising doubts among beneficiaries and the administration. Trust had been broken due to delays in settling claims and complaints about balance billing. The question of fiscal sustainability is at risk, as the State is heading toward ₹10 lakh universal coverage and would need much higher allocations due to the capabilities and risks of hybridization. Expanding the framework of PM-JAY with inclusions paid by the state insurance provided Punjab with wide coverage, but also introduced administrative complications. The shift by the MMSY to the MMSY presents a valuable case study on whether a universal health insurance is both economically and institutionally feasible in an Indian state setting.

7.3 Uttar Pradesh and Bihar: Scale without Depth

The most populous and the poorest states in India, Uttar Pradesh and Bihar, serve as examples of how health insurance can be difficult to implement in environments with limited capacity. The standard model adopted by both states, with a coverage of ₹5 lakh, is that of PM-JAY, further supplemented in U.P by the Mukhya Mantri Jan Arogya Abhiyan (MMJAA), which allows coverage of non-SECC families. Uttar Pradesh has one of the best enrolment figures in the country, with the State running strong campaigns to issue cards. However, the utilization data shows a difference between enrolment and actual use. Empowered hospitals are concentrated in urban areas, leaving large rural populations underserved. The beneficiaries usually pay out of pocket because they are unaware of its availability or because the hospitals around them are not empanelled. There are also fraudulent claims and poor grievance-redress systems, which, in turn, only serve to water down the scheme further. Bihar is at a more disadvantaged position. Even though enrolment under the Bihar Swasthya Suraksha Yojana (BSSY) is high, utilization rates are low. This is seriously curtailed by the lack of tertiary hospitals beyond Patna; accessibility is hampered, and administrative delays in empanelment will keep private investors away. Awareness is low, and most beneficiaries do not know their rights. There are still informal payments, which compromise the scheme's cashless promise. Indeed, when combined, these experiences of UP and Bihar demonstrate that scale is not the same as impact. Large enrolment volumes are masking weak infrastructure, sensitization, and management capabilities. Compared with Rajasthan and Punjab, which experienced expansion and exposure through political ownership, the states of UP and Bihar highlight the extreme potential of health insurance in fragmented states with fragile health systems and weak governance.

7.4 Lessons from the Case Studies

The three case studies underscore different pathways of health insurance reform in India:

- Rajasthan demonstrates how political ambition and fiscal autonomy can create expansive, high-coverage schemes, though sustainability remains a concern.
- Punjab illustrates the potential of hybrid models, balancing central frameworks with state-funded inclusions, but also reveals administrative complexities.

- Uttar Pradesh and Bihar reveal the challenges of low-capacity contexts, where scale in enrolment fails to translate into real financial protection due to infrastructural and governance constraints.

These cases highlight that while PM-JAY provides a common baseline, state-level choices decisively shape outcomes. Understanding these pathways is crucial for designing future reforms that combine generosity with sustainability, inclusiveness with efficiency, and federal coordination with state innovation.

8. Findings

The comparative analysis of Ayushman Bharat (PM-JAY) and State health insurance schemes across Haryana, Rajasthan, Punjab, Uttar Pradesh, and Bihar reveals a complex landscape of achievements, challenges, and lessons for public administration. Several key findings stand out.

- 1) Variations in State-Level Innovation:** Among the most eye-opening is the variety of benefit designs across states. Whereas Haryana, Uttar Pradesh, and Bihar have been moving in the same direction as PM-JAY with ₹5 lakh per family coverage, Rajasthan and Punjab are moving towards universal coverage of ₹25 lakh and ₹10 lakh, respectively. These expansions demonstrate strong political ownership and financial commitment, but they also highlight the unevenness of financial protection across the states. The coverage of a family in Rajasthan is five times that of a family in Bihar, which is one way of contracting federal inequity.
- 2) Federal-State Dynamics:** PM-JAY is modelled federally to give states the option to adopt insurance, a trust, or a hybrid insurance plan. This flexibility has introduced creativity and disintegration. Rajasthan and Punjab were using autonomy built on inclusiveness, while Bihar and Uttar Pradesh were grappling with the basics. The findings confirm that cooperative federalism in health governance does not enjoy equal footing because it is guided by state capacity, financial strength, and political will.
- 3) Political Narratives and Ownership:** Health insurance has become a political instrument for state governments. Compared to PM-JAY, the Chiranjeevi Yojana in Rajasthan is discussed as a welfare pledge led by the State. The shoving of Punjab to the Mukh Mantri Sehat Yojna is an embodiment of the same. However, the schemes of Haryana and Bihar are not as focused on political branding, and they present their schemes as a continuation of PM-JAY. A political speech contributes significantly to the visibility of the schemes and the Trust of the people, since state-led branding can sometimes increase awareness and adoption rates.
- 4) Infrastructure and Provider Participation:** Healthcare infrastructure and hospital involvement are directly associated with the success of health insurance. The states of Rajasthan and Punjab, which are more privately involved, had greater utilization and more specialty care claims. Conversely, Bihar had a poor network of hospitals, which limited access, even with coverage rights. With a large population, Uttar Pradesh had strained infrastructure, leading to an unequal distribution of services. The results indicate that incomplete supply-side preparedness cannot guarantee access to and protection from insurance.
- 5) Awareness and Utilization Gaps:** Awareness emerged as a critical bottleneck, particularly in Bihar and rural Uttar Pradesh. Despite high enrolment numbers, many households were unaware of their entitlements or encountered difficulties accessing empanelled hospitals. In Haryana, awareness was moderate, but utilization was skewed towards urban centres. Rajasthan and Punjab's intensive enrolment drives, linked to Jan Aadhaar and community outreach, significantly improved awareness. This shows that enrolment is not enough; sustained information campaigns are vital for meaningful utilization.
- 6) Financial Risk Protection:** The promise of reducing out-of-pocket expenditure (OOPE) is only partially realized. While PM-JAY and its state variants have enabled millions of cashless hospitalizations, informal payments and balance billing persist, especially in private hospitals. Rajasthan's expansive cover has improved protection for high-cost procedures, but fiscal pressures

loom large. Punjab's hybrid scheme has improved inclusiveness but has yet to demonstrate significant reductions in OOPe. Bihar and Uttar Pradesh continue to struggle, with many beneficiaries still paying out of pocket. The evidence suggests that financial risk protection is strongest where both benefit design and provider regulation are robust.

- 7) **Challenges of Fraud and Monitoring:** Across states, the challenge of fraud—such as ghost hospitals, duplicate claims, and inflated bills—remains significant. While the NHA has introduced IT-enabled fraud detection systems, their effectiveness depends on state-level enforcement. Rajasthan and Punjab, with higher claim volumes, are especially vulnerable to fraudulent practices. Bihar and Uttar Pradesh face difficulties in monitoring due to weak institutional capacity. This highlights the need for stronger accountability mechanisms and real-time auditing across both central and State levels.
- 8) **Equity Implications:** The findings reveal sharp equity implications. Generous schemes like Rajasthan's and Punjab's benefit a broader population, including middle-class households, while poorer states with limited fiscal space restrict coverage to basic PM-JAY norms. This deepens the federal inequities in health protection, whereby a citizen's level of financial security against illness is determined more by the State of residence than by national entitlement. Such disparities raise questions about the principle of equal citizenship in welfare provision.
- 9) **Impact on Cooperative Federalism:** The analysis shows that PM-JAY has created a common platform for federal cooperation in health insurance, yet its outcomes vary widely. While the national IT system and portability have enhanced cohesion, the divergence in coverage, financing, and performance reflects both the strengths and weaknesses of cooperative federalism. States with capacity and political ownership innovate and expand, while weaker states struggle to deliver even the minimum package. The implication is that federal cooperation must be supported by capacity-building and fiscal equalization to ensure balanced outcomes.

9. Policy Recommendations

The comparative analysis and case studies highlight both the strengths and weaknesses of India's current health insurance landscape. While Ayushman Bharat (PM-JAY) has laid the foundation for a unified national framework, state-level innovations have created uneven outcomes. To achieve equity, sustainability, and efficiency, several policy interventions are recommended.

9.1 Harmonization between Central and State Schemes

A key challenge is the disparity in benefit packages across states. Rajasthan offers ₹25 lakh coverage, Punjab is moving towards ₹10 lakh, while Haryana, Uttar Pradesh, and Bihar remain at ₹5 lakh. Such variation creates inequity in financial protection. The central government, through the National Health Authority, should:

- Establish a minimum standard package across all states, ensuring at least a baseline of equity.
- Allow states to expand beyond the baseline, but require transparent financing plans and actuarial assessments to ensure sustainability.
- Develop a unified beneficiary database that integrates SECC, Aadhaar, and state registries to reduce duplication and exclusion.

9.2 Strengthening Fiscal Sustainability

Expansive schemes require careful fiscal planning. Rajasthan and Punjab's generous packages, while politically popular, risk creating unsustainable liabilities. To address this:

- Introduce fiscal equalization transfers from the Centre to weaker states like Bihar and UP to reduce inequities.

- Encourage public-private reinsurance models, which can absorb high-cost risks while reducing pressure on state budgets.
- Institutionalise annual actuarial reviews of all state and central schemes to forecast liabilities and adjust premiums or packages accordingly.

9.3 Improving Hospital Empanelment and Infrastructure

Insurance can only be effective if the healthcare infrastructure is adequate. Bihar and UP show that weak supply-side capacity undermines insurance. Recommended measures include:

- Incentivizing private hospital participation in underserved areas through viability-gap funding and preferential package rates.
- Strengthening district hospital capacity to enable beneficiaries to access care closer to home.
- Establishing state-level quality assurance cells to continuously monitor empanelled providers, ensuring that network expansion does not compromise standards.

9.4 Enhancing Awareness and Citizen Engagement

Awareness gaps remain one of the biggest barriers to effective utilization. Enrolment drives have not always translated into service use. States and the Centre should:

- Launch continuous IEC (Information, Education, and Communication) campaigns using local languages, community radio, and digital platforms.
- Leverage frontline health workers (ASHAs, ANMs) to disseminate information and assist with grievance redressal.
- Introduce citizen-reporting tools (mobile apps, hotlines) that enable beneficiaries to report denials of service, informal payments, or delays.

9.5 Strengthening Fraud Control and Transparency

Fraudulent claims, ghost hospitals, and balance billing undermine both finances and Trust. Building on NHA's IT-enabled monitoring, the following reforms are critical:

- Develop real-time fraud analytics dashboards accessible to both central and State health authorities.
- Mandate random audits and mystery beneficiary checks to identify malpractices.
- Publish annual state-level transparency reports, detailing claims approved, denied, and flagged for fraud.
- Establish blocklist databases of fraudulent providers accessible across states to prevent "forum shopping" by errant hospitals.

9.6 Expanding Scope Beyond Hospitalization

Outpatient care, diagnostics, and preventive services form the bulk of OOPE in India, yet remain excluded from PM-JAY. To truly reduce financial vulnerability:

- Gradually include outpatient consultations and essential diagnostics within the benefit package.
- Link PM-JAY with Health and Wellness Centres (HWCs) for a seamless continuum of primary-to-tertiary care.

- Pilot capitation-based primary care packages in select districts before scaling nationally.

9.7 Building Cooperative Federalism in Health

Finally, the findings show that cooperative federalism is both essential and fragile. To strengthen this dimension:

- Institutionalized regular Centre–State Health Insurance Councils, where states share innovations and challenges.
- Encourage interstate learning platforms to showcase successful practices from Rajasthan's enrolment model or Punjab's hybrid design.
- Create capacity-building grants to train state-level administrators in actuarial science, fraud detection, and claims management.

10. Conclusion

The Ayushman Bharat (PM-JAY) and the state health care insurance programs under analysis illuminate the opportunities and drawbacks of financial risk insurance coverage in a federal welfare state. PM-JAY has introduced a standardized national structure of care based at hospitals, providing ₹5 lakh per family and establishing a digital backbone that enables portable care and its large-scale administration. Nevertheless, the cross-state comparison of protections and experiences for beneficiaries in Haryana, Rajasthan, Punjab, Uttar Pradesh, and Bihar indicates that state selection yields strikingly different outcomes. As Haryana, Uttar Pradesh and Bihar are more or less a replica of the national design, the fiscal and political space of Rajasthan and Punjab have been deployed to cover ₹25 lakh and ₹10 lakh exposures respectively, and through health insurance as a branding and flagship welfare tool. These disparities, caused by fiscal capacity, infrastructure, and varying political priorities, are translated into inequality: more able or wealthier states can afford to provide generous benefits and better networks, but those that are poorer are at a loss on how to make basic implementation, leaving many household purse-strings open to out-of-pocket spending. Three cross-cut findings can be observed.

To begin with, the variables of equity in financial coverage and access are structurally unequal, and the State's capacity and resources heavily condition who benefits from health insurance. Second, efficient coverage requires the cooperation of easy infrastructure and citizen awareness, as well as the density of provider networks and the maintenance of communications; schemes outperform where a system is strong and weak where awareness is poor. Third, federalism, in particular, can and should be collaborative, but again, results depend on the State's ownership, coordination, and the extent to which the central government comes to its rescue. Regarding the example of public administration, the implications of these findings include that, in addition to being a funding instrument, health insurance is a governance problem that raises the question of how central standard-setting and state autonomy can be reconciled in equilibrium. The policy priorities thus include: incremental expansion of PM-JAY to encompass outpatient and preventive care to cover the most of the out-of-pocket spending; strategic fine-tuning of health infrastructure and incentive to attract private participation in underserved is required; ongoing awareness and grievance-redress systems to build confidence and institutionalized centre- state platforms with sufficient fiscal transfers to provide diffusion of best practice and eliminate capacity gaps. Conclusively, India will approach its health insurance structure with national cohesion and state-level innovation, such that the State of residence does not define the quality and safety of health care, but rather by a willingness to enhance universal health care equality.

References

- Baru, R. V. (2020). Citizens' experiences of health insurance in India: Evidence from qualitative studies. *Health Policy and Planning*, 35(8), 1023–1031. <https://doi.org/10.1093/heapol/czaa078>
- Choudhury, M., & Nath, S. (2012). Health financing in India: The role of federalism. *Economic and Political Weekly*, 47(32), 45–52.
- Fan, V. Y., et al. (2020). Impact of Ayushman Bharat on access to tertiary care: Evidence from early implementation. *The Lancet Regional Health - Southeast Asia*, 2, 100015. <https://doi.org/10.1016/j.lansea.2020.100015>
- Frenk, J., et al. (2012). Health reform in Mexico: Lessons for universal health coverage. *Bulletin of the World Health Organisation*, 90(5), 387–392. <https://doi.org/10.2471/BLT.11.097915>
- Gill, H., & Singh, P. (2021). Sarbat Sehat Bima Yojana: Punjab's hybrid health insurance model. *Indian Journal of Public Health*, 65(4), 345–350.
- Government of Bihar. (2020). Bihar Swasthya Suraksha Yojana guidelines. Department of Health, Government of Bihar.
- Government of Punjab. (2022). Sarbat Sehat Bima Yojana annual report 2021-22. Punjab Health and Family Welfare Department.
- Government of Rajasthan. (2022). Mukhyamantri Chiranjeevi Swasthya Bima Yojana scheme guidelines. Rajasthan Medical Services Corporation Ltd.
- Government of Uttar Pradesh. (2021). Mukhya Mantri Jan Arogya Abhiyan operational guidelines. State Agency for Comprehensive Health and Integrated Services (SACHIS).
- Greer, S. L., & Méndez, C. A. (2019). Federalism and health policy in comparative perspective. *Journal of Comparative Policy Analysis*, 21(4), 301–315. <https://doi.org/10.1080/13876988.2019.1612792>
- Gupta, A., & Roy, S. (2020). Fraud and abuse in India's health insurance schemes. *Economic and Political Weekly*, 55(42), 34–40.
- Hooda, S. K. (2017). Health financing reforms in India: Getting it right. *Journal of Health Management*, 19(2), 153–171. <https://doi.org/10.1177/0972063417693515>
- Karan, A., et al. (2017). The impact of public health insurance schemes on hospitalization. *Social Science & Medicine*, 193, 80–89. <https://doi.org/10.1016/j.socscimed.2017.09.056>
- Khetrapal, S., & Acharya, A. (2019). Cooperative federalism and health insurance in India. *Health Policy and Planning*, 34(6), 422–429. <https://doi.org/10.1093/heapol/czz052>
- Kumar, R. (2021). Implementation challenges of PM-JAY in Bihar. *Journal of Health Policy and Implementation*, 4(2), 89–102.
- Lahariya, A. (2020). Ayushman Bharat and the path to universal health coverage. *Indian Journal of Public Health*, 64(1), 1–5. https://doi.org/10.4103/ijph.IJPH_450_19
- Malik, J. S. (2022). Equity concerns in Haryana's Ayushman Bharat implementation. *Public Health Research Journal*, 3(1), 23–31.
- Mishra, R., & Srivastava, A. (2022). Scale versus quality: Uttar Pradesh's health insurance experience. *Journal of Health Management*, 24(3), 178–185. <https://doi.org/10.1177/09720634221109876>
- Nair, S. K., et al. (2021). Beneficiary awareness under PM-JAY: Rural-urban disparities. *Indian Journal of Community Medicine*, 46(2), 245–250.

- Nandi, S., et al. (2020). State-level variations in PM-JAY outcomes. *Health Policy OPEN*, 1, 100012. <https://doi.org/10.1016/j.hpopen.2020.100012>
- National Health Accounts. (2019–20). National Health Accounts Estimates for India. Ministry of Health and Family Welfare, Government of India.
- National Health Authority. (2021). Ayushman Bharat PM-JAY annual report 2020-21. Government of India.
- National Health Authority. (2022). Progress and challenges of PM-JAY. Government of India.
- NITI Aayog. (2021). Health Index Report: State-level performance under Ayushman Bharat. Government of India.
- Prasad, R., & Chakraborty, S. (2020). Balance billing in private hospitals under PM-JAY. *Economic and Political Weekly*, 55(28), 32–37.
- Prinja, S., et al. (2019). Cost-effectiveness of PM-JAY. *PharmacoEconomics*, 39(6), 743–759. <https://doi.org/10.1007/s40273-019-00846-3>
- Prinja, S., et al. (2020). Impact evaluation of Ayushman Bharat. *The Lancet*, 396(10265), 1823–1834. [https://doi.org/10.1016/S0140-6736\(20\)32135-3](https://doi.org/10.1016/S0140-6736(20)32135-3)
- Prinja, S., et al. (2021). Inter-state disparities in PM-JAY implementation. *Health Policy and Planning*, 36(5), 712–721. <https://doi.org/10.1093/heapol/czaa178>
- Ragin, C. C. (2014). *The comparative method: Moving beyond qualitative and quantitative strategies*. University of California Press.
- Rao, M. G., & Choudhury, M. (2013). Health care financing reforms in India. NIPFP Working Paper No. 2013-115.
- Reddy, K. S., & Mary, V. K. (2018). Federalism and health policy in India. *Indian Journal of Medical Research*, 148(4), 377–385. https://doi.org/10.4103/ijmr.IJMR_1450_18
- Saltman, R. B. (2016). Federalism and decentralization in health care. In *The Palgrave International Handbook of Healthcare Policy and Governance* (pp. 339–356). Palgrave Macmillan.
- Selvaraj, S., & Karan, A. K. (2012). Equity in public health insurance. *Economic and Political Weekly*, 47(38), 47–54.
- Sharma, R. (2022). Punjab's health insurance experiment: Opportunities and challenges. *Journal of Public Administration*, 10(2), 112–125.
- Singh, P., & Gupta, R. (2023). Rajasthan's Chiranjeevi Yojana: Fiscal sustainability concerns. *Indian Journal of Public Policy*, 7(1), 45–59.
- State Health Agency, Haryana. (2021). Ayushman Bharat Haryana annual performance report. Government of Haryana.
- Xu, K., et al. (2018). Financial protection in health systems. *Bulletin of the World Health Organization*, 96(8), 573–583. <https://doi.org/10.2471/BLT.17.204743>