Background

A major feature of PM-JAY is its coverage of hospital care up to an annual limit of INR 5 lakh per household. The predecessor federal scheme, Rashtriya Swasthya Bima Yojana (RSBY), had an annual cap of INR 30,000, while those states managing their own expanded schemes (“brownfield” states) had coverage limits ranging from INR 50,000 to 3 lakh. PM-JAY’s higher cap offers greater financial protection and coverage of more advanced care, particularly in those “greenfield” states that were previously implementing RSBY only or had no government-sponsored scheme at all. But more generous coverage also implies larger financial outlays, higher stakes in the fight against unnecessary care and fraud, and possibly more uneven access to care across the country. Understanding high-value claims is therefore important for program implementation.

This policy brief provides an analysis of PM-JAY and aligned state schemes’ high-value claims, defined here as those exceeding the previous RSBY limit of INR 30,000, and very-high-value claims, or those exceeding INR 1 lakh. Analysis covers less than one full year of claims data1, including the launch phase when beneficiary identification and hospital empanelment were at an early stage in greenfield states, and therefore findings should be seen as preliminary. However, early evidence on high-value claims is valuable as a first window into financial protection under the scheme, an important topic given India’s high dependence on out-of-pocket payments. It is also highly relevant for other policy and implementation areas, such as fraud management, benefit package design and implementation, claims processing, financial risk management, and high-value claims. The top 20 hospitals account for 17% of high-value claims and 5% of total outlays. These offer potential focal points for deeper dives into PM-JAY achievements and challenges.

1. PM-JAY claims as defined for the purpose of the policy brief include total preauthorizations raised from States wherever the launch of PM-JAY resulted in extension of the family coverage to INR 5 lakh.
management, equity, efficiency, and sustainability. This policy brief aims to characterize high-value claims to inform scheme implementation.

This policy brief focuses on characterizing: 1) the distribution of high-value claims with respect to geographic and demographic coverage; and 2) the drivers of high-value claims, by examining the most frequent service types, provider types, and patient types.

Findings and Implications

High-value claims (>INR 30,000) account for only 7% of the total claim volume but 32% of total claim value

Over 20 lakh claims have been preauthorized up to 15 May 2019. The mean claim size is around INR 13,000, and half of all the preauthorized claims are below INR 7,000. In contrast to the large number of low- and medium-size claims, 7% are high-value claims (above INR 30,000), and 1% of total claims are very-high-value claims (above INR 1 lakh) (Figures 1, 2). Despite the relatively small volume, these high-value claims contribute 32% of PM-JAY claim payout, amounting to nearly INR 1,000 crore. Similarly, very-high-value claims constitute 9% of the total value of claims. If this trend continues, the projected total number of high-value claims will be over 3.2 lakh, with expected claim value over INR 2,300 crore (Table 1). This estimate is likely to be a lower bound, given the natural acceleration of implementation after the early launch phase.

This pattern gives a good indication of the potential scale of PM-JAY and aligned state schemes in improving access to high-cost medical services and providing financial risk protection. A medical bill of INR 30,000 is likely to be catastrophic (defined as exceeding 10% of total household spending) for the large majority of SECC households. At the same time, it highlights the importance of efforts to improve quality of care, fraud management, and cost-effectiveness of high-value packages to ensure value for money and efficient use of public funding. Over time, these issues will become increasingly important to ensure program sustainability.

Box 1: METHODOLOGY

Time period for the analysis: Launch of the Scheme on September 23, 2018 to May 15, 2019, unless otherwise noted.

Data source: PM-JAY’s Transaction Management System (TMS) claims database. Not all states are presently integrated (e.g., Andhra Pradesh, Rajasthan).

Definition of PM-JAY population: All families with 5 lakh coverage. This includes those covered by PM-JAY (co-financed by Govt of India and states) and all additional “extension” families fully funded by states under their own expanded coverage initiatives.

Definition of high-value claims: Preauthorized claims with approved amount >INR 30,000 and package amount >INR 30,000 are selected for analysis.

Definition of very-high-value claims: Preauthorized claims with approved amount >INR 1 lakh and package amount >INR 1 lakh.

Definition of family wallet: Cumulative claims value within the family.

Table 1: Projected volume and value of high-value claims in 2019

<table>
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<tr>
<th></th>
<th>Number</th>
<th>Total amount (crore INR)</th>
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<tbody>
<tr>
<td>High-value claims</td>
<td>2,81,661</td>
<td>1,863</td>
</tr>
<tr>
<td>Very-high-value claims</td>
<td>40,659</td>
<td>516</td>
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Note: extrapolated based on January-April 2019 data
About 36,000 households have claims exceeding INR 1 lakh; 354 households have exhausted the 5 lakh limit by May 2019

On average, about 37 in 1,00,000 beneficiary households have incurred claims exceeding INR 1 lakh, and 0.4 in 1,00,000 beneficiary households have reached the 5 lakh limit (Table 2). Most households exceeding 1 lakh wallet are in Maharashtra, Tamil Nadu, and Karnataka. The vast majority of households exceeding the INR 5 lakh limit are in Tamil Nadu, where very expensive procedures such as transplants are covered.

High-value claims are concentrated in brownfield states and districts in the south and west

While 79% of all PM-JAY and aligned state schemes’ claims come from brownfield states, this percentage is 87% for high-value claims, showing a high degree of concentration (Figure 3, 4). For example, Maharashtra accounted for nearly half of all high-value claims up to May 2019, with 62,913 such claims amounting to INR 429 crore. The other two high utilization states for high-value packages are Tamil Nadu (28,907 claims, INR 184 crore) and Karnataka (20,759 claims, INR 154 crore). This pattern is partly due to significant coverage expansions beyond the SECC population by several brownfield states (Box 1). Furthermore, high-value claims tend to concentrate in a few districts (Figure 5). The eight districts with over 5,000 high-value claims are Bengaluru Urban, Mumbai Suburban, Ahmednagar, Aurangabad, Pune, Nashik, Chennai, and Raipur.

Adjusting for the state-wise scheme launch dates and eligible SECC and extension population, the highest incidence of high-value claims per 1 lakh SECC beneficiaries are seen in Maharashtra (82), Dadra and Nagar Haveli (61), Daman and Diu (50), Karnataka (30), Chhattisgarh (30), and Tamil Nadu (20) (Figure 6). Higher incidence in brownfield states is to be expected, since their mature schemes imply that beneficiary identification and hospital empanelment processes had been completed in previous years. Greenfield states had to undertake these tasks largely from scratch. But looking ahead, structural differences between brownfield and greenfield states – including differences in supply availability and care-seeking behavior by their populations – could mean that these patterns will persist to a significant extent. Thus, while access to specialized care will be a key challenge related to high-value claims in greenfield states, ensuring quality of care and fraud management are likely to represent the key issues in brownfield states.

<table>
<thead>
<tr>
<th>Table 2: Number and incidence of families with high cumulative claims amount</th>
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<tbody>
<tr>
<td>Families cumulative amount</td>
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<tr>
<td>&lt;INR 30,000</td>
</tr>
<tr>
<td>Number of families</td>
</tr>
<tr>
<td>Incidence (per 1,00,000 eligible families)</td>
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</tbody>
</table>
Figure 6: Incidence of high-value claims by States and UTs
Number of high-value claims per 1 lakh beneficiaries

Number of claims per 1 lakh beneficiaries

- 0
- 10
- 20
- 30
- 40
- 50
- 60
- 70
- 80
- 90

High-value claims (>INR 30,000)  Very-high-value claims (>INR 1 lakh)

Maharashtra  Dadra and Nagar Haveli  Daman and Diu  Karnataka  Chhattisgarh  Tamil Nadu  Gujarat  Himachal Pradesh  Haryana  Uttarakhand  Manipur  Madhya Pradesh  Jammu and Kashmir  Jharkhand  Kerala  Punjab  Arunachal Pradesh  Meghalaya  Tripura

Figure 7: Gender and age distribution among beneficiaries of high-value claims (by volume)

Gender

- All claims: 48% Female, 52% Male
- Claims >INR 30,000: 38% Female, 62% Male

Age

- All claims: 3% 5-18, 19-50, 51-65, 66+
- Claims >INR 30,000: 14% 5-18, 28% 19-50, 39% 51-65, 33% 66+

The availability, distribution, and access aspects of high capacity providers will need to be investigated to identify state-specific bottlenecks and work towards more equitable access nationwide.

Beneficiaries of high-value claims are predominantly male and include a slightly higher percentage of children and elderly

Only 38% of high-value claims are for female beneficiaries, compared to 48% of all PM-JAY claims (Figure 7). National surveys, such as the 71st round National Sample Survey (NSS) data also shows nearly equal rates of general hospitalization (excluding child-birth). The higher male share in high-value claims might be a result of a higher prevalence of cardiovascular diseases among men resulting in higher utilization of expensive cardiology and cardio-surgery packages. But it might also reflect gender-specific barriers that impede access to more specialized and expensive procedures by women. Identifying and addressing barriers for low-income women to access necessary high-level services will be important to effectively increase population coverage and improve women’s health. Compared to the overall claims profile, high-value claims are more prevalent among children under 5 years, and those above 50 years, which are known to bear a higher disease burden.

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High-value claims differ from the average claim in many respects

High-value claims are mostly related to surgical packages (79%) and tertiary packages (89% of volume, 92% of value) (Figure 8). While only 61% of all claims are from private hospitals, the share from private hospitals is higher for high-value claims (74%), and very-high-value claims (82%). This will also help identify the capacity gaps in public hospitals. While states use different modes to process claims (insurance mode, mix mode, and trust mode), there are few differences in the value of claims across implementation modes. High value claims are slightly more common among the mixed mode and trust mode, mostly because Karnataka, Maharashtra and Tamil Nadu fall into these categories.
Portability among patients is more common for high-value claims

While only 0.7% of all claims are portability cases (across states), this percentage is 2.4% for high-value claims and 5.3% for very-high-value claims (Figure 9, 10). This is to be expected, and represents a major positive feature of PM-JAY. When including the within-state but cross-district claims, portability is even higher. The higher portability for high-value claims reflect potential service gaps in many states, and patient preferences to go to bigger hospitals in other regions to seek care.

High value claims are mostly from Cardiology packages and Cardio-surgery packages

The high-value claims concentrate in several specialties: cardiology, radiation oncology, cardio surgery, orthopedics, and neurosurgery. The very high-value claims are also from these specialties. The top packages are shown in Figure 11. During medical audits, these packages should be closely monitored to ensure appropriate indication and high-quality services.

Hospitals with a larger volume of high-value claims concentrate in a few cities, and the top 20 hospitals account for 17% of all high-value claims

There is huge geographic variation in the number of hospitals delivering highly specialized services that lead to high value claims (Figure 12). Hospitals with large volume of high-value claims concentrate in several states, districts and big cities. For example, 874 hospitals in Tamil Nadu had
submitted high-value claims. In contrast, in many Northeastern States, less than 10 hospitals had high-value claims. In fact, 20 hospitals account for 17% of all high-value claims (and therefore over 5% of total PM-JAY spending) (Figure 13). This is partly due to higher population coverage in these states through state-funded expansions. But the highly unequal distribution also suggests that many regions face significant capacity gaps. While the portability feature of PM-JAY allows patients to seek care in other states, it is likely that not all patients have the financial sources and knowledge to effectively seek care at distance. Therefore, the lack of provider capacity in some regions may restrict the ability of patients to fully benefit from PM-JAY. Potential mechanisms related to empanelment, portability, and referral may need to be strengthened. On the other hand, the high concentration of high-value claims also offer opportunities to significantly strengthen fraud management and quality control in large hospitals.
High-value claims are being processed more quickly than average claims

Most high-value claims are processed in a timely manner. The time from preauthorization initiation to approval has a median of 7.5 hours for high-value claims, and 44% of preauthorizations submitted are approved within 6 hours (Figure 14). This is partially due to the auto-approval mechanism for many surgical packages. However, this may increase the possibility of abuse. The average claims processing time for high-value claims is significantly shorter than for all claims (22.9 days vs 33.5 days) (Table 3). The timely payment of claims is important for hospitals to have adequate cash flow. The faster processing may be due to the fact that a large share of high-value claims come from higher capacity states and hospitals. However, the small proportion of claims subject to long delays should be investigated to improve claims processing.

Summary

PM-JAY and aligned state schemes are on pace to have nearly 3 lakh high-value claims in 2019, accounting for almost one-third of total outlays. This reflects the positive impact on poor patients’ access to specialized services and financial protection. Yet the uneven distribution of high-value claims across geographic regions and patient groups highlights the need to broaden the footprint of high-value claims, especially to greenfield states, and to reach more women beneficiaries. The high concentration of high-value claims in specific districts and hospitals offers opportunities for deep dives to improve quality and fraud management.

References

Disclaimer
The findings, interpretations, and conclusions expressed in the policy brief are entirely those of the authors, and do not represent the views of any author’s employer, official policy or position of any agency of the National Health Authority (NHA). The PM-JAY data used in the analysis should not be utilized/quoted without prior permission of NHA.

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List of PM-JAY Policy Briefs Published so far
1. Raising the Bar: Analysis of PM-JAY high-value claims (July 2019).