Meghalaya Employee Health Scheme

Department of Health and Family Welfare

ADVISORY NOTE FOR CONVERGENCE WITH MEGHA HEALTH INSURANCE SCHEME

Submitted by:

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ABBREVIATIONS:

AB PM-JAY	Ayushman Bharat Pradhan Mantri Jan Arogya Yojana
Bi-PAP	Bilevel Positive Airway Pressure
CEO	Chief Executive Officer
CGHS	Central Government Health Scheme
CPAP	Continuous Positive Airway Pressure
DHS	Directorate of Health Services
EHCP	Empanelled Healthcare Providers
HBP	Health Benefit Packages
IC	Insurance Company
ISA	Implementation Support Agency
IVF	In Vitro Fertilisation
MEHS	Meghalaya Employee Health Scheme
MHIS	Megha Health Insurance Scheme
MMA Rules 2021	Meghalaya Medical Attendance Rules 2021
MoU	Memorandum of Understanding
OPD	Outpatient Department
PSU	Public Sector Undertaking
SHA	State Health Agency
TPA	Third-Party Agency

PREAMBLE:

The Government of Meghalaya has adopted Meghalaya Medical Attendance Rules (MMA) 2021 under the Department of Health and Family Welfare. These guidelines will be applied to both Employees in service and pensioners of the Government of Meghalaya, including All India Service officers in service opting for these rules. These are also applicable for retired members of the Joint Assam-Meghalaya cadre of the All-India Service who had served and retired from the Meghalaya Wing, irrespective of their place of permanent settlement, or who are re-employed under the Government of Meghalaya, or who proceeded on deputation from Meghalaya Wing to the Central Government or Public Sector Undertaking (PSU).

RATIONALE:

The Meghalaya State currently has 68,280 in-service employees and their dependent families and 24,044 pensioners and All-India Service employees. Overall, 4,43,155 members are getting medical reimbursements from different departments based on MMA rules 2021. Presently the Government of Meghalaya employees do not have cashless coverage for medical services, despite the State of Meghalaya having Universal Health Coverage for all the citizens. There are requests to provide a cashless facility for the healthcare needs of Meghalaya employees and their dependent family members.

PRESENT SCENARIO:

The Government of Meghalaya employees have been provided health coverage through a reimbursement scheme within their departments. All the details are maintained manually and hence are not amenable to any detailed analysis regarding the conditions for which the claims are reimbursed and the value of each claim across the different departments. For the effective implementation of the scheme, transparency, data management, fraud control measures, and timely claim adjudication, the current system needs to be integrated into a robust IT system. The present reimbursement process followed is that the claims from employees from various departments are submitted to the Directorate of Health Services (DHS) in standard format along with supporting documents duly authorised by the Head of the concerned department. These are reviewed and approved by the DHS, sent for financial approval, and then recommended for payment through the concerned department, as shown below.

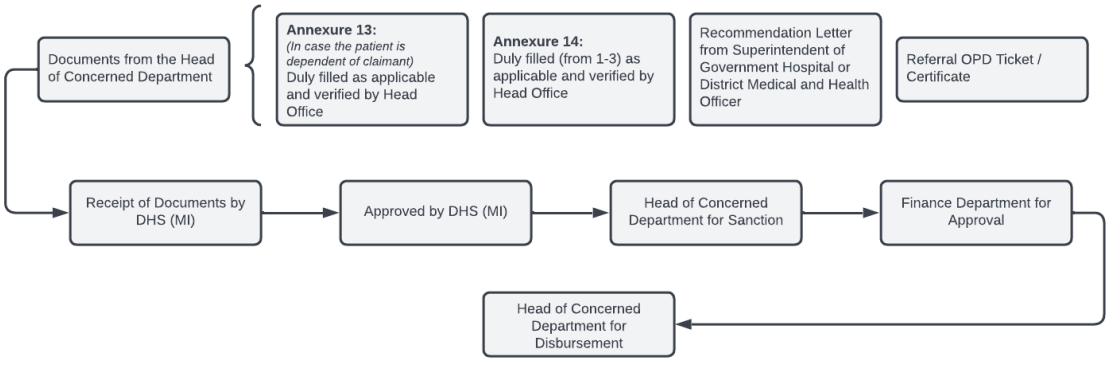

Fig.1: Current reimbursement process for employee health scheme

ISSUES WITH THE CURRENT PROCESS:

The employee scheme offers comprehensive services across 11 hospitals within Meghalaya and 82 hospitals located outside the state. This coverage includes transport charges, ensuring comprehensive support for beneficiaries. Historically, most claims were fully reimbursed, with only a few exceptions for non-admissible expenses. However, a shift occurred in 2021 with the adoption of new CGHS rates, leading to increased deductions due to discrepancies between hospital claims and CGHS rates. Notably, when a treatment package isn't covered by CGHS, the entire claimed amount by the hospital is approved.

Challenges have arisen due to the current staffing structure's inadequacy to review all claims meticulously. The review team comprises one doctor and eight assistants responsible for assessing technical and non-technical documentation. This team is currently grappling with around 2000 pending claims, with extended hospital stay bills causing further delays. Additionally, the option of a medical advance necessitates accurate calculations to determine refunds for bills with a lesser final amount.

Hospitals express their interest in offering services by formally notifying the directorate. Subsequently, a hospital inspection is conducted, a dedicated committee evaluates the hospital, and the hospital is empanelled based on the committee's decision.

MEGHA HEALTH INSURANCE SCHEME:

Since 2012, the State Health Agency (SHA) in Meghalaya has successfully implemented the Universal Health Coverage initiative, the Megha Health Insurance Scheme (MHIS). This scheme has been carried out in multiple phases, with a continual expansion in both the coverage extent and the range of services offered. Currently, the scheme extends its benefits to 6,92,694 households, encompassing the entire state population. The scheme provides cashless medical treatment, covering up to INR 5,00,000 per annum per family. Additionally, INR 30,000 is allocated for outpatient services, encompassing both OPD benefits and OPD diagnostics.

In September 2019, MHIS V was commenced, converging with the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY), increasing the services offered to 2264 packages and 3311 procedures. The services are provided by a network of 175 Empanelled Healthcare Providers (EHCP), including 158 public and 17 private facilities. The State has adopted the National Health Authority's IT systems for the streamlined operations of the scheme. The MHIS is currently implemented through an insurance model, with an annual premium of INR 178.44 Crores. The scheme receives approximately 1,05,256 claims on an annual basis. Public hospitals account for 53% of the claim volume and 43% of the claim value.

EMPANELMENT PROCESS IN MHIS:

A tripartite Memorandum of Understanding (MoU) is established to govern the relationships between various stakeholders within the healthcare sector. In the context of public hospitals, this MoU involves the DHS (MI), which represents all public hospitals in the state, along with the Insurance Company (IC) and the Chief Executive Officer (CEO) of the SHA. For private hospitals, a similar trilateral MoU involves representatives from each respective private hospital, the IC, and the CEO of the SHA. Speciality-specific eligibility criteria are outlined for healthcare providers across both public and private sectors to ensure equitable access to quality healthcare.

Several gate-keeping mechanisms are in place to ensure the effective implementation of the scheme. For instance, cross-speciality treatments are restricted to applicable Health Benefit Packages (HBP) in the EHCPs specifically empanelled for that speciality. To maintain accountability and accuracy, hospitals that exhibit repetitive errors or provide incomplete medical records may face penalties or partial payment of claims. Rigorous oversight is maintained, including a 100% audit of rejected and mortality claims and a 3% audit of all other claims.

The beneficiary engagement division conducts follow-up calls through a dedicated call centre to enhance beneficiary engagement and post-hospitalisation care. To monitor compliance effectively, various measures are implemented, including daily physical audits, weekly submissions of claims reports, and monthly meetings of District Medical Officers. These forums address concerns, tackle issues, and bridge any identified shortfalls in the scheme. The Broad overview comparison between MHIS and the Meghalaya Employee Health Scheme (MEHS) is shown below:

Sl. No.	*Process*	*MHIS*	*MEHS*
1.	Nodal Agency for Implementation	Yes (SHA)	Yes (DHS)
2.	Dedicated Field Staff for Support	Yes	No
3.	IT-based Transaction Management System	Yes	No
4.	Insights Dashboard for Better Monitoring	Yes	No
5.	Dedicated Claim Processing Unit	Yes	No
6.	Online Payment Mechanism Directly to Hospital	Yes	No
7.	Complete Cashless Facility for Beneficiaries	Yes	No
8.	Online System for Grievance Redressal	Yes	No
9.	Number of Empaneled Healthcare Providers	175	93
10.	Access to PM-JAY Empanelled Hospitals in Other States		
11.	Transparency and Data Security Features	Yes	No

Table-1: Differences in Capabilities of the Implementation Agency for MHIS and Employee Reimbursement Scheme

Based on the table above, it is evident that the SHA has already established the process required to efficiently implement health insurance schemes in the State.

DESIGN OF CONVERGED SCHEME:

As outlined earlier, a more practical approach to implementing the proposed scheme would involve integration through the SHA in alignment with MMA Rules 2021. The forthcoming sections explain the criteria for beneficiary eligibility, the definition of family, and the benefits of the proposed scheme.

ELIGIBLE BENEFICIARY:

1. Employees in service and pensioners of the Government of Meghalaya, including All-India Services officers in service, opting for these rules.
2. Retired members of the Joint Assam-Meghalaya Cadre of the All-India Services who had served and retired from the Meghalaya Wing, irrespective of their place of permanent settlement, or those who have been re-employed by the Government of Meghalaya, or those who proceeded on

deputation from Meghalaya Wing to the Central Government or Public Sector Undertaking (PSU). *It should be noted that in situations where officers have retired from the Central Government or PSUs and are eligible for similar benefits extended by these bodies, they have the prerogative to select either the benefits outlined in these Rules or those offered by the Central Government or the respective PSU. The option, once exercised, shall remain final.*

3. Retired High Court judges having jurisdiction over and residing in Meghalaya unless they choose to opt for Rules otherwise applicable to them on this behalf.

DEFINITION OF FAMILY:

'Family Members' include: -

1. 'Spouse', also to include judicially separated 'Spouse'.
2. Solely dependent 'parents', also to include 'step-parents' and 'adopted-parents'. In the case of adopted parents, the birth parents are to be excluded. A Government employee may opt to include either his/her parents or parents-in Jaw. Change of option may be allowed only once during service.
3. Solely dependent Son/Daughter, Brother/Sister, not exceeding 25 years.
4. Solely dependent Son/Daughter, Brother/Sister, who has a permanent disability of any kind (physical or mental), with no age limit.
5. Solely dependent Son/Daughter, Brother/Sister, suffering from diseases specified in Annexure-I, with no age limit.

Note: Children include those adopted according to any law of custom.

BENEFITS COVERED UNDER THE PROPOSED SCHEME:

COVERAGE AND BENEFITS:

The proposed scheme will cover all the procedures included under the MHIS scheme in the national master without any upper limit for coverage with cashless benefits in all the network hospitals of MHIS. The proposed scheme will provide pre-hospitalisation expenses up to 3 days before admission, complete hospitalisation expenses and post-procedure expenses up to 15 days for complication and post-discharge medicines.

OTHER BENEFITS:

Special packages will be designed to cover Home-based Care for Chronic conditions, repeated Outpatient care, Lifelong Hospitalisation, Ongoing Follow-up, and other relevant scenarios. These packages will be developed following a comprehensive assessment of the ailment's seriousness. They will encompass provisions such as Dentures, Spectacles, Artificial Appliances, CPAPs and Bi-PAPs, and cover Transportation Costs for the patient and their bystander. Additionally, the scheme will encompass treatment within the Indian System of Medicine and extend support for up to 3 cycles of IVF (for employees without living children).

INTEGRATION WITH E-RUPI INITIATIVE:

e-Rupi vouchers may be integrated with Dialysis, Dentures, Spectacles and other Medical Appliances/Implants, and OPD Diagnostics, if any.

WARD ENTITLEMENTS:

The Scheme will have different levels of ward eligibility for the employees and their dependent families as per the MMA Rules 2021, as given below. Accommodation in Government Hospitals shall be provided following the scale suitable to the status of employees and may be amended by the Government from time to time.

Category	*Differential Pricing*	*Pay of Govt. Servant/Pensioner (immediately before retirement)*	*Accommodation*
Category I	25%	INR 45,600 and Above	AC Single Room (Private Ward with a Single Bed in a Room)
Category II	15%	Between INR 37,800 – INR 43,700	AC Sharing Room (Semi-Private with not more than Two Beds in a Room) or Non-AC Single Room
Category III	10%	Between INR 19,000 – INR 35,100	Non-AC Sharing Room
Category IV	0%	INR 17,000 and Below	General Ward

Table 2: Differential Accommodation Categories

PRICE AND PACKAGES:

The MEHS is currently following the CGHS rates. However, for enhanced accessibility, uniformity, and the facilitation of cashless and quality healthcare services, it is prudent to adopt the package rates set forth by MHIS – PMJAY. The MHIS rates would apply to the general ward category, and differential pricing can be incorporated for Private and Semi-Private wards. The recommended approach involves a 10% increase over the general ward rates for Category II, a 15% increase in Category III and a 25% increase in Category IV. This methodology mirrors the successful implementation observed in Karnataka.

OPERATING GUIDELINES:

The converged scheme is proposed to be implemented in the trust mode through the State Health Agency Meghalaya by engaging with Implementation Support Agencies (ISA) or Third Party Agencies (TPA). They will support SHA in claim adjudication, field implementation support, and facilitating medical audits. More comprehensive operational guidelines can be developed once the proposal is approved.

CONTRIBUTION BY THE EMPLOYEES:

With the dual objectives of promoting equitable access to high-quality medical services and cultivating a sense of ownership and active engagement among beneficiaries, minimise moral hazard, it is proposed that eligible employees make a nominal contribution for each family member as a prerequisite for enrollment in the scheme. The contributions proposed for each category of employees are:

Category	*Employee Contribution (For Each Member of Family)*
Category I	INR 750
Category II	INR 600
Category III	INR 450
Category IV	INR 300

This prudent provision not only guarantees the scheme's viability over time but also mitigates the strain on the State's financial resources. As a result of this initiative, the State government stands to collect a substantial fund amounting to INR 20.61 Crores, which can then be strategically allocated to fortify and expand the scope of healthcare services offered under the scheme.

A GLANCE AT A FEW PUBLIC EMPLOYEE SCHEMES ACROSS THE COUNTRY:

Sl. No.	*Category*	*Nagaland*	*Uttar Pradesh*	*Tamilnadu*	*Karnataka*
1.	Mode of implementation	Trust	Trust	Insurance	Trust
2.	Coverage	No ceiling limit	No ceiling limit	No ceiling limit	No ceiling limit
3.	Members covered	Self + Dependent Family	Self + Dependent Family	Self + Dependent Family	Self + Dependent Family
4.	Adoption of PM-JAY Packages	Yes	Yes	No	Yes
5.	Coverage for Employees and Pensioners	Yes	Yes	Yes	No
6.	Implemented through State Health Agency	Yes	Yes	Yes	Yes

Table 3: Government Employee Scheme Implementation Across the Country

FINANCIAL IMPLICATIONS:

The State of Meghalaya boasts extensive experience in implementing health insurance schemes, allowing valuable insights into the State's incidence rate. The information detailed below has been assumed to derive the estimated financial implications of the proposed scheme.

Sl. No.	*Criteria*	*MHIS*	*Employee Scheme*
1.	Total Population Covered	38.16 Lakhs	4.43 Lakhs
2.	Avg. Incidence Rate recorded in Last Three Years	2.7 %	1.4 %
3.	Avg. Annual Claims raised in Last Three Years	1,05,256	6421
4.	Avg. Claim Size in Last Three Years	11,500	52294
5.	Expected Annual % Increase in Utilisation	10%	15%

Table 4: Information and Assumptions for Estimate Calculations

Based on the above information and assumptions, a comprehensive financial estimation has been calculated:

- Total Annual Claims in the first year of scheme implementation: 11,965
  (Based on a 2.7% Incidence Rate, similar to PM-JAY)

- As the split of the beneficiary category was not available, the proportion of the beneficiaries in each category has been assumed as follows:

Category	*Proportion of Employee Beneficiaries*
Category I	15%
Category II	20%
Category III	25%
Category IV	40%

- Based on the above, the number of employee beneficiaries in each category is:

Category	*No. of Beneficiaries*
Category I	66,473
Category II	88,631
Category III	1,10,789
Category IV	1,77,262

- The estimated annual claim volume in each category is:

Category	*Annual Claim Volume*
Category I	1795
Category II	2393
Category III	2991
Category IV	4786

- Considering the differential pricing for each category based on the accommodation, the average claim size in each category is:

Category	*Differential Pricing*	*Average Claim Size*
Category I	25%	INR 65,367.50
Category II	15%	INR 60,138.10
Category III	10%	INR 57,523.40
Category IV	0%	INR 52,294.00

- The Estimated Annual Claim Value in each category is:

Category	*Estimated Annual Claim Volume (INR in Crores)*
Category I	11.73
Category II	14.39
Category III	17.21
Category IV	25.03
Grand Total	68.36

- Estimate Annual TPA Fees @ INR 30 per Claim: INR 3.6 Lakhs

- Employee Contributions as per employee category:

Category	*Estimated No. of Beneficiaries*	*Employee Contribution (For Each Member of Family)*	*Amount*
Category I	66473	INR 750	INR 4.99 Crores
Category II	88631	INR 600	INR 5.32 Crores
Category III	110789	INR 450	INR 4.99 Crores
Category IV	177262	INR 200	INR 5.32 Crores
Total			INR 20.61 Crores

- Total Estimated Expenditure for Meghalaya Employee Health Scheme after Convergence with MHIS:

Category	*Estimate (INR in Crores)*
Annual Claim Value	68.36
Annual Administrative Expenses (10%)	06.84
Annual TPA Fees	00.04
Total	75.23
Employee Contributions	20.61
Grand Total	54.62

CONCLUSION:

To enhance the quality of healthcare services and ensure efficient utilisation of public funds, implementing a cashless scheme within the existing MHIS framework for government employees is strategic. Drawing inspiration from successful precedents in states such as Uttar Pradesh, Telangana, and Karnataka, integrating the employee scheme with the broader universal health schemes is a promising model. Using predefined healthcare packages and transparent rate structures can be instrumental in warranting financial viability. These well-defined health benefit packages offer clarity and facilitate consistent data management, fostering ongoing analysis and feedback loops.

To realise this vision, it is proposed that the State Health Agency, Meghalaya, is entrusted as the nodal office to implement the Meghalaya Employee Health Scheme by converging into the MHIS framework. The scheme can extend comprehensive medical benefits to all government employees and their dependents by operating in a cashless mode. This strategic approach is poised to streamline access to healthcare services and alleviate employee financial burdens. Most claims could be channelled through public hospitals, fortifying the public healthcare infrastructure and bolstering the State's healthcare system.