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

RAJYA SABHA
UNSTARRED QUESTION NO. 1085
TO BE ANSWERED ON 29TH JULY, 2025

EXPANSION OF HEALTHCARE COVERAGE UNDER AB- PMJAY

1085. SMT. RAJANI ASHOKRAO PATIL:

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

(a) the measures taken to reduce the age criteria for senior citizens to 60 years for obtaining Ayushman Vay Vandana Cards as recommended by Parliamentary Committee;

(b) the steps taken to expand the healthcare coverage under Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) up to ₹ 10 lakh per family annually;

(c) the measures taken to address the delay in settlement of empanelled hospitals under AB-PMJAY;

(d) whether many patients have been denied treatment by empanelled hospitals due to unattractive/ non-viable revision of package rates; and

(e) if so, the steps taken to address this issue?

ANSWER
THE MINISTER OF STATE IN THE MINISTRY OF HEALTH AND FAMILY WELFARE
(SHRI PRATAPRAO JADHAV)

(a) and (b): Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) is a flagship scheme of the Government of India that provides health coverage of ₹5 lakh per eligible family per year for secondary and tertiary care hospitalizations. The Government of India has expanded AB-PMJAY to provide free treatment benefits up to ₹5 lakh per year to all senior citizens aged 70 years and above, irrespective of their socio-economic status.

Expansion in treatment is done by inclusion of new procedures, empanelment of new hospitals, inclusion of new beneficiaries and other improvements as per requirements from time to time.

(c): Settlement of claims is an ongoing process. Under AB-PMJAY, claims are settled by respective State Health Agencies (SHA). NHA has laid down guidelines for payment of claim to hospitals within 15 days of claims submission for the intra-state hospitals (hospitals located within State) and within 30 days in case of portability claims (hospitals located outside State).

Claims are required to be settled within the timeline specified under the scheme. Notable improvements have been recorded in the overall average Turnaround Time (TAT) for claim settlements year on year. Regular review meetings are organized to take stock of the progress with regards to the claims. Further, capacity building activities are organised for efficient claims settlement.

(d) and (e): As per the terms and conditions of empanelment, hospitals cannot deny treatment to eligible beneficiaries of the scheme. In instances other than treatment denial due to exclusion by the empaneled hospital, beneficiaries can lodge grievances. Under AB-PMJAY, a three-tier grievance redressal system at District, State and National level has been created to resolve the issues faced by beneficiaries in utilizing healthcare services. At each level, there is a dedicated nodal officer and Grievance Redressal Committees to address the grievances.

Beneficiaries can file their grievances using different mediums including web-based portal Centralized Grievance Redressal Management System (CGRMS), Central & State call centers (14555), email, letter to State Health Agencies (SHAs) etc. Based on the nature of grievance, necessary action including providing of support to the beneficiaries in availing treatment under the scheme, is taken.

Further, to improve hospital participation, Health Benefit packages (HBPs) used under AB-PMJAY have been revised and rationalized five times since the launch of the scheme.

*****