

MEDISEP – Queries raised by Insurers - Clarifications

Sl.No.	Queries	Authority response												
1	Approximate number of families to be covered and average family size of the population	10.6 lakh families (5,21,260 employees + 5,41,609 pensioners) approximately. Family size ranges between 1 to 7members, average family size for pensioners will be 1.6 members & that of employees will be 4 members approximately. (An age wise abstract of data collected so far is attached)												
2	The State Government spends around Rs.230 crores/year to meet medical expenses of the employees & pensioners. This includes Rs.70 crore for medical reimbursement, Rs.150 crore for medical allowance for pensioners & Rs.10 crore for IFMA (asper RFP) – share the claims settlement data / statistics as settled by Government. Will IFMA be continued upon introduction of MEDISEP?	State Government have not been providing/assisting any type of Health Insurance Scheme so far, for the employees and pensioners. Rs.150 crore given to the pensioners is not as per requirement, but a fixed allowance paid at the rate of Rs. 300 per month. Once the MEDISEP is rolled out IFMA will be discontinued.												
3	Provide past three years demography, premium and claim experience of any Government health scheme including RSBY.	<div>The RSBY premium for the pervious years are as follows</div> <table><tr><th>Year</th><th>Premium per family (Rs.)</th></tr><tr><td>2016-17</td><td>558/-</td></tr><tr><td>2017-18*</td><td>738/- + 182/-</td></tr><tr><td>2015-16</td><td>678/-</td></tr><tr><td>2014-15</td><td>738/-</td></tr><tr><td>2013-14</td><td>738/-</td></tr></table> <div>As treatment outside the state is also required to be covered please share separate claims experience data of last three years against secondary care also, separate details of child care, Cardiac and DM, OPD diagnosis benefits and Maternity care, Catastrophic care, City wise claims.</div> <div>Not available</div>	Year	Premium per family (Rs.)	2016-17	558/-	2017-18*	738/- + 182/-	2015-16	678/-	2014-15	738/-	2013-14	738/-
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4	Will the Government restrict the premium outgo to Rs.230 crore? Is there a possibility for the Government to exceed the present outgo of Rs.230 crore, towards the premium	Premium outgo is not restricted as Rs.230 crore. The maximum premium prescribed is Rs.3600 + GST applicable per annum / per family. The annual premium should not be changed for a block period of												

	for this scheme?	three years.
5	Cashless facility. (page 9, (IV), RFP)	The scheme is purely intended as a cashless one. But in case of emergencies where the beneficiary has to avail treatment from non-empaneled hospital, the approved package rate has to be reimbursed, provided the treatment availed is included in the packages specified for MEDISEP.
6	In case of absence of a specified package, how the claims cost will be calculated? Whether pre-post benefit of 30/60 days is part of package rate? (page14,XXIX,RFP)	The scheme will only include defined surgical packages and medical packages. In a procedure does not fall in the defined packages it will have to be borne by the beneficiary. Pre and Post Hospitalisation expenses: Expenses incurred for consultation, diagnostic tests and medicines before the admission of the patient (minimum 15 Days before admission) in the same hospital and cost of diagnostic tests and medicines and up to minimum 15 days of the discharge from the hospital for the same ailment/ surgery. The package rate is inclusive of these expenses. (corrigendum)
7	i. The packages under AM-PMJAY scheme are meant for general wards only, however the medical packages have been allowed to a maximum of Rs.1750 per day in a ward..... Would these rates be applicable to all cadres of the eligible members? ii. What would be the system of payment in case the patient opts for a higher room or newer higher end medicine / devices etc? iii. Elaborate the point on using a template for certain packages.	i. The enhancement of rates have been done to cater to the admission in private ward /room also. The rates are applicable to all beneficiaries who are part of the scheme. The insurance company need to fix the ceiling for room rates of General/Semi Private Ward/Private Ward for the fixed daily rates of medical packages and any amount over and above the ceiling would have to be borne by the beneficiary. ii. The package rates are the applicable rates and if the patient opts for any higher room or high-end treatment which is above the specified package rates, the difference in amount will have to be borne by the beneficiary themselves. iii. The treatment packages and the details were finalized by the expert committee on procedures and costing of services. The template for the specified procedures will be provided by the authority as and

	<p>Provide Day care package list (ABPMJAY)</p> <p>iv. General medicine – High end drugs such as immunoglobulin – how will it be charged? Whether it would be based on MRP?</p> <p>v. Clarify whether admission with ventilation is invasive ventilation or covers non-invasive ventilation too.</p> <p>vi. In the case of organ transplants, oncology, complex open-heart surgeries, catastrophic neurology, poly trauma – Most of these excepting organ transplants are already a part of the basic procedures. Would the basic sum insured be exhausted first and then catastrophic cover to come into play?</p> <p>vii. Medical and radiation oncology – Most of the packages for medical oncology are capped at 6-8 cycles – What would be the system of payment in case a patient requires more than the dose prescribed by AB-PMJAY scheme?</p> <p>viii. Clarify, that once the catastrophic benefit is offered to a family, then this would be capped at 6 lakhs for the complete family, even if more than one person in the family is affected.</p> <p>Clarify, that once the catastrophic benefit is offered to a family, then this would be capped at 6 lakhs for the complete family, even if more than one person in the family is affected.</p> <p>ix. Can the basic sum insured be clubbed with the catastrophic illness cover?</p>	<p>when fixed by the medical experts.</p> <p>The package list annexed is inclusive of day care procedures.</p> <p>iv. The applicable rates will be the Kerala Medical Services Corporation Rates (Karunya Pharmacy)</p> <p>v. Invasive or Non- invasive same rate</p> <p>vi. After the basic sum is exhausted only the catastrophic cover will be applicable.</p> <p>vii. In almost all cases six to eight cycles are required and if in a scenario if any beneficiary is requiring the same, approval of Government will have to be sought before any claim is raised.</p> <p>viii. yes</p> <p>yes</p> <p>ix. Yes.</p> <p>x. The coverage meant for a family is Rs.2 lakh, basic package per year and for catastrophic illness, Rs.6</p>
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8	<p>The companies should be given the discretion to enhance/reduce the package rates specified.</p>	<p>The insurer shall have the discretion to reduce the package rates provided they can ensure hospital empanelment as per the guidelines specified. However, enhancement of package rates of surgical procedures is allowed and limited to a maximum of 25% over the listed rates in case of surgical procedures only. (No enhancement can be made in medical rates). The insurance company need to fix</p>

	(Annexure I, page 43, RFP)	the ceiling for room rates of General/Semi Private Ward/Private Ward for the fixed daily rates of medical packages and any amount over and above the ceiling would have to be borne by the beneficiary. corrigendum
9	Empanelment of hospitals at the listed package rates (within or outside the state) will be done by the insurer/Government? Please clarify, that the insurer is expected to empanel 302 hospitals within Kerala with >= 50 beds	The insurance company should ensure minimum 25 general purpose hospitals in each of the three clusters and a minimum of five hospitals for each specialities in each cluster.
10	What is the defined enrollment period? For employees joining after the enrollment period – will the insurer get full/pro-rated premium for new employees joining the group in any year? Whether they are excluded for catastrophic illness and corpus fund? In case the employee has not filled in the form during this time, would he be ineligible? If yes, then will the ineligibility be for all three years or only for one year?	Up to two months from the policy date in case of existing employees and pensioners. Enrollment is round the year for newly joining employees. For newly joining employees, whenever they join the scheme either they have to pay the full premium to get the benefit package or will have to join the next policy year. No employee or pensioner is ineligible to join the scheme. The above mechanism will be followed for premium and benefit cover.
11	i. In case, the employee and the spouse are both eligible members, would they be able to get covered more than one time? ii. Pensioners who have opted for NPS, can opt for the insurance scheme. Does it mean that the scheme is not compulsory for all pensioners? If it is so, then how many pensioners are there who have opted for NPS? iii. Difference between insured pensioner and insured family pensioner	i. No, both the employees have to join the scheme as principal members. Same is the case with pensioners also. ii. The scheme is compulsory for all State Government Employees and pensioners, except for All India Service Officers (which is approximately 700 officers statewide). The scheme is a single one and is common (except family definition) to employees as well as pensioners. For Government Servants who joined service after 01.04.2013, NPS is applicable, hence at present NPS pensioners hardly exist. iii. Pensioner – Retired employee. Family Pensioner – Spouse/eligible dependent of a deceased employee/pensioner, who is receiving family pension on behalf of such

	iv. Member has the option to modify the beneficiary details. What is the scope of this provision? (Point No.vi of the enrollment section)	<p>deceased employee/pensioner.</p> <p>iv. Modification of the beneficiary details is only allowed in the events such as marriage, child birth, death and beneficiary becoming ineligible on condition of dependency.</p>
12	<p>i. ID cards – difficulty in reaching out for individual employee.</p> <p>ii. Do the insurer have to do any field enrollment.</p>	<p>The insurer shall have the discretion to provide electronic ID cards or other IT enabled provisions.</p> <p>No, the insurer must use the beneficiary details provided by the Government.</p>
13	<p>Penalty Clause – Classification of parameters.</p> <p>(page31,RFP)</p>	<p>The failure to abide by the terms will attract penalty related but not limited to the following. The details and the modalities of the penalty will be part of the agreement with the insurance company.</p> <p>Claim Servicing: There will be a penalty for delay in settlement of claims by the Insurance Company beyond the turnaround time of 15 days. A penalty of 1% of claimed amount per week for delay beyond 15 days from submission of bills to be paid directly to the hospitals by the Insurance Companies. This penalty will become due after 30 days in case of payments to hospitals which are empaneled outside the state.</p> <p>Grievance Redressal: It is mandated that all orders of the grievance redressal committee is carried out within 30 days unless stayed by the next higher level. Any failure to comply with the direction of the Grievance Redressal Committee at any level will meet with a penalty of Rs. 25,000/- per decision for the first month and 50,000/- per month thereafter during which the decision remains un-complied. The amount shall be paid by the insurance company to the Authority.</p> <p>Apart from the above, in the event of non compliance of guidelines and agreement leading to disruption of the project will attract a penalty subject to a maximum of 75% of estimated annual project cost.</p> <p>Corrigendum</p>

14	Claim Settlement – Period is given as 15 days, requests to make it for 30 days in place of 15 days which is the normal in Government schemes.	The period set by AB Mission across the country is 15 days and that will be applicable.
15	<p>i. Cost of IT platform – Will Government provide IT system or insurer has to bear the cost.</p> <p>ii. 24 x 7 – call center – specify minimum number of concurrent lines to be set up.</p>	<p>Borne by the Insurer.</p> <p>Five lines with facility for two languages, and insurance company should adhere response guidelines as specified by authority upon execution of agreement.</p>
16	<p>Tender processing fees – Insurers are not supposed to pay any tender processing fees as per guidelines provided by IRDAI & GI Council.</p> <p>If mandated , confirmation on Electronic fund transfer, any provision to make payment through online portal or will get account details.</p>	<p>Insurer can upload supporting document on such exemption and can avail exemption from tender processing fee.</p> <p>The provision for electronic fund transfer is envisaged in the e-tender.</p>
17	Appellate Authority – Requests are put forth to include representative of insurer in appellate authority for grievance redressal.	Normally there is no representation in the Appellate Authority. Insurance company representatives are called, and their views are heard before taking the decision.
18	Financial proposal – Premium is capped of Rs.3600/- per family – Will this is applicable for Basic policy of Rs.2 lakhs or will be applicable for all?	The maximum premium allowed is Rs.3600/- + GST (as applicable) per annum per family for the entire coverage on family floater basis for a block period of 3 years. The annual premium should not change for 3 years.
19	What will be the procedure, if more than one private company/more than one public sector company quote the same premium?	<p>The insurers will be given the opportunity to submit the financial bids one more time and the L1 among them will be selected.</p> <p>Corrigendum</p>
20	<p>Financial Bid submission.</p> <p>Will the company stamp with Emp code suffice the requirement for Annexure V.</p>	<p>Financial Bid submission should be as per the BOQ document available in the e-tender.</p> <p>Annexure V , RFP, stands withdrawn.</p>

		Corrigendum.
21	Companies or Consortium	Delete the term ‘Consortium ‘ where ever it appears in RFP - Corrigendum
22	Inclusion of finance department representative as convener in DGRC. (page29,RFP)	<p>District level grievance redressal committee (DGRC) will constitute following members:</p> <ul style="list-style-type: none"> i) District Collector / Representative ii) District Medical Officer iii) Representative of insurer iv) Finance Officer of District Collectorate (convener) <p>Corrigendum</p>