



**Health Insurance
Commission**
Cayman Islands

Application Package for New Approved Insurer Certificate

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1. Overview

1.1. Introduction

This information pack has been prepared to facilitate the filing and processing of the application for a new “**approved insurer certificate**” as per the *Health Insurance Act (2021 Revision)* and the *Health Insurance Regulations (2017 Revision)*.

Section 4 of the Health Insurance Act (2021 Revision) states:

(1) No person carrying on business in or from within the Islands, other than an approved insurer, shall issue a contract of health insurance to provide insurance cover in respect of healthcare benefits relating to a person resident in the Islands.

(2) A person who contravenes subsection (1) commits an offence and is liable on summary conviction to a fine of one hundred thousand dollars and to imprisonment for one year, and in the case of a continuing offence to a fine of ten thousand dollars for each day during which the offence continues.

1.2. Application Procedure

Application for a new Approved Insurer Certificate is made to the Department of Health Regulatory Services (DHRS) for review and approval by the Health Insurance Commission (HIC) Board. The application must contain:

- The completed Application Form
- The required information and supporting documentation as outlined in Section 2 of this document

To enable assessment, the applicant should ensure that their application is complete prior to submitting it to the DHRS/HIC. Please note that incomplete applications **will not** be accepted.

Applications and any enquiries should be forwarded to:

Department of Health Regulatory Services
Health Insurance Commission
Government Administration Building Box 132
Grand Cayman KY1-9000
Telephone: +345 946 2084
Email: hic@gov.ky

1.3. Application Fee

The fee for the application is One Thousand Five Hundred (\$1,500.00) Cayman Islands dollars or One Thousand Eight hundred & Twenty-nine Dollars and Twenty-seven cents (\$1,829.27) United States dollars, payable to the Cayman Islands Government via cheque or cash.

2. Application Assessment Processes

2.1. Application Process

An application for a new Approved Insurer Certificate must be received by the Health Insurance Commission. Once the application is accepted by the Commission it will be acknowledged within ten days of receipt.

Should it be determined that any documentation/information is insufficient or missing, the application **will not** be accepted.

Once all documentation and information has been provided, and meets the requirements, a detailed evaluation of the application will be conducted.

2.2. Approval Process

Once all criteria have been met, the application will be considered by the Health Insurance Commission (HIC) for approval.

3. Guidelines for Submission of Documents

All documentation relating to the requirements listed below must be part of or appended to the application. The application **will not** be accepted if the required documents are not provided.

3.1. Information to be included with the completed application

- Completed Approved Insurer Certificate Application Form (Appendix #1)
- Copy of Current Class “A” Health License from the Cayman Islands Monetary Authority (“CIMA”) and a license from the regulatory body of the previous jurisdiction in which the company was licensed to operate.
- Copy of approval letter from CIMA.
- Application fee of One Thousand Five Hundred (\$1,500.00) Cayman Islands Dollars or One Thousand Eight Hundred & Twenty-nine Dollars and Twenty-seven Cents (\$1,829.27) United States Dollars.
- Letter of Good Standing (LoGS) from the Cayman Islands Monetary Authority (CIMA) and a LoGS from the regulatory body of the previous jurisdiction in which the company was licensed to operate unless a publicly traded company listed on a stock exchange recognized by CIMA, list all names, addresses, details of percentage of shareholdings and shareholders.
- Proposed premium rate for the Standard Health Insurance Contract (“SHIC”)
- Copy of the Standard Health Insurance Contract (“SHIC”)

- Copy of any health insurance contract(s) with supplemental healthcare benefits and/or supplemental medical benefits.
- Proposed premium rate for health insurance contract with supplemental healthcare benefits and/or
- Business Plan including funding, risk assessment and contingency plan
- A copy of the proposed memorandum of association and articles of association of the applicant
- Memorandum and Articles of Incorporation of the Company
- Reinsurance agreement(s)
- Copy of any contract(s) with Network Medical Provider(s) including any local and overseas agreements
- Copy of any contracts(s) with Broker(s) and/or Agent(s), approved insurers or other insurance company local or overseas
- Local and Overseas Key Personnel Information (Appendix #2)
- Current Organizational Chart
- Completed Operational Functions Questionnaire (Appendix #3)
- An analysis of projected assumptions
- The proposed minimum expected loss ratio of claims to premiums
- List of Shareholders
- Capitalization and Solvency Information provided to CIMA
- Line of Credit – Conditions & Terms

3.2. Reviewing the application

The assessment of the application will include but not limited to the following criteria:

- The insurer is able to meet the approval requirements
- Adequate level of staffing to support the “book of business” in the Cayman Islands.
- The proposed premium rate for the SHIC is in line with the standard rate approved by the Commission
- Any other requirement deemed necessary

3.3. Other requirements

Provide current information on the “Network” of healthcare providers as per Regulation 2 (2) of the Health Insurance Regulations (2017 Revision).

2 (2) A “network” is a collection of medical practitioners, hospitals and other providers of medical care (“medical providers”) that:

- (a) are under contract with an approved insurer and the contracts provide-
 - (i) for adequate notice requirements for termination by the approved insurer and medical providers;

- (ii) that the medical provider maintains a minimum level of service to the approved insurer's subscribers (e.g. office hours per week for a physician) or other specified availability;
- (iii) that the medical provider maintains operating licences in good standing with regulatory authorities;
- (iv) that the medical provider agrees to charge the approved insurer's subscribers only those cost sharing features (deductibles, copayments, etc.) provided for in the approved insurer's contracts with employers and individuals even if the approved insurer fails to pay the medical provider the balance required for services covered by the approved insurer; and

(b) collectively, can provide the bulk of the services covered under the approved insurer's policies.

Services are considered to be "in-network" when they are provided by a network medical provider.

Services are considered to be "out-of-network" when provided by a medical provider not in the network. If the network cannot provide certain services (e.g. transplants), the approved insurer is obligated to identify a qualified medical provider to provide them. If the approved insurer is unable, is obligated to consider the medical provider selected by the insured person as "in-network". For emergency services, all medical providers are considered "in-network". For the Cayman Islands, a portion of the network would need to be located outside of the islands.

If an approved insurer does not have a network, all services would be considered to have been provided on an "in-network basis".

4. Reporting to the Commission

- **Payment of the Segregated Insurance Fund (SIF)** - SIF Payments are due on the 21st day of each month for the previous month i.e. for the premiums collected during the month of September; the SIF payment is due by 21st October.
- **Number of Insured Persons** - A detailed list of the number of insured persons is due no later than the 2nd working day of the same month i.e. the number of insured persons for the month of October is due on 2nd October (or the next working day).
- **Audit Certificate** - As per Regulation 15 (a) and (b) of the Health Insurance Regulations (2017 Revision) the Audit Certificate is due annually for the twelve-month period 1st June to 30th July.
- **Policy Terminations** - Policy Terminations must be reported to the Commission by the 45th day after the last premium was paid as per Regulation 20 of the Health Insurance Regulations (2017 Revision). Note that approved insurers can report to the Commission the lapse of payment on the 31st day after the last premium was paid.

New Approved Insurer Certificate Application Form

Name of Approved Insurer		Agent:	
Local Postal Address: P.O. Box		Cayman Islands KY	
Physical Address			
Website Address			
Office Manager:(Main Contact)			
Email Address			
Financial Controllers			
Email Address			
Telephone Contact			
Date on which applicant proposes to commence conducting health insurance business in the Cayman Islands			
Provide details of all business (including non-financial business) conducting or to be conducting business with the Cayman Islands by the applicant or by the group to which it belongs			
Provide a list of all jurisdictions or territories where the applicant or the group to which it belongs, if any, currently conducts health insurance business			

List all Cayman Islands issued licenses held by the applicant or by the group to which it belongs

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Overseas/Head Office

Contact Person

--

Postal Address

--

Physical Address

--

--

Email Address

--

Telephone Contact

--

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New Approved Insurer Certificate Application Form- (Contd.)

Name of Reinsurer	
Financial Rating	
Name of Auditor	
Third Party Administrator	
Name of Local Bank(s)	
Network Provider(s) (Local & Overseas)	

Name duly considered by the Directors (print
name of person completing application):

Signature:

Title:

Address:

Date:

Witness by Notary Public or JP:

Forward application and accompanying documents via email to:

Department of Health Regulatory Services

Health Insurance Commission

Government Administration Building Box 132, Grand Cayman KY1-9000

Email: hic@gov.ky

Reference: AIC New Application

Application is hereby made for the approved insurer certificate and it is certified that all particulars and other information contained in this application and in the documents attending or otherwise provided to support the application are true and correct at the date of the application. I understand that the provision of false or misleading information may result in the rejection of the application.

For HIC Use only

<u>Date Received</u>	<u>Received By</u>

Local and Overseas Key Personnel

(Including CFO and Managers etc.)

Name	Title	Email Address	Local/Overseas

Business to be Conducted in the Cayman Islands (“C.Is.”)

- 1) Provide rationale for conducting business in the Cayman Islands, include short, mid and long-term goals
- 2) Provide any feasibility reports/studies to support business plan
- 3) Provide strategies for risk management and internal controls
- 4) Outline of Marketing strategy
- 5) Copy of underwriting policies, procedures and guidelines
- 6) Copy of health insurance claims management procedures
- 7) Copy of the complaints policy and procedures
- 8) Copy of Privacy Policy

Operational Functions Questionnaire

Please stipulate if the following functions are processed locally or overseas by ticking the box Yes or No. If overseas, please list location(s):

		Yes	No		Yes	No
Claims Processing	Local			Overseas		
Payment of Claims	Local			Overseas		
Underwriting	Local			Overseas		
Premium Payment Collection	Local			Overseas		
Billing	Local			Overseas		
Complaint Resolution	Local			Overseas		
Segregated Insurance Fund Payments	Local			Overseas		
Reporting the Number of Insured persons	Local			Overseas		
Reporting Policy Terminations	Local			Overseas		
Financial Reporting	Local			Overseas		

Appendix#4

Approved Insurer Certificate Checklist

In order for the application to be processed, please ensure that you have included all of the below documents with your submission:

- 9) Completed Approved Insurer Certificate Application Form (Appendix #1)
- 10) Copy of Current Class “A” Health License from the Cayman Islands Monetary Authority (“CIMA”)
- 11) License from the regulatory body of the previous territory or jurisdiction in which the company was licensed to operate (if any)
- 12) Application fee of One Thousand Five Hundred (\$1,500.00) Cayman Islands Dollars or One Thousand Eight Hundred & Twenty-nine Dollars and Twenty-seven Cents (\$1,829.27) United States Dollars.
- 13) Letter of Good Standing (LoGS) from the Cayman Islands Monetary Authority (CIMA) and a LoGS from the regulatory body of the previous jurisdiction in which the company was licensed to operate
- 14) Proposed premium rate for the Standard Health Insurance Contract (“SHIC”)
- 15) Copy of the Standard Health Insurance Contract (“SHIC”)
- 16) Copy of any health insurance contract(s) with supplemental healthcare benefits and/or supplemental medical benefits.
- 17) Business plan
- 18) Reinsurance agreements
- 19) Copy of audited Financial Statements for the previous three years
- 20) Copy of any contract(s) with Network Medical Provider(s) outlining the local and overseas agreements
- 21) Copy of any contracts(s) with Broker(s) and/or Agent(s)
- 22) Local and Overseas Key Personnel Information (Appendix #2)
- 23) Current Organizational Chart
- 24) Completed Operational Functions Questionnaire (Appendix #3)

25)The minimum expected loss ratio of claims to premiums

26)A review of projected assumptions

27)List of Shareholders

28)Capitalization and Solvency Information provided to CIMA

29)Line of Credit – Conditions & Terms

Note: If any of the aforementioned documents are not provided the application will be rejected.

Attachment

<u>Act and Regulations for Approved Insurers</u>

4.1. Health Insurance Act (2021 Revision)

All approved insurers are bound by the Health Insurance Act (2021 Revision). The relevant sections of the Act applicable to an approved insurer are set out below:

- No person carrying on business in or from within the Islands, other than an approved insurer, shall issue a contract of health insurance to provide insurance cover in respect of healthcare benefits relating to a person resident in the Islands. Section 4 (1)
- A person who contravenes subsection (1) commits an offence and is liable on summary conviction to a fine of **one hundred thousand dollars** and to imprisonment for one year, and in the case of a continuing offence to a fine of **ten thousand dollars** for each day during which the offence continues. Section 4 (2)
- The new Section 4A empowers the Health Insurance Commission to issue to an insurer a certificate stating that the insurer has been approved by the Commission to provide Standard Health Insurance Contract (SHIC). The certificate would be **valid for one year** but could be revoked at an earlier date, if there is a breach of a condition to which the certificate is subject. One such condition is that the holder of the
- certificate shall provide cover to individuals, groups and organizations under the terms and conditions of a contract of health insurance.
- Where the holder of the certificate acts in contravention of the principal Act, the new Section 4B would empower the Commission to either revoke the certificate or order the holder of the certificate to cease the illegal activity.
- Except as permitted by regulations prescribed under section 25, **no underwriting** is permitted under the standard health insurance contract. Section 5 (15A)

To have and maintain records relating to:

- the number of insured persons in the Islands;
- the number of contracts of health insurance under each of which only one person is provided with cover;
- the number of contracts of health insurance under each of which more than one person is provided with cover;
- the premiums paid for health insurance;
- the financial performance and status of the approved insurers. Section 14(1)
- audited annual reports or documents relating to the financial performance and status of the approved insurer. Section 14(2). The Commission will submit the

information received under this section to the Governor in Cabinet as per Section 14 (3)

Termination of contract:

An approved insurer shall not terminate, fail or refuse to renew a Standard Health Insurance Contract (SHIC) except where the premiums under the contract are thirty days or more in arrears, in which case the contract shall terminate on the last day of the month for which premiums were fully paid; or the contract was obtained-

- by non-disclosure of a material fact; or
- by representation of a fact that was false in some material particular; or
- the employer has given written notice to the approved insurer that a new contract of health insurance has been affected with another approved insurer; or
- the employer's business has been taken over by or amalgamated with another employer. Section 15(1)

Prohibition against reduction of level of benefits:

An approved insurer **shall not reduce the level of supplemental healthcare benefits or supplemental medical benefits** provided under a contract of health insurance, except where the contract was obtained –

(a) by non-disclosure of a material fact; or

(b) by representation of a fact that was false in some material particular. 15A (1)

- An approved insurer who contravenes subsection (1) commits an offence and is liable on summary conviction to a fine of ten thousand dollars. Section 15A (2)

Fees to be paid by Approved Insurers for healthcare benefits-Standard Health Insurance Fees (SHIF)

- The Governor in Cabinet, consults with the Health Insurance Commission (HIC), and publishes the fees in the Gazette (Standard Health Insurance Fees) that an approved insurer is liable to pay under a Standard Health Insurance Contract (SHIC) for a healthcare benefit provided to a compulsorily insured person. Section 19

Payment of benefit provided by healthcare provider:

- An approved insurer shall pay directly to a healthcare facility or to a registered medical practitioner the cost of or such part of the cost as the approved insurer is liable to pay under a Standard Health Insurance Contract (SHIC) of a benefit provided to a compulsorily insured person by that health insurer. Section 21 (1)
- Where a compulsorily insured person provides a receipt or other evidence that he has paid the cost of a benefit received by him, an approved insurer shall reimburse

such person the cost of or such part of the cost of a benefit as the insurer is liable to pay under the contract. Section 21 (2)

- In respect of any healthcare benefit provided to a compulsorily insured person an approved insurer shall be liable only to pay the fee or that part of the fee (as the case may be) filed and published in accordance with section 19. Section 21 (3)

Disputes:

- Any disputed claim to a health benefit or a question arising in connection with a standard health insurance contract shall be determined by the Commission in the first instance after such inquiry as the Commission may deem necessary. Section 22

Appeals:

- A person aggrieved by a decision of the Commission on any claim or question referred to the Commission under section 22 may, within ninety days of the date on which the decision was given, appeal to the Grand Court. Section 23 (1)
- On an appeal under this section, the Grand Court may confirm or reverse the decision of the Commission. 23 (2)

4.2. Health Insurance Regulations (2017 Revision)

All Approved Insurers must conduct business in accordance with the Health Insurance Regulations (2017 Revision). The relevant sections of the Regulations applicable to an approved insurer are set out below:

Prescribed healthcare benefits

- The prescribed healthcare benefits to be covered by a standard health insurance contract are specified in Schedule 1 of the Health Insurance Regulations (2017 Revision).
- An employer shall offer to his employee's insurance coverage no less than the standard health insurance contract as set out in Schedule 1.
- An application for the issue of the standard health insurance contract shall be made to an approved insurer in the form set out in Schedule 4 and the approved insurer shall, within ten working days of receipt of the application, advise the applicant and his employer, if any, whether the standard health insurance contract will be issued. Regulation 3(2A)

Insurance for high risk insured persons:

- Where a person applies to an approved insurer to obtain insurance for a high risk individual, **Regulation 4** states that the approved insurer may:
 - (a) provide insurance cover under the standard health insurance contract at the standard premium; or

- (b) subject to the following provisions of this regulation, provide insurance cover under the standard health insurance contract –
- i. at an increased premium that does not exceed two hundred percent of the standard premium, to take into account the increased risk being assumed by the approved insurer; or
 - ii. at an increased premium that exceeds two hundred percent of the standard premium, to take into account the increased risk being assumed by the approved insurer. Regulation 4 (1)
- Where, after consideration of an application for the issue of the standard health insurance contract for a high risk insurance person, an approved insurer decides to provide insurance cover for the high risk insurance person under the standard health insurance contract at an increased premium that does not exceed two hundred percent of the standard premium, the approved insurer shall, within fifteen days of making the decision, notify the Commission of the decision and provide the Commission with such documents and information as the Commission considers necessary, including an actuarial assessment. Regulation 4 (2)
 - Where, after consideration of an application for the issue of the standard health insurance contract for a high risk insurance person, an approved insurer decides to provide cover for the high risk insurance person under the standard health insurance contract at an increased premium that exceeds two hundred percent of the standard premium, the approved insurer shall, within fifteen days of making the decision, apply to the Commission for approval of the decision and provide the Commission with such documents and information as the Commission considers necessary, including an actuarial assessment. Regulation 4 (3)
 - Where the Commission is of the view that a decision made by an approved insurer pursuant to sub-regulation (2) or (3), is unreasonable, the Commission shall, within fifteen days of receipt of the decision, order such variation of the decision as the Commission considers appropriate and the approved insurer shall give effect to the decision as varied. Regulation 4 (4)
 - An order made by the Commission under sub-regulation (4) shall take effect on the tenth day after the date on which the order was made. Regulation 4 (5)
 - A person aggrieved by an order of the Commission under sub-regulation (4) may, within ten days of the date on which the order was made, appeal to the Grand Court in accordance with rules made by the Rules Committee for the purposes of this regulation. Regulation 4 (6)
 - On an appeal under sub-regulation (6), the Grand Court may confirm or discharge the order of the Commission. Regulation 4 (7)
 - A person who fails to provide information or documents under sub-regulation (2) or (3) commits an offence and is liable on summary conviction to a fine of ten thousand dollars. Regulation 4 (8)

Insurance for uninsurable persons:

- Where a person applies to an approved insurer to obtain insurance for a Uninsurable Persons, Regulation 4A states that the approved insurer may:

- Where, after consideration of an application for the issue of the standard health insurance contract, an approved insurer decides to deem a person unacceptable for cover under the standard health insurance contract, the approved insurer shall, within fifteen days of making the decision, apply to the Commission for approval of the decision and provide the Commission with such documents and information as the Commission considers necessary, including an actuarial assessment. Regulation 4A (1)
- Where the Commission is of the view that a decision made by an approved insurer pursuant to sub-regulation (1), is unreasonable, the Commission shall, within fifteen days of receipt of the decision, order such variation of the decision as the Commission considers appropriate and the approved insurer shall give effect to the decision as varied. Regulation 4A (2)
- An order made by the Commission under sub-regulation (2) shall take effect on the tenth day after the date on which the order was made. Regulation 4A (3)
- A person aggrieved by an order of the Commission under sub-regulation (2) may, within ten days of the date on which the order was made, appeal to the Grand Court in accordance with rules made by the Rules Committee for the purposes of this regulation. Regulation 4A (4)
- On an appeal under sub-regulation (4), the Grand Court may confirm or discharge the order of the Commission. Regulation 4A (5)
- A person who fails to provide information or documents under sub-regulation (1) commits an offence and is liable on summary conviction to a fine of \$10,000 dollars. Regulation 4A (6)

Healthcare for indigent persons:

- The Commission on behalf of the Government shall, in order to cover medical costs for indigent persons (Regulation 5), collect from:
 - (a) each approved insurer, ten dollars per month of each premium charged by the approved insurer under each standard health insurance contract effected by such insurer in respect of an insured person with no dependants; and
 - (b) each approved insurer, twenty dollars per month of each premium charged by the approved insurer under each standard health insurance contract effected by such insurer in respect of an insured person with dependants. Regulation 5 (1)
- If the Commission considers necessary in the interest of the public, after giving three months' notice it may give a written notice to the approved insurers of its intention and vary the amount to be paid under sub-regulation (1). Regulation 5 (2)
- The payments that are collected by the approved insurer under sub-regulation (1) shall be paid to the Commission for payment into the segregated insurance fund established under the Health Insurance Commission Act (2016 Revision). Regulation 5 (3)

Premiums:

- At least **30 days before effecting a Standard Health Insurance Contract (SHIC)**, **notify** the Health Insurance Commission of its standard rate for such contract and provide the Health Insurance Commission with:
 - The minimum expected loss ratio of claims to premiums;
 - A review of projection assumptions; and
 - Such other information as the Commission considers relevant. Regulation 6 (1)
- At least **30 days before effecting an increase** to its standard rate for a SHIC, notify the Health Insurance Commission of its **intent to increase** and provide the Commission with the documents and information necessary including:
 - (a) The minimum expected loss ratio of claims to premiums;
 - (b) A detailed history of premiums and claims; and
 - (c) A review of projection assumptions. Regulation 6 (2)
- If the Commission determines that the rate is excessive, inadequate, unfairly discriminatory, or unreasonable, the Health Insurance Commission:
 - (a) Shall notify the approved insurer
 - (b) Conduct an inquiry
 - (c) Order adjustment to rate. Regulation 6 (3)
- An order made by the Commission under sub-regulation (3) shall take effect on the tenth day after the date on which the order was made. Regulation 6 (4)
- A person aggrieved by an order of the Commission under sub-regulation (3)(b) may, within thirty days of the date on which the order was made, appeal to the Grand Court in accordance with rules made by the Rules Committee for the purposes of this regulation. Regulation 6 (5)
- On an appeal under sub-regulation (5), the Grand Court may confirm or discharge the order of the Commission. Regulation 6 (6)
- A standard premium shall become due on the first day of the month for which it is payable. Regulation 6 (7)
- The part of the employee's premium payable by the employee under sections 7 and 8 of the Act shall be paid at regular weekly or monthly periods during his employment. Regulation 6 (8)
- Whoever fails to comply with sub-regulation (1) or (2) commits an offence and is liable on summary conviction to a fine of ten thousand dollars. Regulation 6 (9)

“projection assumptions” means conditions or circumstances that may affect a premium rate.

Cover:

- Subject to these Regulations, the minimum period of cover provided under any standard health insurance contract shall be three months or the period for which premiums have been paid, whichever is less. Regulation 7 (1)
- Where a premium is paid by the employer in respect of any insured person, that insured person and his dependents, if any, shall be covered under the standard

health insurance contract for the month for which the premium is paid notwithstanding that, during the course of that month, the insured person's employment may be terminated or he otherwise ceases to be compulsorily insured. Regulation 7 (2)

- Cover under a standard health insurance contract ceases on the first day of the month next following the date of the termination of employment except that, in accordance with section 15 of the Act, if the insured person does not become insured under any other employer, cover under the contract shall continue to be made available for a period of three months from the date of termination of employment or until he becomes employed, whichever is earlier. Regulation 7 (4)

Portability of health insurance:

- Where an insured person changes his approved insurer and prior to that change, the insured person had been insured continuously for a period of not less than one year under one or more other health insurance contracts effected by an approved insurer, with breaks in insurance cover not exceeding three months in the aggregate, then –
 - (a) the new approved insurer for the insured person shall provide health insurance cover to the insured person and his dependants –
 - i. under a plan of benefits which is favourably comparable to the plan of benefits provided by the previous approved insurer; or
 - ii. where there is no favourably comparable plan of benefits, under a plan of benefits which is offered by the new approved insurer for the insured person and which is as similar as possible to the supplemental plan of benefits provided by the previous approved insurer;
 - (b) the insurance cover so provided to the insured person and his dependants shall not contain, with respect to the medical condition of the insured person or his dependants, any exclusions or limitations of cover that were not specified by the previously approved insurer;
 - (c) the insurance cover so provided to the insured person and his dependants may be provided at an increased premium and
 - (d) for the purpose of applying any pre-existing condition requirements for the insurance cover, the insurance cover of the insured person and his dependants shall be deemed to have begun on the date that it was deemed to have begun under the respective previous health insurance contracts effected by the previous approved insurer. Regulation 7 (6)
- Where an employer changes his approved insurer, Regulation 7 (7) provides that:
 - (a) the newly approved insurer shall not refuse to provide insurance cover to any employee insured under the previous health insurance contract effected by the previous approved insurer;
 - (b) the insurance cover so provided to the employee shall not contain, with respect to the medical condition of the employee, any exclusions or

limitations of cover that were not specified by the previous approved insurer;

(c) the insurance cover so provided to the employee may be provided at an increased premium; and

(d) for the purpose of applying any pre-existing condition requirements for the insurance cover, the employee's coverage shall be deemed to have begun on the date that it was deemed to have begun under the previous health insurance contract effected by the previous approved insurer.

- An approved insurer shall not refuse to renew a contract of insurance on the ground that a compulsorily insured person has **contracted an illness** Regulation 7 (8)
- **Definition of pre-existing condition Regulation 7(9)** – pre-existing condition”, in relation to an employee or insured person, means a medical condition known to the employee or insured person prior to the date of a health insurance contract or a medical condition for which treatment was given or recommended or drugs taken or prescribed or of which symptoms were or had been manifest during the period of **twelve months** prior to the date of the health insurance contract and of which the insured person should have been aware.

Payment of claims:

- Where a healthcare facility or a registered medical practitioner has submitted a claim form and any other documents required under regulation 8 and there is no dispute as to the claim made, an approved insurer shall process and respond to or pay (as the case may be) the claim **no later than thirty working days after receiving the claim**, Regulation 9 (1)
- Where an approved insurer fails to pay a claim in accordance with the time limit set out in sub-regulation (1) and there is no dispute as to that claim, the approved insurer shall be liable to pay interest on the money owed from the thirty-first day after the claim has been submitted to the date on which payment is made to the healthcare facility or the registered medical practitioner. Regulation 9 (6)
- The rate at which interest is payable under sub-regulation (6) is at the rate of 2% above the US prime interest rate in force from time to time. Regulation 9 (7)

Prescribed healthcare benefits (Annual and Lifetime):

- Under the Standard Health Insurance Contract, an approved insurer shall be liable to pay on behalf of each compulsorily insured person-
 - (a) during each calendar year, not more than \$100,000 in medical fees; and
 - (b) during the life of an insured, not more than \$1,000,000 in medical fees (Regulation 10)

Renewal of Contract:

- Subject to sub-regulation (2), a standard health insurance contract shall provide that it continues in force for a period not exceeding twelve months provided that the premium is paid. Regulation 11 (1)

- Sub-regulation (1) is without prejudice to an approved insurer's right to terminate a standard health insurance contract in accordance with section 15 of the Act (Regulation 11 (2))

Insurer ceasing to be approved:

If-

- (a) the licence of an approved insurer is revoked or suspended for any reason by the Governor in Cabinet under the Insurance Act, 2010; or
- (b) an approved insurer withdraws from the provision of health insurance,

the approved insurer shall not be relieved of any liability in respect of any standard health insurance contract in force at the date of such revocation, suspension or withdrawal (Regulation 12).

Records:

- An approved insurer shall keep a record in respect of each person insured by that approved insurer under SHIC. Regulation 13 (1)
- A record kept in accordance with sub-regulation (1) shall be produced to the Commission upon request. Regulation 13 (2)

Documents to be submitted to the Commission:

- An approved insurer shall submit to the Commission at least once every twelve months (Regulation 14) a certificate signed by an auditor stating:
 - (a) The amount of premium collected under each SHIC effected by that provider; and
 - (b) That the approved provider has complied with Regulation 5

Identification Card:

- An approved insurer shall, **within two weeks of the making of a SHIC**, issue an identification card to each person insured by the approved insurer under that SHIC. Regulation 15 (1)
- An identification card shall contain such minimum information as is specified in the Third Schedule. Regulation 15 (2)
- An approved insurer who fails to provide an identification card in accordance with sub-regulation (1) is guilty of an offence and is liable on summary conviction to a fine of \$2000. Regulation 15 (3)

Powers of inspectors:

An inspector shall, for the purpose of performing his functions under these regulations, have power-

- (a) without previous notice and at all reasonable times, to enter and have access to, through and over any premises, where the inspector has

reasonable grounds to believe any book, paper, document, thing or electronically stored data are kept that relate to any matter under the Act or these regulations;

(b) to make examinations, investigations and inquiries, and require the production of any book, paper, document, thing or electronically stored data that relate to any matter under the Act or these regulations;

(c) to make, take, remove or require the making, taking or removal of copies or extracts that relate to any such examination, investigation or inquiry; and

(d) to exercise such other powers as may be reasonably necessary.
Regulation 17 (1)

- An inspector shall not, under sub-regulation (1), enter a private residence without the consent of the occupier, and, on entering any premises or place for the purposes of the Act or these regulations, shall produce the identification card issued to him under regulation 16. Regulation 17 (2)
- An inspector may, for any purpose specified under this regulation, upon giving a receipt, remove any, books, papers, documents or electronically stored data respecting health insurance, and may copy such books, papers or other documents within a reasonable period of time and return them as soon as reasonably practicable after the copying is completed. Regulation 17 (3)
- A copy of any book, paper, document or electronically stored data respecting health insurance, made under this regulation by an inspector in the course of any investigation, examination or inquiry and certified by the Commission, is admissible in evidence in any action for all purposes for which the original would have been admissible. Regulation 17 (4)
- Where an owner or occupier of premises -
 - (a) denies entry or access to, through or over premises to an inspector;
 - (b) instructs the inspector to leave the premises;
 - (c) obstructs the inspector; or
 - (d) refuses to comply with a request for the production of any book, paper, document or electronically stored data the production of which is requested for the purpose of examination and investigation or inquiry or for a purpose mentioned in sub-regulation (1),

he commits an offence and is liable on summary conviction to a fine of ten thousand dollars. Regulation 17 (5)

- Where any documents are held in or kept by means of a computer, the powers of the inspector to require the supply of information and production of documents shall include powers -
 - (a) to require any person having charge of, or otherwise concerned with the operation of a computer or associated apparatus which is or has been

in use in connection with such information or documents, to afford to the inspector such assistance as he may reasonably require; and

(b) to require the information or documents to be produced or copied in any form which the inspector may reasonably request. Regulation 17 (6)

“document” includes any information or document held or kept by means of a computer. Regulation 17 (7)

Duty of approved insurer:

An approved insurer, with whom an employer has effected a contract of health insurance, shall report to the Commission any failure on the part of the employer to pay the required premiums on the date such premiums were due, and the approved insurer shall make the report **no later than 45 days** after such due date. Regulation 20 (1)

- An approved insurer who fails or refuses to comply with sub-regulation (1) **commits a procedural offence** and, subject to a right of appeal to a summary court, shall pay to the Commission a fine not exceeding five thousand dollars and a further fine not exceeding one hundred dollars for each day or part of a day during which the contravention has continued; and the fines collected by the Commission under this regulation shall be paid into the revenue of the Islands. Regulation 20 (2)

Determination of Disputes:

- Where a person disputes a matter under a SHIC including a claim to a benefit, he may apply to the Commission by notice in writing requesting a determination of the matter, and such application shall state briefly the nature of the matter. Regulation 23 (1)
- On receipt of a notice under sub-regulation (1), the Commission may request such further information and documents as it deems necessary to assist it in determining the matter. Regulation 23 (2)
- Where the Commission disallows a claim under a SHIC contract or determines a question adversely to the applicant, it shall notify the applicant in writing of its decision, the reasons for the decision and the right of appeal under section 23 of the Act (Regulation 23 (3))