Institute of Actuaries of India
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Expanding the horizon, strengthening the core

20th Global Conference of Actuaries
4th - 6th March, 2019 | Mumbai, India

PMJAY - Ayushman Bharat

Speaker(s)

Sanjay Datta

Vishwanath Mahindra

Rajagopal Rudraraju

Session p12
Dated : 06-Mar-19

Ayushman Bharat – A scheme for comprehensive care

Sanjay Datta
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Session p12
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AYUSHMAN BHARAT

A vision for Holistic Health

- Sub- Health Centres (SHCs) & Primary Health Centres (PHCs) to be transformed to Health & Wellness Centres (HWCs) to deliver
- **Comprehensive Primary Health Care** with a focus on wellness: expanded range of services, close to communities

Continuum of Care

Two way referral

Gatekeeping

- Pradhan Mantri Jan Arogya Yojana (PMJAY) to provide for free & cashless hospital based **secondary and tertiary care.**
  Government moving from provider to payer of health services

AYUSHMAN BHARAT

What is new

- Expanded package of services in place of just Reproductive, maternal and child care & selected communicable diseases: from selective to comprehensive
- Enhance productivity of vast network of currently underutilized primary health care facilities
- Universal screening of 30 + population (about 40 crores) and management of common Non-Communicable Diseases such as Diabetes, Hypertension and 3 common cancers
- Posting a Mid-level Health Provider at SHC-HWC -B.Sc. Community Health/ Nurse or Ayurveda Practitioner trained for 6 months in public health and primary care
- Use of Tele-health & ECHO for continuum of care & enhancing competencies of HWC team in management of expanded disease conditions

Community – Facility

Maintaining Continuum of Care

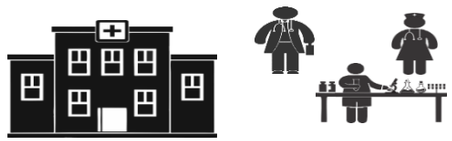
Village/Urban Ward

- Population Enumeration
- Community Based Risk Assessment/outreach services
- Follow up of confirmed cases
- Health Education for Lifestyle change; treatment adherence
- Health and Wellness Ambassadors

SHC-HWC

- First Level Care
- Screening
- Use of Basic Diagnostics
- Medicine Dispensation
- Tele-health for referral/ Extension for Community Health Outcomes (ECHO) for skilling

CHC/SDH/DH



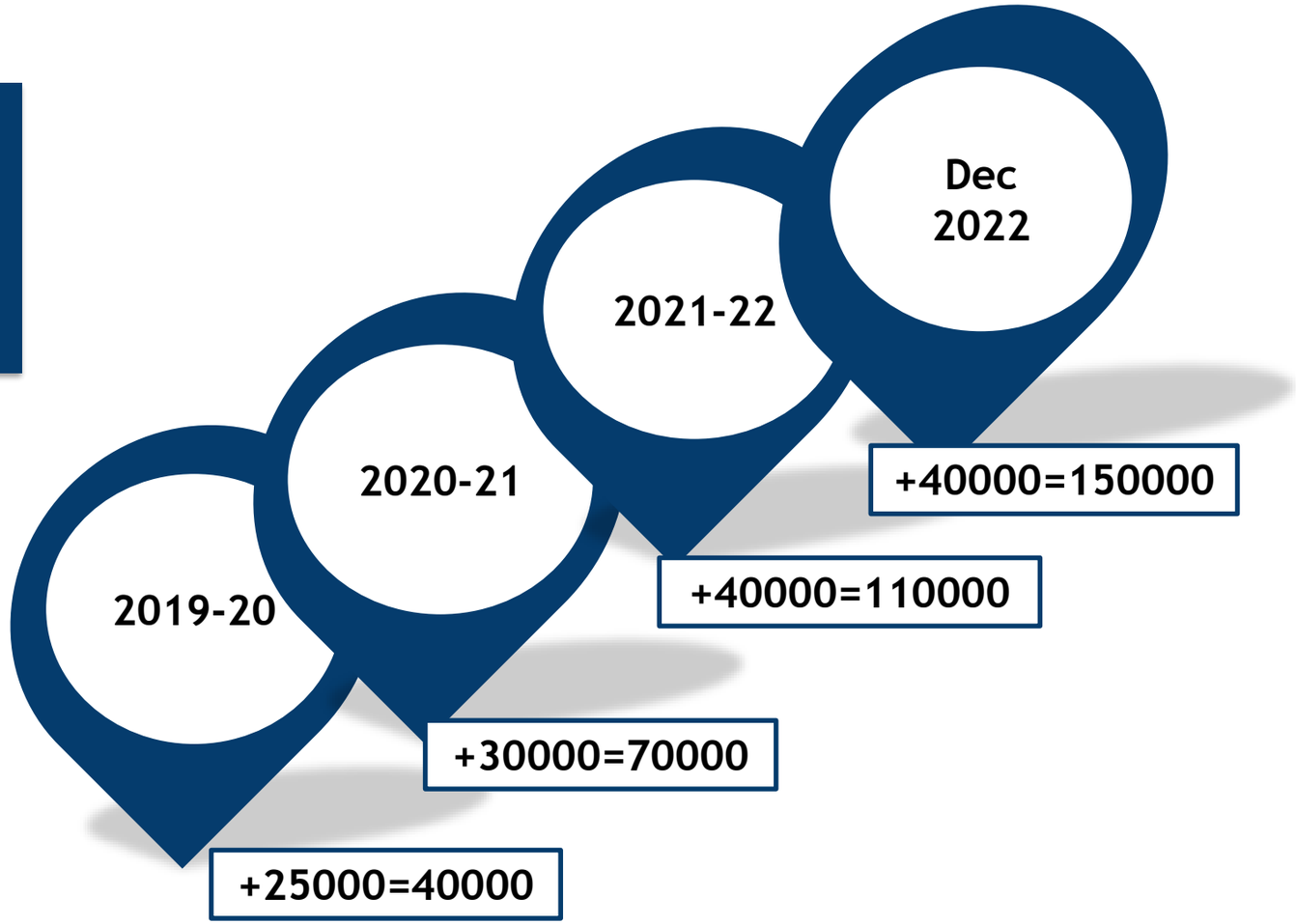
- Advanced diagnostics
- Complication assessment
- Telehealth/Extension for Community Health Outcomes (ECHO)
- Tertiary linkage/PMJAY

PHC-HWC

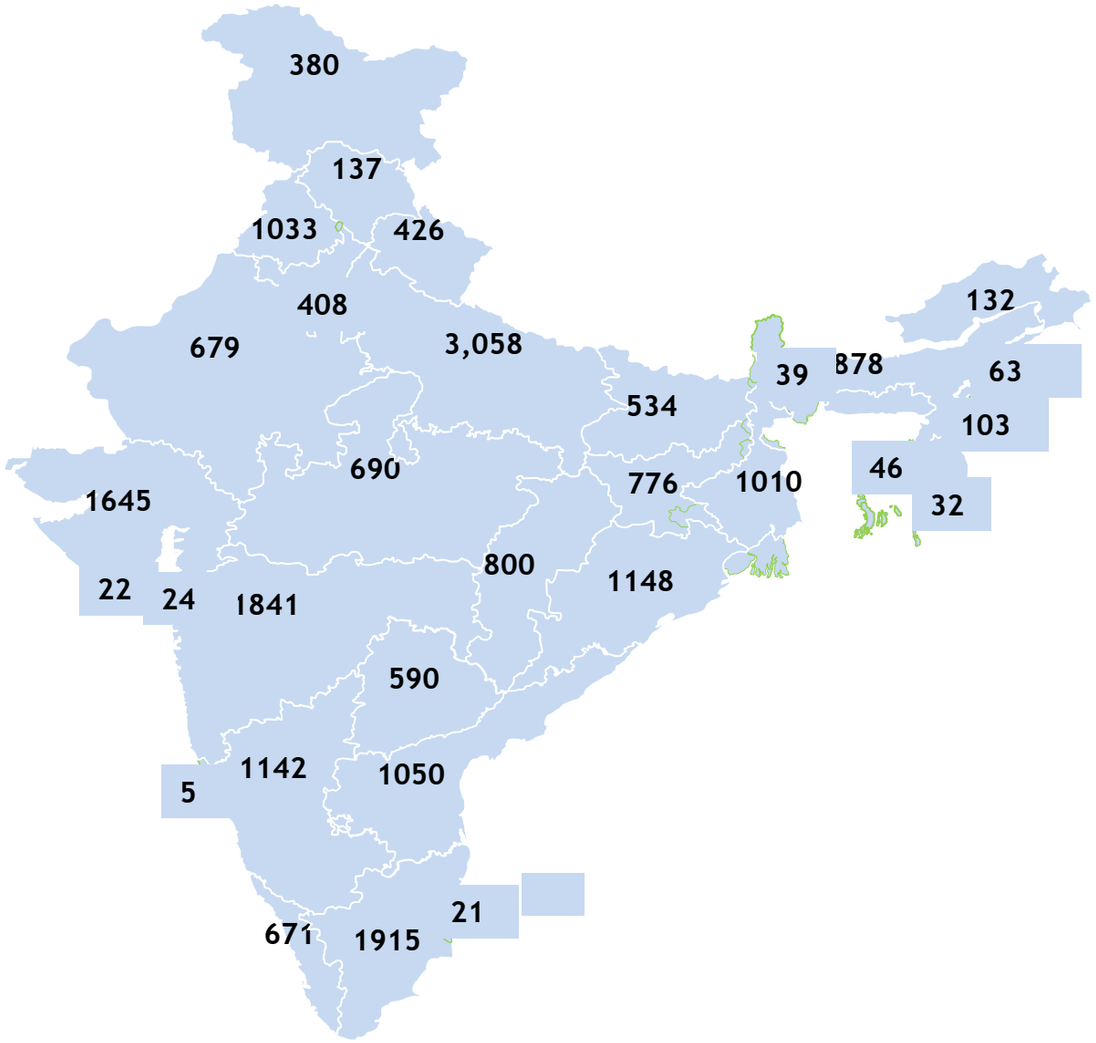
- Diagnosis
- Prescription and Treatment Plan
- Referral of complicated cases
- Telehealth/ECHO
- Real time monitoring

Roll out of Health and Wellness Centres

Ayushman Bharat-
Comprehensive Primary Health Care (CPHC) through Health and Wellness Centres (HWC)



Total HWCs approved for FY 2018-19 - 21411



HWC , Jangla, Bijapur, Chhattisgarh- launched on April 14, 2018 by Hon. PM

Ayushman Bharat

Pradhan Mantri Jan Arogya Yojna

10.74
Crore

Poor and Vulnerable Families Entitled as per SECC

5
Lakh
Cover per family per year for serious illnesses

Portable

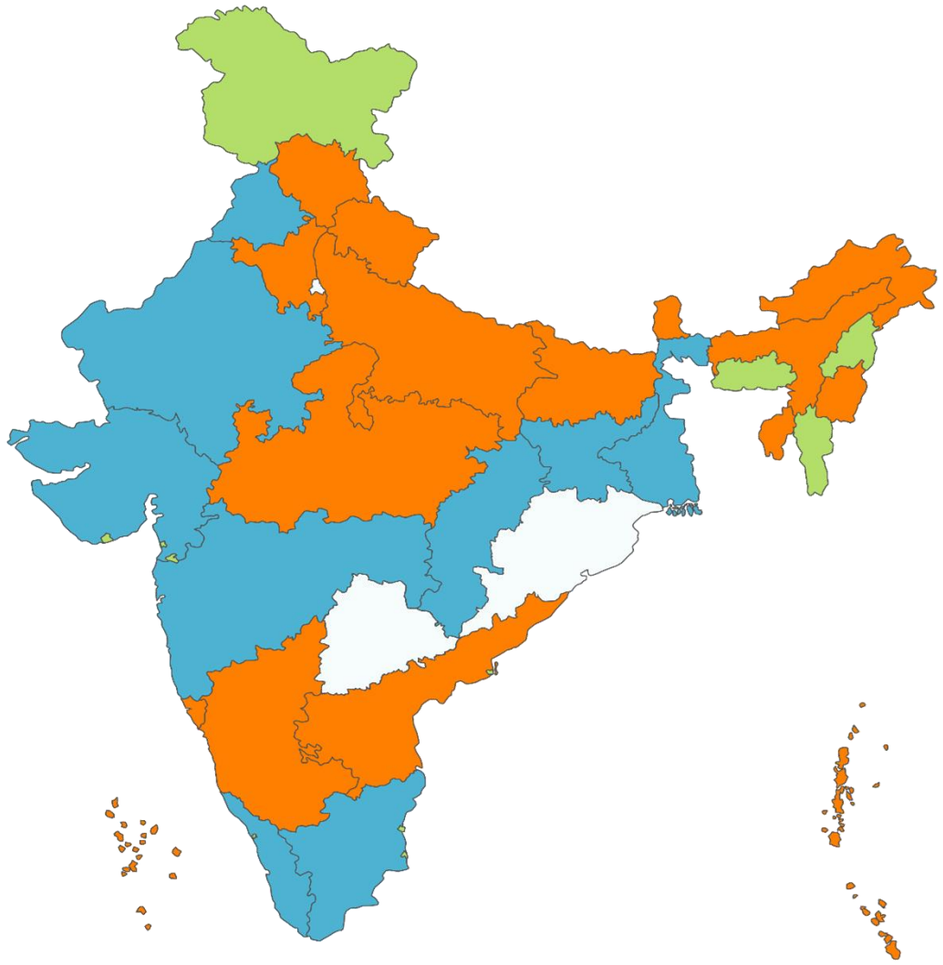
Benefits can be availed at all empaneled hospitals across the country

No Cap

On Family Size, Age or Gender and covers pre-existing diseases

Nation-wide Launch of PM-JAY by Hon. PM on September 23rd from Jharkhand

PM-JAY gaining traction



33	States/UTs signed MoUs
27	States/UTs implementing

7	Insurance Mode
17	Trust Mode
9	Mixed Mode

Insurance Mode
- Mizoram
- Meghalaya
- Nagaland
- Dadar and Nagar Haveli
- Daman and Diu
- Jammu and Kashmir
- Puducherry

Trust Mode
- Andhra Pradesh
- Assam
- Arunachal Pradesh
- Bihar
- Madhya Pradesh
- Himachal Pradesh
- Haryana
- Tripura
- Uttar Pradesh
- Uttarakhand
- Lakshadweep
- Andaman & Nicobar
- Chandigarh
- Karnataka
- Goa
- Manipur
- Sikkim

Mixed Mode
- Chhattisgarh
- Gujarat
- West Bengal
- Rajasthan
- Kerala
- Tamil Nadu
- Jharkhand
- Maharashtra
- Punjab

State-wise implementation

Year 2018

States / UT's and Models

- Tender closed (5)
  - Sum Insured : 5 Lacs (Insurance Model) - 7
    - J&K (775), Nagaland (444) < INR 1082 govt. budget
    - Daman & Diu (1712) > INR 1082
  - Sum Insured : 50 K (Hybrid) – 9
    - Gujarat (360) < INR 1082 govt. budget
    - Chhattisgarh (1100) > INR 1082
    - SI is only 10% of actual SI considering premium on tenders closed
- Trust model: 17
- Not Implementing - 6

PM-JAY Report Card (1/2)

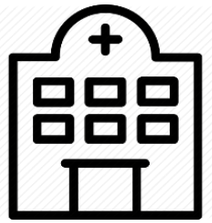
Hospital Admissions

10.8 Lakh got benefits worth 1,456 Cr

e-Cards (Golden Records) Issued

1.2 Cr

Hospitals Empanelment (Approved/In-Process)



17,826

PM-JAY Report Card (2/2)

56%
Hospitals Empanelled are Private

65%
Treatment in Private Hospitals

77%
Amount for Tertiary Cases

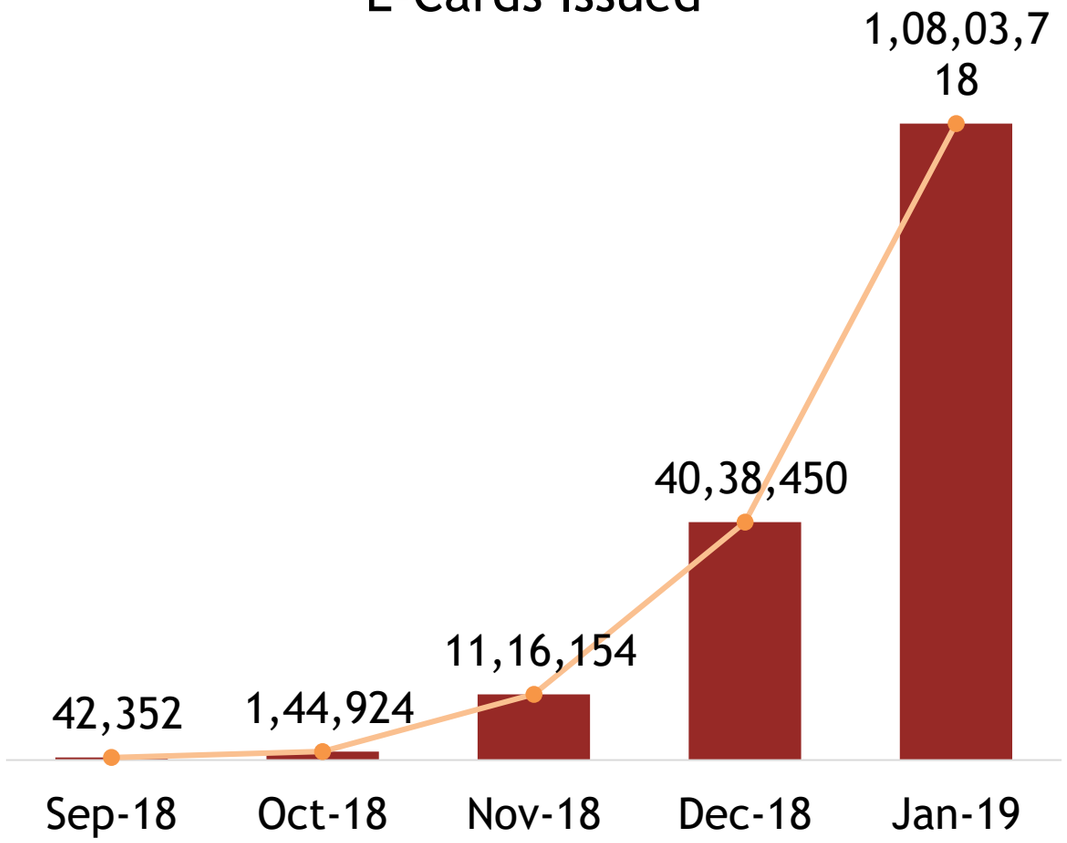
2,000+
Portability Cases

69%
Multispecialty Hospitals

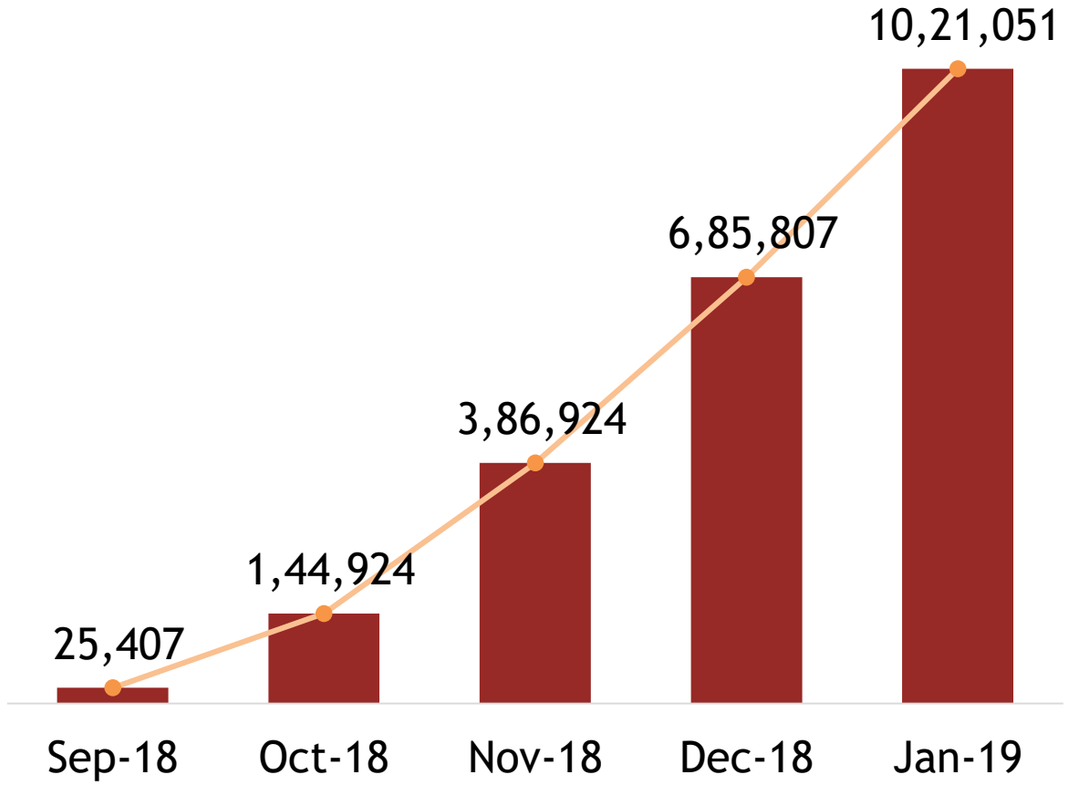
83%
E-Card Issued Using Aadhaar

PM-JAY Growth Trends (1/2)

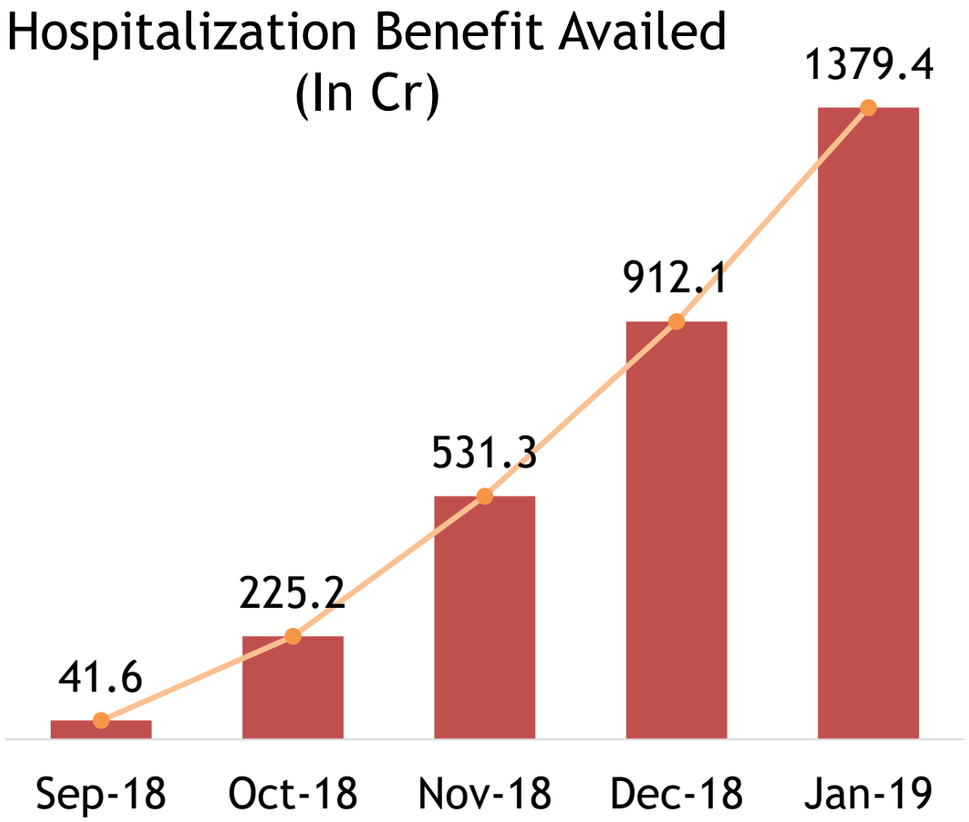
E-Cards Issued

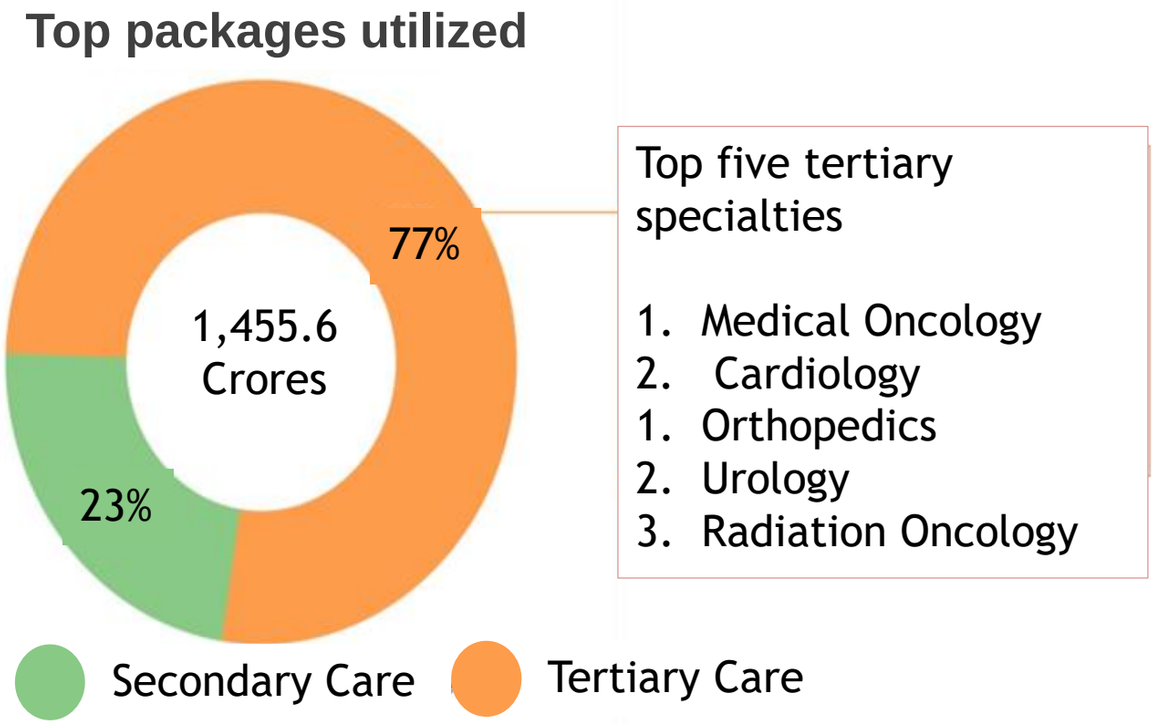


Beneficiaries Admitted in Hospital

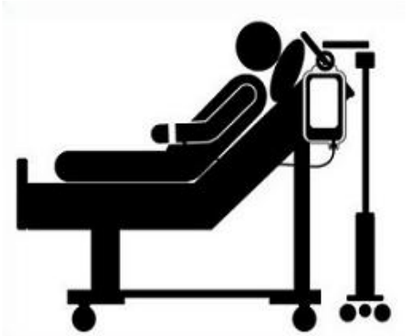


PM-JAY Growth Trends (2/2)





Hospitalisation Demand Impact - Year 1



1.3 crore additional bed days ~ 43,000 additional hospital beds

More than 5,000 additional doctors

More than 20,000 other health workforce

- Average Length of Stay of 7 days, estimates from NSSO 71st (excludes childbirth), approx 80% occupancy rate of hospitals (300 days)
- Assuming at least 1 duty doctor for every 8 beds is required
- Assuming at least 1 other health workforce for every 2 beds is required

System Strengthening & Capacity Building

Fund Flow due to
1.7 crore hospitalizations under PM-JAY (Year 1)

₹ 5,260 crore
Public Hospitals (40%)

₹ 7,290 crore
Private Hospitals (60%)

Outcomes

Increase in quality and services in hospitals

Increase in private hospitals at Tier 2 and Tier 3

Job creation across the healthcare ecosystem

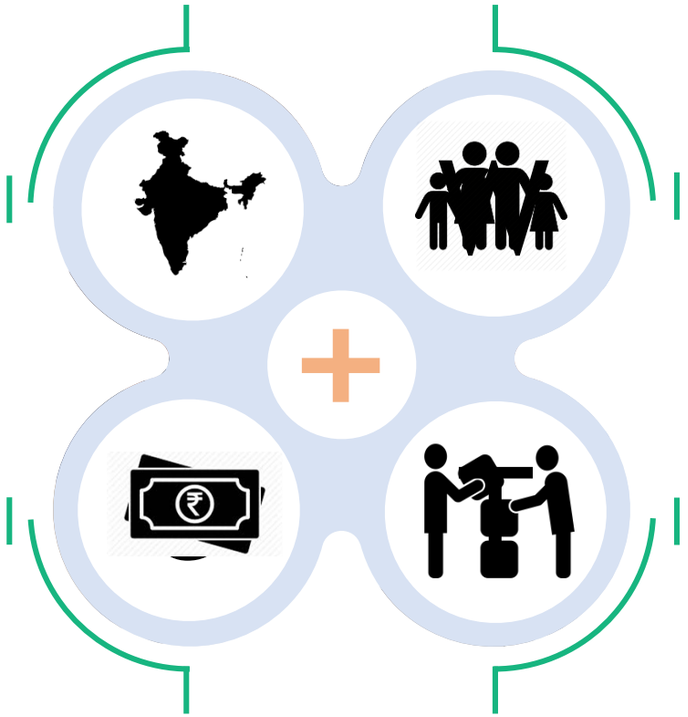
How will PM-JAY disrupt the health care sector?

Scale

Population, benefit packages, financial cover

Demand side financing

Cash on delivery



Collective bargaining

Services, consumables, devices

Private sector

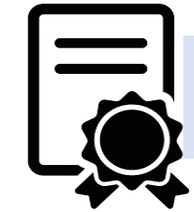
Meaningful engagement

How will PM-JAY promote quality of care?

Choice with beneficiary : Natural preference towards quality care

Minimum eligibility criteria

Standard Treatment Guidelines



Incentive for NABH accreditation

Data for monitoring of fraud and abuse

Beneficiary feedback and usage patterns

Impact on healthcare quality and economics

- Payer–provider relationship
  - Fortify payment mechanisms
  - Introduce disease coding and EMR
  - Reduce fraud
  - Introduce standard treatment protocols

- Health priorities and outcomes
  - Widening of population coverage – 500 million
  - OPD, drugs and diagnostics & 1300 Illnesses
  - Progress towards preventive and rehabilitative care
  - Monitor the health outcomes

- Standardized treatment guidelines (STGs)
  - Quality of care - Improved quality of services received by patient
  - Health outcomes - Increase in evidence-based medicine treatments, leading to improved health outcomes
  - Consistency of care - Improved consistency of care

- Standardized package rates
  - Claims management - Uniformity of surgical expenses, thereby enabling efficient management of claims
  - Uniformity - Helps in curbing tendency to overcharge
  - Price optimization - Helps in standardizing prices of treatment across the country for similar type of institutions

Impact on stakeholders

- Hospitals:
  - Push for package rates
  - Focus on quality
  - Focus on accreditation
  - Focus on operational improvements to reduce costs

- Pharmaceuticals and diagnostics
  - Focus on low-cost, good-quality drugs and on centralized procurement
  - Focus on supply side shortages

- Insurance
  - To build capacities for effective claims management, actuarial capacities, clinical audit capacity and hospital scrutiny
  - Negotiate package rates, improve system automation

- Government
  - Identify additional sources of financing
  - Build in system automation for monitoring and grievance redressal
  - Regulators to ensure fair competition

Single scheme impact

Incentive – Decrease in

- Duplication of beneficiaries across multiple schemes
- Inefficiencies in scheme management and roll-out
- Poor beneficiary Targeting
- Dual premium for same services
- Insurance frauds

Concerns

- Assuming 33% new entrants and IR of 6% with the 3-day ALOS , there will be a need of 15.1 lakh beds compared to the current capacity of 13.5 lac beds
- Difference between market price and PMJAY price is higher for costly procedures and limits the availability of these procedures
- Trust vs. insurance model and limited upside, unlimited downside

Right leakage management to make it successful above all

Avoid

- Enrolment of genuine/ghost beneficiaries & Impersonation of cardholders leading to fraudulent admissions
- Conversion of OPD patient into an IPD patient
- Showing medical management cases as day care procedures
- Deliberate blocking of higher priced package or multiple packages to claim higher amounts
- Treatment of diseases which a hospital is not equipped for
- Non-payment of transportation charges
- Hospitals/doctors not following standard protocols
- Doctors performing procedures needlessly
- Hospitals charging money even though it's a cashless scheme

Must do

- Fraud analytics based on diagnostics
- Analytics on consumption patterns of drugs, from a fraud and predictive standpoint

Ayushman Bharat – Pricing Considerations

Vishwanath Mahendra
Chairperson, Advisory Group on Health Ins – IAI
Chief Actuary – Apollo Munich Health Insurance

Session #
Dated

Pricing

Traditional Vs. Ayushman Bharat (AB)

Similarities

- Like any other traditional indemnity insurance product pricing involves estimating frequency and severity of claims along with expenses and profit margin

Dissimilarities

- Experience is not available. Closest reference point is erstwhile RSBY scheme where SI varies hugely – 30,000 Vs. 5,00,000 (avg claim size 4000 in RSBY Vs 13000 in PMJAY)
- In traditional products severity is important while given the fixed package rate of AB it is frequency which is key point
- The range for expense and profit margin are given in most of the tenders and linked with loss experience

Pricing Considerations of AB

Variation is huge!

- Analysis of some of the winning bids shows that they vary from Rs 444 to 2,020 for pure play insurance schemes and Rs 361 to 1,100 for hybrid schemes.

Pricing Considerations

- Availability of health care infrastructure
- Level of awareness
- Enrolment process
- Price guarantee for ‘X’ years

Future Trends in AB Pricing

Some of the variables will change which are keeping the pricing low currently

- Awareness will go up with passage of time
- Pent-up demand for health care will show up
- Supply of health care infrastructure will develop
- Package rates will need revision in line with medical inflation
- Incidence rate will slowly catch-up with the insured population, may stabilize at a rate lower than insured population

Ayushman Bharat – Provider Management & Packages

Rajagopal Rudraraju
Senior Vice President & Product Head, Health & Health Claims - Tata AIG General Ins Co Ltd, India

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Provider as partners

Providers - Partners in successful implementation of the scheme

- Empanelment/de-empanelment process is structured - Empanelment Advisory and Disciplinary Committee (EADC)
- Specialty-wise criteria for empanelment
- Incentivization to providers for structured quality programs
  - Entry level certification
  - Full Accreditation
  - Aspirational/ Backward districts
  - Teaching Hospitals
- 45% of providers are public facilities – more private facilities likely to join
- Payment to public facilities – case of scheme supporting state health budget

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New payment Methods

Multiple payment methods – Need to build system/process capabilities

- New payment methods for many payers
  - **Per Day**; Per Week; Per Month
  - **Per Procedure**
  - Full treatment cycle
  - Per Fraction
  - Per Session
  - Per Stage
  - Per Cycle

PMJAY

Payment and not reimbursement

Remove inconsistencies in procedure pricing

- Price should drive behavior and not cover costs
- Same procedure – multiple nomenclatures
- Need to bring consistency in package rates
- Packages of exclusions need to be removed
- OPD procedures need to be relooked
- Abuse bigger problem than fraud
- Need to build outcome driven Incentives

Procedure Name	Rates (INR)
Orchiopexy-with laparoscopy, bilateral	30,000
Orchiopexy-with laparoscopy, unilateral	30,000
Orchiopexy-without laparoscopy, bilateral	15,000
Orchiopexy-without laparoscopy, unilateral	15,000
Undescended Testis - Bilateral Non-Palpable	20,000
Undescended Testis - Bilateral Palpable	15,000
Undescended Testis - Bilateral-Palp + Nonpalp	15,000
Undescended Testis – Nonpalpable	13,000
Undescended Testis - Reexploration/ Second Stage	20,000
Undescended Testis - Unilateral-Palpable	15,000
Breast Lump - Left – Excision	5,000
Breast Lump - Right – Excision	6,500
Cystocele - Anterior repair	12,000
Cystocele - Anterior Repair + Perineal Tear Repair	10,000

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Focus on STP

Clinical Protocols – New skill for payers to master

- Not comprehensive but a good start
- Suggested length of stay
- Preauthorization control
  - 636 listed procedures require reauthorization
  - 187 for extensions only
- Pre and post procedure investigations
- Treatment cycles (max weeks, cycles, etc)
- Incentives for quality (10% extra for entry level / 15% for full accreditation)

PMJAY

Case Study

Clinical Protocols – New skill for payers to learn

Category	Procedure Name	Rate	Type	Other Conditions
Oncology	Acute Lymphatic Leukemia – Induction	50,000	Per Procedure	
Oncology	ALL- Consolidation	50,000	Per Procedure	
Oncology	ALL- Maintenance	5,000	Per Month	24 Months
Oncology	Acute Myeloid Leukemia – Induction	1,00,000	Full Treatment	Daunomycin and cytosine arabinoside (3:7) 100,000
Oncology	AML- Consolidation	75,000	Per Cycle	High dose cytosine arabinoside 75000 x 3-4 cycles
Oncology	Chronic Myeloid Leukemia	6,000	Per Month	60 Months; Imatinib
Paediatric	Acute lymphoblastic leukemia	1,30,000	Full Treatment	Includes Chemo, Radiation and Supportive care
Paediatric	Acute Myeloid leukemia	1,20,000	Full Treatment	Induction, Consolidation, Maintenance
Paediatric	Chronic Myeloid Leukemia	1,00,000	Full Treatment	As Above

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THANK YOU

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