GOVERNMENT OF DUBAI

DUBAI HEALTH AUTHORITY

Standards Notice pursuant to the Health Insurance Law (No 11 of 2013) of the Emirate of Dubai

Standards Notice Number 2 of 2015 (SN 02/2015)

Subject of this Standards Notice	Minimum standards for Training and Competence Schemes, Complaints Procedures, Code of Conduct and Data Protection and Client Personal Data Confidentiality Policies
Applicability of this Standards Notice	This notice applies to all intermediaries marketing within or into the Emirate of Dubai and who intermediate in the business of health insurance
Purpose of this Standards Notice	To detail the minimum requirements for the subject matter referred to above
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This document replaces	Not applicable
This document has been replaced by	Not applicable
Effective date of this Standards Notice	Immediately upon publication
Grace period for compliance	31 August 2015

Preamble

- Having reviewed the documentation submitted over the last several months by intermediaries operating in the health insurance market in the Emirate of Dubai it is clear that standards in the areas noted below fall far short of international norms. Health Funding Department (HFD) of Dubai Health Authority (DHA) is by way of this Standards Notice providing guidance on the minimum standards to be applied by all intermediaries whom this notice affects. The areas covered are:
  - **a)** Training and Competence schemes
  - **b)** Complaints handling procedures and complaints logs
  - **c)** Code of Conduct for Permitted Health Insurance Representatives (PHIRs)
  - **d)** Data protection and client data confidentiality policies
- All intermediaries who have registered for the Health Insurance Intermediary Permit (HIIP) since 1 December 2014 were recently awarded "conditional compliance" status. One of the conditions to achieve "**unconditional compliance**" status was that they must submit by 31 August 2015 documents in relation to the above listed items that meet defined minimum standards. HFD advised that it would provide guidance on the standards required
- Policy Directive PD 01-2014 on complaints handling was issued on 21 September 2014 and applied to all parties involved in the sale, distribution, marketing and administration of health insurance plans in the Emirate of Dubai, specifically, insurance companies, health insurance claims management companies **and health insurance intermediaries. In relation to intermediaries only**, the complaints procedure element of this Standards Notice replaces Policy Directive PD 01-2014

Purpose of this Standards Notice

The purpose of this Standards Notice is to confirm the minimum standards required for the aforementioned documents and to advise the consequences of failure to comply or to meet the required standards

Content of this Standards Notice

The minimum standards in relation to all four topics are described in a set of appendices to this Standards Notice together with an initial appendix which defines an “adviser” and the activity of “marketing, advising upon or selling health insurance”

Appendix A: Definitions of “adviser” and the activity of “marketing, advising upon or selling health insurance”

Appendix B: Training and Competence schemes

Appendix C: Complaints handling procedures and complaints logs

Appendix D: Code of Conduct for Permitted Health Insurance Representatives (PHIRs)

Appendix E: Data protection and client personal data confidentiality policies

APPENDIX A

Definitions

Definition of adviser

Any person who markets, advises upon or sells policies of health insurance or other schemes of whatever nature designed to mitigate the cost of medical expenses for individuals, groups of individuals, associations or corporate entities

Definition of marketing, advising upon or selling

Marketing, advising upon or selling is any activity, the object of which is to encourage a client or potential client to enter into any contract designed to mitigate the cost of medical expenses for individuals, groups of individuals, associations or corporate entities.

This is inclusive of but not limited to cold calling by whatever means (written, electronic or telephonic), face to face discussions and any other electronic marketing on the part of the individuals or companies concerned.

This definition of marketing, advising upon or selling includes all such activities whether conducted with or to the ultimate client or through or to an intermediary.

The provision of "information only" on a **reactive** basis to a client's (or potential client's) questions does not constitute advising or selling (such as when a member of a technical team is asked specific product or benefit related questions). However, where the information is being provided on a **proactive** basis (e.g. cold calling) this constitutes marketing.

A key differentiating factor is this: if the employee is answering questions beginning with "What? When? Where? or How?", these will normally be answered with information. However, should the question begin with "Why? What should I do? What do you recommend?" the answer will invariably involve selling or the provision of advice

Regulation of advisers

Any person falling within the above definition of **adviser** and who is engaged in the activity of **marketing, advising upon or selling** health insurance as defined above within or into the Emirate of Dubai can only do so if granted **Permitted Health Insurance Intermediary Representative (PHIR)** status

For more information refer to General Circular GC 03-2015 Registration of health insurance intermediaries

APPENDIX B

Training and competence schemes

The following provides guidance upon the minimum components of a Training and Competence scheme for Permitted Health Insurance Representatives (PHIRs)

What is "competence"?

Competence has been defined as "having the skills, knowledge and expertise needed to discharge the responsibilities of an employee's role". (Source: UK Financial Conduct Authority)

Key elements of a T&C scheme

1. **Assessing competence**

   This is the first step in any T&C scheme. There are many methods that can be used to assess competence, i.e. to measure the existing skill levels, knowledge and expertise possessed by a PHIR

   For an experienced hire, assessment of competence should take place as part of the recruitment process or no later than one month after joining. The assessment must take place before PHIR status will be awarded

   For an inexperienced hire, the assessment must take place within 6 months of joining. The assessment must take place before PHIR status will be awarded

   HFD does not mandate what methods are used but whichever methods are selected the PHIR's employer must document those methods in its T&C scheme and detail when and how frequently the assessment is performed

   It should also record the content of the assessment and the results for each individual PHIR who is assessed

   Whatever tests are used, clear criteria must be detailed to identify what standards need to be reached in order for the PHIR to be judged as competent

2. **Achieving competence**

   Outside of mature markets that have well developed regulatory regimes, regulators are gradually increasing compliance standards, including in relation to T&C. Accordingly, it is not HFD's intention as yet to prevent anyone who does not meet the required standards of competence from being a PHIR. However, it is expected that any person awarded PHIR status who falls short of the standards required in his or her employer's T&C scheme should have their work monitored and **all recommendations reviewed** by a manager or other competent person who has been assessed as competent. Once the PHIR achieves competent status in their own right, this close monitoring may cease

   In order to determine the point at which competence is reached, there should be a **post assessment individual training plan (ITP)** developed to address the training needs of the individual in order that they can be assisted to achieve the required level of competence. The ITP must detail the following:

   - The specific areas of shortcoming (the training needs)
   - The content of the required training
   - The means by which the training will be delivered
   - The time period over which it will be delivered (maximum 4 months)
   - The date for reassessment (no later than 2 months after training delivery is completed)

   Where a PHIR fails to meet the standards required a **remedial ITP** should be put in place with a target date to meet the standards. If the standards are not met by that target date the employer must deactivate the PHIR on the eClaimlink register and that person will no longer be permitted to act as an adviser (as defined in Appendix A)

3. Maintaining competence

Once a PHIR is assessed as competent (whether upon initial assessment, upon joining or on achieving competence as above), his or her level of competence must be maintained

Maintaining competence should be done against the background of changes in the marketplace, in products, regulation and legislation. Consequently it is not sufficient for the PHIR to simply maintain existing skills and knowledge but also necessary to acquire new skills and update knowledge

The T&C scheme must therefore include the following:

- The means by which the employer will ensure its PHIRs are kept informed and trained in relation to the changes mentioned above
- The means by which the employer will continue to maintain and improve upon the skills required of a competent PHIR (such as ongoing training and development programs)
- At the minimum an annual review of competence including the timing and the methods to be used in the assessment
- The steps to be taken where it is found that the competence of the PHIR no longer meets the standards
- The consequences if a PHIR cannot meet the levels of competence within the stated timeframes (these timeframes should be as above in point 2 “Achieving competence”

4. Record keeping

All T&C schemes must include a system of documenting all matters relating to the training, competence and development of a PHIR at both the individual and collective level. These must at a minimum include **general training plans** of the employer for the coming year as well as **individual training and competence records** (electronic or physical) for each PHIR

- The general training plan must include a schedule of planned training courses, their objectives, content and target audience
- The individual records must include dates and details of all assessments, ITPs, remedial ITPs, results of tests or other assessments, training sessions attended, self-learning undertaken and any other matters pertaining to the T&C record of the individual PHIR

All such records may be subject to inspection and verification by the concerned regulatory authorities.

Where it is found that such records are incomplete, inaccurate or falsified, appropriate action will be taken against the individual PHIR and/or the employer including but not limited to withdrawal of permits.

APPENDIX C

Complaints handling procedures and complaints logs

Objectives of complaints handling procedures

- Improve customer confidence in the health insurance market
- Improve customer confidence, satisfaction and loyalty in respect of market participants
- Promote the dealing by companies with customer dissatisfaction in a swift, effective and fair manner
- Provide a clear escalation process regarding complaints received both internally and externally
- Use complaints to enhance procedures and correct procedural or policy deficiencies
- To allow customers to report instances where parties are not complying with the Health Insurance Law

Complaints procedure

All intermediaries must have a formally documented complaints procedure.

Definition of a complaint

Any expression of dissatisfaction by a customer, potential customer or other business partner or any regulatory body made to the intermediary either directly or indirectly which is related to a product or service provided by the intermediary or which is related to an employee of the intermediary or is provided by another business partner of the intermediary such as but not limited to a health insurance company, health claims management company, hospital, clinic or physician.

What is not a complaint?

Any expression of dissatisfaction concerning denial of coverage for a consultation, treatment or procedure which is **clearly** not covered under the policy or where the cost of the treatment exceeds the monetary limits under the terms of the policy are not complaints.

Identifying a complaint

An explicit comment or statement such as “I want to make a complaint” or “Who do I complain to about this?” indicates the existence of a complaint

An expression of dissatisfaction such as “I am not happy with…” or “I am not satisfied with what you are saying…” or “This policy that I was sold does not meet my needs” indicates the existence of a complaint

A statement that expectations were not met such as “I was told that…..but this has not happened” or “You promised to… but…” or “I asked for…but did not receive…” indicates the existence of a complaint.

Complaints from multiple members of the same group scheme relating to the same subject

The intermediary is allowed to log such complaints as a single complaint.

Complaints logging

All complaints **against an intermediary in respect of its products or services or against any of its employees** must be logged, preferably in an automated system. As a minimum, the complaints log must detail the following:

- Name of complainant
- Name of patient (where applicable)
- Date of complaint
- Name of staff member receiving and registering the complaint
- Name of staff member to whom the complaint has been directed
- Identification of a repeat complaint (that is a repeat of an earlier complaint made by the same complainant)
- Policy detail (if an existing insured member) including Policy Number, Member Number, Company name (if a corporate scheme)
- Category of complaint (see below)
- Detail of the complaint
- Source of complaint (telephone, email, personal visit, online facility, via a third party, etc)

Complaint ownership

The complaints procedure must specify who will own the complaint. This must be a named person or a specific jobholder title. The complaint holder cannot be a department. He or she must be a clearly identifiable staff member.

The complaints procedure must specify the reporting lines for complaints handling. Complaints cannot be handled by the person about whom the complaint is made nor by a department which is the subject of the complaint.

Facilitating complaints channels

The intermediary must provide complaints reception channels of varying types including by telephone (freefone), SMS, email, personal visit, and company website.

All channels must be offered (where technologically feasible) in languages appropriate to those spoken by at least 70% of the insured members .

Complaints procedures must be openly and actively publicized (in documentation, on websites, in sales literature and in offices).

Reporting

A monthly report of all complaints received and the status of ongoing complaints must be submitted to the Chief Operations Officer, Chief Risk Officer or similar.

An annual report covering the calendar year must be submitted to Dubai Health Authority, Health Funding Department no later than 7 January each year. (See key Performance Indicators below for report content).

Categories of complaint

All complaints must be categorized in the complaints log as relating to one of the following:

- Advice provided or product suitability
- Accuracy of documentation provided
- Delays in process (issue of quotations, response to correspondence etc)
- Administrative or operational process or procedures (i.e. a complaint about the process itself rather than the implementation of it)
- Service provided by advisers, staff or departments (efficiency, attitudinal, behavioural, knowledge)

Key performance indicators

The intermediary must produce an annual report to include the items detailed below:

- Complaints actual TATs by number of days to resolution or point of referral to third party deliberation
- Number of complaints outstanding at end of each calendar month
- Number of complaints unresolved after 15, 30, and 90 days at the end of each calendar month
- Number of complaints escalated for outside deliberation or arbitration.
- Complainant satisfaction with outcome of internal dealing with the complaint (as a minimum a scoring system with 1= fully satisfied, 2= largely satisfied, 3= largely unsatisfied, 4= completely dissatisfied)
- Number of complaints by category
- Number of complaints fully upheld
- Number of complaints partially upheld
- Number of complaints denied (prior to any external escalation)

Staff training

The intermediary must demonstrate that it has a program to train staff in complaints handling procedures, how to identify a complaint and how complaints should be dealt with and recorded.

The intermediary must keep a record as part of its Training Log to record which staff have received such training and when.

Complaints escalation process

The Complaints Procedure must contain a clear written policy and process for the escalation of complaints both internally and externally. It should also contain a clear written policy and process for ensuring that the complainant is kept fully informed of the progress of their complaint.

Complaints process flowchart

The intermediary must develop and maintain a clearly understandable flowchart identifying the complaints procedure from end to end. The flowchart must be made available to both customers and prospective customers. As a minimum it should be published on the company website and be included with policy documentation for new customers.

Complaints review procedures

The intermediary must have a documented process describing how it will review the outcome of all complaints and make necessary adjustments to its policies, services, products, processes or procedures to avoid repetitions of upheld complaints.

APPENDIX D

Code of Conduct for Permitted Health Insurance Representatives (PHIRs) (Minimum requirements)

1. **Public interest is paramount**
   PHIRs must at all times place the public interest (including that of existing or potential clients be they employers or individuals) above their own

2. **Standards of advice**
   Any advice or recommendations that PHIRs might provide to the public, clients or potential clients must be impartial. In order to do so they must obtain all relevant information and frame their advice or recommendation based upon that information and not be influenced by matters that may produce a benefit to themselves other than as provided for under their normal terms of remuneration

3. **Improving and maintaining competence**
   PHIRs must seek continually to maintain and improve their professional knowledge, skills, and competence through regular self-learning, training and keeping up to date with regulatory, market and product developments.

4. **Professional qualifications**
   PHIRs commit to comply with any requirements issued by the concerned regulators to attain professional qualifications that may be mandated

5. **Compliance**
   PHIRs must obey all laws and regulations applicable to the market in which they operate and should avoid any conduct or activity that would cause loss or injury to others

6. **Diligence**
   PHIRs must exercise due care and diligence in the performance of their occupational duties

7. **Professional and ethical standards**
   PHIRs must aspire to raise the professional and ethical standards of the insurance profession by adopting such standards and applying them at all times in their occupational duties

8. **Conduct with fellow professionals and regulators**
   PHIRs must maintain dignified and honourable relationships with fellow insurance professionals (both inside and outside their own organisation), with insurance companies, with regulators and with members of other professions

9. **Improving public understanding of health insurance**
   PHIRs must assist in improving public understanding of health insurance, its benefits and limitations. They must never mislead the public or any client by way of the information they provide

10. **Adherence to the Code of Conduct**
    PHIRs must maintain the integrity of the Code of Conduct and are required to sign a copy of the Code which his or her employer will retain in either physical or electronic format

11. **Reporting of breaches by other PHIRs**
    It is a responsibility of a PHIR to report to his or her employer any breach or suspected breach by another PHIR, whether by a PHIR within the same company or outside the company

12. **Breaches of the Code of Conduct**
    All breaches of the Code of Conduct will be recorded by the PHIR's employer and maintained in a Register of Breaches that will be available for inspection by the concerned regulatory authorities

APPENDIX E

Data protection and client data confidentiality policies

All health insurance intermediaries must have a formal written policy covering data protection and client confidentiality. The policy should cover the following four main areas:

- Data access controls
- Data protection
- Data backup procedures
- Client confidentiality

This Appendix provides guidance as to the content of the policies. The actual content and methods used for the data policy will vary between companies based upon their company size, systems in use and level of technological sophistication. However, the data policy must meet minimum accepted standards to ensure its operational integrity

Data access controls

This section of the policy relates primarily to network access security and must contain the following:

- Physical asset security policy (fixed and moveable technology assets)
- Password policy including duration validity, change procedures and password format guidance for users
- Access controls in relation to new employees/users and policy for deactivation of user access permissions

Data protection

This section of the policy relates primarily to data storage and protection against loss or damage, whether or not malicious, and must contain the following:

- Firewall measures and anti-virus software in use
- Remote access and dial-in security systems and procedures in use
- Data storage policy at both onsite and remote facilities
- Policy in relation to cyber security insurance
- Contingency plans to mitigate against the effect of catastrophic events or other major disruption

Data backup procedures

This section of the policy relates primarily to routine backup procedures and recovery procedures and must contain the following:

- Detailed policy on backup procedures including methods, archiving, responsibilities and frequency
- Policy on storage of backed up data (location, access and retention periods)

Client personal data confidentiality

More so than in any other line of insurance business, data held in respect of health insurance clients is by its nature extremely personal and confidential. All health insurance intermediary companies and their employees must adhere to a policy regarding client personal data confidentiality. **This element of policy extends to ALL employees, not just PHIRs**

The policy should as a minimum cover the following:

- Statement of the types of client personal data the intermediary will collect and store
- Policy on access to client personal data by employees within the intermediary company
- Statement on the use of client personal data by the intermediary company and its employees

- Statement on the rights of clients to access personal data held by an intermediary company and to request correction of incorrect or false information
- Policy on retention periods of client personal data and its means of collection, storage, protection and destruction (including personal data collected in respect of a potential business transaction that does not proceed)
- Circumstances in which client personal data may be released to third parties and the client consents required
- Statement that disclosure of client personal data of an employee by the intermediary company to that person's employer is prohibited without the consent of the employee

All employees must sign a statement to say they have read the client confidentiality policy and understand its terms and that they will abide by it. A physical or electronic copy of this signed statement must be retained by the intermediary company within the employees personnel file