

CAYMAN ISLANDS



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HEALTH INSURANCE LAW

(2018 Revision)

Law 15 of 1997 consolidated with Laws 28 of 2001, 13 of 2003, 13 of 2004, 9 of 2005, 34 of 2010, 19 of 2012 (part), 30 of 2012, 8 of 2016 and 6 of 2017 and as amendeded by the Cayman Islands (Constitution) (Amendment) Order 2003 (U.K.S.I. 2003 No. 1515) and the Cayman Islands Constitution Order 2009 (U.K.S.I. 2009 No.1379).

Revised under the authority of the Law Revision Law (1999 Revision).

Originally enacted -

Law 15 of 1997-19th June, 1997
Law 28 of 2001-26th September, 2001
Law 13 of 2003-18th July, 2003
Law 13 of 2004-11th June, 2004
Law 9 of 2005-28th February, 2005
Law 34 of 2010-15th September, 2010
Law 19 of 2012-31st August, 2012
Law 30 of 2012-21st November, 2012
Law 8 of 2016-6th May, 2016
Law 6 of 2017-27th March, 2017.

Originally made-

U.K. Order-12th June, 2003
U.K. Order-10th June, 2009.

Consolidated and revised this 28th day of February, 2018.

Note (not forming part of the Law): This revision replaces the 2016 Revision which should now be discarded.

HEALTH INSURANCE LAW

(2018 Revision)

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HEALTH INSURANCE LAW

(2018 Revision)

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| 1. This Law may be cited as the Health Insurance Law (2018 Revision). | Short title |
| 2. In this Law- | Definitions |
| “approved insurer” means an insurer licensed under the Insurance Law, 2010 as a Class “A” insurer and approved by the Commission, under section 4A(3)(a) of this Law, to provide standard health insurance contracts; | Law 32 of 2010 |
| “Caymanian” means a Caymanian as defined in the Immigration Law, (2015 Revision); | 2015 Revision |
| “child” means an individual who is under eighteen years of age and who is -
(a) the offspring of both parties to a marriage;
(b) an individual who has been treated by both parties to a marriage as a child of the family, including a step child, adopted child or foster child; or
(c) born out of wedlock; | |
| “Commission” means the Health Insurance Commission established under the Health Insurance Commission Law (2016 Revision); | 2016 Revision |
| “compulsorily insured person” means a person in respect of whom an employer is required to effect a standard health insurance contract under section 5; | |
| “dependant”, in relation to an insured person or a prospective insured person, means a child of that person, the unemployed spouse of that person, and any dependent offspring of that person; | |
| “dependent offspring”, in relation to an insured person, means -
(a) a child of the insured person;
(b) an individual who is eighteen years of age or over and who for medical or physical reasons is dependent on the insured person for shelter or care (whether or not the individual is financially independent); or
(c) an individual who is eighteen years of age or over but under thirty years of age and who, for financial reasons, is dependent on the insured person for shelter or care; | |
| but “dependent offspring” does not include a grandchild of an insured person, unless the grandchild has been adopted by, or is the foster child of, the insured person; | |
| “employee” means any individual who enters into or works under a contract of employment with an employer whether the contract be oral or written, express or | |

implied, and the term includes a person whose services have been interrupted by a suspension of work during a period of leave or temporary lay-off;

“employer” means any person who has entered into a contract of employment with an employee, and includes any agent, representative or manager of such person who is placed in authority over an employee;

2017 Revision

“health care facility” includes the George Town Hospital in Grand Cayman, the Faith Hospital in Cayman Brac and any public hospital or health care centre established or operated in the Islands by the Government, and any private hospital or medical practice approved under the Health Practice Law (2017 Revision);

“high risk insurance person” means a person who has been provided with cover under the standard health insurance contract by an approved insurer but who, by reason of a medical condition or illness, may be subject to rates that exceed the standard premium;

“indigent person” means a person who, in the opinion of the Minister for the time being responsible for social services acting on the advice of the Director of the Department of Children and Family Services, is unable, by reason of inadequate financial resources, to pay for health insurance or medical services;

“inspector” means a person appointed, pursuant to regulations made under section 25(1)(e), as inspector for the purposes of this Law;

“insured person” means any person, group, or organisation for whom or for which cover is provided by an approved insurer under the terms and conditions of a contract of health insurance;

2015 Revision

“legal resident” means a Caymanian or a person entitled to reside in the Islands in accordance with the Immigration Law (2015 Revision);

“prescribed” means prescribed by regulations under section 25;

“prescribed health care benefits” means the minimum benefits prescribed by regulations under section 25 to be included in the standard health insurance contract;

2017 Revision

“registered dental practitioner” means a person registered to practise dentistry under the Health Practice Law (2017 Revision);

2017 Revision

“registered medical practitioner” means a person registered to practise medicine under the Health Practice Law (2017 Revision) and includes a registered dental practitioner;

“seaman” means a person who resides in the Islands and who-

- (a) is a member of either the Veterans’ and Seamen’s Society of Cayman Brac and Little Cayman or of the Cayman Islands Seafarer’s Association;

- (b) first went to sea before the 1st January, 1985; and
- (c) was a Caymanian during the period of time when he was at sea;

“self employed person” means a person over school leaving age whose earnings (otherwise than in the capacity of an employee) derive from his production (in all or part) of goods or services in or from the Islands;

“spouse”, in relation to a person, means a legal resident who is -

- (a) the legal husband or wife of that person; or
- (b) a person of the opposite sex who, although not legally married to that person, lives with that person in the same household under the same domestic arrangements as a legal husband or wife and has been so living with that person for a continuous period of five years,

and any reference in this Law to marriage or to a married person shall be construed, with the necessary changes being made, so as to give effect to paragraph (a) or (b), as the case may be; but where a person is judicially or otherwise separated from a legal spouse he shall not be considered to have any other spouse except that legal spouse;

“standard health insurance contract” means a contract issued by an approved insurer to provide insurance cover in respect of the prescribed health care benefits, being a contract that complies with the prescribed terms and conditions; and under such a contract an approved insurer shall not-

- (a) require a compulsorily insured person to pay for a benefit if that benefit is covered by the contract; or
- (b) require a compulsorily insured person to pursue third party claims before claiming under the standard health insurance contract;

“standard premium” means a premium charged under a standard health insurance contract for any person other than a high risk insurance person;

“Superintendent” means the person appointed under section 6(1) of the Health Insurance Commission Law (2016 Revision), to serve as Superintendent of Health Insurance;

2016 Revision

“supplemental health care benefits” means -

- (a) dental benefits;
- (b) vision benefits; and
- (c) alternative medicine benefits;

“supplemental medical benefits” means benefits provided to compulsorily insured persons in excess of benefits under the standard health insurance contract, including in-patient and out-patient services, routine medical examinations and tests, emergency medical services, hospital services, and other medical services specifically defined by an approved insurer;

“unemployed spouse”, in respect of an employer or employee, means (in the case of a male employer or employee) a female legal resident, or (in the case of a female employer or employee) a male legal resident, to whom that employer or employee is married and who-

- (a) is not living apart from that employer or employee under a deed of separation or order of the court;
- (b) is not an employer or employee; and
- (c) is resident in the Islands,

and includes a retired person;

“uninsurable person” means a person who, by reason of a medical condition or illness, has been deemed unacceptable for cover under the standard health insurance contract by two or more approved insurers and has been certified by the Commission to be uninsurable and eligible for coverage with an approved insurer designated by the Commission;

“veteran” means a person who resides in the Islands, served in any armed force before 1973 and was a Caymanian at the date of service; and

“Veterans’ Association” means the Cayman Islands Veterans’ Association.

Administration of this Law

Restriction on issue of health insurance

3. The Superintendent shall be responsible for the administration of this Law.

4. (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 health care 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.

Approved insurer certificate
Law 32 of 2010

4A. (1) An insurer licensed under the Insurance Law, 2010 as a Class “A” insurer shall make written application to the Commission for approval to provide the standard health insurance contract.

(2) An application under subsection (1) shall be accompanied by a fee of one thousand five hundred dollars.

(3) On receipt of an application by an insurer under subsection (1) and the fee specified under subsection (2), the Commission shall consider the application and may -

- (a) grant the insurer approval to provide the standard health insurance contract; or
- (b) reject the application and return the fee.

(4) Where approval is granted under subsection (3)(a), the Commission shall issue to the insurer a certificate stating that the insurer has been approved by the Commission to provide the standard health insurance contract.

(5) A certificate issued under subsection (4) shall be subject to -

- (a) a condition that the holder of the certificate shall provide cover to individuals, groups and organisations under the terms and conditions of a contract of health insurance; and
- (b) such other conditions as the Commission sees fit;

and, subject to section 4B(1)(a), the Commission may revoke the certificate upon breach of any condition.

(6) A certificate issued under subsection (4) shall be valid for a period of one year unless earlier revoked under subsection (5).

4B. (1) Subject to subsection (2), where the Commission makes a determination that there are reasonable grounds for believing that the holder of a certificate issued under section 4A(4) -

Cease and desist orders

- (a) failed to comply with a condition of the certificate;
- (b) prepared or submitted false or misleading information to the Commission;
- (c) failed to contribute or meet its obligation to the segregated insurance fund established under the Health Insurance Commission Law (2016 Revision); or
- (d) is acting in contravention of this Law or any regulations made under this Law,

2016 Revision

the Commission may revoke the certificate or may order the holder of the certificate -

- (i) to cease or refrain from committing the act;
- (ii) to cease the issuing of any new contract of health insurance that would provide health insurance cover in respect of healthcare benefits relating to a legal resident; and
- (iii) to carry out such acts as in the opinion of the Commission are necessary to remedy the matter.

(2) Before making a determination under subsection (1) in relation to the holder of a certificate, the Commission shall -

- (a) advise the holder of the certificate, in writing, of the nature of the conduct alleged against the holder;
- (b) provide an opportunity for the holder of the certificate to give an explanation of the alleged conduct; and

(c) take into consideration any explanation given by the holder of the certificate.

(3) An order under subsection (1)(i), (ii) and (iii) shall -

- (a) state the nature of the alleged conduct and the name of the approved insurer against whom the allegation is made; and
- (b) be accompanied by documents, if any, in support of the allegation.

Compulsory health insurance

5. (1) Every person resident in the Islands shall, unless he is -

- (a) covered by a contract of insurance effected by an employer under subsection (2);
- (b) covered by a contract of insurance effected by Government under subsection (3), or where Government does not effect such a contract, medical services are provided to him by Government in accordance with the Personnel Regulations (2017 Revision); or
- (c) an uninsurable person,

2017 Revision

effect a standard health insurance contract in respect of himself and his dependants.

(2) Subject to this section, every employer shall effect and continue on behalf of-

- (a) himself;
- (b) his dependants;
- (c) each of his employees; and
- (d) the dependants of each of his employees,

a standard health insurance contract.

(3) Government may effect and continue on behalf of-

- (a) each officer in a pensionable office or on probation to such an office;
- (b) each officer serving under a local or an overseas contract;
- (c) *Repealed by section 4 of Law 34 of 2010;*
- (d) each officer in a temporary office;
- (e) each public office pensioner;
- (f) each indigent person;
- (g) each elected member of the Legislative Assembly and, where the Speaker is not a member of the Legislative Assembly, the Speaker;
- (ga) each past Speaker who was not a member of the Legislative Assembly;
- (h) each past elected member of the Legislative Assembly who is a public office pensioner; and

(i) the dependants of any person specified in paragraphs (a) to (h),
a contract of health insurance on such terms and conditions as are specified in regulations made by the Cabinet.

- (4) Government may, on written application to it by or on behalf of -
- (a) a seaman fifty-five years of age or older and his dependants;
 - (b) a widow of a seaman;
 - (c) a veteran and his dependants;
 - (d) a widow of a veteran; or
 - (e) any other person approved by the Cabinet,

where that person is not covered by a contract of health insurance, agree to effect a contract of health insurance with an approved insurer on behalf of such person on such terms and conditions as are specified in regulations made by the Cabinet in respect thereof.

(5) Government may, on written application to it by or on behalf of a partially uninsurable person or an underinsured person, agree to pay for health care services provided to that person at a government health care facility in respect of any medical condition of that person which is the subject of an exclusion or limitation in his standard health insurance contract, and that person shall, unless he is indigent, repay the cost of such health services to the Government.

(6) If a spouse ceases to be the unemployed spouse of an employee within the meaning of section 2, the obligation imposed on the employer shall, subject to subsection (7), cease to have effect.

(7) Where an employee and his spouse are employed by different employers, each employee may, subject to his employer's agreement, elect which employer shall insure both of them or whether they shall be insured separately by each employer.

(8) Subsection (1) shall not require more than one health insurance contract to be effected in respect of any person and, accordingly, if a person is employed by more than one employer, insurance must be effected on his behalf and on behalf of his dependants by his principal employer.

(9) Where a person is employed by two or more employers, the principal employer of that person shall be deemed to be the employer who employs that person for the most hours each week.

(10) Where a person is employed by two or more employers and each employer employs him for a similar amount of hours a week, the principal employer shall be that employer who first retained the services of the employee.

(11) The children of two employees and who are employed by different employers who are spouses of each other shall be covered under only one insurance contract which shall be determined by the employees.

(12) The employer who is liable in accordance with subsection (11) to provide health insurance for the children of an employee shall provide health insurance for children born after such health insurance has been provided and the insurance shall cover post-natal care for a period of not less than one month after birth in those cases where the children are Caymanian or where the children are entitled to reside in the Islands in accordance with the Immigration Law (2015 Revision).

2015 Revision

(13) The employer of a child shall not be required to effect a contract of health insurance in respect of a child where that child is employed on a part-time basis or only during school holidays.

(14) Subsection (1) shall apply to every self-employed person, and every partner in a partnership shall be regarded as self-employed.

(15) Where, after the 22nd September, 2003, an employee applies for health insurance for his spouse as defined in paragraph (b) of the definition under this Law, he shall provide to his employer an affidavit stating that his spouse falls within the definition.

(15A) Except as permitted by regulations prescribed under section 25, no underwriting is permitted under the standard health insurance contract.

(16) A person who fails to comply with subsection (1) or (2) commits an offence and is liable on summary conviction to a fine of thirty thousand dollars, and on conviction on indictment to a fine of forty thousand dollars.

Insurance for high risk insurance persons

6. High risk insurance persons shall be insured as prescribed by regulations made by the Cabinet.

Payment of premium

7. An employer shall be liable to pay under section 5(2)-

- (a) the total cost of the standard premium payable under any standard health insurance contract effected in respect of an employee who is not a high risk insurance person; and
- (b) the total cost of the premium payable under any health insurance contract effected in respect of an employee who is a high risk insurance person,

but shall be entitled to recover directly from the employee or to deduct, from the salary, wage or other remuneration of each employee-

- (i) in the case of an employee specified in paragraph (a), an amount not exceeding fifty per cent of the premium so paid in respect of the employee; and
- (ii) in the case of an employee specified in paragraph (b), the difference between the amount of the premium paid by the employer and the amount the employer would have been liable to pay if the employee was not a high risk insurance person and was covered under a standard health insurance contract.

8. An employer shall be liable to pay the total cost of the standard health insurance contract effected in respect of the dependants of an employee under section 5(2), but shall be entitled to deduct from the salary, wage or other remuneration of the employee, in addition to any amount deducted under section 7, the total cost of the premiums so paid in respect of the dependants of that employee.

Premium of dependants

9. An employer who deducts from the salary, wage or other remuneration of an employee more than the amount which he is entitled to deduct in respect of any person under section 7 or 8 commits an offence and is liable on summary conviction to a fine of thirty thousand dollars, and on conviction on indictment to a fine of forty thousand dollars.

Unlawful deductions by employer

10. (1) Every employee shall keep his employer informed of all facts related to the employer's liability under section 5(2) and of any change of circumstances which would affect the employer's liability under that section.

Employees to provide information to employer

(2) An employee who contravenes subsection (1) is liable to his employer for any expense incurred by the employer for which he would otherwise not have been liable.

11. (1) An employer, within fifteen days after the commencement of an employee's employment with that employer, shall give a written statement to the employee consisting of-

Duty of employer to provide information to employee

- (a) the name and address of the approved insurer with whom the employee's standard health insurance contract has been effected;
- (b) the effective date of cover under the contract; and
- (c) the insurance number of the contract of health insurance.

(2) Where an employer fails or refuses to comply with subsection (1), the employee may make a written complaint to the Commission and the Commission, where it is satisfied that the employer has so failed or refused, shall notify the employer in writing that he is in breach of subsection (1) and shall give the employer such period of time as the Commission considers necessary to give the statement to the employee.

(3) Where the employer fails to comply with the notice under subsection (2) within the period of time set out in the notice the Commission shall advise the Director of Public Prosecutions that the employer has contravened subsection (1).

(4) An employer who contravenes subsection (1) commits an offence and is liable on summary conviction to a fine of fifteen thousand dollars and to a further fine of one thousand dollars for each day or part of a day during which the contravention continued after receipt of a notice from the Commission under subsection (2).

(5) Where, in proceedings for an offence under this section, the court is satisfied that the employee or any of his dependants has suffered or is likely to suffer loss or damage because of the contravention of this section by the employer, the court, on convicting the employer, may make such orders as it considers appropriate against the employer for the purpose of compensating the employee or any of his dependants wholly or in part for the loss or damage or preventing or reducing the extent of the loss or damage.

Recovery of damages
from employer in default

12. (1) Where an employer to whom this Law applies fails or neglects-
- (a) to effect any contract of health insurance which he is required to effect by section 5; or
 - (b) to comply with the requirements of this Law or any regulations made thereunder relating to the payment of premiums and submission of records,

and, by reason thereof, any person has lost any benefit to which he would have been entitled if such failure or neglect had not occurred, that person shall be entitled to recover from the employer in a court of summary jurisdiction for loss or damages which result directly from the employer's failure or neglect.

(2) In any proceedings brought under subsection (1), a certificate issued by the Commission specifying the amount of any benefit which would, in the absence of any failure or neglect of an employer, have been payable for any benefit under the standard health insurance contract shall be evidence of the facts stated therein.

(3) In any proceedings under this section relating to the failure or neglect of an employer to comply with this Law in respect of the dependants of an employee, it shall be a defence for the employer to prove that he did not know, and could not reasonably be expected to have known, that the employee in question had dependants or that such dependants were persons in respect of whom he was required to effect a contract of insurance.

Voluntary health
insurance

13. Notwithstanding section 5, nothing in this Law shall be construed as preventing any person from concluding with any approved insurer, in addition to a standard health insurance contract, any other contract of health insurance providing for himself, his employees or his employee's dependants supplemental

health care benefits or supplemental medical benefits that are in addition to those contained in a standard health insurance contract, and such additional contract may provide that benefits to an employee or the employee's dependants shall be covered under the additional contract for any stated period of time while he is employed, or after the employee has retired.

14. (1) The Commission, in order to monitor effectively the performance of the health insurance industry in the Islands, shall at such times each year as it may determine, by notice in writing, request from approved insurers specified information or information of a specified description and shall request such approved insurers to produce specified documents or documents of a specified description relating to -

Reporting to the
Commission

- (a) the number of insured persons in the Islands;
- (aa) the number of contracts of health insurance under each of which only one person is provided with cover;
- (ab) the number of contracts of health insurance under each of which more than one person is provided with cover;
- (b) the premiums paid for health insurance; and
- (c) the financial performance and status of the approved insurers,

and the approved insurers shall provide such information.

(2) Further to subsection (1), the Commission shall request and the approved insurers shall provide audited annual reports relating to the information specified in subsection (1).

(3) The Commission shall submit the information received under this section to the Cabinet once a year and at such other times as the Minister for the time being responsible for health may direct.

(4) An approved insurer who fails to comply with subsection (1) or (2) commits an offence and is liable on summary conviction to a fine of thirty thousand dollars, and in the case of a continuing offence to a fine of two thousand dollars for each day or part of a day during which the offence continues.

15. (1) An approved insurer shall not terminate, fail or refuse to renew a standard health insurance contract except where-

Termination of contract

- (a) 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;
- (b) the contract was obtained-
 - (i) by non-disclosure of a material fact; or
 - (ii) by representation of a fact that was false in some material particular; or
- (c) the employer has given written notice to the approved insurer that-

- (i) a new contract of health insurance has been effected with an approved insurer; or
- (ii) the employer's business has been taken over by or amalgamated with another employer.

(2) A standard health insurance contract terminates on the first day of the month next following the date of termination of employment of an employee; but if that employee does not become compulsorily insured with any other employer, cover under the contract shall continue for a period of three months from the date of termination of employment or until he becomes employed, whichever is earlier.

(3) An employee shall be liable to pay the total cost of the premiums payable under a contract of health insurance which has been continued pursuant to subsection (2).

(4) An employer who, having been notified by his former employee that he is not employed and that he is not compulsorily insured, fails or refuses to extend the cover under the contract as provided in subsection (2) commits an offence and is liable on summary conviction to a fine of thirty thousand dollars.

Prohibition against reduction of level of benefits

15A. (1) An approved insurer shall not reduce the level of supplemental health care 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.

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

False declarations, etc.

16. A person who, for the purpose of obtaining a benefit or other payment under a standard health insurance contract, whether for himself or some other person, or for any other purpose connected with this Law, knowingly -

- (a) makes a false statement or false representation; or
- (b) produces or furnishes or causes or allows to be produced or furnished information or any document which he knows or believes to be false in a material particular,

commits an offence and is liable on summary conviction to a fine of two thousand dollars and on conviction on indictment to a fine of five thousand dollars.

Liability of officers of corporate bodies

17. (1) Where an offence under this Law committed by a corporate body is proved to have been committed with the consent or connivance of, or to be attributable to any neglect on the part of, a manager, director, secretary or other similar officer of the corporate body, or any person who was purporting to act in

any such capacity, that person commits an offence and is liable on summary conviction to a fine of five thousand dollars and on conviction on indictment to a fine of fifteen thousand dollars.

(2) Where the affairs of a corporate body are managed by its members, subsection (1) shall apply in relation to the acts and defaults of a member in connection with his functions of management as if he were a director of the corporate body.

(3) A person may be convicted of an offence under subsection (1) although no proceedings are brought against the corporate body in respect of the offence or the corporate body is found not guilty in respect of the offence.

18. (1) Every health care facility and registered practitioner shall file with the Commission annually, and not later than one month after any adjustment, the maximum fee charged for each health benefit provided by such health care facility and registered practitioner.

Filing of medical fees

(2) A health care facility or a registered practitioner who contravenes subsection (1) commits an offence and is liable on summary conviction to a fine of fifteen thousand dollars.

19. The Cabinet, after consultation with the Commission, shall cause to be published in the Gazette the fee an approved insurer shall be liable to pay under a standard health insurance contract for a health care benefit provided to a compulsorily insured person.

Fees to be paid by approved insurers

20. (1) Subject to subsection (2), a sum due to a health care facility or to a registered medical practitioner in respect of medical care or dental care provided to a compulsorily insured person may, without prejudice to any other remedy, be recovered as a debt either from that person or from the approved insurer, and the health care facility or registered medical practitioner shall first seek to recover such debt from the approved insurer.

Recovery of payment by provider of a health benefit

(2) Notwithstanding any provision of the Limitation Law (1996 Revision), no sum due to a health care facility or to a registered medical practitioner in respect of medical care or dental care provided to a compulsorily insured person, shall be recovered as a debt under subsection (1), either from that person or from the approved insurer, after the expiration of one hundred and eighty days from the date on which the medical care or dental care was provided.

1996 Revision

21. (1) Subject to subsection (2), an approved insurer shall pay directly to a health care 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 of a benefit provided to a compulsorily insured person by that health insurer.

Approved insurer shall pay benefit directly to health provider

(2) 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.

(3) In respect of any health care 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.

Disputes

22. 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.

Appeals

23. (1) A person aggrieved by a decision of the Commission under section 4A, 4B or 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.

(2) On an appeal under this section, the Grand Court may confirm or reverse the decision of the Commission.

Administrative fines

24. The Superintendent may -

- (a) subject to such conditions as he thinks fit, stay or compound any proceeding for an offence under section 5, 11, 14, 15 or 15A (irrespective of when the offence was committed); and
- (b) subject to a right of appeal to a court of summary jurisdiction, impose a fine of one thousand dollars, and in the case of a continuing offence to a fine of one hundred dollars for each day or part of a day during which the offence continues,

and the fines collected by the Superintendent under this section shall be paid into the revenue of the Islands.

Restitution

24A. (1) Where a person is convicted of an offence under this Law, the court before which he is convicted may order that person to pay restitution to the person against whom the offence has been committed.

(2) Restitution shall compensate, where applicable, for any of the following-

- (a) costs of medical and psychological treatment;
- (b) costs of physical and occupational therapy and rehabilitation; and
- (c) any other losses, suffered by the person against whom the offence has been committed, which the court considers applicable.

Regulations

25. (1) Subject to subsection (2), the Cabinet may make regulations for the purpose of carrying this Law into effect and, without prejudice to the generality of the foregoing, such regulations may-

- (a) prescribe the health care benefits to be covered by one or more standard health insurance contracts;

- (b) prescribe the terms and conditions of a standard health insurance contract, including allowable exclusions and exceptions, provisions as to termination and cancellation, and automatic renewal;
- (c) prescribe the way in which deductions may be made from the remuneration of employees to cover premiums paid in respect of standard health insurance contracts;
- (d) prescribe the reports and records relating to compulsorily insured persons that approved insurers shall submit to the Commission and when and how they shall be submitted;
- (e) provide for the appointment of, and the conferment of powers on, inspectors for the purposes of this Law;
- (f) provide for the maintenance of records relating to standard health insurance contracts;
- (g) provide for the manner in which disputed matters may be referred to the Commission and the procedures to be adopted by the Commission when considering such matters;
- (h) provide for insurance cover for high risk insurance persons; and
- (i) provide for fines for contravention of the regulations.

(2) Regulations made under this Law are subject to affirmative resolution by the Legislative Assembly.

26. (1) The non-payment and non-collection of any amounts -

Validation

- (a) specified in regulation 5(1)(a) and (b) of the Health Insurance Regulations (2013 Revision); and
- (b) relating to premiums charged by Cayman Islands National Insurance Company during the operative period in respect of an insured person, other than an insured person who is specified in section 5(3)(a) to (i) or (4)(a) to (e) of the Health Insurance Law (2016 Revision),

2013 Revision

2016 Revision

are validated and deemed not to be in contravention of regulation 5(1) or (3) of the Health Insurance Regulations (2013 Revision).

2013 Revision

(2) In section 26(1) -

“operative period” means the period commencing on 1st July, 2014 and ending on 20th June, 2016.

27. (1) An existing approved insurer shall, within ninety days of the 5th May, 2017, the date of commencement of the Health Insurance (Amendment) Law, 2017, make written application under section 4A(1) of this Law for approval to provide the standard health insurance contract and the provisions of that section shall apply with any necessary changes except that the Commission shall

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consider the application for no more than ninety days before deciding whether to grant the approval or reject the application.

(2) In section 27(1) -

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“existing approved insurer” means an insurer who at 5th May, 2017 is licensed under the Insurance Law, 2010 as a Class “A” insurer and approved by the Commission to provide standard health insurance contracts.

Publication in consolidated and revised form authorised by the Cabinet this 13th day of March, 2018.

Kim Bullings
Clerk of the Cabinet

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