Good Governance Practices in Public Administration

Documentation of Professional Best Practices

on

Mizoram State Health Care Scheme
(A Health Insurance Scheme implemented by the Mizoram State Health Care Society)

Government of Mizoram

Documentation supported by:

Department of Administrative Reforms and Public Grievances
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1. Background:

1.1 In the last few years, there has been a visible shift in government thinking on healthcare, from provision of healthcare to financing it. This change is reflected in the growing inclination of both, the Central Government and many State Governments, towards using health insurance as a means of improving access to healthcare delivery for large vulnerable sections of the populations1. It is with this background that the **Mizoram State Health Care Scheme (MSHCS)**, a health insurance Scheme for the whole population of Mizoram was envisaged and implemented in Mizoram since April, 2008. It aimed at improving access of families to quality medical care for treatment of diseases involving hospitalization and surgery through an empanelled network of healthcare providers. The Scheme of universal coverage stands out for its good features in comparison to other similar state sponsored schemes, both with reference to the coverage amount as well as benefits covered. Its coverage of pre-existing conditions and ailments, maternity and no age restrictions for eligibility adds to its appeal.

1.2 MSHCS was introduced in April 2008 on the model of public-private partnership between the Government represented by the Mizoram State Health Care Society, Insurance Company and a Third Party Administrator and a network of empanelled public healthcare facilities and private hospitals. However, dissatisfaction with the Insurance Companies relating mainly with lack of sensitiveness and flexibility in claims payment to the insured beneficiaries and general apathy from the Insurers resulted in defeating the very purpose of providing easy access of healthcare to the beneficiaries, thus the Society has embarked on a **Self-Finance or Self-Insurance basis since 2011.**

1.3 For the successful provision of comprehensive health insurance coverage to all eligible persons, the Government of Mizoram established the **Mizoram State Health Care Society** as the **Innovator**. Since 2010, RSBY has been implemented by the same agency and linked with MSHCS as a top-up to RSBY, i.e the two Schemes though slightly dissimilar in strategies (RSBY is being implemented through an Insurance Company while the Society is directly implementing MSHCS on self-finance basis) are implemented as one Scheme. The details of MSHCS enclosed in **Annexure I** have evolved after annual modifications and revisions since its inception in April 2008.

Documentation methodology

The following section comprises documentation of the Mizoram State Health Care Scheme (MSHCS). The format for this documentation has been prescribed by the Department of Administrative Reforms and Public Grievances (DAR & PG), Government of India. Accordingly, the documentation is presented in 10 sections namely (1) Situation before the practice (2) Title of the intervention (3) Name of the innovator (4) Uniqueness of the practice (5) Strategies adopted (6) Challenges, Strategies adopted and the results achieved (7) Tangible gains (8) Cost effectiveness and citizen friendliness (9) Sustainability (10) Lessons learnt (11) Replicability. Two Annexures have also been enclosed for necessary references.

This documentation is based on primary and secondary data through qualitative and quantitative methods available from evaluation of the said scheme as well as MIS reports and records of the innovator.

2. Situation before the practice:

2.1 In India, about 40% of all hospitalization episodes are met by selling major assets/gaining loans and about 78% of health expenditures is Out of Pocket. Studies have shown that 20 million Indians are pushed below the poverty line due to inability to afford medical expenses. Large proportions of people, especially BPL and borderline Above Poverty Line (APL) borrow money or sell assets to pay for their treatment. Though quantifiable data is unavailable for Mizoram per se, the situation is the same, perhaps more so because of socio-economic constraints in the State.

2.2 The Scheme targets people who have no formal health insurance cover, the most vulnerable sections of the population. Prior to the implementation of the schemes, these sections had to borrow or sell assets to access health care or in many situations, would not avail healthcare services, leading to unnecessarily prolonged morbidity, untimely mortality etc, thus hampering the quality of their lives as well as the healthcare providers, who were exposed to many instances of economic barriers to health seeking or healthcare and at the same time, their frustrations at the unavailability of tangible solutions to it. Hence, not only from the beneficiaries but the provider's perspectives as well, MSHCS is a welcome respite amidst the gloom of inaccessible healthcare.

2.3 The Scheme was thus launched with the following visions:

- Reduce financial barriers to healthcare
- Improving access to healthcare
- Reduce distress by reducing out of pocket expenditure
- Protect households from catastrophic health expenditure
- Improving quality healthcare

3. Title of the Practice

3.1 Mizoram State Health Care Scheme

3.2 **RSBY (Rashtriya Swasthya Bima Yojana)** implemented by Government of India has been linked with **MSHCS** to provide comprehensive health insurance coverage. MSHCS, provides not only top-up cover for RSBY beneficiaries up to Rs. 2.7 lakhs, which makes the total health insurance cover of Rs. 3 lakhs (MSHCS + RSBY= 2.7+0.3 lakhs= Rs. 3 lakhs), **but also covers APL (Above Poverty Line) families with a cover of Rs. 3 lakhs for identified critical illness** (encompassing over 100 illnesses/conditions) and details of which are enclosed in **Annexure I**.

4. Name of the Innovator

4.1 Mizoram State Health Care Society, the nodal agency to implement RSBY and MSHCS is a registered Society under the Mizoram Societies Registration Act, 2005 (Act No. 13 of 2005), bearing registration No. MSR 168 of 03.04.2008. The Governing Body of the Society is headed by the Chief Minister and the District Executive Committee is headed by the Deputy Commissioner.

4.2 The office of the Society is headed by the Chief Executive Officer and its headquarter is at the Directorate of Health & Family Welfare, Government of Mizoram and is assisted by technical, financial, IT professionals and clerical staff to serve as the implementation arm of the Society. District Coordinators are also placed in each district and under the Chief Medical Officer, they oversee the daily functioning of the Scheme at district levels. The staffing status at headquarter is as follows:

Table I. Categories of staff at the implementation arm of the society headquarters

Category of Staff	Nos	Category of Staff	Nos
Chief Executive Officer	1	Claims Officer	1
Deputy Executive Officer (Public Health)	1	Claims Processor	5
Senior Medical Officer (Medical)	1	Accounts Staff	2
Data Manager (IT expert)	1	Data Entry Operator	1

Data Manager, Claims Officer, Claims Processor, one Accounts Staff and District Coordinators are all employed on contractual basis while the remaining staffs are deployed from the existing institution.

4.3 The terms of reference of the Mizoram State Health Care Society are broad enough and provide sufficient freedom to the Society in discharging the responsibilities it has been created for and details of the ToR are enclosed in Annexure II.

5. Uniqueness of the Practice

5.1 The objective of the Scheme is to improve access of families to quality medical care for treatment of diseases involving hospitalization and surgery through an identified network of Health Care Providers. Each family covers all eligible family members under this Scheme and the eligible members comprises of the total population of Mizoram but excluding Central & State Government servants and their dependants. All pre-existing illnesses are covered.

The covered benefits are:

i. *Hospitalisation* - The Scheme shall provide coverage for meeting expenses of hospitalization and surgical procedures of BPL beneficiary members up to Rs. 70,000/- per family per year subject to limits, in any of the network hospitals, after having exhausted RSBY cover of Rs. 30,000/- only. The cover shall be on family floater basis, i.e all family members can individually/collectively utilize the benefit amount up to the sum insured.

ii. *Critical Illness* - A buffer floater amounting to Rs. 2,00,000/-, over and above the normal cover of Rs. 70,000 can be availed of individually or collectively, by members of the BPL family suffering from listed critical illness enclosed in Annexure I. APL families will avail benefits only under this critical illness cover within a sum insured amount of Rs. 3,00,000/-.

iii. *Transport Allowance* - Expenses for travel (Fares only) with one Attendant would have a ceiling of Rs. 1,000/- per claim within the State and Rs. 10,000/- per claim for travel outside the State.

iv. *Pre and post hospitalization cover*- Relevant medical expenses incurred for the period up to 1 clear day prior to hospitalization and up to 10 clear days from the date of discharge from the hospital shall be part of the benefit. This pre-hospitalization coverage would also include all pre-admission investigations pertaining to the particular hospitalization and not subject to the 1 clear day pre-hospitalization coverage and duly certified by the treating doctor. However, in cases of organ transplantation patients, post hospitalization coverage would be extended up to 30 days.

v. *Day Care Procedures:* Given advances in treatment techniques, many health services formerly requiring hospitalization can now be treated on day care basis and the Scheme covers such procedures on day care (OP). Examples of such OP services which are included for coverage under hospitalization benefits are:

Table 2. List of day care (OP) services covered

Dialysis	Hepatitis B & C	Drug Resistant TB	Hysterectomy	D&C (not MTP)
Epilepsy	Radiotherapy	Parenteral chemotherapy	Surgery of prostate	Surgery of hydrocele
Genital surgery	Surgery of hernia	Surgery of appendix	Surgery of urinary system	Gastrointestinal surgery
Eye surgery	Surgery of Ear, Nose & Throat	Lithotripsy	Laparoscopic therapeutic surgeries	Dental surgery following accident
Any surgery under general anaesthesia	Treatment of fractures/dislocations (excluding hairline fracture), contracture releases and minor reconstructive procedures of limbs which require hospitalization		Any disease/procedure mutually agreed upon by the Society before treatment	

Vi. *All pre-existing conditions (diseases/ailments/treatment procedures) are covered with minimal exclusions as given:*

a. Conditions that do not require hospitalization/that can be treated at home and provided that they do not fall under Day Care Procedures (Ref. 4iii).
b. Sterilization and Fertility related procedures.
c. Circumcision unless necessary for treatment of a disease not excluded herein above or as may be necessitated due to an accident.
d. Vaccination or Inoculation.

e. Change of life or cosmetic or aesthetic treatment of any description other than as may be necessitated due to an accident or as a part of any illness.
f. Cost of spectacles, contact lenses and hearing aids.
g. Dental treatment or surgery of any kind unless requiring hospitalization.
h. Convalescence, general debility, 'run-down' condition or rest cure.
i. Congenital external diseases, except where intervention is required to maintain the functionality of the individual.
j. Sterility, venereal or sexually transmitted diseases.
k. Intentional self-injury, unlawful activity associated injury (intentional/unintentional), suicide and direct consequence of use of intoxicating drugs/alcohol.
l. All expenses arising out of any condition, directly or indirectly, caused to or associated with human T-Cell Lymphotropic Virus type III (HTLV III) or Lymphadinopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind commonly referred to as AIDS / HIV, if otherwise treatable under Mizoram State Aids Control Society (MSACS) Programme.
m. Charges incurred at Hospital or Nursing Home primarily for diagnostic, X-ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any ailment, sickness or injury, for which confinement is required at a Hospital / Nursing Home or at home under domiciliary hospitalization as defined.
n. Expenses on vitamins and tonics unless forming part of treatment for disease or injury as certified by the Medical Practitioner.
o. Domiciliary Treatment, Naturopathy Treatment.
p. Disease or injury directly or indirectly caused by or arising from attributable to war, invasion, act of foreign enemy, warlike operations (whether war be declared or not), disasters (man-made, natural).
q. Disease or injury directly or indirectly caused by or contributed to by nuclear weapons / materials.

vi. Maternity is covered for BPL families and New born child is automatically covered for both BPL and APL beneficiaries (Maternity is covered under RSBY for RSBY beneficiaries such as BPL, MNREGS Workers, Street Vendors etc.)

vii. Dependants or family members is 'any one living under the same roof'

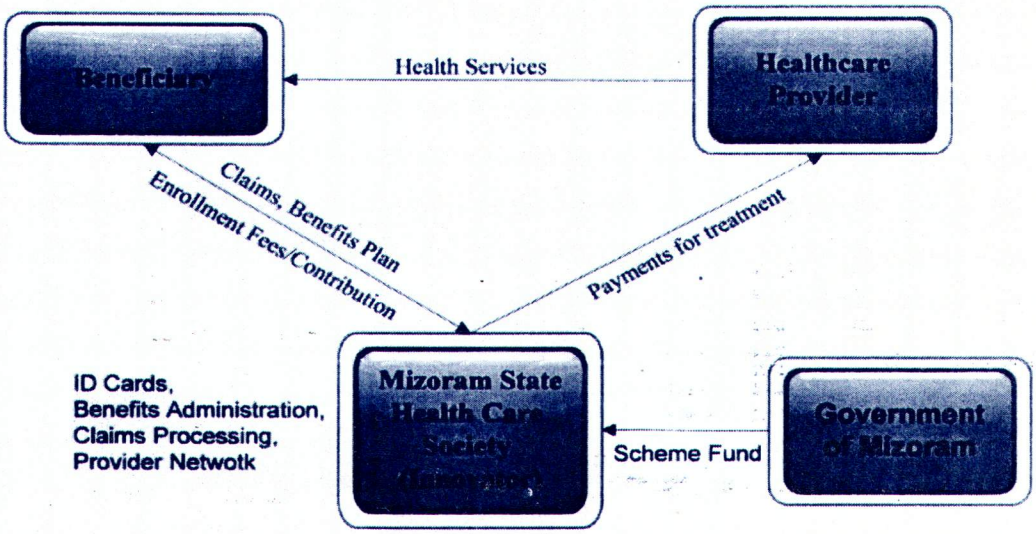
6. Strategies adopted

a) Selection of Insurance Provider

Selection of Insurance Provider was initially done through open competitive bidding. The scheme was implemented state wide without prior pilot testing and as such lack of requisite knowledge about Insurance Laws and Regulations had impeded their capacity in dealing with Insurance Company which often renegaded from discharging their verbal assurances quoting restrictions placed under various insurance regulations. Further, there was disappointment with the Insurance Companies which largely relates to failure to pay claims or delays in claims payment leading the innovator to implement the scheme on Self-Finance or Self Insurance basis since 2011 and beneficiaries have accepted it resulting in wider acceptance. The concept of Self-Finance or Self Insurance pertains to a healthcare benefits plan established by the project implementation agency (Innovator) directly or through a nominated entity which assumes the functions, responsibilities and liabilities of the Insurance Company.

It also pertains to the healthcare plan established by the Innovator directly, assuming the functions, responsibilities and liabilities of an Insurance Company. It decides on and develops a plan of healthcare benefits for target beneficiaries. It also realizes that the innovator has available financial resources to meet the claims. The Innovator operates the scheme such as, creating/generating awareness among the target group, data preparation with enrollment, generating Identification Cards, creating a network of healthcare providers, processing of claims, disbursement of claims, recording claims paid and monitoring. Thus Self-Finance/Insurance was the capping point to turn the tide of public grievances. Figure 1 depicts operation of a self finance benefit plan.

Figure 1: Operation of a Self-Finance Health Insurance Plan



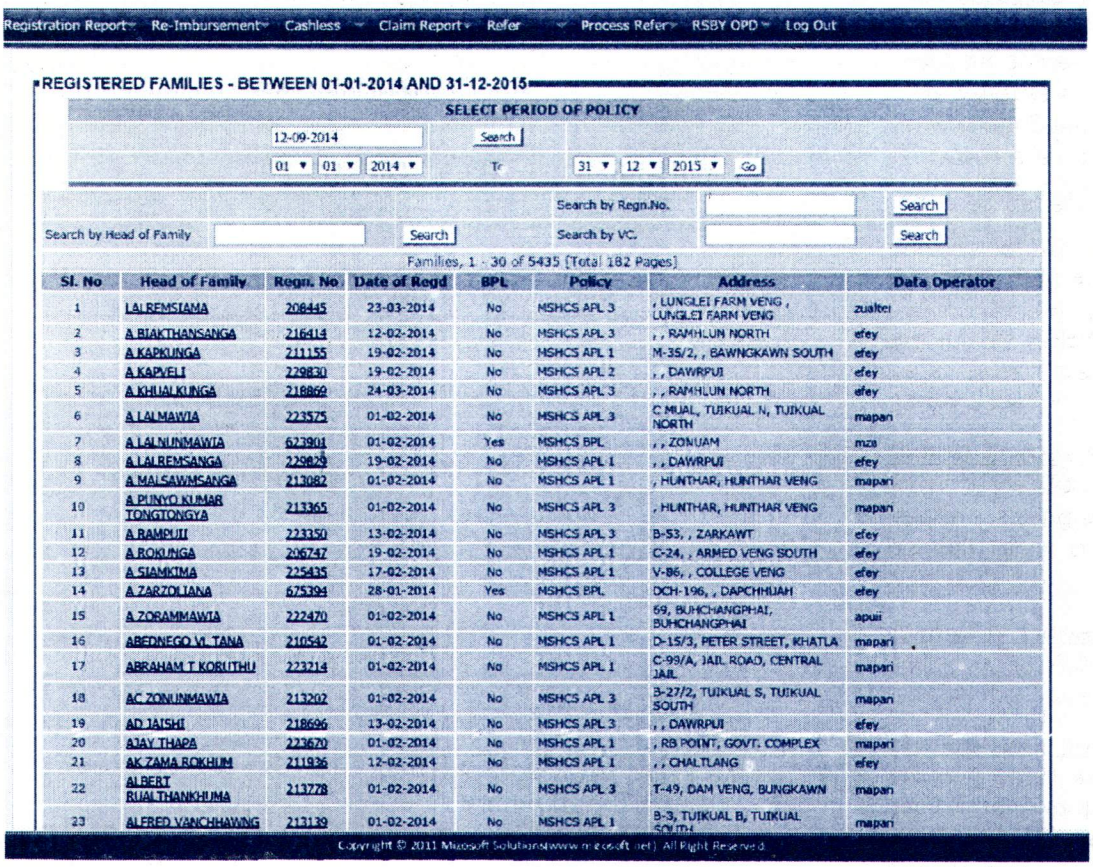
b) Capacity building

The innovator's functions includes policy development, executions of agreements, developments of operational guidelines, preparations of policy change, monitoring the performance of the scheme, mobilizations of funds from various sources, management for the scheme's implementation etc. and thus the innovator has to be empowered. It equips various levels of the functionaries and stakeholders with a basic understanding of insurance principles and practices and other management skills. Training and exposure interventions for building the requisite knowledge and skills based on job profiles of different levels are undertaken through trainings, seminars, workshops, conferences and through experience on the job. Capacity building is an exercise that requires patience and time and calls for long term commitment.

c) Enrollment

Enrollment format was designed in the local vernacular and using the existing manpower and infrastructural set up, enrollment is initiated at all Sub-Centre levels on 'closed period basis', 3 months prior to the start date of the next policy, ensuring that at the start date of the policy, about 90% of the beneficiaries is enrolled. Enrollment data are entered into the in-house MIS software at district levels. Figure 2 depicts the sample page for entered enrollment data in the in-house software.

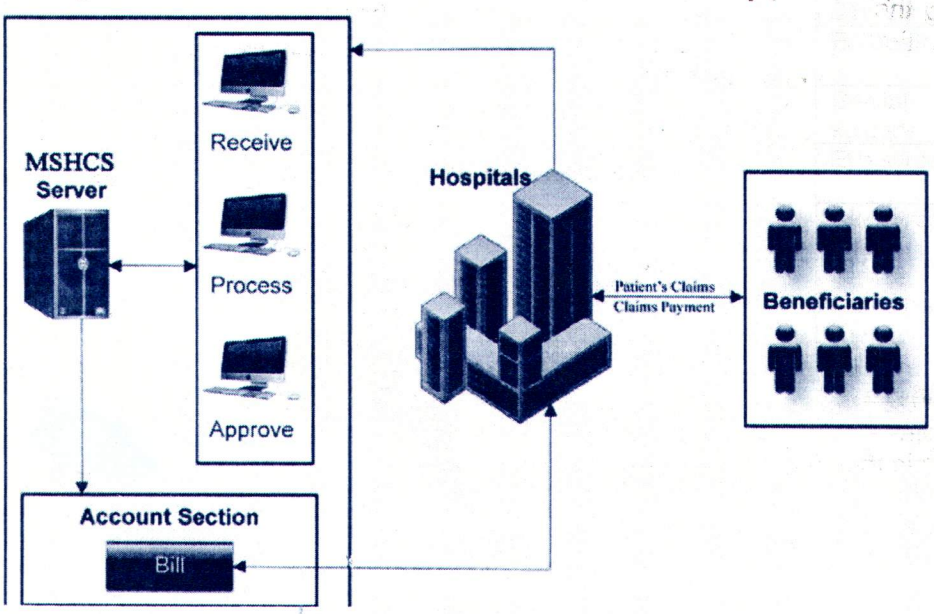
Figure 2: Enrolled beneficiaries page in the software



d) Claims

A customized simple one page format for claims submission, pre authorization and referrals designed by the innovator are used. Hospitals submit Claims, the innovator, after processing it sends the paid claims back to the hospital for further disbursement to the patients. Payment is done as per the package rates of the Government. The average Turn-around Time is 15 days with a standard deviation of 10 days. Figure 3 below highlights the flow of claims processes.

Figure 3: Claim Flow under Mizoram State Health Care Society (Innovator)



e) In house software

A robust IT system with an in house MIS software was locally developed, enabling it for enrollment data entry, claims processing, pending claims, ageing analysis of pending claims, rejected claims and reasons for it, average length of stay, disease profiles with costs, geographical cost variations, demographic profiling of diseases, frequency of claims etc. A claims review and audit system is in place, all to ensure speed, accuracy, transparency, effective claims processing, enhanced service delivery and beneficiary satisfaction. The next target for further improvement is electronic claims submission. Figure 2 afore have depicted the enrollment page in the software while Figures 4-7 below depicts samples in the claims processing pages in the software.

Figure 4: Claims receipt page in the software

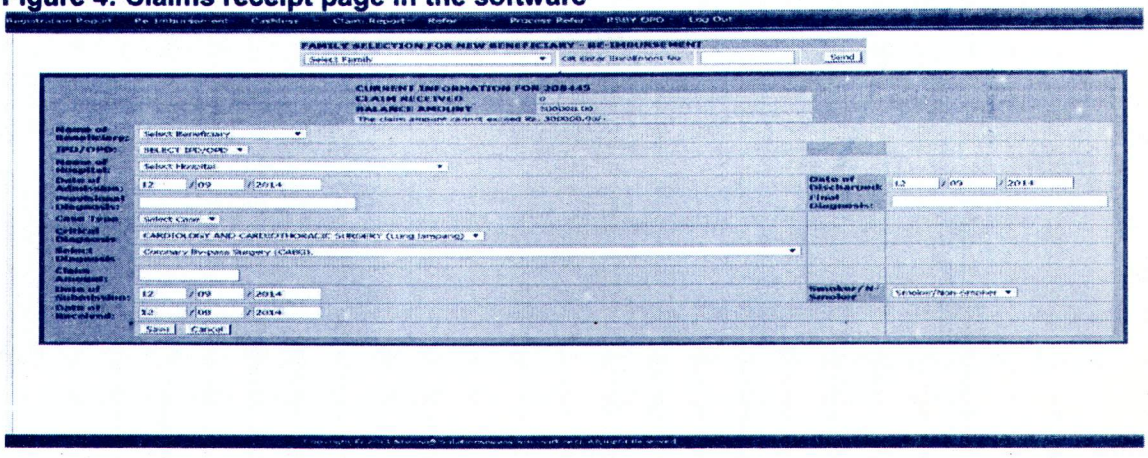


Figure 5: Claim entry and process page in the software

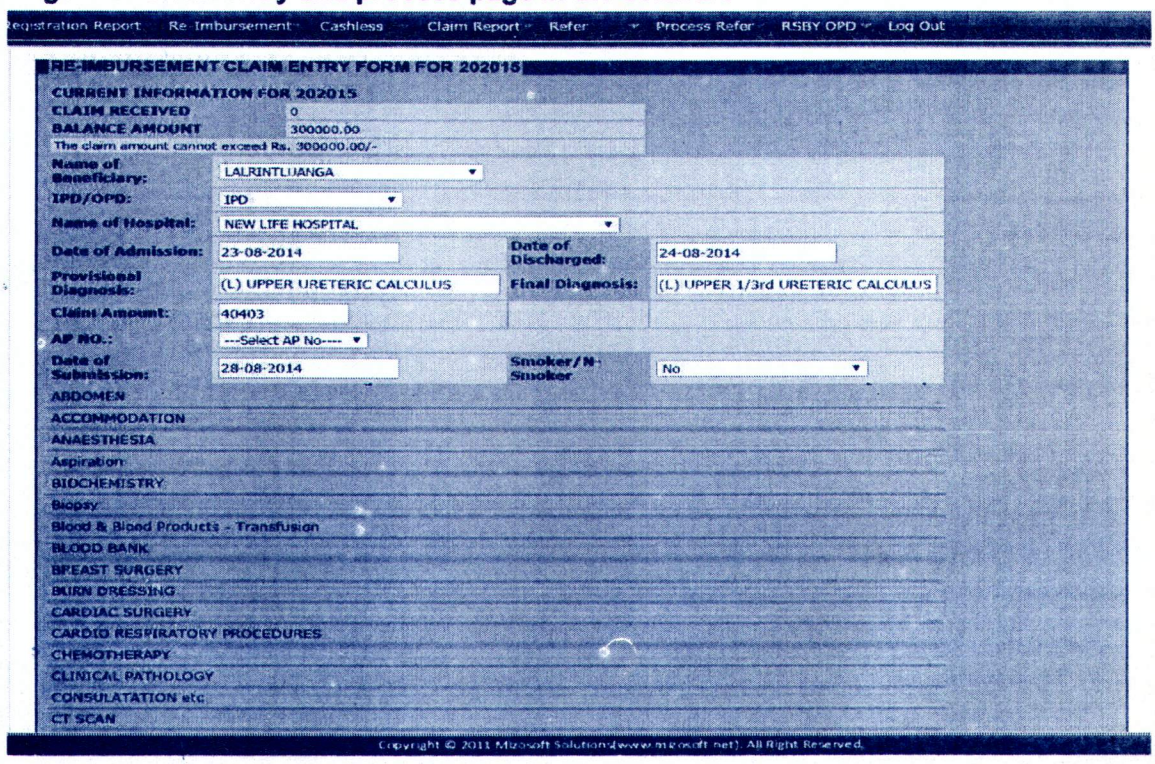


Figure 6: Approved claims list

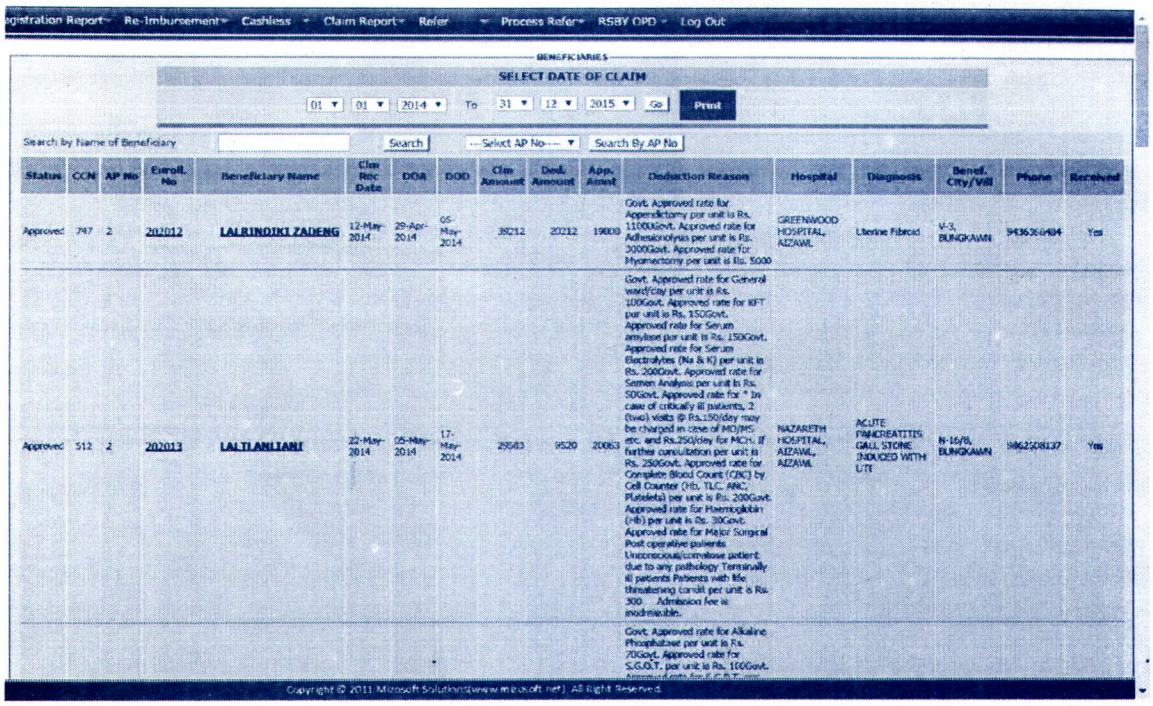
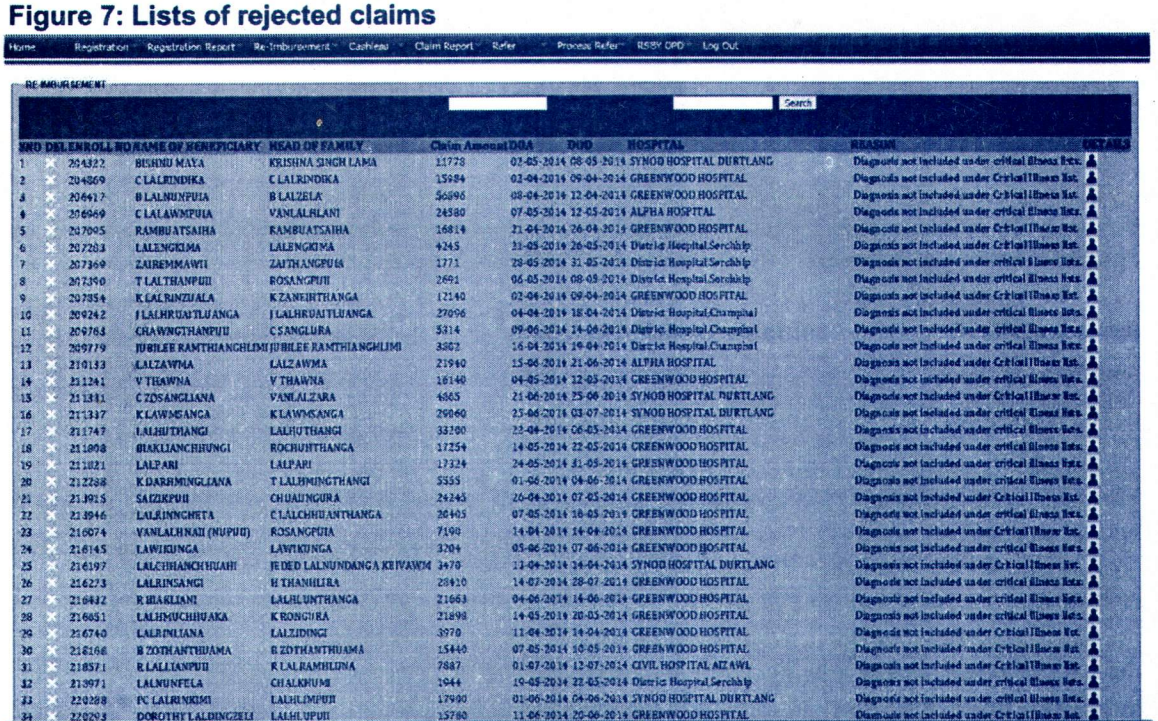


Figure 7: Lists of rejected claims



f) Ever greening

Based implementation experiences, feedback and suggestions, the benefit package is continuously revised to clearly address issues of ambiguity, incorporate necessary clearer explanations of benefits, incorporate provisions to control misuse, provisions for reduction of claims outgo without adversely affecting the direct impact to the beneficiaries etc., thus the scheme is ever improvising and reviewed, is not static, thereby allowing for continuous quality of services.

g) Evaluation of the Scheme

Any population based programmes would not be successful without an evaluation. During the 5th month of implementation, it was evaluated by an independent Consultant and tremendous improvement was instituted based on it and again, by the Department of Economics, Mizoram University during June to August 2013 and some of the excerpts from this evaluation report is highlighted (*italics*) as below: *The MSHCS is one of the most universal health care schemes ever adopted in the country in terms of breadth of coverage (eligible population); as against this, its achievement in case of enrolment is rather low. Meanwhile, the majority of the respondents are in favour of furthering its depth of coverage by broadening the list of critical illness and upward revision of package rate.*

Analysis of turn around time (TAT) revealed that the time taken for processing the bills is fairly quick. The Society took an average of 15 days with standard deviation of 10 days to finalize all medical bills from the date of receipt. One of the indicators of the successful implementation of any health care scheme should be the existence of the system that expedite settlement and disposal of claims. Consequently, the fairly quick settlement of claims must be a commendable success of the Mizoram Health Care Society.

There persist unfavourable health care seeking behaviour among beneficiaries of the scheme that 95 percent of them said they do not have regular medical check up and almost 50 percent of them said they seek institutional health care only when serious illness befall them. This aversive behaviour towards institutional health care can have ramifications on the failure of the public health care schemes to serve its purposes. The performance of hospitals in providing health care services to the patients is fairly impressive that the majority of the respondents said they are good, except for MR Bill preparation/processing reflecting the public confidence on the medical staff in their service of health care delivery. However, unimpressive performance is observed in case of bill preparation for onward submission to Health Care Society.

The scheme has significantly positive impact upon the lives of the beneficiaries that most of the beneficiaries interacted with said that the scheme has enhanced their health care access and significantly reduced family expenditure burden on illness. A big portion of the respondent (88 percent) said the scheme has enhanced their care access, while 90.5 percent said it has reduced their expenditure burden, which had to be met with by borrowing. Thus, more than 94 percent of the total respondents considered the scheme as good and should be continued; and 98.86 percent of them said they would enroll the next year.

Further, under 'Conclusions and Recommendations', it states "*The scheme has significantly positive impact upon the lives of the beneficiaries that most of the beneficiaries interacted with said that the scheme has enhanced their health care access and significantly reduced family expenditure burden on illness. A big portion of the respondent (88 percent) said the scheme has enhanced their care access, while 90.5 percent said it has reduced their expenditure burden, which had to be met with by borrowing. Thus, more than 94 percent of the total respondents considered the scheme as good and should be continued; and 98.86 percent of them said they would enroll the next year. In a nutshell, it must be concluded that the scheme has been successfully implemented and the positive impacts are clearly visible on the lives and thinking of the stakeholder patients and their families*".

Note: *Based on this evaluation report, tremendous thrust was undertaken for awareness generation for policy 2014-15 and enrollment has improved to 73%.*

7. Challenges, strategies adopted and the results achieved

MSHCS, with its size and scope had its share of operational and implementation issues. Some of the important implementation issues are given below in Table II:

Table 3: Key challenges, strategies adopted and some of the results achieved

Challenges	Possible reasons	Strategies adopted/ results achieved
Lower than expected level of adoption of the Scheme by the beneficiaries	• Low awareness about the Scheme • Inability to afford enrollment fees • Limited accessibility as only critical illness are included • Political reasons	• Tremendous thrust, enrollment up to 73% in 2014-15 • Continued advocacy campaigns for the usefulness of the Scheme • Has enhanced critical illness by about 35 ailments • Patient perseverance
High claims ratio	• Increase in incidence of critical illness • Increased frequency and severity of claims • Over utilization by the beneficiaries/hospitals	• Rationalise benefit design to control claims costs • Claims control measures adopted including fraud control measurers • Periodically review package rates
Ineffective implementation	• Service deficiency from the Insurers and their TPA	• Self finance/insurance • In-house software • Periodic review of benefit design
Reluctance of private providers to participate in the Scheme	• Delays in claims settlements • Inappropriate deductions from claim amounts • Inadequate cost recovery due to medical inflation	• Self-Finance/insurance • Periodically review rates • Claims audit process • Continued dialogue and negotiations
Fraud issues	• Provider related- false or inflated claims • Beneficiary related over-utilisation, impersonation	• Claims audit and utilization reviews • Rationalize benefit design • Continued education
Lack of technical capacity among the Innovator	• New initiative by the State • Lack of in-house health insurance expert • Lack of implementation skills	• Technical capacity building measures-training, conferences, seminars, workshops, case studies • On the job experience

8. Tangible Gains

Health is a fundamental human right and the Government of Mizoram has taken this initiative to provide universal health coverage to its population through this Scheme. Many patients, with no hope of taking further treatment had been helped, distresses and duress of families minimized and many financial catastrophes due to illness/high treatment costs averted and these, though difficult to quantify are the tangible gains that have occurred because of this Scheme.

Substantial amount of diseases were treated and it can be gauged that many people, whose treatment would further be a cause for further impoverishment had been averted due to the Scheme, not to mention the number of lives saved and the quality of life restored. The amount of claims paid in Rs. for treatment within and outside Mizoram are as given:

Table 4: Trend in amount of claims paid in Rs.

	2008 - 2009	2010 - 2011	2012 - 2013	2013 – 2014
Treatment in Mizoram	158694183	82613094	48575230	70565515
Treatment outside Mizoram	22559578	10462656	12109358	22289710
Total	**181253761**	**93075750**	**60684588**	**92855225**

Note: Claims paid have substantially reduced from 2010-11 as it has been used as a top-up to RSBY.

Further data analysis has enabled identifying the top disease burden that would aid in health planning process.

9. Cost effective and Citizen Friendliness

i) No extra burden on the State Exchequer

A loan of US$ 25 Million was taken from Asian Development Bank (ADB) in 2009 and this Corpus amount of about Rs. 117.8 crores is invested in Banks in fixed deposits and only the interests accrued of about Rs. 11-12 crores is being utilized for the Scheme. It has contained the expenses of claims outgo and administrative costs of MSHCS within the financial availability out of the interest of the Corpus amount.

ii) Minimal hassles

A family would just go to the nearest health Sub-Centre with the Voter ID of the head of the family and after paying the required registration amount, gets registered by the Health Worker. Thereafter, when a patient needs hospitalization, he goes to the empanelled hospitals, gets the treatment on cashless or on reimbursement. The hospitals submits the bills and claims are paid to the hospitals, who in turn the gives the payment to their patients against their claims. If the patient gets cashless treatment, he walks into a hospital for treatment and walks out after getting the treatment.

iii) Easy accessibility

All public and Mission hospitals in Mizoram are empanelled and even patients from interior Mizoram are enabled to get their re-imbursement or cashless treatment at a centre close to their homes. About 70% of private hospitals in Aizawl, the capital of Mizoram are empanelled which creates the environment for availability of choice of service for the patients. Further, the innovator has about 6-8 (it is not static as tie up with hospitals is an ever on-going process) private hospitals outside Mizoram for cashless and tertiary treatment.

iv) Average turn- around time for bill processing

The average turn-around time (TAT) as indicated by the average number of days required by the innovator to approve the medical bills from the date of receipt of claims is 15 days with a standard deviation of 10 days. Thus, the expedite settlement and disposal of claims is a factor noteworthy.

10. Sustainability

The concept of sustainability in a mass-based health care benefits scheme can be defined as the ability of the Scheme to cover its costs so as to ensure permanent access of healthcare benefits to its beneficiaries. Controlling claims outgo and building operational efficiencies go in chorus with developing divergent sources of funds flow as well as service providers for enabling long-term sustainability to a Scheme. Sustaining measures are as follows:

i) Operation costs for enrollment

Existing institutional setups such as ASHA and Health Workers with Village Council members at grass root levels are used for enrollment at village levels and they are responsible for information dissemination, public education, information source, organization and execution of enrollment camps, liaising with the Innovator and the public etc. Their functionings are supervised by the Medical Officers from Primary/Community Health Centres and by the Chief Medical Officers from district levels, thus minimizing operational costs. Annual capacity building exercises are undertaken and today they are well versed with the programme and the processes involved such as enrollment, accessing the service etc. They are given Rs. 5/- as incentives for each family registered.

ii) Financial viability

US$ 25 Million was taken from Asian Development Bank (ADB) in 2009 and this amount was about Rs. 117.8 crores. The amount is kept as Corpus fund in Banks in fix deposits and the interests accrued, amounting to about Rs. 12 crores annually only is being utilized for implementing the Scheme. Based on the trend analysis of the claims, the critical illnesses have been identified so as not to over spend the interests accrued and so far, expenditures for claims payment have been within the interests accrued from the Corpus fund. Further, tying up with RSBY, a centrally sponsored Scheme has further reduced claims outgo, thereby ensuring its financial sustainability while at the same time provision of uncompromising services is ensured.

iii) Cost control measures

Cost control measures such as using package rates for hospitalization and day care procedures has been undertaken. Further, for public hospitals, re-imbursement is limited for expenses incurred on buying medicines, investigation expenses and other medical consumables not provided by the hospitals only.

iv) Registration fees

Registration fees as one of the cost recovery mechanism are collected and they contribute about 8-10% of the total claims outgo. Registration period is also limited to 4 months, 3 months before the start of the policy and one month after the start of the policy thereby limiting beneficiary enrollment as and when they are sick only. This also creates opportunities for Insurance literate education exercises. Registration fees collected for are as given:

Table 5: Registration fees collected for BPL/APL families

BPL	APL	APL family < 5	APL member > 5
Nil	Sum insured up to Rs 1 lakh	Rs 500/-	Rs 100 per additional member
	Sum insured up to Rs 2 lakhs	Rs 7 50/-	Rs 200 per additional member
	Sum insured up to Rs 3 lakhs	Rs 1000/-	Rs.300 per additional member

11. Lessons learnt

i) No magic bullet

We need to remember that 'MIZORAM STATE HEALTH CARE SCHEME IS NOT A MAGIC BULLET THAT WILL SOLVE ALL THE PROBLEMS IN THE HEALTH SYSTEM' but it is a useful Scheme to improve access to health care and protect families from impoverishment.

ii) Technical expertise

Insurance system being difficult to deal, the innovator/organization needs to be well versed with such a system and needs to have expertise not only in insurance but also in public health, IEC (information, education and communication), IT and managerial skills. It also needs to be trustworthy, have good quality providers network and have support with local communities and grass root health workers.

iii) Quality Network hospitals

Even with the onslaught of cost escalations, needs to negotiate with the network hospitals so as not to be pressurized but at the same time ensure continued provision of quality services. In this aspect, since there is no pricing criteria on the hospitalization services and no bench mark on how much care is really required by the beneficiary, it needs to be ever alert on the moral hazard of the patients, doctors/hospitals and deal with them technically, tactfully and firmly.

iv) Constant alertness and perseverance

The claims needs to be carefully scrutinized to avoid such moral hazards which can result in over payment, therefore, the need for experience and constant alertness. Never give up, persevere, improvise and re-learn is the refrain of the Society.

12. Replicability

The officials from Asian Development Bank had informally suggested for replication of the Scheme and it is in the process of being replicated in the State of Meghalaya. Further the Ministry of Labour & Employment has also made a recommendation to the State of Tripura to replicate this model in Tripura and officials from Mizoram and Tripura have coordinated and shared information and experiences. The innovator has also received feedback from officials of Gujarat and Uttarankhand that they are also interested in implementing similar schemes. The Scheme is easy to replicate as it only needs political will and at its core, dedicated and committed personnel to organize it.

List of Critical Illness:

A. CARDIOLOGY AND CARDIOTHORACIC SURGERY

1. Coronary By-pass Surgery (CABG).
2. Valve Replacement / Repair or Valvuloplasty.
3. Correction of Congenital Heart Diseases eg. VSD, ASD, TOF, etc.
4. Angioplasty and PTCA Stent.
5. Permanent and Temporary Pacemaker Implantation.
6. Surgeries for Repair of Aneurysm.
7. Electrophysiologic Study and Radiofrequency Ablation.
8. Pericardial Surgery & Pericardial Effusion requiring Drainage.
9. Acute Coronary Syndrome (Unstable Angina, Myocardial Infarction).
10. Heart Failure / Cardiogenic Shock.

B. ONCOLOGY (*Cancer*)

1. Surgical Management of all Malignant Tumours and Brain Tumours
2. Radiation Treatment of Malignancies
3. Chemotherapy / Targeted Therapy for Treatment of Malignancies
4. Complications and Toxicities of Treatment of Malignancies

Note : Supportive Cancer Treatment not included.

C. MEDICINES

I. NEPHROLOGY

1) Kidney Failure requiring Replacement Therapy

II. RESPIRATORY SYSTEM

1) Respiratory Failure
2) Pulmonary Thromboembolism.
3) Empyema Thoracis.
4) Pneumothorax.
5) Pleural Effusion requiring Intervention other than simple Drainage.
6) Lung disease requiring Pneumonectomy.

III. GI TRACT

1) Non-alcoholic acute Pancreatitis with or without complications.
2) Chronic Diarrhoea (in-hospital Investigation).
3) Non-alcoholic GI bleed where upper GI Endoscopy is normal

IV. ENDOCRINOLOGY

1) Diabetic Coma/Hyperosmolar Coma.
2) Other Metabolic Emergencies (eg: Thyrotoxic Crisis, Myxoedemic Coma, Pheochromocytoma, Cushing's Disease, Hyponatremia, Dyselectrolytemic Crisis).

V. CNS

1) CVA
2) Myelopathies (non-traumatic).
3) Hydrocephalus (Pathological).
4) Myasthenia Graves.
5) Intra Cranial Space Occupying Lesions (ICSOL).
6) Severe CNS Infections.

VI. HEPATOLOGY

1) Liver Abscess.
2) Hepatic Encephalopathy.
3) Hep B & C - Interferon/Antiviral Therapy only.

VII. HEMATOLOGY

1) Complicated Cytopenias (eg: Aplastic / Hypoplastic Anaemias, Neutropenias, Thrombocytopenias).
2) Hemoglobinopathies requiring Splenectomy (Thalassemia/Sickle Cell Anemia).
3) Thromboembolic Disease (eg: DVT, Mesenteric Artery Thromboembolism, Pulmonary Thromboembolism, etc).
4) Bleeding Disorders (eg : Hemophilia).

VIII. INFECTIVE DISEASES

1) Complicated Malaria (identified according to WHO criteria).
2) Multi Drug Resistant Tuberculosis.
3) Septic Shock requiring Inotropic Support.

IX. CONNECTIVE TISSUE DISEASE - SLE, Mixed Connective Tissue Disease, etc.

X. ORGAN TRANSPLANT: Renal/Bone Marrow/Liver/Heart/Stem Cell (for Treatment of Malignancies) etc., and Procedures/Treatment Cost of the Donor.

D. SURGERY

I. *UROLOGY/NEPHROLOGY:*

1) Nephrectomy and Surgery for Perinephric Abscess.
2) Urinary Stone cases requiring Surgery.
3) Surgery for BPH.

II. *PLASTIC SURGERY-*

1) Treatment of Major Burns with complications.
2) Post Infective raw area requiring extensive skin grafting.
3) Cleft Lip/Palate (Congenital).

III. *GASTROENTEROLOGY*

1) Acute Abdomen requiring Major/Emergency Surgery : eg – Gut Perforation, Acute Appendicitis, Volvulus, Intussusception, Peritonitis, Intra-Abdominal Abscess, Acute Cholecystitis with Cholelithiasis, Blunt Trauma requiring organ removal/repair.
2) Non alcoholic GI Bleed requiring Surgical Intervention (Thi a luak emaw ek emaw zaipui ngai).
3) Chronic Cholecystitis/Cholelithiasis.

Note : Recurrent Appendicitis not included.

IV. *NEUROLOGY AND NEUROSURGERY*

1) Life saving Surgeries on Brain (eg : Intracranial Hematomas/Abscess) and Spinal Cord.

V. *HEAD & NECK*

1) Pleomorphic Adenoma, Warthin's Tumor.

E. OPHTHALMOLOGY

1. Surgery and other procedures for detachment of Retina.
2. Surgery for Glaucoma.
3. Vitreous Heamorrhage, Vitrectomy.
4. Laser Treatment of Retinopathies. (SSN, Gauhati & Sushrut Eye Foundation, Kolkata-a zai chauh).
5. Orbital Fracture and Penetrating Eye Ball Injury.
6. Intraocular Blood Disorders.
7. High Myopia with impending Retinal damage.
8. Intraocular Foreign body.
9. Hemifacial Spasm/Blepherospasm/Cervical Dystonia requiring Therapeutic Botox Injection (in Aizawl only).

F. ENT

1. Complicated CSOM requiring surgery
2. Otosclerosis requiring Surgery.
3. Complicated Sinus disease requiring Surgery (Government Hospital only).
4. Ludwig's Angina.
5. Upper airway Obstruction requiring Trachaestomy.
6. Sensorineural hearing lost requiring Cochlear Implant (up to 14 years).

G. ORTHOPAEDIC SURGERY

1. Joint Replacement (Hip/Knee, etc).
2. Surgery for correction of Fractures of Bones and Joints.
3. Arthroscopic Repair of Ligaments
4. Major limbs amputations (Legs/Arms/Foot) due to any diseases excluding single digits/terminal Phalanged Amputations (with prosthesis).
5. Correction of Locomotor disabilities due to Congenital & Acquired Contractures.
7. PIVD with Severe Cord Compression requiring Surgery.
8. Severe Crush Injury.
9. Necrotizing Fascitis.
10. Osteomyelitis requiring Surgery.
11. Removal of 'in-situ' Implant under GA/SA.

H. PAEDIATRICS

1.	*CNS*	-	Meningitis/Encephalitis.
2.	*Respiratory System*	-	Severe Pneumonia with related complications.
3.	*Nephrology*	-	Nephrotic Syndrome.
		-	ARF.
4.	*Newborns*	-	Birth Asphyxia and related complications
		-	Preterm/VLBW requiring NICU care.
		-	Congenital Malformations requiring Major Surgery.

I. DERMATOLOGY

1. Steven Johnson's Syndrome – drug induced.
2. Erythroderma due to any cause.
3. Pemphigus (all variants).
4. Deep Fungal Infection.

J. PSYCHIATRY

1. Schizophrenia.
2. Major Depressive Disorder.
3. Generalised Anxiety Disorder.
4. Bipolar Disorder.
5. Dementia.

K. OBS & GYNAECOLOGY

1. Ruptured Ectopic Pregnancies, DUB, Twisted Ovarian Cyst, Bleeding Fibroid, Post partum Haemorrhage.
2. LSCS complicated by Rupture Uterus, Re-opening of Abdomen.
3. Genital Fistulae requiring Surgery.
4. Tubal Block requiring Surgery (Government Hospital only).

L. DENTAL SURGERIES

1. Post Traumatic Maxilofacial Fractures requiring Surgery.
2. Dento-facial deformity requiring Therapeutic Corrective Surgery.
3. Ameloblastoma.

M. ICU CARE

1. Any seriously ill patient requiring ICU admission to sustain life (excluding routine post-operative patients and uncomplicated surgeries).

N. OTHERS:

Seizure Disorders requiring Hospitalisation.

Annexure 2

MEMORANDUM OF ASSOCIATION

RULES & REGULATIONS

OF THE

MIZORAM STATE HEALTH CARE SOCIETY

(Registration NO-MSR 168 of 03.04.2008)

Health & Family Welfare Department
Government of Mizoram

1. Name of the Society:

The name of the Society shall be the **'Mizoram State Health Care Society'** hereinafter referred to as the **'Society'**

2. Area of operation:

The area of operation of the Society shall be the whole State of Mizoram.

3. Principal office:

The principal office of the Society shall be situated at the Office of the Commissioner, Health & Family Welfare Department, Government of Mizoram. The office of the Society may be shifted to any other place as may be decided upon in this regard by the Members of the Society, with liberty for it to establish one or more subordinate offices or outlets at District headquarters or elsewhere in the state, if so required.

4. Objectives:

The main objectives of the Society are:

4.1 To implement, establish, provide, administer, monitor, modify, and supervise either directly or indirectly the Mizoram State Health Care Scheme, Rashtriya Swasthya Bima Yojana or other such health insurance schemes under the Government of Mizoram for the benefit of the Beneficiaries.

4.2. To collect contributions as may be decided by the Members from the Beneficiaries.

4.3. To do or cause to be done all such acts, deeds and things as would further the objectives of the scheme for the benefit of the beneficiaries.

5. Scope of functions:

To achieve the above objectives, the Society shall direct its resources and efforts towards performance of the following key tasks:

5.1 Receive, manage and disburse funds received from the Government of Mizoram and the Ministry of Health & Family Welfare, Ministry of Labour Welfare, Government of India or such other funding sources

5.2 Function as a Resource Centre for the implementation of the Scheme including policy development (development of operational guidelines, preparation of policy change proposals)

5.3 Organize workshops, seminars, conferences, policy review studies, conduct surveys/ policy review studies, exchange visits etc. for deriving inputs for improving the implementation of the Scheme.

5.4 Manage the Public Private Partnership of the scheme such as execution of MoU/terms of Agreement, contracts, disbursement of funds and monitoring performances.

5.5 Strengthen the technical and management capacity of the State and District Society by various means including recruitment of individuals/experts from t he open market.

5.6 Mobilize financial/non financial resources for complementing/supplementing the activities under the Scheme.

5.7 Undertake such activities for strengthening the implementation activities of the Scheme as may be identified from time to time.

For performing the above tasks, the Society shall:

i. Establish and carry out the administration and management of the Society's Office (CEO Office) which will serve as the implementation arm of the Society.

ii. Create administrative, technical, ministerial and other posts under the Society as deemed necessary and to make appointments thereto on approval from the Governing Body of the Society.

iii. Establish its own compensation package and employ, retain or dismiss personnel as required.

iv. Establish its own procurement procedures and employ the same for the procurement of personnel as required.

v. Make rules and bye-laws for the conduct of the activities of the Society and its office and to add, rescind or vary them from time to time, as deemed necessary.

6. SIGNATORIES OF THE MEMORANDUM OF ASSOCIATION

We the undersigned are desirous for framing a society named 'The Mizoram State Health Care Society' under societies Registration Act 13 of 2005, as extended to the State of Mizoram.

Name	Occupation & Address	Signature
Pu Zoramthanga	Chief Minister Mizoram	
Pu R. Tlanghmingthanga	Minister, Health & Family Welfare Deptt Government of Mizoram	
Pu Haukhum Hauzel	Chief Secretary Government of Mizoram	
Pu J.C. Ramthanga	Commissioner & Secretary Health & Family Welfare Deptt. Government of Mizoram	
Dr. N. Pallai	Director, Health & Family Welfare Deptt Government of Mizoram	
Dr. Zoremthangi	Director, Hospital & Medical Education, Government of Mizoram	
Pu C. Ralkapa	Joint Secretary Health & Family Welfare Deptt Government of Mizoram	

GOVERNMENT OF MIZORAM

RULES AND REGULATIONS OF THE MIZORAM STATE HEALTH CARE SOCIETY

This RULES AND REGULATIONS executed on this the ..... day of....., 20... by the GOVERNER OF MIZORAM, represented by the Commissioner, Department of Health & Family Welfare, Govt. of Mizoram, (hereinafter referred to as the "AUTHOR" which term wherever the context so admits or permits, shall mean and include his successors and assigns.)

A. WHEREAS the Government of Mizoram having realized the vulnerability of the poor and having a desire to remove the financial barriers and improving access to quality medical care; of providing financial protection against high medical expenses; and negotiating with the providers for better quality care and to incentivize creation of health related infrastructure, both in the public and private domain.
The Government of Mizoram has accordingly formulated the Mizoram Health Care scheme for all families for implementation in all districts of the State and the Department of Health & Family Welfare has been set up to act as the "Nodal Agency" for the implementation of the Scheme (hereinafter also referred to as the "Scheme", the details where of are more particularly set out as 'The Mizoram Health Care Scheme').

B. WHEREAS The Government of Mizoram has accordingly formulated the Mizoram Health Care scheme for all families for implementation in all districts of the State and the Department of Health & Family Welfare has been set up to act as the "Nodal Agency" for the implementation of the Scheme WHEREAS it is deemed necessary that this Rules & Regulations of the Society be executed in detail and record the various powers, duties and functions and such other matters in relation to the Society.

NOW THIS **RULES AND REGULATIONS OF THE SOCIETY** WITNESSTH AS FOLLOWS:

1. SHORT TITLE

1.1 These Rules and Regulations shall be called 'The Rules and Regulations of the Mizoram State Health Care Society, 2008'

1.2 These Rules shall come into force with effect from the date of registration of the Society by the Registrar of Societies, Government of Mizoram.

2. DEFINITIONS

In the interpretation of these Rules and Regulations, the following expressions shall have the following meaning unless inconsistent with the subject or context thereof:

2.1 'Act' means The Mizoram State Health Societies Registration Act, 2005
2.2 'Beneficiaries' means the people, defined as "Beneficiaries" under the Scheme.
2.3 'Chairman/Chairperson' means the Chairman/Chairperson of the Governing Body and the Executive Committee of the Society
2.4 'Chief Executive Officer (CEO) means the Member Secretary of the Executive Committee of the Society
2.5 'Executive Committee' means the Executive Committee of the Society
2.6 'Governing Body' means the Governing Body of the Society
'Member' means the Member of the Society
2.7 'Government' means the Government of Mizoram
2.8 'Ministry' means the Ministry of Health & Family Welfare, Government of India
2.9 'Nodal Agency' means the Department of Health & Family Welfare, Government of Mizoram
2.10 'Rules' means these Rules & Regulations registered along with the Memorandum of Association and as amended by the Governing Body of the Society from time to time
2.11 'Scheme' means the Mizoram State Health Care Scheme
2.12 'Society' means the Mizoram State Health Care Society
2.13 'Society Office' means the office of the CEO
2.14 'Year' means the financial year of the State Government of Mizoram

3. SOCIETY FUNDS AND SOCIETY PROPERTY

Society funds or property shall mean and include not only the corpus of the Society but also the income arising to the Society which remains unapplied or accumulated for application towards the objects keeping treating it as part or the corpus of the time being representing the same.

4. AUTHORITIES OF THE MIZORAM STATE HEALTH CARE SOCIETY

The following shall be the authorities of the Society:

i. Governing Body
ii. Executive Committee
iii. Such other bodies as may be prescribed by the General Body

COMPOSITION OF THE MEMBERS OF THE GOVERNING BODY

The names, addresses, occupations and designations of the Members of the Governing Body of the Society as by the Rules and Regulations of the Society, the management of the affairs of the Society is entrusted under Section 2 of Societies Registration Act, 1860 (No. XXI of 1860) and are as follows:

Sl. No	Status	Name / Designation
1	Chairman	Chief Minister
2	Co Chairman	Minister, Health & Family Welfare
3	Vice Chairman	Chief Secretary
4	Member Secretary	Commissioner/Secretary, H & FW
5	Member	Labour, Employment & Industrial Training Deptt.
6	Member	Finance Deptt.
7	Member	Rural Development Deptt.
8	Member	Urban Development & Poverty Alleviation Deptt.
9	Member	Law & Judicial Deptt
10	Member	Director of Health Services
11	Member	Director of Hospital & Medical Education
12	Members	President- MUP, YMA, MHIP

4.2.1. The management of the affairs of the Society shall be entrusted to the Governing Body and the property of the Society shall be vested in the Governing Body.

4.2.2. The membership of the Governing Body shall terminate when he/she ceases to hold the office by virtue of which he / she was member and his / her successor to the office shall become such member.

4.2.3. All members of the Governing Body shall cease to be members if they resign, become of unsound mind, become insolvent or be convicted of a criminal offence involving moral turpitude or removal from the post by which, he was holding the membership.

4.2.4. Non-Official members of the Society will be nominated by the Chairperson in consultation with other members of the Governing Body. Nominated members shall hold Office for a period of three years from the date of their nomination by the Chairperson. Such members will be eligible for re-nomination for another period of three years. The Member Secretary shall maintain a register of Members of the Governing Body of the Society indicating the individual names of the Non-official members,

4.2.5. Resignation of Membership shall be tendered to the Governing Body in person to its Secretary and shall not take effect until it has been accepted on behalf of the Governing Body by the Chairperson

4.2.6. The Society may sue or be sued in the name of the Member Secretary of the Governing Body of the Society or of such other members as shall, in reference to the matter concerned, be appointed by the Governing Body for the occasion.

4.3 PROCEEDINGS OF THE GOVERNING BODY

4.3.1. The meetings of the Governing Body shall be held at least once in every 6 months and at such time and place as the Chairman shall decide. If the Chairman receives a requisition for calling a meeting signed by one- third members of the Governing Body, the Chairman shall call such a meeting as soon as may be reasonably possible and at such place and time as he may deem fit.

4.3.2 At the annual meeting of the Governing Body, the following business shall be discussed and disposed off:

i. Action taken and resolution in the last meeting, if any,
ii. Up-to-date income and expenditure statements
iii. Implementation, monitoring and review activities of the scheme
iv. Annual report of the Society
v. Budget for the next year with action plan
vi. Any other business brought forward with the permission of the Chairman

4.3.3 Every notice calling meeting of the Governing Body shall state the date, time and place at which such meeting will be held and shall be served upon every member of the Governing Body not less than 10 clear days before the date appointed for the meeting. Such notice shall be under the hand of the Member Secretary and shall be accompanied by an agenda of the business to be placed before the meeting provided that accidental omission too give such notice to any member shall not invalidate any resolution passed at such meeting. In the event of urgent business, the Chairman may call the meeting of the Governing Body at clears 5 days notice. All decisions shall be taken by majority

4.3.4 The Chairman shall take the Chair at the meetings of the Governing Body. In his/her absence, the co-Chair will chair the meeting, and further, in his/her absence the Vice Chairman will chair the meeting, failing which the Governing Body shall elect one from among the members present as Chairperson of the meeting.

4.3.5 The quorum for the meeting of the Governing Body shall be more than half of the members.

4.3.6 All disputed questions at the meeting shall be determined by votes. Each member of the Governing Body shall have one vote and in case of any equality of votes the Chairperson shall have a casting vote.

4.3.7 Should any official members be prevented for any reason whatsoever from attending a meeting, the Chairperson of the Society shall be at liberty to nominate a substitute to take his place at the meeting. Such substitute shall have all the rights and privileges of a Member of the Governing Body for that meeting only.

4.3.8 Any business which it may become necessary for the Governing Body to perform except such as may be placed before its Annual meeting may be carried out by circulation among all its members and any resolution so circulated and approved by majority of the members shall be as effectual and binding as if such resolution had been passed at a meeting of the Governing Body, provided that at least one third members of the Governing Body have recorded their consent of such resolution

4.3.9 The Chairman shall have the right to adjourn the meeting at any time.

4.3.10 In the event of any urgent business, the Chairman of the Governing Body may take a decision on behalf of the Governing Body. Such a decision shall be reported to the Governing Body at its next meeting for ratification.

4.3.11 A copy of the minutes of the proceedings of each meeting shall be furnished to the Governing Body members as soon as possible after completion of the meeting

4.3.12 The office of the Members of the Governing Body as the case may be, shall be honorary and any person holding such office shall not be entitled to draw any remuneration for carrying out his duties other than reimbursements of expenditure incurred in connection with the Society.

4.4 POWERS OF THE GOVERNING BODY

The Governing Body shall have full control of the Society and will have the authority to exercise and perform all the powers, acts and deeds of the Society consistent with the aims and objectives of the Society. It shall hold, administer and manage the Society with a view to carry out the objectives of the Society herein above mentioned and to augment its funds and administer them and to discharge their duties, and it shall have the following powers:

4.4.1 To establish, formulate, provide, administer and monitor the Scheme or any other Health Care Schemes formulated by the Government of Mizoram in the field of medical diagnosis, medical surgeries, post operation treatment and the likes for the Beneficiaries. Undertake such other activities for strengthening the implementation of the scheme in the state as may be identified from time to time. It would assist and provide necessary support to the Insurer on various matters for the smooth implementation of the scheme.

4.4.2 To select, authorize and identify Network Hospitals in which the Beneficiaries of the Scheme would be provided health care and surgical operations and prescribe the tariff for medical/surgical interventions as well as user charges from government institutions.

4.4.3 To fix rates of interventions/procedures at health institutions and disbursement of charges collected at government institutions for different levels of workers/stakeholders.

4.4.4 In particular and without prejudice the generality of foregoing provision, the Governing Body may:

a. Make, amend or repeal any bye laws relating to administration and management of the affairs of the Society subject to the observance of the provisions contained in the Act.
b. The Governing Body shall be empowered to pay the charges and expenses, preliminary and incidental to its establishment and registration.
c. To receive, collect or realize funds by way of grants, donations, contributions, subscriptions, presents or any monetary or other assets and properties etc. in any share or form as and when given by the Government or any other persons as gift or to augment the Society's funds towards the furtherance of the objectives of the Society or towards Corpus fund and treating the same as income of the Society or to make donations and endowments or contributions or otherwise apply the Society Funds towards the objects of the Society.
d. To acquire on lease or by purchase or otherwise and to sell mortgage or lease out or transfer in any other properties, movable or immovable, and to construct building, manage and to deal with such properties and all other assets of the Society and to pledge, hypothecate or otherwise lien over them to raise funds, and to deal generally with the assets for the purpose of achieving the objectives of the Society.
e. To invest the Society funds in fixed deposits in banks, Government Securities, bonds, mutual funds, National Savings Certificates or any other scheme of the Government and vary the same from time to time, depending upon the needs of the Society.
f. To open and maintain accounts of any nature in any banks of their choice and authorize operation of the said accounts by the CEO and the Chairman of the Executive Committee jointly.
g. To execute or negotiate all the necessary papers and documents whether negotiable or non-negotiable and to receive monies or other assets and to grant receipts and discharge in respect thereof
h. The Members in discharge of their duties and in the exercise of all discretionary and other powers hereunder may appoint/employ /retain advocates, bankers, brokers accountants, auditors, registrars, professional advisors and consultants to transact any business required to be done under these presents.
i. To frame rules and regulations with regard to the Society inconformity with statutory requirements for such administration and governance.
j. Appoint Committees, sub Committees and Boards etc. for such purpose and on such terms as it may deem fit, and to dissolve/remove any of them.
k. Develop and adopt its own rules and regulations for recruitment and appointments of experts and set its own compensation package for such personnel to be recruited from the open market and / or deputation/attachment basis.
l. Strengthen technical/management capacity of the Society at state and district level and create posts to appoint officers/staff for the office of the Society who shall be employed from time, to time including accounting staff.
m. Establish its own procurement procedures and employ the same for the procurement of equipment, personnel etc. as required.

n. Authorize the Member Secretary to execute such contracts on behalf of the Society as it may deem fit in the conduct of the business of the Society.

o. To do all other acts, deeds, matters and things, which may be deemed necessary and expedient for carrying out the objectives of the Society or for its administration.

4.5 POWERS AND FUNCTIONS OF THE CHAIRPERSON OF THE GOVERNING BODY

4.5.1 The Chairman shall have the powers to call for and preside over all meetings of the Governing Body

4.5.2 The Chairman may himself/herself call, or by a requisition in writing signed by him/her, may require the member Secretary to call a meeting of the Governing Body at any time and on the receipt of such requisition, the Member Secretary shall forthwith call such a meeting.

4.5.3 The Chairman shall enjoy such powers as may be delegated to him by the Governing Body

4.5.4 The Chairman shall have the authority to review periodically the work and progress of the Society and to order inquiries into the affairs of the Society and too pass orders on the recommendations of the reviewing or inquiry Committee

4.5.5 Nothing in these Rules shall prevent the Chairman from exercising any or all the powers of the Governing Body in case of emergencies and for the furtherance of the objectives of the Society. However, the action taken by the Chairman on such occasions shall be reported to the Governing Body subsequently for ratification.

5. STATE LEVEL EXECUTIVE COMMITTEE

a. The Governing Body will constitute a State level Executive Committee which will be responsible for, acting for and on behalf of the Governing Body, doing all deeds and for taking all decisions and exercising all the powers vested in the Governing Body, except those which the Governing Body may specifically specify to be excluded from the jurisdiction of the Executive Committee.

5.2 The composition of the State Executive Committee shall be as follows:

Sl. No	Status	Designation
1	Chairman	Commissioner/ Secretary (HFW)
2	Vice Chairman	DHME
3	Member Secretary	CEO- to be nominated by the Government
4	Member	DHS
5	Member	Addl/Joint/Dy Secretary, Finance
6	Member	Addl/Joint/Dy Secretary, Law & Judicial
7	Member	Addl/Joint/Dy Secretary, Health & Family Welfare Deptt.
8	Member	Under Secretary, Health & Family Welfare Deptt.
9	Member	One representative from Insurance Company/TPA, co opted by the Chairman, as and when necessary

1.3. The State Executive Committee may co-opt additional members and/ or invite subject experts to its meetings from time to time.

5.4 The term of office of non-official members of the State Executive Committee will be two years. However, they will be eligible for re-nomination.

1.4. The meetings shall be held at least quarterly or as necessary.

1.5. The minutes of the State Executive Committee meetings will be placed before the Governing Body at its next meeting.

5.7. The various Committees constituted by the Governing Body shall submit their report to the State level Executive Committee who shall be empowered to take decisions on their recommendations.

6. SOCIETY OFFICE AND CHIEF EXECUTIVE OFFICER (CEO)

6.1. The Executive Committee shall hold the Society office to be headed by the Chief Executive Officer, a Senior Officer of the State Government from Grade II of MHS (Mizoram Health Service) and will be assisted by technical, financial, IT professionals and clerical staff to serve as the implementation arm of the Society. The additional required human resource may be determined by the Governing Body.

6.2 The composition of the office of the Chief Executive Officer shall be as follows:

Sl No	Status	Designation
1	Chief Executive Officer (CEO)	Grade II, Mizoram Health Service (MHS)
2	Dy CEO (Medical)	Public Health Expert, MHS
3	Dy CEO (Finance)	Senior Grade, MFAS
4	Executive Officer (Medical)	Medical Officer, MHS (5 nos)
5	Executive Officer (Administration)	Superintendent Grade, MSS (1 no)
6	Executive Officer (Finance)	MBA (Marketing, Investment), contract
7	Clerical Assistant	Supporting staff- Assistant (1)
8	Clerical Assistant	UDC (1)
9	Clerical Assistant	LDC (6)
10	Group D	Group D (5)

6.3. The Society office shall consist of all such technical/management units put together and as may be determined by the Governing Body with due regard to the scope and functions as set out in Article 5 of the Memorandum of Association.

6.4. The Executive Committee of the Society will have the overall responsibility for planning and executing the work of the office, supervising the work, directing and overseeing the implementation through this Office.

6.5 The office will be responsible for the day-to-day management of the Society's activities.

6.6 It will be responsible for financial management of funds as well as undertake monitoring activities of the scheme with health institutions as well as Insurance Company/TPA.

6.7 The office will provide technical support to the District level Executive Committee.

6.8. The CEO will have the authority to sanction payment of re-imbursement and credit bills of government employees and will control the administrative, financial and investment issues.

6.9 With authority vested by the Executive Committee, it will take care of re-dressal/ grievances issues.

7. DISTRICT LEVEL EXECUTIVE COMMITTEE

7.1 The Governing Body shall constitute District Executive Committee at all District headquarters. The District Committee will have the overall responsibility for the execution of the scheme at district level, in conjunction with the state level Executive Committee, and would serve as the implementation arm of the Society at district level. They will assist in enrollment of beneficiaries, address grievances issues and submit the same to the CEO. They could be also utilized as a medium for disbursement of re-imbursement bills of government employee pertaining to their area.

7.2 The composition of the District Executive Committee shall be as follows:

Sl. No	Status	Designation
1	Chairman	Deputy Commissioner
2	Member Secretary	Chief Medical Officer
3	Member	CEM or EM i/c Health in each Autonomous District Council Area
4	Member	District Medical Superintendent
5	Member	Senior Medical Officer (designated)
6	Member	2 Non official to be nominated by DC for 1 year
7	Member	One representative from Insurance Company/TPA, co opted by the Chairman, as and when necessary

8. FUNDS OF THE SOCIETY

The funds of the Society shall consist of the following:

a. Grant-in-aid from the State Government
b. Cash assistance from the Government of India
c. Premium collection from Beneficiaries
d. Grants and donations from industry, trade, institutions and individuals
e. Interests from investments, fixed deposits, National savings certificates etc.
f. Receipts from disposal of assets

9. ACCOUNTS AND AUDITS

9.1. The Society shall cause true and correct accounts to be kept of the sum of the money received and expended on behalf of the Society including income realized by the Society.

9.2 The accounts of the Society shall be audited annually by the auditors authorized by the State Government and any expenditure incurred in connection with such audit be payable by the Society to the auditors and shall be countersigned by the Chairman and the Member Secretary of the Executive Committee and the Society shall obtain the report of the auditor on its accounts

9.3 The reports of such audit shall be communicated by the auditor to the Society which shall submit a copy of the Audit Report along with its observation to the State Government and to the Chairman of the Governing Body.

9.4 The Executive Committee may cause separate Bank Accounts in respect of each Scheme or separate ledgers for each Scheme under one account. In such an event, the Governing Body shall prescribe written instructions relating to submission of Statement of Expenditure (SoE) for each Scheme. The separate accounts could be audited by different auditors or by the same auditors.

9.5 The funds and the income of the Society shall be solely utilized for the achievement of the objectives of the Society and no portion of it shall be utilized for payment to members by way of profits, dividends, interest, etc.

9.6 The Members of the Society shall be indemnified against any expenses and losses incurred or suffered or any payments made by them in the administration of the Society, such expenses, losses and payment shall be borne by the Society or the Members of the Society, as the case may be, shall in any way be personally liable or responsible for the same, except for such act as may amount to fraud.

9.7 The Members of the Society shall be accountable for such monies or securities which they actually receive. They shall also be further accountable for the monies or securities in respect of which there is a default by other persons, including bankers, brokers or auctioneers with whom or into whose hands the trust monies or securities maybe deposited resulting in loss, such loss having occasioned on account of the willful acts on the part of the trustees.

9.8 The official year for the purpose of the accounts of the Society shall be from 1st April to 31st March of the following year.

9.9 The Society shall carry out their duties as economically and as carefully as may be possible.

10. BANK ACCOUNT

10.1 The account of the Society shall be opened in a nationalized bank approved by the Executive Committee or in a scheduled commercial bank as may be specified by the Governing Body. All funds shall be paid into the Society's account with the appointed bank and shall not be withdrawn except through a Cheque, bill note, other negotiable instruments or through electronic banking procedures signed/electronically authorized by such authorities of the Society office as may be determined by the Executive Committee.

10.2 AMENDMENTS

11.1 The Society may amend these Rules provided that such changes shall not alter the nature and/or the objectives and/or the purpose for which it has been set up. The proposals for any amendments shall be carried out only through the following process:

11.1.1 Proposals for amendments have been circulated to all members of the Governing Body and have been duly included in the written agenda of the ensuing meeting of the Governing Body or a special meeting of the Governing Body.

11.1.2 The Governing Body has endorsed the proposal by more than half the members of the Governing Body in person at any meeting of the Governing Body which shall have been duly convened for the purpose.

11. DISSOLUTION

12.1 The Governing Body may dissolve the Society by bringing a proposal to that effect in a special meeting to be convened for the purpose, provided that the proposal for dissolution has been duly approved/endorsed through the process for amendment as set out in para of 13.1 of these Rules

12.2 The proceedings shall be made in accordance with the provisions of the Act as amended from time to time in its application

12.3 Provided that the Society shall not be dissolved unless more than half of the members shall have expressed a wish for such dissolution by their votes delivered in person or by proxy at the Governing Body convened for the purpose.

12.4 Provided that the Society shall not be dissolved without the consent of the State Government.

12.5 Upon the dissolution of the Society, the entire Society funds shall be realized and first be used for expenses of the realization of the Society and its properties and the remaining amount as on the date of dissolution under no circumstances be distributed among the Members but the same shall be transferred to another charitable trust/society, whose objects are similar to those of this Society and which enjoys recognitions u/s. 80-G of the Income Tax Act.1961 as amended from time to time. In the event of noon availability of such, the funds shall be reverted to the State Government for such purposes as it may deem fit.

12. COMMON SEAL

The Society shall have a common seal of such make and design as the Governing Body may approve.

13. COMPLIANCE OF STATUTORY REQUIREMENTS

The Society shall register itself with relevant Government agencies for the purpose of complying with the statutory requirement including regulation, governing, tax reduction at source or exemption, consultants and experts employed by it or consultancies/contracts awarded by it in the course of performance of its tasks.

14. MISCELLANEOUS PROVISIONS

14.1 All provisions of the Societies Registration Act XXI of 1860 as extended to the State of Mizoram will apply to this Society

14.2 The State Government shall have the power to issue such directives as they deem fit from time to time for the furtherance of the objectives laid down.

15. GOVERNMENT POWER TO REVIEW

15.1 Notwithstanding anything contrary contained in these Rules, the Governing Body and/or the State Government may appoint one or more persons to review the work and progress of the Society and hold enquiries into the affairs thereof and report thereon. The State Government may also cause the accounts of the Society to be audited through Financial Management Group and issue directions as deemed appropriate to the Society.

15.2 The Chairman of the Governing Body shall have the right to nominate one or more persons to be part of the review/enquiries.

15.3 The progress review reports and/or enquiry reports shall be included in the written agenda of the ensuing meeting of the Governing Body.

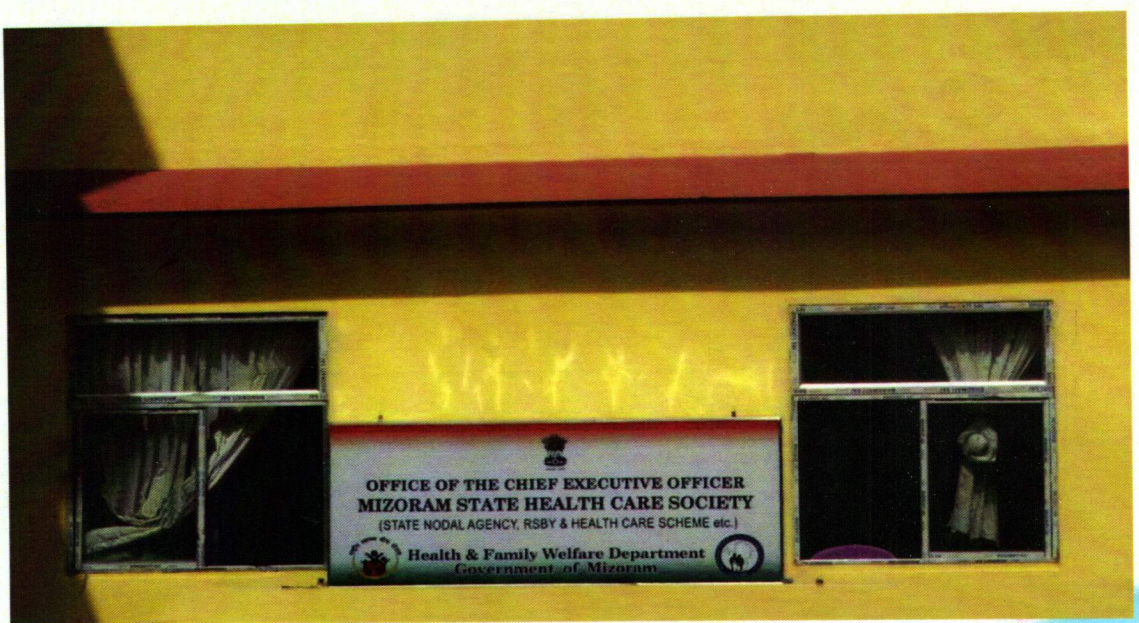
In witness whereof the Author has executed this Rules and regulations on the day, month and year above mentioned.

'WITNESSES

Governor of Mizoram
Represented by

Duly confirmed and accepted by the Governing Body of the Society

COMMISSIONER & SECRETARY TO
GOVERNMENT OF MIZORAM



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Aizawl, Mizoram