GOVERNMENT OF INDIA
MINISTRY OF HEALTH AND FAMILY WELFARE
DEPARTMENT OF HEALTH AND FAMILY WELFARE

RAJYA SABHA
UNSTARRED QUESTION NO. 2660
TO BE ANSWERED ON 21ST DECEMBER, 2021

IMPLEMENTATION OF AYUSHMAN BHARAT SCHEME

2660. DR. ABHISHEK MANU SINGHVI:

Will the Minister of **HEALTH AND FAMILY WELFARE** be pleased to state:

(a) the timeline of implementation of the Ayushman Bharat Scheme;

(b) the details of fund allocation under the scheme;

(c) the break-up of fund allocation under different procedures covered under the scheme;

(d) the deadline by when the scheme would cover 100 percent population of the country; and

(e) the details of rates that insurance companies would pay hospitals for the 1,350 procedures covered under the scheme?

ANSWER
THE MINISTER OF STATE IN THE MINISTRY OF HEALTH AND FAMILY WELFARE
(DR. BHARATI PRAVIN PAWAR)

(a) to (e): Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) was launched on 23rd September 2018 to provide health coverage up to Rs. 5 lakh per annum per beneficiary family to around 10.74 crore poor and vulnerable families identified from Socio Economic Caste Census (SECC) data of 2011 on the basis of select deprivation and occupational criteria across rural and urban areas respectively. 33 States/UTs are implementing the scheme. State/UT of Odisha and Delhi have not yet joined the scheme. The State of West Bengal withdrew from the scheme in January, 2019.

Details of fund allocation are as under:

(in crore of Rupees)

Financial Year	Budget Estimate	Revised Estimate
2018-19	2400.00	2160.00
2019-20	6400.00	3200.00
2020-21	6400.00	3130.00
2021-22	6400.00	3100.00

As per Cabinet approval, beneficiary database is defined. However, States/UTs have been given the flexibility to run their own health protection scheme(s) in alliance with AB-PMJAY at their own cost.

The Central share of premium is paid based on market determined rate in such States/ UTs where PMJAY is implemented through insurance companies. In States/UTs where the scheme is implemented in Trust/ Society mode, the Central share of funds is provided based on actual expenditure. In both the cases, it is subject to overall ceiling approved by the Government from time to time.

Medical treatment claims are filed by empanelled private hospitals with insurance companies/trust, as per the case. The insurance company/trust settles these claims after verifying the genuineness thereof. Public hospitals empanelled under the scheme are reimbursed treatment charges at par with private hospitals.

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