GOVERNMENT OF DUBAI

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

Procedural Notice Number 1 of 2015 (PN 01/2015)

Subject of this Procedural Notice	Health Insurance Permit applications for 2015
Applicability of this Procedural Notice	This notice applies to all insurers marketing health insurance plans in the Emirate of Dubai as well as all health insurance claims management companies servicing such insurers
Purpose of this Procedural Notice	The purpose of this notice is to advise the availability of the online 2015 HIP application system
Authorised by	Dr Haidar Al Yousuf, Director, Health Funding Department
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Publication date	1 January 2015
This document replaces	2014 HIP application requirements issued 1 October 2013
This document has been replaced by	Not applicable
Effective date of this Procedural Notice	Immediately upon publication
Grace period for compliance	See submission deadlines in application and evaluation process sections

Preamble

All applicants for the 2015 HIP should understand that the standards of assessment will be much higher than for 2014 applications. We will not be accepting substandard documents or submissions. All applicants should be well aware of our approach to improving standards in the health insurance market in Dubai as well as the focus on consumer rights and patient protection.

It is clear from the standard of the recent PI applications that some companies are still not giving their applications the attention required in terms of both content and presentation. Applicants should not assume that the renewal of their HIP is automatic.

Objectives of this Procedural Notice

- To advise of the availability of the online 2015 HIP application system
- To advise of the application process and deadlines
- To advise of the evaluation process
- To identify certain sections in the requirements that may require some additional guidance to applicants
- To advise applicants of the standards of evaluation that will be applied for 2015 applications compared to those applied in 2014

Availability and completion of the online 2015 HIP application system

- The application form can be found by primary registered users accessing the eClaimLink portal
- The 2015 HIP requirements can also be found on the same menu as the application form itself
- The 2015 HIP requirements are also included as an Appendix to this Procedural Notice
- The form requires applicants to do several things:
  a) Upload documents (maximum size per document is 50MB). If applicants wish to upload more than one document in relation to one section they must be combined into one document or uploaded as a .zip or .rar file
  b) Commit to certain requirements by the use of check boxes or radio buttons
  c) Enter information in free form text boxes where required

- The form does not need to be completed in one session. There is a "save" facility at the end of the form. Do not click "submit" until you have completed all sections and uploaded all required documents
- Ensure that the contact details section is competed**. If it is not completed we will not respond to your application**.
- If technical support is required, please contact Dimensions Healthcare Help Desk (support@eclaimlink.ae or over the phone 600 522 004)for further instructions

Application process and timelines

- Health Insurance Permits remain valid until 15 February in the year following that in which they were approved. This means that all existing permit holders' HIPs for 2014 will be valid until 15 February 2015
- Accordingly, a successful outcome to a 2015 HIP application must be achieved by this date
- In view of this, the deadline for submission is 1800 GST on 22 January 2015. This will allow time for the submissions (expected to be well in excess of 60) to be evaluated and an initial response issued from DHA Health Funding Department in advance of the 15 February 2015 expiry date of existing 2014 HIPs
- No applications will be accepted after 1800 GST on 22 January 2015

The evaluation process

- As soon as a fully completed application is submitted, the evaluation of that application will commence and an **evaluation results form** will be submitted to the applicant within 3 working days
- The evaluation results form will indicate those sections of the submission that are:
  a) "Accepted"
  b) Will result in the issue of a conditional HIP with a deadline for compliance
  c) Demonstrate deficiencies of such a nature that will prevent the issue of a HIP for 2015 unless those deficiencies are rectified within the timeframe below
- **Applicants whose evaluation forms indicate deficiencies will have only until 1800 GST on 8 February to rectify such deficiencies. We will not be extending the process indefinitely as happened with a number of applicants during 2014.** The expectation should be that if an applicant wishes to secure a 2015 HIP it should ensure that it meets all the criteria by the above stated deadline of 8 February
- Clearly, those applicants who submit early will benefit by having a longer period between receipt of their evaluation form and the deadline to allow for rectification

Additional guidance

Applicants should read carefully the following that refer to sections of the application that some applicants appear to misunderstand:

Section 2: Capital requirements

As for 2014, we require a confirmation letter from the Federal Insurance Authority that the applicant meets the capital requirements at the date of application (i.e. during the month of January 2015). We will accept no other evidence this year (such as bank statements or other documentation) as we did last year

Section 4: Data security

The requirement is for an up to date data security policy of the applicant itself, not that of any third party. The policy must include the precise details specified in the requirement

Section 6: Medical department structure

A structure which does not show jobholder names will be rejected

Section 12: Training and competence program

Please submit a proper program. Copies of course attendance certificates, emails, training invitations or qualification certificates **do not constitute a T&C scheme**. For 2015 we will not grant a HIP to any company that cannot demonstrate that it has such a program in place

Section 16: Member communication

This section requires applicants to demonstrate what types and frequency of communication they have with insured members in terms of health education, health awareness, wellness programs, screening programs and reminders etc. A file dump of call logs is not what is meant by member communication

Standards of evaluation

In evaluating applications in 2014, we took a lenient approach on many aspects of the application on the basis that many of the concepts were new or required applicants to establish new policies or procedures. The approach in 2015 will be more stringent. As stated in the preamble, we will not be accepting substandard documentation when assessing 2015 applications. Applicants should therefore carefully and fully review the quality of their submissions before uploading and submitting

List of Requirements for Dubai Health Insurance Permit 2015

No.	Section	Requirement	Documents to be submitted or evidence required	Mandatory or recommended
	General			
	Index	1. Status (Mandatory) 2. Capital Requirement (Mandatory) 3. Service (Mandatory) 4. Data security (Mandatory) 5. Authority (Mandatory) 6. Medical department structure (Mandatory) 7. TPA relationships (Mandatory) 8. Provider relationships (Mandatory) 9. Financial reporting (Mandatory) 10. Disease management and prevention (Recommended) 11. Staffing (Mandatory) 12. Training and competence (Mandatory) 13. Reinsurance (Recommended) 14. Complaints ratio (Mandatory) 15. Network management systems (Mandatory) 16. Member communication (Mandatory) 17. Commitment to regulatory compliance (Mandatory) 18. eClaimLink compliance (Mandatory) 19. e-Prescription & related eAuthorization (Mandatory) 20. Call centre effectiveness (Mandatory) 21. Medical insurance product registration (Mandatory) 22. Document and process management systems (Mandatory) 23. Coding edit checks (Recommended) 24. Fraud, waste and abuse control systems (Recommended) 25. Certified Coders (Recommended)		
1.	Status	The applicant (whether insurer or Third Party Administrator (TPA)) must be licensed to operate as an insurer or a TPA (a Free Zone entity is excluded from applying unless it, or a UAE branch, has a license from the Federal Insurance Authority or, in the absence of which an NOC) and possesses the necessary trade license as well as a license from the UAE Federal Insurance Authority. If the applicant is an insurer using a TPA, that TPA must hold a HIP	• Copy of trade license • Copy of UAE Federal Insurance Authority license or NOC	Mandatory

2.	Capital requirement	The applicant (whether insurer or TPA) must at the time of application meet the capital requirements of the UAE Federal Insurance Authority	• Confirmation letter from UAE Federal Insurance Authority (no other evidence will be admitted)	Mandatory
3.	Service	The applicant (whether insurer or TPA) must: 1. Have a formally documented complaints handling procedure that complies with Policy Directive PD 01/2014; 2. Record evidence of all complaints received in relation to its medical insurance business and the outcomes of the complaints; 3. Have formally documented procedures for measuring turnaround times for policy issuance, claims processing, claims settlement and general correspondence between payer and insured together with key performance indicators; 4. Provide a 24 hours a day, 7 days a week customer contact mechanism which can provide instant responses to customer queries; 5. Offer a telephone contact service in languages relevant to the insured population (Arabic & English are mandatory); 6. Be able to pay claims (after receiving all the needed documentation) within a time period agreed upon in the provider's contract.	• Complaints handling procedure • Complaints log for 2014 • Turnaround times and associated KPIs • Detailed description of customer contact mechanisms and telephone contact service • Pay claims (after receiving all the needed documentation) within a time period agreed upon in the provider's contract.	Mandatory
4.	Data security	The applicant (whether insurer or TPA) should have a policy in relation to data security, storage of and access to data including measures to protect client personal data and which details its backup procedures.	• Copy of the policy	Mandatory
5.	Authority	The applicant (whether insurer or TPA) should provide a list of names of officers who are authorised to sign on behalf of the company in relation to either specific or general aspects of its business	• List of authorised signatories	Mandatory
6.	Medical department structure	The applicant (whether insurer or TPA) should have a clearly defined organisation structure in respect of its medical insurance sales, operations, underwriting and claims management functions	• Organisation structure including jobholder names	Mandatory
7.	TPA relationships	Insurers should submit a list of all TPAs with which they have contracts	• List of all TPAs with whom the insurer has contracts	Mandatory
8.	Provider relationships	The applicant (whether insurer or TPA) should submit a list of all their network(s) providers: Hospitals, clinics, primary healthcare centres, laboratories, pharmacies and any other healthcare service provider.	• List of all providers with whom the applicant has contracts (directly or through TPA)	Mandatory
9.	Financial reporting	Insurers will be required to submit financial reports relating specifically to its medical insurance business to include: GWP, reinsurance premium ceded, gross claims paid, reinsurance share of claims, gross commission income, commissions paid, income and expenses related to underwriting activities.	• Financial statements relating specifically to the insurer's medical business for 2013 and 2014	Mandatory
10.	Disease management and prevention	The insurer will operate a disease management and prevention program directly or through its TPA.	• Details of the program	Recommended

11.	Staffing	The applicant must employ the following: 1. In the case of all insurers and within 6 months of the date of the HIP application a suitably qualified Chief Medical Underwriting Officer; 2. In the case of an insurer administering claims in-house and for all TPAs a Chief Medical Officer (or equivalent) with suitably recognized qualifications 3. In the case of an insurer administering claims in-house and for all TPAs a dedicated team of medical professionals to include physicians, clinicians and pharmacists (where in-house administration is used)	• Name, designation and evidence of qualifications for 1 and 2 • Organisation structure for 3	Mandatory
12.	Training and competence	The applicant (whether insurer or TPA) shall have a formal Training and Competence program in place with the specific aim of updating, maintaining and improving the skills and knowledge required for its medical, administrative, customer service, financial and sales staff involved in the business of health insurance or claims management.	• Details of the program	Mandatory
13.	Reinsurance	The insurer must retain at least 30% of the risk in relation to its gross written premiums for its medical insurance portfolio for each 12 month financial accounting period commencing on or after 1 January 2015.	• Report to be submitted by 31 January 2016 with details of GWP for 2015, amount retained, amount ceded, type of reinsurance contract used with each reinsurer being named	Recommended
14.	Complaints ratio	The applicant (whether insurer or TPA) must achieve an upheld complaints ratio in relation to its medical insurance business no greater than 25% of the mean complaints ratio for all insurers or TPAs as appropriate (as will be published by DHA). Upheld complaints are to include those that were partially upheld.	• Report to be submitted showing total number of complaints received in 2014, number partially upheld, number fully upheld and number outstanding as at 31 December 2014	Mandatory
15.	Network management	The applicant (whether insurer or TPA) must demonstrate (directly or through the TPA) that it has an organized and efficient network management system to ensure proper access for its members to healthcare facilities. DHA will validate such systems for: 1. Network organization, qualification, selection and management 2. Network coverage per location and type	• Documentation to explain how the insurer (or its TPA) selects, inspects, validates, manages and removes providers from its network of providers. The document should detail any initial or ongoing charges that the insurer (or its TPA) charges the provider to enrol and remain enrolled in its network.	Mandatory

16.	Member communication	The applicant must demonstrate an active and highly efficient member communication program including frequency and content of communication and channels utilised (SMS, mobile apps, phone calls, etc.). If the applicant is an insurer and does not have its own program it must submit the program used by all of the TPAs that it employs.	• Document describing channels used for member communication. • Summary report of member communication activities conducted throughout 2014 including frequency, content, purpose, target audience and communication channel employed.	Mandatory
17.	Commitment to regulatory compliance	The applicant (whether insurer or TPA) must commit to be compliant with all DHA requirements and regulations throughout 2015 by uploading a letter to this effect signed by an authorised signatory.	• Written commitment to comply with all DHA requirements and regulations.	Mandatory
	Technical Requirement			
18.	eClaimLink compliance	The applicant (whether insurer or TPA) must demonstrate (directly or through their TPA) how its claiming cycle works fully in line with the rules , regulations as announced by the Dubai Health Authority under the eClaimLink project including but not limited to: **Full transactional compliance** • Receiving electronic eRxRequest (e-Prescriptions) • Receiving electronic PriorRequest • Sending electronic PriorAuthorization • Receiving electronic ClaimSubmission • Sending electronic RemittanceAdvice • Sending electronic PersonRegister **Full Data compliance** • eClaimLink Medical Coding data sets • eClaimLink Essential lists code sets **Notes** • Insurers using a TPA for their claim management cycle need to assure that the requirements are met through their TPA, acknowledging that the ultimate responsibility remains with the insurer. • DHA will extract and evaluate payers and TPAs based on the transactional and data compliance counts mentioned above from the Dubai Health Post Office (DHPO) • Effective Mandatory Dates to start applying transactions are as follows for ALL Insurance Related Packages (paper-based only transactions are not allowed beyond these deadlines): - January 1, 2013: Receiving ClaimSubmission from Providers - January 1, 2013: Sending RemittanceAdvices to Providers	- DHC will extract the counts for every given payer and TPA in relation to the transactional and data compliance points. - Payers will acknowledge that they are doing the mentioned transactions.	Mandatory

		- January 1, 2014: Receiving eRxRequest for e-Prescriptions from Providers (Physicians) - Real time - January 1, 2014: Receiving PriorRequests of e-Prescriptions from Providers (Pharmacies) - Real time - January 1, 2014: Sending PriorAuthorization for e-Prescriptions to Providers (Physicians & Pharmacies) – Real time - January 1, 2014: Sending PersonRegister to DHA on a monthly basis.		
19.	e-Prescription & related eAuthorization	The applicant (whether insurer or TPA) must demonstrate (directly or through their TPA) how its internal systems are able to manage e-Prescription and related eAuthorization as mandated by the DHA within its e-Prescription initiative including: 1. Providing accurate and consistent valid patient related information in a timely manner. 2. Demonstrating operational efficiency: • Provide real-time responses (eAuthorization) on ePrescriptions to physicians on: - Member benefits coverage - Clinical checks such as: Drug-drug interactions, contraindications, indications, etc. - Formulary management (e.g. Open, Closed, Mixed, Tiered, etc. once formulary is implemented and product requires it) - Have adequate support staffs and online real-time tools with the ability to see prescriptions in real time in order to answer physician and pharmacist questions regarding the ePrescription messages: Why was this claim rejected and ability to override it real-time as needed. 3. Provide evidence based clinical decision support systems that cover: • Severe Drug to Drug Interactions to prevent patient harm and unnecessary doctor and hospital visits from unnecessary adverse-drug-events - Based on current prescription - Based on available drug history • Review potential issues based on Patient Age • Review potential issues based on Dosing • Review potential issues based on Patient Gender • Check for duplicate therapy issues, including refill too soon editing so that the patient does not take too much of a prescribed medicine or abuse the system • Drug to Diagnosis Contraindication checking to prevent patient harm • Drug to Diagnosis indication editing to prevent patient harm or abuse of the system **Notes** • DHA will extract and evaluate payers and TPAs based on the transactional and data compliance counts mentioned above from the Dubai Health Post Office (DHPO) • Insurers using a third party (TPA or a solution provider) for their e-prescriptions need to assure that the requirements are met through their third party, acknowledging that the ultimate responsibility remains with the insurer. • January 1, 2014 is the effective date for mandating e-Prescriptions	- DHC will extract the counts for every given payer and TPA in relation to the transactional and data compliance points. - Payers will acknowledge that they are doing the mentioned transactions.	Mandatory

20.	Call centre effectiveness	The applicant (whether insurer or TPA) must demonstrate (directly or through their TPA) that it maintains high call centre accessibility. DHA will be evaluating call centre effectiveness through: 1. Average speed of answer: all incoming telephone calls from insured members shall be answered on average within 30 seconds and from all others within 60 seconds. 2. Abandoned Rate: no more than 5% of all incoming telephone calls shall be abandoned calls. (> 30 seconds) 3. Average call times for claims enquiries: all incoming telephone calls from Members shall be completed on average within 7 minutes.	· Documentation of call centre system(s). · Documentation of call centre workflows and procedures. · Documentation of call centre SLA. · Submit quarterly reports on call centre performance: total calls, average speed of answering, total # of abandoned calls, and average call times for claim enquiries.	Mandatory
21.	Health insurance product registration	The applicant must commit to uploading to the Product Registration Library (once available online) all of the health insurance products that it markets. The requirement applies to all insurers in respect of products that it insures as well as to TPAs that may operate self-funded arrangements.	Commitment to comply	Mandatory
22.	Document and process management systems	The applicant (whether insurer or TPA) should have effective document management and processing systems and procedures. Effectiveness must be documented through clear well defined workflows.	· Evidence of document management and processing systems and procedures. · Documentation of workflows and policies	Mandatory
23.	Coding edit checks	The applicant (whether insurer or TPA) must provide (directly or through their TPA) a description of how the solution performs medical code checks to guarantee proper quality standards for the coding of healthcare services provided to the members. DHA aims to maintain these high standards for their members through several checks including: 1. Identify coding errors and coding error relationships for Dubai's medical and dental services; 2. Verify medical necessity by cross checking claims through the ICD – CPT, ICD – HCPCS, and ICD – CDT codes; 3. Claim checking to identify unacceptable billing with codes resulting from errors in claim bundling, mutually exclusive coding, duplicate claiming, maximum allowed frequencies, services relationship, and encounter related claims coding; 4. Claim checking in accordance with each of the following Codes: - Diagnosis Codes (ICD-10-CM) - Procedure Codes (CPT 4) - Disposable and Consumables (HCPCS L4) - Dental Codes (CDT) - Dubai Service List (DSL) Utilizing the Coding Edit Engine of Dubai (CEED) ensures coding edits checks in line with the DHA standards and covers all the points mentioned above. Payers may utilize an alternative\equivalent medical coding checking solution that offers the same minimum claim validation standards as CEED, such solution needs to demonstrate the capabilities to provide the DHA standards mentioned above. Results will be tested through running samples of two (2) months' of processed claims on CEED to validate its capabilities.	· Show proof if currently utilizing CEED or similar solution. · If payer currently doesn't apply CEED or any other solution but commit to apply it by the deadline then, a proof with detailed plan is needed in this regard. · eClaimLink shall assess a representative processed claim sample (submission vs. remittance) against CEED.	Recommended
24.	Fraud, waste and abuse control systems	The applicant (whether insurer or TPA) must demonstrate (directly or through their TPA) the presence of an effective system to detect, control and mitigate fraud, waste and abuse.	· Documentation of utilized system for Fraud, waste, abuse control system.	Recommended

25.	Certified coders	The applicant (whether insurer or TPA) must demonstrate (directly or through their TPA) the employment of a dedicated certified coder(s) with appropriate certification (AHIMA, APCC) with relevant experience in the coding sets mandated by the eClaimLink.	· List of coder details · Copy of coders certificates	Recommended